Advocating for the advocates, caring for the caregivers: physician health and wellbeing

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Over the past decade there has been burgeoning interest in physician health and wellbeing driven by sobering statistics, including average burnout rates of 50% increasing to 71% in young female specialists, current suicidal ideation of 6% and suicide completion of 3–5 times the rates in the general population.[1–3] Frizelle and Mulder recently summarised the evidence.[1] The numbers are difficult to comprehend. We are at risk of becoming desensitised to them. However, we must acknowledge that the human cost of churning young people through medical school and spitting them out into the complex world of modern healthcare is outrageous.

This is a dangerous profession. It is emotionally demanding, stressful, complex, rapidly changing and intense. By nature, medicine is a 24/7 unrelenting machine. There are many career and life transitions across a doctor's life-course where risk to health and wellbeing may be increased.

These statistics represent mothers, fathers, sisters, brothers, children, partners, friends and colleagues. Each one has a story. A full life or a life tragically and wastefully shortened. A life of happiness and pain. A life of expectations and reality. Illness and health. Confusion and clarity. Disappointments and successes. High achievements and failures. Each doctor is a person. A complicated, messy, lovable person. We are like teachers who, somewhat surprisingly to our children, continue to exist outside of the classroom. Doctors exist even when patients and managers don't see us or hear us.

Whether our work is seeing patients, undertaking research, leading services, policy and strategy, or pushing the boundaries of entrepreneurship and healthcare, we find value and meaning in our work, and we find value and meaning outside of our work. We have hobbies and skills, faith, culture, sports teams we follow, travel and adventures to undertake. We have people to care for and people that care for us who also sacrifice for our patients. We are diverse.

These statistics are you. These statistics are me.

The World Medical Association's Declaration of Geneva now includes a responsibility to our own health and wellbeing. It is important that as doctors we stop and consider how well we are looking after ourselves and what challenges we are currently facing. What we previously accepted as the necessary culture and unfortunate by-products of efficiently and selflessly caring for others is being challenged. Politicians, managers, patients and clinicians are developing an increased understanding of how critical sustainability is. They are learning about the impact of unwell, unhappy and disengaged doctors on health outcomes, errors, patient satisfaction, staff turnover and providing sustainable healthcare.[3,4]

But we shouldn't only care about doctor health and wellbeing for the benefit of patients. We should care because it is how we should treat any human being. It is what is right and just. It is ethical to stop treating doctors as cogs in a machine, a means to an end… and to start treating doctors as humans first and foremost. Doctors who exist before and after they see their patients, who have lives and loves outside of medicine, who deserve to turn up to do worthwhile work in a healthy workplace, who deserve encouragement and support and compassion; people who deserve full

and rich lives both while working and while away from work. As with all healthcare professionals, doctors should be valued in our work. We should be valued outside of our work. We should be valued primarily for ourselves, but also for our colleagues, patients, the medical profession, society as a whole and our whanau—our families.

A focus on individuals

Much of the initial research into physician health and wellbeing focused on the individual doctor prioritising their own health and wellbeing to reduce the effects of toxic exposures. At the time, these were ground-breaking conversations: doctors should have their own doctor, cultivate a balanced lifestyle, reserve time to exercise, fuel their bodies well, look after any health needs, practice gratitude, foster happiness, be present and mindful, develop support networks, find mentors, pursue hobbies, recharge, cultivate resilience, recognise early warning signs of distress and seek support.[3]

As Watkins writes in *Personal experience and opinion of junior doctor burnout* in this edition, it is important that early in their careers, high-achieving doctors understand the benefits and risks of individual traits, including personalities, strengths and expectations.[5] Doctors need to recognise the limits of their skills and knowledge and seek to address these. However, doctors are not superheroes and despite many having perfectionistic tendencies, let's accept that physicians do make mistakes. Doctors need to recognise the limits of their skills and knowledge and seek to address these.

Traditionally, medical students have not been taught how to start and manage a business, inter-personal skills or negotiating techniques, despite many doctors being small business owners or needing to influence systems.

We don't discuss with medical students or doctors how to manage the day-to-day cognitive dissonance that exists in medicine, where an emotional reaction occurs in response to holding simultaneous and contradictory ideas or feelings. In this edition, Gupta et al outlines that there is conflict among the key principles of balancing respect for the patients' autonomy, beneficence, non-maleficence and distributive justice.[6] In practice this is demonstrated by the finding that many intensivists practice under the tension of providing care that is different to what they would choose for themselves or their loved ones, or that they believe to be inappropriate, ineffective or contrary to best practice for that patient.

Medical schools are charged with preparing students for a career as a doctor which, requires a holistic view of the necessary knowledge and skills.[5,7] It is broader than teaching procedural skills and knowledge of disease; it includes exposure to difficult situations and positive coping strategies. We need to understand the stress performance curve (Figure 1): after we have

Figure 1: Stress performance curve.

