

THE BASICS



Strategies for coping with stress
and building personal resilience for physicians

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B is for
Body



B IS FOR
BODY



AS THE DIRECTOR OF THE OMA PHYSICIAN HEALTH PROGRAM, I AM OFTEN INVITED TO SPEAK TO MEDICAL GROUPS AND OTHER HEALTH PROFESSIONALS ABOUT COPING WITH STRESS, WORK-LIFE BALANCE, AND TOPICS GENERALLY RELATED TO LIFESTYLE CHOICES THAT SUPPORT GOOD HEALTH AND PREVENT SUCH PROBLEMS AS BURNOUT, DEPRESSION AND SUBSTANCE ABUSE.

I have gathered a fair bit of material about these topics from a variety of authors and experts, the scientific literature, personal experience, and mostly from the lessons learned and championed by the many doctors we have come to know in recovery from drug and alcohol dependence and other personal problems and conditions. However, I have never taken the time to commit these ideas to paper.

Like many physicians, my focus is usually upon solving the problems presented to me. Health promotion and disease prevention are really good ideas, but my professional energy now, just as it was when I practised family medicine, has been largely devoted to responding to the needs of the stressed and distressed.

Now, as the Physician Health Program enters its second decade of service, it's time to change that.

There are so many good ideas and practical suggestions available about stress management. Many were

taught to us in medical school, most were taught to us by our parents and grandparents. So why would it be useful to present these ideas to a medical audience at all?

The problem for many of us is that the experience of medical training, and practice, was and is one of learning to live with stress, rather than reducing it to manageable, healthy levels.

As a medical student and resident, the amount of control one has over lifestyle choice is limited due to the demands of training: there is only so much time available to acquire all of the requisite skill and knowledge to practise our profession. After that, there is a real possibility that doctors in practice will maintain the less healthy coping patterns learned in residency when faced with the complex demands of a patient population growing beyond our resources to respond as we would like.

Besides, a reminder about fundamental, "basic" common sense self-care strategies is still a good thing.

In medicine, we are skilled at organizing large bodies of information into categories. Using a biological psychological - social-spiritual construct, I will do the same. Thinking about returning to fundamental principles, I have devised the acronym "BASICS."

Each letter of the word introduces a category for discussion: "B" is for body, or physiological considerations; "A" stands for affect, attitude and matters psychological; "S" is for social, and refers to our personal relationships; "I" is for intellect, and the many ways we can use it to our advantage; "C" stands for community, and introduces a discussion about the nature and importance of healthy personal and professional groupings; the final "S" refers to the spiritual domain, perhaps the least discussed and the most alluring.

"B" is for Body

Homeostasis

"B" might also stand for biology, and the biology of stress is interesting.

Consider first the concept of homeostasis, the maintenance of the internal physiological environment of an organism within healthy limits.

Homeostasis means that we eat when hungry, drink when thirsty, sleep when tired, and so on. Thus we are restored. This is the physiology of our regular patterns, routines and diurnal variations — the baseline biochemical "hum" of existence.

Homeostatic processes and mechanisms have been long studied and are well understood.

Allotasis

But what happens when we don't eat when hungry, or fail to sleep when tired?

A newer concept is that of allostasis.¹ The body adapts to potentially diverse and dangerous situations through the activation of neural, hormonal, or immunological mechanisms. Liberation of cortisol and adrenaline are just two such stress responses.

The problem is that the organism is fatigued and otherwise stressed by such an attempt to deal with "danger" (which might be only skipping meals on a very busy day).

Allotasis is the combined physiological and psychological adaptation to adversity and threats which creates wear and tear upon the organism. Allostatic responses are mediated by the brain and nervous system, but probably affect every cell and system within the body.

When allostatic challenges are few, the body has time to recover and return to a healthy homeostatic state. When the individual is challenged repeatedly, or when the allostatic systems remain turned on when no longer needed, the mediators of allostasis can produce a wear and tear on the body that has been termed "allostatic load."

Examples of allostatic load include the accumulation of abdominal fat, the loss of bone minerals, and neuronal atrophy, to name only a few.²

In short, when we are chronically stressed, the physiological changes that result render us less resilient, more susceptible to the diseases and

disorders that we know through experience often occur in that context.

Physicians, despite what they might think of themselves, are not exempt from these physiological fundamentals.

So, working long hours, often facing demanding patient care situations, missing meals and losing sleep — the resident’s and physician’s all-too-often routine — causes lasting physiological changes in the body that predispose to all of the diseases, and especially those to which the individual is genetically susceptible, that we are trained to treat. How ironic!

Nutrition

If we are to address the “basics,” then let’s start with perhaps the most basic of them all: diet and nutrition.

The food we eat is our physiological fuel. Feed ourselves properly, according to sound nutritional principles, and we feel well and perform at our best. But, just as running high performance engines on low-octane fuel can result in reduced performance and engine damage, eating poorly drains energy and, over time, can cause health problems. Again, all doctors know this already.

The notion of “sound nutritional principles” is constantly evolving. Documents such as *Canada’s Food Guide to Healthy Eating* and the *American Heart Association (AHA) Dietary Guidelines* are available and offer useful suggestions.^{3,4}

I note that the AHA considers reducing risk factors for coronary artery disease through diet. Specifically, high blood cholesterol, high blood

pressure, and excess body weight are targeted—all markers of allostatic load. Therefore, healthy eating can modify these risks, decrease allostatic burden, and increase resilience and our ability to cope with stress.

Basic recommendations in these guidelines include eating a diet rich in vegetables and fruits, whole grains and high-fibre foods. Foods that are metabolized slowly into glucose (low glycemic) are preferred compared to those that release glucose rapidly, such as sweets and processed carbohydrates (high glycemic).

It is suggested that fish be consumed at least twice a week, and that dairy and meat products are of the low-fat, lean variety. Choose and prepare foods with little or no salt. Limit saturated fats and trans-fats, which come from foods prepared with partially hydrogenated vegetable oils.

For me, I guess this means that eating the ubiquitous fatty, sugary Danish pastry with the red or yellow gooey stuff on it during all those years of medical training wasn’t such a good idea. But, combined with a couple of sugared cups of coffee (not the decaf variety), they provided energy bursts that replaced breakfast and lunch and kept me going through the demanding days of residency. It took me years to recognize that the intermittent fatigue, irritability and poor concentration I experienced were as much due to plunges into hypoglycemia as any other factor.

