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Navigating Work-Life Integration, Legal Issues, Patient Safety: Lessons for Work-Life Wellness in Academic Medicine: Part 1 of 3

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INTRODUCTION

For many people who study or work in physical and organizational spaces in and around healthcare, the events of recent years have placed incredible additional stressors in an already taxing environment. Political upheaval, COVID-19, demonstrations for racial justice, and economic turmoil have exacerbated the tensions many learners, physicians, allied health providers, researchers, and leaders have felt for some time. The capacity to handle complex personal and workplace issues has become diminished.[1-3] While every situation is unique and should be addressed with a thoughtful, individualized response, clarity about where to begin to address complex issues often is lacking. Recognizing that there are no succinct, evidence-based resources for individuals and leaders to reference, we set out to bring together expert authors from all facets of our academic community to develop this resource.

In this series of three manuscripts, real-life scenarios encountered by clinicians, learners, and researchers in healthcare are explored, which challenge traditional assumptions and understanding of how to navigate issues as diverse as mental health, racial diversity, gender discrimination, imposter syndrome, and substance use disorder. Although the issues need not be organized by specialty, as they clearly cross disciplines, for ease of organization, the scenarios were arranged based on the career type or learning stage of the protagonist in the scenario.

Stories are powerful vehicles for learning and connecting. Stories help us understand, connect with others, and remember things. In stories, relatable characters and situations are found. Stories inspire and often teach valuable lessons that are easier to relate to and are more memorable than abstract concepts. Stories are how we understand the world. Readers can find themselves either as the character or the supporting crew and find practical ways to cope or support through the complex and difficult real-life scenarios that are likely to be encountered in their careers.

Part 1: Core Medical Disciplines (Cases 1-6)

In the first of three manuscripts, cases are explored with the central character based in a core medical specialty: Internal Medicine, Pediatrics, Psychiatry, Obstetrics/Gynecology, Emergency Medicine, and Family Medicine. However, the issues to be examined are not unique to the specialty of the physician. Here, the delicate issues of physician aging, child abuse reporting, leadership insecurity, the loss of a patient, physician substance use disorder, and an overwhelming work burden are considered. The authors of each scenario provided thoughtful, evidence-based responses to the real-world situations and reveal the underlying fear, anxiety, and stress emotions that drive the character into their current predicament.

Case 1 (Author: Tracy Gunter, M.D.)

Internal Medicine: A 67-year-old male who has been in the same practice for decades, has a loyal panel of patients, and a long history of great patient rapport. However, in compliance and outcomes, he recently has been noted by his younger colleagues to be a little "off". He has repeatedly told the same stories to his staff at lunch time and his nurse has noticed on two occasions that he has written prescriptions for the wrong medications for a patient.

Contextual Features: His wife, who often comes to the office to see him, has made a few comments to the staff, with whom she has long-standing friendships, that she is a little worried about his memory.

Solutions/Suggestions for Handling the Current Crisis: This scenario outlines two near-miss errors in an aging physician who is well-established in an outpatient private practice, against a background of non-specific compliance and outcome concerns and off-putting interpersonal behavior with staff members (telling the same stories repeatedly). There were no patient complaints and no errors that led to patient harm in the scenario. There was supplemental, informal information from the physician's wife to staff to suggest that there may be additional concerns outside the office setting.

In this scenario, the physician's behavior was more persistent than a single incident and the scenario included information of concern from the physician's wife. An intervention might best begin with a private conversation initiated by a peer of this physician at a neutral location. The conversation would be about the compliance and outcome concerns and incorrect prescriptions. The tone could reflect concern as opposed to judgment. At this point, the goal of the intervention is to raise the physician's awareness of the concerns of his peers and office staff members and give him the opportunity to reflect on how the events might have happened, solicit feedback, and engage in self-reflection and self-correction.