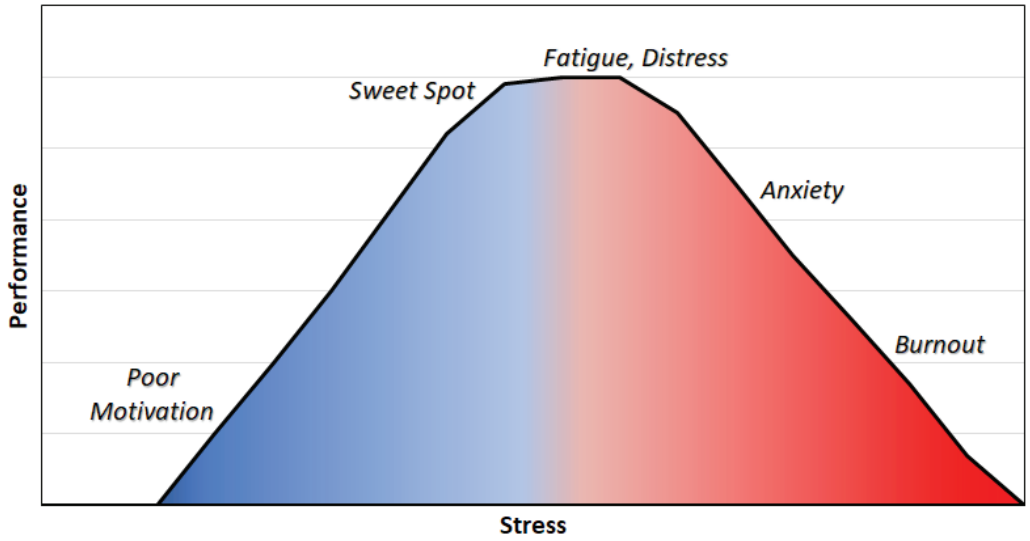

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Figure 2: WellMD Professional Fulfillment Model.[1]

- **Culture of Wellness**
  Shared values, behaviors, and leadership qualities that prioritize personal and professional growth, community, and compassion for self and others.
- **Efficiency of Practice**
  Workplace systems, processes, and practices that promote safety, quality, effectiveness, positive patient and colleague interactions, and work-life balance.
- **Personal Resilience**
  Individual skills, behaviors, and attitudes that contribute to physical, emotional, and professional well-being.

[1]https://wellmd.stanford.edu/center1.html

travelled up the inverse-U and reached our 'sweet spot' of moderate stress and optimum performance, adding increasing stressors leads to increased fatigue and feelings of distress, followed by decremental effects on performance with anxiety and burnout. We need to appreciate that individuals have different shaped curves and therefore different abilities to cope with exposure to the same stressors, and to recognise that these curves are dynamic for individuals over time as they are exposed to stressors in all facets of their life.

We need to acknowledge that doctors will experience ill-health and significant life traumas themselves and provide education on coping strategies and safe services to seek help. One in five junior doctors and one in six senior doctors report recent personal experience of bullying, harassment or discrimination—and many did not know how to report these events.[8] Gupta et al found that 7.9% of responding intensivists had been intensive care patients themselves.[6] It is unlikely that many received psychological support to process the trauma of being a patient (possibly in their current workplace), how this might impact future clinical decisions and how to manage triggers in the future.

A focus on systems and organisations

However, it requires greater changes than action by the individual, with the elimination or control of toxic exposures. Why have attempts to overturn the toxic status quo struggled to gain momentum? Why do workers that should be valued by an organisation feel so poorly valued and prioritised?

Stanford Medicine's WellMD Professional Fulfillment Model identifies three key values to advance the wellbeing of physicians and their patients, including a culture of wellness, efficiency of practice and personal resilience (Figure 2).

Using these key values, we must identify lead and lag indicators at an individual and organisational level, require them to be key performance indicators for leaders and politicians, and provide the resources and culture to value our staff.

There is compelling Australasian and international evidence that good work is a key determinant of the health and wellbeing of the employee, their whanau (family) and broader society.[9] It is also good business.

"Good work is engaging, fair, respectful and balances job demands, autonomy and job security. Good work accepts the importance of culture and traditional beliefs. It is characterised by safe and healthy work practices and it strikes a balance between the interests of individuals, employers and society. It requires effective change management, clear and realistic performance indicators, matches the work to the individual and uses transparent productivity metrics."

"Realising the health benefits of good work for all Australians and New Zealanders requires a transformation in both thought and in practice. It necessitates cooperation between a broad range of participants including workers, governments, employers, unions, insurers, legal practitioners, advocacy groups and healthcare professions."

– Consensus Statement on the Health Benefits of Good Work (HBGW)

The New Zealand Ministry of Health is a signatory to Health Benefits of Good Work (HBGW) publicly stating that they "are committed to actively implementing the principles articulated in the Consensus Statement to create safe, healthy workplaces". When discussing how to improve physician health and wellbeing, HBGW can be used to lobby for systemic change in the healthcare sector.