Here, then, are a few practical ideas about matching sound nutritional principles to the reality and routines of a modern medical day:

- Eat breakfast—even if you round at 0700! Your mother was right—it is an important meal. There is no sense in starting the day without quality fuel in the tank, relying instead upon the “supercharged” effect of caffeine, fat and sugar in your morning “double double.” Consider low-fat yogurt, high-fibre cereals, fruit, some cottage cheese, or even, yes, eggs from time to time.
- Eat smaller portions more often—every three to four hours during the day. Keeping blood sugar and insulin levels steady is preferable to the peak and trough effect of occasional eating of large meals. It’s probably a good idea to have a healthy snack mid-morning (especially if breakfast is very early), late afternoon or in the evening before bed. Consider fruit, vegetable sticks, cheese, whole grain bread, crackers or cereal. It’s easy to throw an apple and an individually wrapped piece of cheese into your bag in the morning and take it with you to the office or hospital. Be especially certain to do this if expecting a long, stressful day with the possibility of having to work through lunch or supper.
- Choose the fruit and yogurt at rounds. Avoid the muffins. If it’s white and fluffy (likely high glycemic) or greasy (saturated and trans-fats), avoid it.
- Choose the salad bar at the hospital cafeteria more often.
- Choose the burgers and fries less often.
- Maintain hydration with water and juices rather than coffee or sugared

beverages. About two to three litres per day is required, depending on gender, body size and activity.

- Avoid heavy eating before sleep.
- If on-call and sleep is not so likely, be sure to have an overnight snack. Bring something with you to the hospital in order to avoid the vending machine with the tempting junk food when the cafeteria is closed.

In general, all the authorities agree: variety is good, fad diets are not so good. The jury is still out on routine use of multi-vitamins, which should not be seen as a good alternative to regular, healthy eating. And, mercifully, even the foods that are not on the “A” list of good nutrition are fine, once in a while.

Toxins

In addition to optimizing our ingestion of foods that are good for us, we also need to consider those substances that aren’t. Food guides and recommendations usually make reference to caffeine and alcohol in this category.

This next statement might sound unusual coming from the perspective of the Physician Health Program, but alcohol is not evil! Most who use alcohol do so safely and responsibly.

Guidelines are available that refer to low-risk use of alcohol, but here are some general principles for doctors to consider:

- Over the course of a week, have no more than about 12 standard drinks (a standard drink being one bottle of beer, one and a half oz. of liquor, 5 oz. of wine).⁵

- Women metabolize alcohol differently than men and should drink a little less.
- Daily drinking should usually be avoided.
- Best to limit the number of standard drinks consumed to two or three per drinking occasion.
- Drinking specifically to relax or to aid sleep is not such a good idea.
- Alcoholism runs in families. Be careful if there is a strong family history of alcohol-related problems.
- Don't drink while working, or on call. The best alcohol serum level for a doctor at work is zero!

Caffeine is a mild stimulant well known to medical professionals. In medical school, I always picked up my first cup of the day on the way to the morning lecture and appreciated the boost in concentration I felt.

Coffee is ubiquitous in the medical world, as in many others. It's there in the lounges, wards, and always at rounds. And, of course, caffeine is present in tea and other beverages and foods, sometimes naturally, sometimes as an additive. So, it's hard to avoid.

While caffeine use has been associated with palpitations, bone loss, breast tenderness, infertility, and other conditions, the good news appears to be that used in moderation, few but the most sensitive will ever suffer any adverse effects. Moderation means about 300 mg of caffeine or less per day. This is the equivalent of about three regular size cups of coffee. It is probably best to discontinue caffeine use in the afternoon and evening if sleep is a problem, though.

I'd like to include a word about tobacco use. One would think that this would not be necessary for a medical audience, and indeed, when compared to the general population, only a small proportion of doctors smoke. But we have had calls from some doctors who began smoking during medical training, or after, and many of the doctors who have problems with substance abuse and dependence are smokers.

There is no amount of tobacco use that is safe. If a smoker, keep trying to quit. And if not a smoker—don't start!

Sleep

I doubt there is any other issue that stresses physicians and residents more than sleep—or the lack of it.

In “Staying Human During Residency Training,” Peterkin cites insufficient sleep as number one in the list of “Top Ten” stressors for residents.⁶ Many doctors are required to be on-call as part of their professional duties, sometimes as often as every three or four nights in these times of pressure on physician numbers. A night on-call likely represents no more than three or four hours sleep — and many carry on with regular work the next day!

Studies of sleep deprivation in residents and trainees confirm what we all know and have experienced. Sleep loss is associated with increased irritability, anger, depression, sensitivity to criticism, decline in cognitive performance, including the ability to solve problems and learn new skills, daytime drowsiness (nodding off), and more.^{7,8}

Losing sleep impairs psycho motor

function. In fact, it has been shown that four hours of sleep loss results in the kind of impairment usually associated with a breath alcohol level above the legal limit for driving in most jurisdictions.⁹ In short, being sleep deprived hurts — us, and potentially those we serve.

Consider that human beings need about seven to eight hours of sleep per night. How many of us achieve that even if not on-call? Long hours of work, complex patient and professional problems, and home and family demands all create night-time thoughts that seem to whirl endlessly in our minds once the head hits the pillow. (I've heard this referred to as “monkey mind.”) And, don't forget that our natural diurnal rhythms would have us sleep some time in the afternoon as well. Who gets to do that?

The truth is, our physiology demands sleep—in the right amounts and at the right time. There is no overcoming that basic need no matter how long we have trained, how often we lose sleep, or how important we are. There is no such thing as conditioning our physiology to adapt to less sleep in a healthy, homeostatic way.

Chronic sleep deprivation only adds to our allostatic load. Chronic sleep loss reduces resiliency, adds to risk of illness, or even causes illness, depending on individual circumstances and genetic predisposition.

Here are some suggestions for healthy, restorative sleep for doctors:

- Listen to your body's rhythms. There are times when falling asleep is easier because it's natural to do so. Plan bed-time and naps ac-

cordingly. To the best of your ability, don't let anything else interfere with this schedule. (I know one family doctor in a small town who has lunch at home followed by a brief nap before returning to the office. He's done that for years and swears by it!)

- “Close shop” sufficiently early in the evenings to give your mind a chance to wind down. This means avoid work-related e-mails, calls, journal reading, paperwork and so on for a few hours before retiring.
- Engage in other, relaxing activities in that time leading to bed that signals sleep is coming. You know what works for you: some TV, listening to or playing music, taking walks, reading a novel or other non-work related material, that sort of thing.
- Avoid alcohol, caffeine, excessive fluid ingestion or a heavy meal too soon before retiring, but a light snack can help prevent overnight hunger.
- Arrange your sleeping quarters according to your preferences considering light level, quiet, temperature, and so on. (I've found a mask and ear plugs work wonders.)
- Light exercise helps promote good sleep, but exercise should be avoided just before retiring.
- Develop a bedtime “ritual,” or routine pattern of behaviours, even post-call, that facilitates the onset of sleep.
- If at all possible, grab a quick nap (about 45 minutes) during the day prior to an overnight shift or call.