While most physicians welcome feedback and the opportunity to improve, it is not uncommon for some physicians to respond negatively.[4] Negative responses may include denial, irritability, and changing the subject or blaming others. Regardless of the reaction, the total interaction should be brief and end with an expression of gratitude to the physician for making the time for the conversation. This informal peer discussion may be documented with follow-up correspondence, depending upon applicable policies and procedures, contextual factors, and whether following up with the physician of concern is anticipated by the person performing the intervention.[4]

If the emerging pattern escalates or remains unaddressed by the physician, then a more concerted intervention by an authority figure would be indicated with formal documentation to the physician following the authority intervention. When physicians practice in healthcare systems or hospitals, the authority figure may be a medical director, chief medical officer, or risk management officer. In the free-standing private practice, the authority figure may be more difficult to identify. Absent a designated supervisor or clinic director designated to address the concerns, the physician peers may encourage the physician to consider an evaluation related to the observed performance concerns or, depending on local policies and practices, a self-referral to a physician wellness program. While a pattern has not emerged yet, and it is important to give the physician the opportunity to identify factors leading to the current concerns and remediate them, it is also important to keep in mind that increasing age has been associated with poorer knowledge base, poorer clinical outcomes, poorer prescribing practices, and lack of benefit from remediation, particularly when health issues are present.[5]

Case 2 (Authors: Kyra Reed, M.D., Heather Kelker, M.D., Julie Welch, M.D.)

Pediatrics: A 29-year-old female who just finished residency and has joined a thriving practice is seeing a six-year-old child with bruises and marks and is concerned about child abuse. The parent of the child is a longtime family friend of this physician. She is upset about having to make a report about suspected child abuse and seems visibly shaken by the whole incident.

Contextual Features: As a teenager, the physician was a volunteer at a shelter for abused women and children. Though she thought that experience would help her navigate situations such as these, she feels ill-prepared to have to handle this particular case.

Solutions/Suggestions for Handling the Current Crisis: The provider was experiencing stress related to an encounter of suspected child abuse and the perceived conflict of interest in reporting the case in the face of a close personal relationship with the family. Her prior experience caring for abused women and children placed her at risk of secondary traumatic stress (STS), the symptoms of which mimic post-traumatic stress disorder even though the traumatic events are experienced indirectly.[6-8] STS is prevalent in providers who care for victims of child abuse and neglect and can lead to burnout and attrition.[6,7] STS risk factors include prior personal trauma, repeated exposure to emotionally disturbing cases, increased empathy, and insufficient training. STS may be diminished by having high compassion satisfaction (CS) and professional fulfillment from helping others.[6]

The combination of high STS and low CS may contribute to a psychological barrier to reporting cases of child abuse.[6,7] The provider in this case had an additional barrier to reporting, which was her close personal relationship with the parent. Front line providers are required by the court to report suspected abuses and being colleagues or friends with the family involved in a case of suspected child abuse can contribute to additional psychological dissonance.

In the moment, it is important to support the provider by acknowledging the challenging situation and by providing encouragement that reporting is in the child's best interest and required by law. This can be accomplished by informal peer support from a colleague, especially one who has encountered a similar experience. Trauma-informed pediatric care with protocols in place that include consultation with specially trained child abuse pediatricians and social workers can mitigate the stress of these encounters.[6] Additionally, allowing time for recovery and debriefing after a stressful incident may counteract STS. Other potential methods to address STS can include individual counseling, peer support groups, and improved communication with child protection services and social work that would provide feedback on the course of the patient's care.[9] Standardizing an approach for reporting suspected abuse results in depersonalizing the scenario for the provider and the caregiver, helping to alleviate guilt and decision making. Using scripted language can help providers feel more prepared in talking with families. For example, stating that "in every situation where we see certain bruises, it is our clinic/hospital policy to have social work involved and look for other injuries". Practicing the scripting of these difficult conversations can help providers feel more prepared when an especially stressful encounter occurs, such as in the case above.

Case 3 (Authors: Kristine Olson, M.D., Elizabeth Harry, M.D.)

Psychiatry: A 35-year-old female psychiatrist recently was hired from an outside institution as a medical director of the consultation liaison service providing care for both emergency department and floor consults. She joined an existing team of seven colleagues including rotating social workers, psychologists, and psychiatrists. Unfortunately, she felt that she was struggling to be accepted as a leader. One of her female colleagues often will ask a male psychiatrist for his opinion or recommendations, even when off service, despite having discussed the case and received the recommendations from her. In meetings, this same colleague made inappropriate comments and generalizations about this physician's cultural background. When these interactions or behaviors were witnessed by others, colleagues did not comment on them or support the medical director, taking what seemed to be a collective approach of "minding your own business".

Contextual Features: The physician had a one-year history of leadership experience and had graduated from various prestigious international institutions with the highest accolades from medical school, residency, and fellowship training, and had a master's in business administration.

Solutions/Suggestions for Handling the Current Crisis: This 35-year-old physician leader felt she was struggling to be accepted as a leader, having her recommendations second guessed, and was subject to inappropriate comments and generalizations which were witnessed

by her team but went unacknowledged.

