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# Doctors' resilience: can physicians heal themselves?

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After medical school I felt as though the process of becoming a doctor had left me stranded in a place where I didn't know who I was, or what to do with the knowledge I had acquired. Finding out was a long and interesting journey, but much of what I discovered for myself could have been made part of my medical education. I eventually realised that many colleagues have been through similar experiences – as the literature amply shows. So I offer this paper, with compassionate concern for my profession and with the conviction that it will evolve.

## Resilience and the medical juggling act

Resilient materials bounce back after they have been stressed. But human beings do more: they respond to persistent strain by changing in ways that either push them towards health and wellbeing or further away. This kind of resilience is moulded by genetic and bodily influences as well as psychological and social factors. A stress-free existence is not possible, and doctors facing difficult occupational demands and expectations realise this. Doctors need to be resilient, yet rewarding though a life in medicine might seem, their rates of alcoholism, drug abuse and suicide are very high. What is wrong, and how can medicine become a more resilient profession?

Concern about this surfaced 20 years ago<sup>1</sup>, but the problem continues to be a cause for concern, while beneath the surface lurk unseen strata of exhaustion, boredom, poor job satisfaction and depression. Burnout is still with us in hospital medicine<sup>2</sup>, and a 2004 BBC survey<sup>3</sup> found that four out of

five GPs felt stressed. Most of the 569 stressed GPs blamed their workloads, pressure from patients and interference from NHS managers. Six out of 10 felt worse than 12 months previously; seven out of 10 expected their stress levels to rise by 2005.

Almost three quarters of NHS expenditure is on staff, and yet in 1991 a BMA report<sup>4</sup> concluded that the work-culture and environment were a prodigious source of stresses for many doctors (and nurses). According to surveys of nurses and all medical grades a decade later<sup>5, 6</sup> not much has changed, though at least the problems have been recognised: occupational health services have improved, and the *Improving working lives* initiative is 'working towards providing a better working environment for staff, one in which many of the causes of workplace stress have been removed'. They will need to be, and quickly, because many doctors regretted their career choices 20 years ago<sup>7</sup> and it seems as many do still.<sup>8</sup> As the medical task becomes more challenging, we can predict the

consequences: more stress-related illness, impairment and staff wastage.

## Are there solutions to the impending crisis?

The loss of qualified personnel alone calls for urgent measures. Until we conceive, practice and organise medicine differently it may be that individual coping skills training will have a more positive influence than any longed-for revolution in healthcare as a whole. The wider application of simple mind-body interventions deserve to find a place at every level, from pre-clinical training to advanced post-graduate practice. Existing stress management programmes in under-graduate and post-graduate training could be incorporated more widely.

Stress management models view disturbed thoughts, feelings and function as signs of impaired adaptation when tension accumulates around powerful unexpressed emotions; perhaps feelings that have to do with the 'here and now' – for instance work problems, daily life hassles and

relationship issues. The techniques involved are designed to change attitudes and behaviour, and to reduce the flight and fight response.

#### Individual approaches to stress management

- Self-awareness: recognise the 'symptoms'.
- Begin to define the underlying problem.
- Consider what help is needed to deal with the problem.
- Consider time management skills: clear sense of goals, resources.
- Rest, respite, recreation.
- Learn how to initiate a relaxation response and practice it regularly.
- Bodily resilience: exercise/fitness/nutrition.
- Emotional resilience: catharsis, psychotherapy.
- Interpersonal resilience: assertiveness, communication.
- Personal needs including: support, intimacy, love, care.
- Transpersonal needs including: spiritual concerns, creativity, existential questions.

Psychotherapists point out that current feelings of anger, worry or sadness overlie deeper psychic sub-strata where early experiences of rage, fear and despair lie; to some extent distress triggered by an emotion-filled situation resonates with earlier trauma in the psychological bedrock. The reverberations may make coping unaccountably more difficult: minor irritations will trigger inappropriate feelings, making it harder to think or act rationally. Psychological and psychosomatic disorders arise from these deeper layers because the inarticulate feelings, whether acted out, repressed or denied, precipitate bodily and psychological disturbances; potentially, professional problems too.