- Be sure to get extra sleep on days off. This is the way to achieve sleep homeostasis, that is to repay the “sleep debt.”
- Generally, avoid sedative drugs for sleep, unless for short periods and as prescribed. This includes over-the-counter preparations. Never prescribe sedative hypnotics for yourself.

Of course, there will be nights when sleep is difficult. Most authorities suggest getting out of bed and doing something else for awhile, rather than lying there ruminating about not sleeping. After that, try repeating the usual pre-sleep ritual, then returning to bed. Remember, an occasional experience of insomnia, while unpleasant, will do no harm.

If sleep remains disturbed in any way, medical evaluation, sometimes including sleep studies, is indicated.

Exercise

It's common knowledge that regular, moderate exercise benefits health in many ways. Benefits include better sleep, improved sense of energy, reduction in physical and emotional tension, fewer feelings of depression and anxiety, lowered risk of many physical illnesses, including cardiovascular disease, and much, much more. In short, thinking physiologically, exercise can contribute significantly to the reduction of our allostatic burden, creating resilience and good health—immediately and in the future.

As doctors, we know this. So why don't we all exercise regularly?

Not enough time—patients and

family come first. Not enough energy—the long work day leaves little reserve for much else, let alone exercise. Not enough motivation—the inertia of a sedentary existence just can't be overcome. Not enough expertise—we aren't already the best at running, rowing, dancing, or whatever.

There are ways to overcome these barriers to an active lifestyle. Perhaps, moderate exercise can be built in to everyday routines. Consider walking, jogging or biking to work. Using the stairs at the hospital is another strategy. If there is a gym, pool or workout room where you work or live, try an exercise routine for 15 or 20 minutes only. You're probably paying for the facility anyway!

Think about recreational activities you really like and which may have been abandoned. Skiing, golf, dancing, playing squash or tennis are just a few examples. Find some friends to join you. Take some lessons. Have fun!

Join a doctors' hockey team or dragon boat crew. Hold occasional journal club meetings in association with a physical activity, such as yoga or swimming. Build dedicated physical activity, such as group walking, into professional meetings.

Some find joining a gym or fitness facility, and using the services of a professional trainer, motivating.

The trick is to start small. Commit to a few minutes two or three times a week. Give yourself permission to be slow and inept at first. Understand that there might be a little discomfort, very soon offset by the many, immediate benefits. Then, gradually build on those initial gains. Before you

know it, you'll be the beneficiary of an active lifestyle you won't want to part with.

I'll offer the usual caveat before concluding this discussion: consult your personal physician before engaging in vigorous physical exercise — that is, if you have a personal physician.

Personal medical care

PHP experience is that the majority of those who call with personal problems don't have a family doctor, or won't involve them in their care.

A PHP survey (unpublished data) of 800 Ontario physicians revealed that approximately half of the respondents did not have a family physician.

What do these doctors do about personal medical care? Do they conduct their own periodic health exams? Check their own cholesterol levels? Perform their own Pap smears? Treat their own illnesses?

A fundamental of self-care is that we have a personal physician and use him or her as others would. Don't let being a doctor get in the way of this basic need.

Taken together, these are a few of the most important considerations regarding our physical health. And, while attending to them all is at once daunting and tempting to the perfectionist doctor, it helps to remember that even small changes towards better physical self-care can result in noticeable benefit.

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A

is for
Affect



“A” IS FOR AFFECT, WHICH REFERS TO OUR EMOTIONAL STATES. HOWEVER, IT MAY BE BETTER CONSIDERED AS ENCOMPASSING PERSONAL ATTITUDES, THINKING AND SELF AWARENESS. THESE ALL INTERACT IN ACCORDANCE WITH THE EXPERIENCES AND STRESSES OF LIFE IN WAYS THAT RANGE FROM UNCONSCIOUS, PASSIVE REACTION TO DELIBERATE SELF MANAGEMENT.

Consider this recent personal experience. Not long ago, I was offered an opportunity to present for 30 minutes during an annual scientific meeting of a particular specialty group. I believed the presentation went well, a perspective largely confirmed when the evaluation results were sent to me a few months later. The great majority of evaluations were very positive and reinforcing for me.

But there was one evaluation that wasn't good. In particular, it said that I didn't make sufficient use of humour. I was taken aback by the comment. It didn't seem to matter that the talk was about depression and suicide in physicians — hardly material that lent itself to a humorous approach!

I admit that I was upset by the poor evaluation, and I remained upset all day, even when my attention shifted to other things.

By evening, I reflected that it hadn't been a good day. I felt glum, as though

work had been unrewarding and less fun. For awhile, I didn't understand why that was so.

Then I remembered the evaluations that I had reviewed at the start of the day — and felt even worse! Thinking more about the whole thing, I realized my problem.

My thinking was the problem. I had given the many glowing evaluations and comments no weight. They barely registered with me. They were compliments thrust to the side so I could dwell on the single grumbling opinion.

In a cascade of linked and barely conscious thoughts, I concluded that

I was:

1. A poor public speaker.
2. Bad at my job.
3. A failure as a doctor.
4. A failure as a person! No wonder I didn't have such a great day.

And, I remember this happening

many times over the years. If a patient didn't show for an appointment, I wondered what I had done wrong the last time I saw them. A request to transfer a patient's chart to another office could devastate me with self doubt, even if I didn't really like that patient, and even though there were many more requests to join my family practice than I could accept.

Today, I know what this is about. I have a tendency to subscribe to the belief that my work performance should be perfect. This belief makes it difficult for me to accept compliments because perfect performance is the baseline expectation I set for myself. That makes a grievance about me an enormous affront that creates feelings of anger, self doubt and irritation. Turns out I have some choice about that.

Personality, stress and suffering

There are a number of personality types and traits observed in medical trainees and doctors that are associated with a tendency to experience life as distressing. They include an introverted approach to life, pessimism, and passivity, to name a few.^{1,2}

Are these traits fixed, "hardwired" into the psyche, or learned? Are they ingrained into our way of being in the world, or can we modify their impact upon our thoughts, feelings and behaviour? I suspect the answer is some of both.

We will look at an example to learn how to become aware of the ways thinking influences feeling.

Perfectionism

Perfectionism is a common trait that we see expressed by many of the health professionals that call the Physician Health Program seeking help. Others who treat doctors observe the same thing.³ There is a strong association generally between perfectionism and increased risk for depression, anxiety, obsessive compulsive symptoms, and even suicide.⁴

At least one study has measured perfectionism in a population of health professional students (medical, dental, pharmacy and nursing) and notes it to be prevalent, and, not surprisingly, highly correlated with symptoms of psychological distress.⁵

Can perfectionism as an attitude and thinking style be recognized by someone who experiences it, and modified to reduce personal emotional tension and enhance resilience? Antony and Swinson think so, as described in their book, entitled *When Perfect Isn't Good Enough — Strategies for Coping with Perfectionism*.