Her first reaction might be to think she is disrespected and ineffective as the vignette mentions her concern, she is 'struggling to be accepted'. This mindset may lead to feelings of self-doubt, discrimination, isolation, irritability, frustration, and defeat. This is important because it may lead her to be terse or punitive, shy away and withdraw, and unable to manage these thoughts and feelings. While totally normal, these reactions may be self-defeating. She may feel she needs to conceal her authentic self and conform to conventional expectations, whether gender, ethnic, or racial expectations. These "norms" perpetuate discriminatory power structures and a hidden pecking order of who and what is acceptable, reinforces bias, and undermines the ideals of diversity, equity, and inclusion. The inclusion of diverse people and ideas is known to improve organizational performance and better patient care.[10]

The physician's reaction and her response could be an opportunity to pause, notice her thoughts and subsequent feelings, and give herself the opportunity to reframe how she chooses to show up as the leader she desires to be. When she senses self-doubt and disrespect, she might notice all the evidence that she is well prepared and well trained for this role. She can choose to lead as a confident, authentic leader who demonstrates compassion for herself and others as they all learn.

To garner support, guidance, and combat isolation and loneliness, this physician leader might consider seeking executive sponsors to help her to remove obstacles and support her decisions, experienced mentors who can help her to grow as a leader, role-models who have overcome similar obstacles, and allies who have chosen her for the job. Similarly, she might recognize the value of maintaining her close relationships with family and friends and her identity outside of work. These actions are designed to help her thrive and succeed in a sub-optimal climate, recognizing she first must support herself to lead others in a way that helps them grow as a high functioning and healthy team.

The dysfunction on her team presented an opportunity to build a team that allows each member to be vulnerable, grow, and develop the safety to learn from one another. The new medical director had an opportunity to raise awareness about unconscious bias and the danger of perpetuating stereotypes and discriminatory norms. There are resources for raising consciousness about one's own implicit bias and for teaching individuals and teams how to recognize microaggressions, discrimination, and disrespect and be effective "bystanders", "upstanders", and "allies" in skillfully calling out and combating unconscious bias that can take some of the educational burden off of the medical director.[11-13] In the process of this growth, the medical director will need to rely heavily on the support network she has built to cope and manage the bumpy learning curve.

Case 4 (Author: Samantha Meltzer-Brody, M.D.)

Obstetrics/Gynecology: A 57-year-old female had been involved in the care of a high-risk pregnancy involving a multifetal gestation. The mother had extraordinary and unexpected complications in the postpartum period and died. The physician had a lot of experience caring for high-risk patients and experienced the loss of a patients in the past, but this case affected her deeply. She worried that her rapid decision making in the most critical aspects of this patient's care could have been to blame for the poor outcome, despite assurances by colleagues to the contrary. She canceled clinic days and asked her partners to cover her operative days.

Contextual Features: The physician recently found out that her own daughter was pregnant with twins, which heightened her identification with this patient.

Solutions/Suggestions for Handling the Current Crisis: The death of a patient, particularly when unexpected, is one of the most catastrophic experiences that a physician can experience. An unexpected maternal death during childbirth is a traumatic event and associated with physicians leaving the profession.[14,15] This consequence has been under-studied, and the literature was sparse regarding the experience of the second victim phenomenon, which can have significant physical, psychological, and psychosocial consequences negatively impacting the health care provider's personal and professional life.[16]

The physician's personal life experience can play an important role in how the event is processed and how "close to home" it can feel. Examination of psychological transference/ countertransference is an important part of understanding the intensity of emotions that a physician experiences and that may drive treatment decisions.[17] There is a great need to support health care providers who are second victims due to adverse patient outcomes. In maternity care settings, there often is an unspoken expectation that maternal mortality should be a "never event", thus, there is significant shame experienced by health care providers when maternal death occurs. Further, the process of investigating adverse patient events can lead to isolation due to concerns of medical-legal consequences.