Feelings of pessimism, cynicism, burnout and isolation do not simply 'come with the job'; in fact they may mean a doctor is clinically depressed – surveys show that many are. When psychiatric help is needed, simple stress management techniques are no substitute, but a doctor suffering frank depression, panic or personality disorder, may shrink from seeking professional help, even though the consequences of evading it would be worse. For historically, the care of doctors has been erratic, and this has stifled their own notions of self-care. Generally they hide their own experiences of stress and its effects; one reason why our understanding of stress amongst doctors is so incomplete.

## Support groups

The psychiatrist Michael Balint challenged doctors' attitudes and their therapeutic over-ambition, encouraging them to become more aware of how current relationships and situations resonate with significant unconscious earlier experiences – the doctor's as well as the patient's. General practitioners influenced by Balint see the therapeutic relationship as their main strength.

Though Balint groups meet to analyse the doctor-patient relationship, they also allow doctors an opportunity to talk more openly with one another; a parallel element of peer-support is entwined with the intellectual task. The notion of doctors' overlapping personal and professional needs has been taken up internationally. Examples in the literature are hard to find, but the strengths of one dynamic support and supervision group for GPs has been described by one of its members<sup>9</sup>:

*'Members wanted help in facing the psychological, political and economic challenges of daily medical practice, in order to avoid the disillusion that seemed to be prevalent among older physicians. Over the years the focus of the group has evolved from the discussions of patient care to explorations of personal values and feelings. It became apparent that our problems with patients, the roots in our personalities and experiences, extended beyond the immediate practice setting. Feelings have gradually replaced intellectualisation as we find the issues critical to our professional performance to be related more to our own marital discords, fears of death, failure to live up to our own goals as parents and persons and feelings of incompetence or uncertain self-esteem.'*

*'It seems that to work well we find we must deal with our own unfinished business. Personal insights and support have become instrumental in moving us towards our original goals and strengthening our work, improving our ability to deal with difficult patients and turning the stress of practice from a burden into a stimulus for personal growth.'*

## Better occupational health services for doctors

The 1991 Nuffield report concluded that the way medical services are provided for doctors will have to change; that a broad approach is needed, and it should include prevention. This report emphasised that this prevention has to be more than individually focused: organisational change is essential, so that support systems can be put in place. How can a balance be struck between helping healthcare workers cope better, and the clear need to improve the job itself and the working environment? Ways have to be found to identify and appraise doctors in need, but without stigmatising them.

### Nuffield Provincial Hospitals Trust's report: summary of recommendations<sup>10</sup>

- Better access to medical services for all doctors with more certainty of confidentiality.
- Support for hospital residents and an inspection system to see that posts and workloads are appropriate.
- Greater emphasis in medical education on humanistic aspects; communication, interpersonal skills.
- Training should help students deal with the emotional impact of medical practice.
- The identification of personal stress – elements widely ignored and consequently marginalised in medical culture – which harm doctors and patients.
- A change in attitude that allows a pastoral structure to develop at all levels of medical education, postgraduate as well as undergraduate.
- Problems should be routinely reviewed and appraised by a formal mechanism.
- Senior hospital doctors should be trained in management skills to ensure this happens.

Confidentiality is crucial, and a profound change of ethos will be required if doctors are to feel safe enough to admit illness and allow themselves to get help. It will require doctors to view health as something dynamic, to reframe the aims and limits of medicine and their own role. Only a broad-ranging overhaul of medical education and organisational culture can bring this about.

## Ways forward – changing medical education

The challenge of difficult work is partly what attracts people into medicine; no doubt doctors put a lot of

pressure on themselves. So if we accept that some uncertainty, intensity, and ambiguity will be inevitable, then how should medical education prepare medics appropriately? In a recent study<sup>11</sup> junior doctors who measured high on extraversion and agreeableness enjoyed work more and felt more supported. Doctors with higher neuroticism scores felt more stressed and emotionally exhausted; they were also less satisfied with medicine as a career, and more likely to be 'surface-disorganised' and less conscientious.