There are three commonly described forms of perfectionism:⁶

- The first is self oriented — placing impossible demands of perfection upon oneself, particularly in the area of work performance. An individual approaching life and work from this perspective reacts negatively to the fact, or the perception, of making a mistake.
- Other oriented perfectionism involves imposing the expectation of perfect performance upon others. Professionals experiencing this form of perfectionism understandably have difficulty delegating tasks to

others, and judge them harshly when they fail to perform to expected levels.

- The third form, socially prescribed perfectionism, involves the perception that others expect a great deal of you and will criticize any kind of failure. This form of perfectionism is most highly associated with distress in medical students, and therefore might be the most malignant in doctors.⁵ It is likely that all three forms of perfectionism are present to some degree in many health professionals.

It can be argued that medical professionalization draws upon all of these elements, beginning with selection to medical school and continuing onwards, thereby encouraging perfectionism in its trainees and practitioners.

Perfectionists might well excel in the areas of life where they apply themselves. That is their mission, after all. So what happens if they aren't able to excel? The tendency is to become upset and drop that activity, or never undertake it at all.

“ THERE ISN'T MUCH RESILIENCE IN A LIFE PRIMARILY DEVOTED ONLY TO THOSE THINGS ONE DOES REALLY WELL. ”

To the extent that perfectionism arises out of temperament, an ingrained personality structure, that can't be helped. But perfectionism is also learned.⁶

Exemplary behaviour throughout life can be reinforced through reward: praise, awards, and so on.

On the other hand, and perhaps more pernicious, punishment experienced for less than perfect behaviour might be an even greater reinforcer of perfectionism. Certainly, in medical practice, the ultimate punishment for what could be seen as less than perfect performance would be the death of a patient. Modeling of perfectionism in teachers and mentors can also contribute to the adopting of a perfectionistic approach to work.

Perfectionists don't dabble. They don't have much fun either, because they don't tend to try new things, and they give up the other things in their lives, often recreational, they can't master.

Test this idea yourself. How many new things have you undertaken in the past year or two? Have you avoided trying new things because you're not immediately good at them? Do you still enjoy playing golf or piano? Have you given up any activities because they were not fun when you couldn't rise to the level of performance you demanded of yourself? Maybe you think it's a matter of time pressure that has forced you to abandon your hobbies, but does honest reflection reveal some other reason?

There isn't much resilience in a life primarily devoted only to those things one does really well.

Cognitive distortions

There are a number of thought patterns and styles associated with perfectionism that I suspect will be familiar to many.⁶ While common, they aren't always helpful or realistic, so they are also known as cognitive distortions. Some of them include:

- All or nothing: All or nothing thinkers approach life in a very black and white manner. They clearly see only two ways about anything: their way or the wrong way. All or nothing thinkers will, of necessity, face frustration trying to navigate a world of uncertainty and shades of gray.
- Filtering: Perfectionists tend to select certain details they will focus upon — usually negative ones. Expecting perfection, they tend to discount the impact of positive feedback. The result can be an obsessive and upsetting preoccupation with criticism that is not balanced by the appreciation of compliments or a job well done.
- Mind reading: The perfectionist, especially one who is socially prescribed, will think he or she knows what others are thinking of them. And all too often they will believe that others are judging them harshly.
- Catastrophizing: This involves the magnification of negative outcomes coupled with the sense that they can't be prevented or managed.
- Over responsibility: This one is common in many health profes-

sionals seen by the Physician Health Program, and involves the sense that they are in greater control of situations than they realistically are. So, when outcomes don't match expectations, the tendency is to blame oneself. Anger, frustration and guilt are common feelings that result.

There are other hazardous assumptions doctors are prone to make that contribute to unnecessary stress.⁷ These can be associated with perfectionism and include:

- Assuming that the doctor's role is to stamp out disease, suffering and death.
- Assuming that one is indispensable to patients and profession.
- Assuming that no patient could ever be angry with you, or leave your practice.
- Assuming that professional esteem and self esteem are the same.

There is a paradox to perfection: attitudes and behaviours designed to exert control over circumstances, and others intending perfect outcomes, can often have the opposite result and cause distress in the perfectionist and others.

The challenge is to differentiate appropriate standards (of excellence, let's say, acknowledging the psyche of most medical professionals) from perfect (and therefore unattainable) ones.

Changing thinking, changing feeling

Antony and Swinson offer a variety of simple, practical, everyday strate-

gies that are well worth learning.⁶ They can be applied to modify the thought distortions and unwanted feelings associated with perfectionism.

The first step is to become aware of the influence of perfectionism when it's happening. We need to ask ourselves: is the adherence to standards of perfection helping or hurting? What is the impact upon our family and professional relationships? Most importantly, what feelings are associated with a perfection based approach to life situations?

This isn't easy. Once and seemingly forever immersed in a particular value system and approach to life, it's hard to see it in action, let alone change it.

Think of a situation in your life, perhaps an experience similar to the ones described at the beginning of this article, and see if you can identify distortions of perfectionism at play. Which ones? Were they "self oriented," "other oriented," or "socially prescribed?" What was the impact upon you, coworkers, and others?

Sometimes it can be helpful to ask others close to you to help with this exercise. Check with a spouse, partner, coworker or friend for their perspective. It's necessary to promote unconscious attitudes and thoughts to conscious awareness in order to change the feelings that follow.

Here are a number of good questions doctors can ask themselves to penetrate their unhelpful assertions:⁸

- Am I thinking in "all or nothing" terms? Look for words that suggest absolutes, like "always" or "never."

- Am I confusing a rare occurrence with a probability? This is a reality check.
- Am I assuming the worst possible outcome? This is not the same as a rational consideration of a worst case scenario when charting a course of action.
- Am I blaming myself for something that was beyond my control? The benefit of accurate hindsight is helpful here.
- What would have happened if I had handled the situation differently? Especially consider alternatives less shaped by perfectionism.
- What difference will this make in a week, a year, or 10 years? Will anyone really judge me harshly in the future? The next step is to consider alternatives to the perfection based approach. Can standards of perfection for oneself or others be "downgraded" to just plain excellent? Or good? How would someone else think about this situation? Return to your own example. Challenge your value system. Open your mind and list alternatives. Then choose a new, more helpful way of thinking about the situation.

Perhaps it's acceptable to be unable to please everyone, every time. Maybe if nine people out of 10 rate a presentation highly, that's good enough. A reminder that even the best of doctors will occasionally make a mistake is a good reality check. Be deliberate. Be realistic. Be daring!