The practice of medicine often has a narrow focus on medico-legal and patient safety perspectives that needs to be augmented with moral and philosophical perspectives that promote non-judgmental recognition and acknowledgement of shame and guilt in health care providers regarding the inherently fallible nature of the practice of medicine.[18] There is an imperative to ensure that health care providers who are second victims receive confidential care that is protected and de-stigmatized. Full disclosure of the adverse events to the patient and family, coupled with a heartfelt apology has been shown to help in the healing of healthcare providers who suffer as second victims and reduce medicolegal concerns.[19] Physician and clinician mental health programs are vital in addressing the complex issues associated with the second victim phenomenon and help to ensure best short and long-term outcomes. Peer support programs have been developed and shown to be the preferred first line intervention for adverse patient deaths, including in the Obstetrics/Gynecology setting.[20] However, there is also a need for referral to formal mental health treatment if symptoms persist to prevent long-term suffering from post-traumatic stress disorder. Formal mental health interventions should help to address symptoms of acute stress reaction, post-traumatic stress disorder, and depression.

Case 5 (Author: Mariah Quinn, M.D.)

Emergency Medicine: A 37-year-old male Emergency Medicine physician working in a large, busy emergency department frequently went to a bar on the way home to "relax and unwind". He recently was cited for Driving Under the Influence and must disclose this to his hospital employer. He was afraid for his job and the potential impact on his career. Throughout his teens and early twenties, he struggled with depression and anxiety but did well with counseling and treatment with a selective serotonin reuptake inhibitor (SSRI) medication. However, since entering medical school, he avoided professional help and has been off the SSRI medication due to concerns about disclosure on medical license and hospital credentialing applications.

Contextual Features: He and his wife of ten years are going through a divorce and navigating a nasty shared custody battle of their two young children.

Solutions/Suggestions for Handling the Current Crisis: Physicians abuse substances at a rate similar to the general population, with alcohol being the most commonly abused substance.[21-23] Substance Use Disorders (SUDs) frequently co-occur with other mental health concerns, particularly mood disorders, and occupational burnout.[23] While physicians abuse substances for the same reasons as the general population, occupational stress, access to substances and the culture of medicine or "physician personality" may contribute.[23,24] Many physicians with SUDs practice without occupational impairment for an extended period of time. Therefore, SUD is often referred to as a "potentially-impairing condition".[25]

As highlighted in this case, licensing and credentialing bodies influence the likelihood that a physician will seek care for mental health and SUDs.[26-28] Many physicians avoid help-seeking, citing concerns about licensure or credentialing. Avoiding care increases suicide risk, which is higher when mental illness is not treated; among physicians who have died by suicide, the rate of receiving mental health care was lower than among non-physicians who died by suicide. Additionally, physicians self-medicate for mental health symptoms more than the general population.[29]

Worry about required disclosure on licensing forms impact physician help-seeking significantly.[29] In a study of women physicians, 46% did not know whether their license application queried current mental health diagnoses or treatment.[30] In the same study, the vast majority (94%) reported not disclosing diagnoses because they felt their condition did not affect care or pose a safety risk for patients, while approximately a quarter to half of women worried about licensure, follow-up paperwork, referral to a Physician Health Program, or privacy. Nearly half of the women in the study reported not seeking treatment to avoid having to report to their care to medical boards. This result also was found in a large study of U.S. surgeons in which 60% of respondents reported not seeking care due to concerns about licensure.[31] This is an important area of advocacy, given that asking questions extending beyond current impairment impedes physicians from seeking help for potentially impairing conditions. Seeking care before impairment develops, can minimize risks for physicians and their patients.

Based upon the experience of Physician Health Programs, physicians who undergo monitoring and treatment for SUD have a high rate of sustained remission and resumption of practice.[32,33] The physician in this case required support for his personal and occupational stressors, to manage comorbid anxiety and/or depression, if present, as well as careful assessment and treatment of SUD. Treatment planning must take into account both occupational impairment and severity of SUD.[25] If there is evidence of occupational impairment, the physician should withdraw from clinical practice until they are able to resume safe practice.

If the physician did not show evidence of occupational impairment, and if he did not meet criteria for moderate to severe SUD, outpatient treatment for SUD, peer support, and psychotherapy may be most appropriate. Co-occurring mental illness increases the chances of relapse.[34] If he shows signs of moderate to severe SUD, he may need supervised withdrawal and residential treatment before consideration of return to practice. If a pause is needed in practice, resumption should be assessed on an individualized basis, considering a physician's ability to care safely and effectively for patients.[25] There should be time for treatment and monitoring during the workday, and a staged return to work might be considered.

Case 6 (Authors: Jennifer Ferrand, Psy.D., Sharon Kiely, M.D.)

Family Medicine: A 32-year-old male recently joined a family medicine practice with two other partners in a small town. The senior partner, shortly after his arrival, announced he would be retiring, and his only other partner decided to take an extended maternity leave and would not return for six months. This new physician felt overwhelmed but responsible to care for all of the patients in the practice, despite the physical and emotional toll it is taking on him.