Our medical workforce is increasingly diverse and must meet changing healthcare needs. Forecast changes in the nature of work are likely to be reflected in medicine with increased numbers of doctors working in isolation (eg, rural and remote, private practice, contracting) which will require novel training and support. In this edition, Poole et al review longitudinal data on choice of specialty and practice location and find it is influenced by medical school selection criteria, exposure and experiences, and impression of the personal fit with the nature of work.[7] Systemic changes to selection and training may be required to match with forecasted sector needs.

Over 40% of the current New Zealand workforce qualified overseas, and there are increasing numbers of rural, Maori, Pacific and female medical students.[7] Sir Mason Durie developed Te Whare Tapa Whā, the four cornerstones of Maori health that cross cultures:[10]

- Taha Tinana (physical health)
- Taha Wairua (spiritual health)
- Taha Whānau (family health)
- Taha Hinengaro (mental health)

The balance of the mind, role of the family and recognition of the spiritual dimension are considered as important as physical issues when treating or preventing illness. The inclusion of the wairua (spirituality) seems to be counter to popular culture in New Zealand and Australia. Doctors infrequently discuss religion and spirituality in medical consultations despite proven benefits and patients indicating they may desire these conversations.[11] Good Medical Practice states "Do not express your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress".[12] Most physicians identify as having a faith or religion.[6] Avoiding spiritual conversations due to lack of time or concerns about being criticised by colleagues, patients or regulatory bodies may affect the wellbeing of doctors with faith due to their cognitive dissonance.

In *Surgical burnout: moving from the academic to the personal* in this edition, Anderson explains that the intensity of personal experiences in clinical medicine should not be underestimated.[13] There is significant stress generated by the constant risk of getting it wrong, multi-tasking and missing something important, complaints, disciplinary action, loss of mana tangata (honour, status) and possible trial by media without a right of reply. Doctors were traditionally expected to compartmentalise stressful situations and ignore the personal impact. "We now know that for many, stress was internalised not deflected, causing not only personality change but potentially suicidal behaviour."[13] This vicarious trauma (aka compassion fatigue, secondary traumatic stress) has been recognised for decades in psychologists and counsellors resulting in the industry standard of employer-paid regular 'supervision' sessions to combat the known adverse effects on behaviour, interpersonal relationships, values and beliefs, and performance. There is little research on vicarious trauma in physicians and even less on effectiveness of interventions for prevention and management.[14] Debriefing after 'significant events' is becoming more common, but it seems remarkable that doctors are still not provided mandatory regular psychology sessions in the same way as our counselling colleagues to recognise that we deal with 'significant events' at least as frequently—and that left on our own we are managing our stress poorly.

Increased administrative burdens, frustrations with electronic health records, increased work intensity, impacts of complaints and poor outcomes, inability to take leave, and extended work hours aggravate physician burnout.[1–3,9] Workers with high workplace demand and low decision-making autonomy are under higher stress.[2,3,9] Health and wellbeing programs for individual doctors must be supplemented with projects to address such systemic issues.[15]

It is complicated being a doctor, weighing conflicting options, values, treatments with varying evidence, time pressures, a finite

pool of funding, business demands, using a cumbersome electronic health record and balancing other roles. Moral injury may result when systemic factors outside a doctor's control conflict with their moral imperative to provide the highest quality care for patients.

Under the Health and Safety at Work Act (2015), employers must take all reasonably practicable steps to identify potential hazards in a workplace that could cause harm to an employee or anyone else. Risk assessment informs appropriate risk management utilising the hierarchy of controls (elimination, substitution, isolation/engineering controls, administrative controls, personal protective equipment). This process must be applied to individual and systemic hazards found in the current practice of medicine that result in risks including physical and psychological injury or illness.

Many medical colleges, associations, unions and universities are advocating for doctor health and wellbeing and conducting research. A forum for interested stakeholders is proposed for the end of 2019.

We need those with direct control over the structure of the healthcare system to sponsor establishing an overarching strategy with initiatives that support organisational change and individual clinicians before they reach crisis. Practical examples include establishing Chief Wellness Officer positions to oversee strategic planning and promote occupational health, resourcing design of intelligent clinician-led health information systems, analysing and streamlining the clinician journey—not just the patient journey, increasing access to occupational and environmental physicians and GPs and psychiatrists who are trained to treat colleagues, providing psychologists and counsellors for clinical supervision to all doctors, supporting agnostic confidential physician health programmes such as the Doctors Health Service, supporting research initiatives, workforce planning and determining both lead and lag performance measures for Boards, the Ministry of Health and other employers to be measured against.

The evidence is clear that caring for others should not come at the expense of the caregivers own physical, mental, spiritual and social wellbeing across their life-course. A comprehensive strategic evidence-based solution with novel approach to the provision of healthcare is required for hospital-based doctors and those in the community. Not just because doctors provide patient care, advance scientific understanding, lead healthcare initiatives or support their colleagues, but primarily because it is the right thing to do: to care for people. To provide safe and healthy workplaces. To support good sustainable work.

What is the most important thing in the world? He tangata, he tangata, he tangata—it is the people, it is the people, it is the people.

Competing interests:
Nil.

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