Finally, consider the feelings that accompany these thought alternatives. Some anxiety? Perhaps at first. Thoughts that challenge deeply held

values, if not pre-emptively dismissed, might be provocative. But, if there are any feelings of relief, then those new, more reality based thoughts are “keepers.” Practise these thought reshaping procedures often, applying them to as many situations as possible — and feel better.

Conclusion

These are the links between “head and heart,” thoughts and feelings. Naturally, they blend like paint on a canvas, colouring everything in our lives. Resilient physicians have learned to recognize and manage them.

They have also learned to share their thoughts and feelings with others in ways of mutual benefit.

Stress resistant doctors accept that they and others are imperfect. They understand that the goal is progress, not perfection.

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S is for
Social



FRIENDS, LOVERS AND FAMILY

“IT IS OUR FIRST NATURE TO BE CONNECTED,” SAYS PSYCHOLOGIST PETRUSKA CLARKSON IN HER BOOK ENTITLED, THE BYSTANDER.¹ HUMAN BEINGS, DOCTORS INCLUDED, ARE SOCIAL CREATURES AND WE NEED EACH OTHER.

Try this exercise: think back to everyone you would have included in your personal support system when you were in high school. Include family members as well as friends, teammates, fellow club members, and so on. Count them up. Repeat the exercise a few more times considering the years spent in university, medical school, residency, and beyond.

What has happened to the total number of individuals in your support system over time? Has it decreased? For many in medicine, the years of rigorous training will take their toll upon social connections causing a robust network to shrink and fray.

Many of the callers seeking help from the Physician Health Program tell of their feelings of loneliness and isolation. They might enjoy financial wealth, but lack of “currency” — the state of being up to date with others — creates a kind of poverty that erodes their resilience.

Friends forever

It’s Friday evening and the phone in my home rings as I’m about to dash out to a meeting. I answer it. “Hi Mike,” the caller says, “How are you?” It’s Lori, a friend and coworker of my wife, Judy.

“Fine,” I answer, and before she can engage me any further, I say, “You must want to speak to Judy. Hold on a moment, I’ll get her.” I hand the phone over and with a quick kiss on her cheek I head for the door as Judy settles onto the couch, phone perched on her shoulder.

An hour later, I return home. Judy is still talking to Lori. Well, laughing, mostly. When she finally hangs up, I ask, “What have you been talking about all this time?”

I’m truly perplexed. They work together and have plenty of opportunity to chat during the week. When my friends call, it’s to arrange a tee time, ask to borrow something, or for some other purpose that a few minutes of talking will handle perfectly well.

“Oh...nothing much,” she replies. “We just like to talk about things that happened during the week. Besides, we make each other laugh.”

Then the email alert on her computer chimes and she’s off to open a letter sent from another friend containing pictures of funny painted cats.

From my perspective, women appear to structure their friendships differently, maybe even a little better than men do. The fellows I know mostly gather around activities. We play golf, watch games on TV, and build things together. And yes, sometimes we talk, too. While we might do it differently, the result is the same: we create friendships that support us for life.

Our friends comfort us. They know our histories, strengths and weaknesses. They are devoted by choice, bonded by shared experience. As true confidants they will listen to our concerns, honour us with the truth as they see it, and won’t judge us.

They share vacations, holidays and special celebrations with us, teach us and learn from us. We play together, share hobbies and favourite pastimes. Sometimes our best friends become family to us. They grow with us and remain loyal and available, even if they live three time zones away.

Good friends share our triumphs and our failures. They help us face whatever life sends our way. They make us resilient. They make our lives worth living.

Marriage and Intimacy

Much has been written about marriage and intimacy relationships in the

medical profession, mostly describing problems and failures.

Every relationship has its own unique challenges, and it is true that doctors’ relationships are often stressed by the demands the profession makes upon them. But my intention here is not to catalogue the problems in medical marriages, rather, I want to emphasize how important stable intimacy relationships can be in fostering stress hardiness. And I don’t intend this discussion to be limited to traditional marriages. There are people who live together without marrying, gay and lesbian couples, those with children and those without. In *The Resilient Physician*, the Sotiles cite family researcher Froma Walsh stating: “It’s not family form but the quality of relationships that matters most for hardiness.”²

The Sotiles go on to say that: “Supportive family relationships are crucial to adaptive coping. Specifically, how intimate partners treat each other has been found to be one of the most powerful determinants of individual mental and physical wellbeing and work productivity.”²

It’s possible that strong, supportive relationships away from work provide the confidence, strength and self-assurance needed to handle anything life sends our way. A happy marriage predicts happiness in life.

Conversely, a troubled and unhappy marriage probably contributes more to difficulty in coping with life problems than being single.

Certainly, many of the callers seeking help from the Physician Health Program experience marital difficul-

ties, even if they are calling for some other reason.

It's useful to consider warning signs of relationships in trouble. Psychiatrist Michael Myers says that doctors need to ask themselves, and answer honestly, the following questions about their intimate relationships:³

- Do you feel bored or lonely, especially when the two of you are alone?
- Does your partner complain that you don't share enough of yourself? How does this criticism make you feel? Defensive? And do your reasons—"I'm tired" or "I don't have anything new to tell you" or "I was born this way"—seem unsatisfactory or tend to fall short?
- Are you arguing without resolving the issues? Do you argue about the same matters over and over? Do your arguments leave you feeling exhausted, frustrated or demoralized?
- Are your arguments increasing in frequency or in intensity?
- Are you not arguing at all but rather silently seething, withdrawing into yourself, or using passive-aggressive manoeuvres (forgetting to meet requests, being stubborn, disappearing, coming home late, responding with sarcasm)? Or, if you aren't doing this, is your partner?
- Do you make a beeline for the liquor cabinet when you get home, and not talk about your day at work — or present only a very abbreviated version once the alcohol takes effect?
- Are you working so hard that you can't find the time to talk with your partner?

- Is it possible that immersing yourself in your medical work has become preferable to talking with your partner? Do you find practising medicine more fun, rewarding, and ego boosting than spending time alone with your partner?
- How is your sex life? Do you find that your sexual relationship doesn't seem very intimate — that you "have sex" but don't "make love" anymore?

A satisfying, and lasting, intimacy relationship is not achieved without effort, even for high achieving individuals that doctors tend to be, no matter how much we love one another.

Life is demanding, the journey complex and convoluted. Professional careers evolve at the same time as our family lives do. Just as we continue to upgrade our medical knowledge and clinical skills, so must we redefine and improve our relationships as we grow.