Contextual Features: This physician and his wife were caring for her ailing grandmother and recently learned they were expecting their first baby.

Solutions/Suggestions for Handling the Current Crisis: Work-life balance is a cyclic, and evolving, relationship between work and other pursuits that is unique at the person level. Many physicians value work-life balance and well-being but may lack the skills and experience to negotiate these challenges in their professional lives.[35] Nevertheless, addressing work-life balance issues early and often is important, as the solutions and lessons learned will set the tone for the remainder of one's career.

Here, an early career physician felt overwhelmed in the face of changed circumstances including a new job and increased personal responsibilities. One cause of this feeling was likely his belief that he was responsible to take on more professional responsibility than was reasonable for one person. Should he act on this feeling by overworking, despite the physical and emotional toll he was experiencing, he risked much in the process. The risks included errors, decreased quality of care, burnout, physical and mental health problems, family strife, and departure from the practice. The error in his thinking was that he alone was responsible for all the patients in the practice, and he might not possess the confidence yet to assert himself to his senior colleagues

and set appropriate boundaries around his time. In this case, there were both short and longer-term solutions that required the investment of resources, time, and attention at both the individual and practice levels.

First, the overwhelmed physician must have a conversation with his two partners, establishing boundaries around his time and clarifying expectations for workload and panel size. To retain this physician and meet their own changing professional needs, the partners are likely to collaborate with him to arrive at a mutually agreeable solution. This could include options such as closing the practice to new patients during the partner's maternity leave, evaluating which patients could be postponed, hiring a recruiting firm to identify another partner for the practice, or the having the senior partner delay his retirement for six more months.

The three partners could agree on other changes to streamline day-to-day operations and improve the overall efficiency of the practice. Research models showed that when portions of preventive and chronic care services were delegated to non-physician team members, practices effectively can provide comprehensive primary care services with achievable panel sizes.[36]

Hiring nursing staff to manage more of the medication refills, blood pressure checks, and inbox communication frees up the physician's time. Ensuring the practice manager is skilled and accountable for improving efficiency, optimizing technology solutions, and fielding patient concerns can help to keep the team running smoothly. Innovative solutions including collaborating with community partners, investing in an onsite behavioral health consultant, providing a teaching opportunity for residents, developing a telemedicine option for after-hours care, and nurturing a team-based approach could help to distribute responsibility further, reduce the likelihood of physician burnout and improve the satisfaction of all in the practice.

The physician should seek personal support in addition to collaborating with his partners to invest in practice-level changes. As a Family Medicine physician, he is equipped to analyze problems and seek consultation when needed, although like many early career physicians he may fail to recognize those needs at a personal level, underestimate their importance, or not know how to ask for help. Recognizing his distress and seeking help can allow him to access a supportive response, validate and normalize his experience, and help him to recognize that he is not alone in his struggles.

External resources for advice and ideas include his former Program Director, informal and formal mentors and peers now in practice, as well as the Senior Partner and the colleague on maternity leave. Mentorship and coaching could help the physician to identify those aspects of his job that he found most meaningful and identify resources to aid him in accomplishing the less-meaningful tasks. Shanafelt[37] recommended that physicians spend at least 20% of their time on meaningful work, but most early career physicians would benefit from support and encouragement to identify what is meaningful, clarify their values, and contribute to the creation of a desired work environment. This doctor chose Family Medicine for specific reasons, and coaching could help him to focus on strengths, reset expectations, and reframe risks and opportunities. The one-to-one, supportive relationship with a physician coach or mentor can help him identify personal strategies to improve work-life balance (i.e., time management, prioritization), identify opportunities to address professional isolation, and ensure that both his personal and professional decisions are aligned with his values.

Focusing on skill-building through mentorship and peer support is important but building a practice culture where self-care is valued, and collaboration is modeled by leadership is a more permanent solution for the physician to craft his future. The physician's engagement in building this practice culture is key. Willard-Grace and colleagues[38] found that 30% of primary care physicians were no longer working in the same practice after two to three years, and that both burnout and low engagement were predictors for clinician turnover. Shanafelt noted that engagement characterized by vigor, dedication and absorption in work, was the "positive antithesis of burnout".[37] Attaining a realistic work-life balance and this physician's engagement in the practice is a shared responsibility between himself, the practice and the community.

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