We should not allow a cop-out for workplace environments where systemic conditions result in high levels of reported stress among doctors. But we should take note that it may be possible to partially predict which people will find the medical workplace particularly stressful, and we should be concerned that these people may be more prone to burnout as doctors.

So if we lack the confidence in our social engineering skills to populate medical schools exclusively with easygoing, contented students, what can we do to support those who struggle and those who encounter dips in their mood? Approaches that apply equally to the undergraduate in medical school as to the doctor already in the workplace would seem appropriate.

Ed Peile & Yvonne Carter. *Making happy doctors. student BMJ 2005; 13:89–132*

Medical students have long been aware of the strain their training imposes, and of their need for help in managing them.<sup>12</sup> The University Medical School in Louisville documented its own programme a decade ago<sup>13</sup>; staffed by final year students who had themselves been through the programme, it used small group teaching and mentoring to help students grasp ethical issues and values, communication skills and stress management techniques. Although voluntary, it attracted more than 75% of the student intake.

This highlights one way forward – a more biopsychosocial approach to medical education where doctors learn how to look after themselves as well as others. However, in the curiously macho culture of medical schools and hospitals, doctors see themselves more as warriors than carers. Reforming the curriculum alone won't transform the workplace; established practitioners must take responsibility for making the necessary corporate and cultural shift, since they cannot be driven by students, nor even by inspired junior doctors, influential though they can be.<sup>14</sup>

## 'Emotional education'

John Heron, when assistant director of the British Postgraduate Medical Federation in the early 1980s, believed that neglecting their 'emotional education' made doctors less competent, not only in coping with the demands of the medical milieu, but also in dealing with their own lives and relationships. He called on doctors to re-sensitise themselves to their own feelings and capacity to relate.

Heron initiated a postgraduate education programme based on humanistic psychology: small group work drawing on techniques pioneered in Fritz Perls' Gestalt approach and Assagoli's psychosynthesis. He argued too that medicine's catastrophically out-dated medical model with its mind-body split, scientific reductionism and rationalism, though it provides a solid foundation for scientific advance, ignores life's intangibles – the mind, feelings, values and spirituality. This results in the repression of feelings and the denial of grief, fear and anger.

The working world of the doctor is full of strong emotions: their own as well as their patients' anger, anguish, sadness, pain and distress. Doctors must either find ways to live with these unavoidable aspects of medicine, or repress them. Heron's view was that in fact their denial moulds the stereotypical medical persona, justifying doctors' traditional objectivity, and shaping a culture where repression of feelings is carried into the professional role and medical objectivity gets acted out through technical interventions done to a mind-less body. And so medicine has become applied bio-technology, overvaluing what can be weighed and measured, while devaluing the lived experience of both doctor and patient. This may sustain the doctor's position of authority and invulnerability but leaves the patient weak and mute. If we are to move towards patient-centred healthcare the old medical model and its tired worldview will have to go.

## The need for a new medical model

Holism is a response to the way late modern medicine has fragmented patients and their healthcare; an applied biopsychosocial approach whose aim is to balance out the excesses of biotechnical medicine that have divided mind from body, predicament from problem, and the person who is healed from

the person doing the healing. Given the current levels of distress and impairment, we now need a perspective that incorporate advances in mind-body medicine without eroding the immense benefits of late-modern techno-triumphs. A less alienating medical model will help the medical profession heal itself; a more holistic approach can transform the illusion of medical objectivity, and embrace both the science and art of healthcare, the power of beauty, love and self-healing.

## Conclusion

The project of helping doctors become more resilient has barely begun. Medicine stands at a threshold; the morbidity figures, the crisis reflected on its theoretical, educational and organisational fronts and the failure of current practice to match rapidly changing expectations, make change inevitable. The turbulence and uncertainty are already unbearable for many doctors. Though self-care and support groups are only micro-solutions, they may help us survive these 'interesting times'.

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