Here are some suggestions for physicians to maintain and enhance relationship intimacy:

- Designate and protect time to be spent with your beloved partner. This precious time can be daily, and brief, such as enjoying morning coffee quietly with one another. Sometimes going for a walk and "escaping" the home environment is a good way to spend time talking, or just being with one another. Consider going to bed a little earlier to talk and unwind together, after children have gone to sleep and the home is quiet.
- Generally, I think it's a good idea to leave work at the office or hospital. Naturally, sharing thoughts and ex-

periences about one's day at work is to be expected, but avoid allowing work themes to dominate home discussion. Your partner won't thank you for that.

- Watch out for “pseudo conversation.” By this I mean attempting discussion with your partner while preoccupied with other, usually work related, thoughts or activities. This is not a good situation for multitasking.

- Don't forget romance. Touch your partner gently and do and say the little things that endear you to one another. Sneak away for romantic weekends from time to time. Be affectionate. Never stop nurturing the love you share.

- Remember to be your partner's best friend.

Stay the course as much as possible. You and your intimacy partner are creating a life history together

“ **HOW INTIMATE PARTNERS TREAT EACH OTHER HAS BEEN FOUND TO BE ONE OF THE MOST POWERFUL DETERMINANTS OF INDIVIDUAL MENTAL AND PHYSICAL WELLBEING AND WORK PRODUCTIVITY.** ”

- Notice your partner's achievements, successes and triumphs, and complement him or her. Don't let perfectionism, the expectation that everything ought to be done well, smother the words that nourish relationships.
- Talk about the difficult subjects too, like money, sex and parenting. And do so in constructive ways, avoiding criticism and control. Writing orders might be the expected way of communicating in the hospital, but that won't work well at home.
- Build a social life together with friends, but avoid doing so around CME events and professional conferences only.

that grows richer with each shared experience and emotion. If there are problems that aren't easy to work out together, seek help.

Certainly, few physicians have had time to learn the kind of communication skills that successful relationships are built upon, while engaged in years of rigorous training and practice. There is no shame in asking for assistance with this most important aspect of life.

It needs to be acknowledged, however, that sometimes relationships become abusive — physically, emotionally and sexually. Feelings of shame, guilt or hopelessness are not good reasons for remaining in a hurtful,

or even dangerous, relationship. Help is available to address this reality as well, and should be sought.

Family

Many of the physicians that use Physician Health Program services for personal support come from medical families themselves. Some have described how much they admired their physician parent, but how little time they spent together, especially with physician fathers.

An article in *Medical Economics* describes the experiences of a number of adult children of physicians.⁴ Absentee, neglectful and unsupportive parenting was common. These physician parents were recalled as being tired and distracted when home, and often called away to tend to the needs of others. Clearly, children of physicians parented this way suffer.

But what does the physician parent give up? I have also had the opportunity to see how much pleasure parents, even medical ones, derive from being fully involved in the lives of their children. They are present for their children's milestones, daily achievements and sorrows. In exchange for their parents knowing the details of their lives, their fears, wants and needs, children give them love and trust, gifts never withdrawn. The family becomes another vital network of support for the doctor, shelter from the storm, bolstering resilience.

Parenting is also one of the most important joint responsibilities for couples. Those duties will seldom be shared equally, especially in single, medical, career homes. Even in dual career

homes (including dual medical careers), responsibilities will have to be divided unevenly, respecting the different roles and abilities of each parent. Resilient couples will recognize and honour that. Success in working through this task will go a long way toward ensuring family health, and will add to the intimacy bond between partners.

I believe a doctor's home and family life should be separate from work life as much as is reasonably possible. How is this achieved? A doctor approached me recently and shared wisdom earlier given to him: "Clearly define the boundaries of your relationships with both your patients and your family," he advised. "Tell your patients early and often when, and under what conditions, you will be available to them — and when you won't be available. Tell your family the same. Make arrangements for hospital and practice emergency and on-call coverage that allow for uninterrupted time with loved ones. Commit to that arrangement."

Being single

Single status might predispose a doctor to loneliness and isolation, especially if work is permitted to fill all of the available time, providing the only social contacts. This doesn't have to be so. Peterkin offers advice to single residents that anyone can use.⁵

Remember the need for support from family and friends, and make a special effort to be in touch. Maintain contact with phone calls, email and visits. Plan vacations together. Join health clubs or other mutual interest organizations to make friends based on common interests. Seek opportu-

nity to develop closer friendships with people at work, and cultivate non-medical friendships as well.

Conclusion

We have observed at the Physician Health Program that doctors recovering from substance use disorders and other problems nurture their friendship and family relationships as though their personal wellbeing depends upon it. This is a good lesson for all physicians.

Don't allow perfectionism to spoil the pleasures of learning, making mistakes and growing together. Resist the traditional dictates of a medical culture that places patients before self and family, sacrificing social connections and personal support systems.

Look upon your friends and family as a blessing — a source of strength and support for life.

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is for
Intellect



INTELLECT REFERS TO THE POWER OF THE MIND TO GRASP IDEAS, TO UNDERSTAND CONCEPTS, AND TO MAKE RATIONAL JUDGEMENTS AND DECISIONS.

Medical training and practice is all about developing our intellectual power, and using it to acquire the requisite skill and knowledge to be good physicians. We take pride in our intellectual prowess, and our rationality.

This article is about the application of a variety of our intellectual abilities and energy to personal stress hardness and resilience.

Intellectual diversion

I suppose the first consideration is diversion from the day to day demands upon our intellectual abilities. While many take a break through recreation, hobbies, time with family and so on, there are others who seek alternative intellectual challenges as a form of pleasure.

I have a colleague who is completing a degree in philosophy, saddened that the process is ending (for now), and another who is fascinated by astrophysics. He takes the latest book on quantum mechanics with him on vacation! I prefer historical novels.

Another physician friend is fascinated by Mayan culture and visits

archeological sites on his vacations. Still another writes and records songs. These are but a few examples of replacing one kind of intellectual energy with another in order to relieve stress.

Occupational considerations

Suppose you could ask a sample of physicians who have achieved balance and healthy resilience for their advice in this area. This is exactly what was done by a team of researchers from McMaster University in Hamilton.¹ Seventeen physicians were interviewed, and several important themes emerged.

Resilient physicians are able to maintain a sense of value in their professional role. They retain a sense of contribution, and having a meaningful role in the lives of others. They like what they are doing and continue to cultivate interest and acquire knowledge through continuing medical education in their area of work. They understand and accept the demands of the physician role, learning such skills as task prioritization and time management to help them cope.

These doctors, like others who are successful achieving balance in life, learn to set limits. They are able to say “no” when too much is asked of them, or when tempted to stray from important priorities and agendas.

Also reported was the need to understand that medical practice is a business. Efficient and effective work organization, staffing, use of technology, delegation to allied health professionals, and scheduling were but a few of the areas needing attention in order to minimize workplace stress.

Brown and Gunderman offer their viewpoint about ways to enhance professional fulfillment of physicians.² Their perspective reinforced the findings above by stating that enhancing motivators intrinsic to the work itself, such as the sense of achievement, responsibility and growth, increased fulfillment.

Interestingly, improving extrinsic factors, such as remuneration level and workplace conditions, contributes to fulfillment in the short term, but these gains aren’t sustained in the absence of intrinsic motivators. In other words, great pay and working conditions don’t make up for professional ennui if one isn’t interested in, and satisfied by, the kind of work they are doing. And, a focus upon the intrinsically rewarding aspects of work is often more within our individual control than focusing primarily upon the extrinsic factors.

Control

It is my observation that most doctors like to be in control. This is especially true in some specialties, notably surgical specialties, intensive care, emergency medicine and, of course,

anesthesia. After all, the directions for care that we write in a patient’s chart are called orders, not suggestions, and we expect them to be carried out to the letter. We’re trained to make critical decisions based on rational analysis and the application of our knowledge. We aren’t afraid to be in charge.

I recall listening to an intensivist describe the stress she was experiencing at home. “Things go fine at work,” she said. “Everyone there does what I ask them to do. But my husband and kids don’t appreciate it when I give them orders.” She was able to appreciate the obvious: we aren’t in control of all aspects of life like we are (to a greater degree) in the clinical setting. And we aren’t always in control there either. That’s because our environment changes, constantly. Health institutions merge, split, and are re-defined. Boards, lawyers, administrators, governments, even patients all “conspire” to alter the healthcare landscape. The greater our need to control our circumstances, the more prone we are to the stress of being unable to do so.

I have often encountered doctors who believe that the best strategy, when faced with the stress of a changing and undesired situation, is to promote and pursue their preferred perspective with unrelenting, bloody minded devotion. They might even strike out against people and institutions who do not share their understanding.

There are times when others might yield to this approach, but probably not that many. More often, the “digging in of heels” is self destructive and makes things worse.

Change

How, then, do we apply our powers of intellect to manage the ever-present issues of control and change in our lives?

First, I think, is acceptance. I've heard it said that change is the only thing that is constant in life. We, everyone and everything in life, are ever-changing—sometimes in ways we like, often in ways that make us uncomfortable. Face it. We can't control everything in our lives. We must learn to accept the things we cannot change—but not with dispassionate resignation.

We can adapt to change in healthy ways. Resilient people are curious and open-minded. When necessary, they are able to put aside a rigidly held stance to consider other ones. They are able to learn, through inquiry and co-operation, the details of new realities and other points of view. They might still prefer their own opinion in the end, but are able to appreciate the merits of alternatives.

Resilient people are flexible and open to the opportunities change brings into their lives, even if born in conflict. When the change to the environment is inevitable, they learn new skills and acquire new knowledge to adapt to that environment. How many of us, previously technologically unskilled and suspicious, now can't be parted from our laptops and iPods?

Some are courageous about change. They become proactive instead of reactive, waiting for change to pass over them, hoping to survive. They make reasoned, positive choices for themselves in areas where they can be in control.

This can mean choosing new occupational situations and leaving old ones. Making healthier lifestyle choices, such as increasing vacation time, would be another example. Developing leadership skills and becoming politically active, thus an agent of change, is another positive way to deal with the stresses of change.

Taking stock, or inventory, at a personal and occupational level, as illustrated in a previous Physician Health article,³ is another facet of coping with change and evolution in our lives.

It's important to check periodically if our work and family circumstances are in keeping with our interests, values and goals. Do we still believe in what we are doing? Are our lives out of balance? How long has it been since we have tried anything new?

Choice

In his book, *Always Change a Losing Game*, Dr. David Posen reminds us that change implies choice, and that we always have choices.⁴

Once we become aware of a situation requiring action, we must make choices. Even choosing to do nothing, he says, is a choice. And every choice has a consequence. Dr. Posen offers four important principles:

1. *Any behaviour you persist in doing after you become aware of it is a conscious choice.*

So, once aware of a situation that causes stress or distress, including yelling at others, overworking, eating improperly and so on, continues as a matter of choice. It's true that some form of help or learning might be nec-

essary to make a change, but seeking that assistance is also a choice that can be made.

2. At times you don't see your choices clearly because of restrictions you put on yourself.

So often I hear from doctors that they can't make important changes in their lives due to any number of self-imposed restrictions. They are concerned about what others will think about them, their financial obligations, their security in their present circumstances, and much more. They feel trapped. Later, once new choices are made — often after great suffering — they wonder why it took so long.

3. Sometimes people don't feel they have a choice because they don't like any of their choices.

There may be times, when all available choices are likely to have unpleasant outcomes, that the best of a bad lot must be chosen. Sometimes, this situation will be an improvement upon the current one.

4. Occasionally, people get off track because they're looking for the ideal choice.

This raises the spectre of perfectionism, which I described in the second article of this series.⁵ Doctors are prone to this condition. Those who look for the perfect choice paralyse themselves by ruling out every alternative, leaving themselves with the status quo.

There are always choices. Doctors are good at weighing options. Choose the best, or the least bad, alternative when change is required.

Accept that outcomes might not be ideal, but they might be an improvement over the current situation.

And, who knows, there might be pleasant surprises. It's possible that making positive choices for oneself might also have a favourable impact upon other people and situations that were not anticipated.

This is the means to gain control over ourselves and our situations.

Suffice it to say, change is often stressful. But I believe that even the most rigid individuals will have the intellectual abilities to understand the realities of control in their lives, explore alternative choices, and learn to deal with their challenges in positive ways.

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is for

Community



IN AND THROUGH COMMUNITY LIES THE SALVATION OF THE WORLD.¹ THIS IS THE FIRST SENTENCE OF A BOOK WRITTEN BY PSYCHIATRIST M. SCOTT PECK, ENTITLED *THE DIFFERENT DRUM – COMMUNITY MAKING AND PEACE*. THIS IS A POWERFUL STATEMENT INDEED, AND I USE IT TO INTRODUCE THE CONCEPT AND ROLE OF COMMUNITY IN PHYSICIAN RESILIENCE AND WELL-BEING.

Just what is meant by “community” in this context? The dictionary defines community as a group of people living together, subject to the same laws and having common interests and characteristics.² Community defined this way usually includes a common geographical location for its members as well.

But this is not what Dr. Peck meant by community in his statement above, and it’s not the meaning I’m considering when thinking about physician health.

True community must be experienced to be understood. Sometimes it helps to describe the absence of a thing in order to better understand its presence.

Thomas Krizek, a surgeon, compared life in his professional community to swimming with sharks.³ He said that the rules for swimming with sharks were surely written for surgeons: Any unidentified colleague is a shark until proven otherwise; don’t

bleed — it attracts more sharks; get out of the water if someone else is bleeding; counter aggression with more aggression.

Dr. Krizek describes a tough, aggressive, suspicious, uncaring grouping of colleagues who are unlikely to reveal their own pain and injury to one another, much less come to the aid of a colleague should his or her problems become known. This might seem like an indictment of surgeons, but it comes from one of their own. And, when I repeat this metaphor to other specialty groups, I am all too often aware that there is resonance with this depiction.

This metaphor also suggests a community that does not tolerate individual differences. You’re either a shark, or you’re not.

As far as I’m concerned, this is the description of anticommunity — even though this is a grouping of individuals in the same place, with common interests, following the same rules,

often implied and modeled, rather than overtly stated. This is a place of personal achievement, even at the expense of others. This is a realm where weakness is ill advised, where others are regarded with suspicion, and mutual support is unlikely.

This kind of place does not feel right, does not foster collegiality, and, too often, is in some way part of the backdrop in the lives of distressed or ill physicians seeking help from the Physician Health Program.

Barriers to community

Medicine has long been a profession that supports the credo of rugged individualism. From the first day of medical school onward, we are reminded of our specialness, that we were selected as a few from the many who would be physicians, that we are the “cream of the cream.”

We are taught the skills to cure, deal with crisis, and comfort our patients. We are trained as leaders of the healthcare team. The fact that the ultimate responsibility for our patients rests with us is a repeated theme, and we take that seriously.

We learn at the bedside, in clinical rounds, and through rigorous examination that, in the end, our success as professionals rests upon our own efforts and personal, sometimes arrogant, authority.

Self-doubt and fear of failure are probably common to all of us, but that is a carefully guarded secret. Not wanting to risk being judged as less than our colleagues, these and other “shortcomings” remain cloaked within

our professional white coats. Feeling like impostors, we try to appear confident and secure when the truth is something else. We become dishonest with ourselves and others.

Our experience of criticism in training is sometimes hurtful. As a result, later in our careers, feedback from others, even constructive, is difficult to hear and accept without feeling threatened.

Sadly, some of us become bystanders in our own professional neighbourhoods. Ignoring our human “first nature,” as described by Clarkson⁴ — to be connected and interdependent, we turn away from colleagues in pain, impropriety in the workplace, ethical dilemma, or other uncomfortable challenges around us in our professional environment. Maybe this is due to our own past experience, stress, fatigue, overwork, ignorance, or ambition. Maybe something else.

So not wanting to get involved becomes “second nature” to us. We avoid really opening ourselves to others or providing a safe place for them to be with us. We fail to join with one another in a meaningful way.

Genuine community cannot form in an environment like this.

Genuine community

Then what is community? Scott Peck says: “If we are to use the word meaningfully we must restrict it to a group of individuals who have learned to communicate honestly with each other, whose relationships go deeper than their masks of composure, and who have developed some signifi-

cant commitment to rejoice together, mourn together, and to delight in each other, make others' conditions our own."⁵

Let's consider how these principles and others can combine to create healthy medical communities.

Genuine community is inclusive. All kinds of doctors, regardless of specialty, cultural origins and gender, doctors in training, and allied health professionals, may belong.

When I was a clinical clerk in my last year of medical school, a nurse in the emergency department said one sentence to me that stands out in my memory. Marked by my short white jacket and yellow name badge, I responded to a page to see a patient in consultation. The nurse, seeing me approach, said, "If your senior resident isn't right behind you, turn around now and go away." I felt hurt, rejected, a very minor member, if that, of the healthcare team.

A healthy community is self-aware. Its members aren't afraid to examine its status and functioning. Such a medical community will pause once in a while to ask: "How are we doing?" Just as personal inventory is important, so is a collective one. Through retreats, medical staff meetings or other mechanisms, a healthy medical community will have members meet, discuss, reflect, plan, and be open to change.

And, being a safe place, all members of the community will be free to speak honestly. All constructive criticism is welcome. Incessant complaining, even silent, unexpressed concerns, are part of the problem.

Active engagement in medical community processes and politics is the solution.

In healthy medical communities, senior members offer the benefits of their experience through mentorship, willingly sought and accepted by its junior members.

All members of a community like this are open to giving and receiving feedback. Once, in a meeting of medical leaders I was addressing about disruptive behaviour, a surgeon offered his opinion that, in the OR culture, "off colour" or sexist jokes were understood as being acceptable. Shortly afterward, as the meeting concluded, two women who worked in the OR approached the surgeon and politely told him that they, and others, did not share his perspective. They risked offering feedback. I felt I was witnessing healthy community in action.

Sometimes there is conflict in communities, even healthy ones. But conflict in genuine community is resolved skillfully by active listening to one another, reflection and decision making guided by effective leaders. This is conflict resolved with grace instead of the aggressive feeding frenzy of the shark tank.

In a genuine medical community, the myth of personal invulnerability is discarded. Instead, our strengths, weaknesses, and individual differences are honoured and accepted. This has implications regarding optimal use of our professional abilities.

For example, doctors with certain disabilities are offered accommodated work that still makes use of their talents and experience.

The same is true for doctors who wish to retire gradually, still offering valued service based on their experience, but without need to take on-call responsibilities or other duties they can no longer manage comfortably.

And, of course, recognizing the possibility of individual suffering due to personal, emotional problems is also accepting the truth in any real community. Beyond acceptance is the ability to offer assistance without shaming or stigmatizing. In healthy medical communities, we can reach out to one another in safety.

Conclusion

We all live and work as part of groupings we call communities. Some will have elements of what I am calling genuine, healthy community; some not. Genuine community usually takes time and effort to form.

We know when we are experiencing dysfunctional community because it drains our energy. Some callers to the PHP describe professional environments that are rigid, unsupportive, lacking in creativity, hurtful places to be.

Many other callers come from caring, encouraging and helpful workplaces. Sometimes, it is just such a community that inspired the caller to reach out. We know we are a part of a healthy community because we feel rewarded, energized and joyful about being a member of it.

Genuine community is at once human, humane and healing. Genuine community fosters resilience in its members.

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S is for
Spirituality



SPIRITUALITY – THE NEGLECTED DOMAIN

IN 2003, I HAD THE GOOD FORTUNE OF BEING INVITED TO PRESENT AT THE ANNUAL MEETING OF THE ROYAL AUSTRALIAN COLLEGE OF SURGEONS IN BRISBANE. THE LECTURE WAS ENTITLED “SURGEONS ARE PEOPLE, TOO,” AND I DISCUSSED THE USUAL PROBLEMS EXPERIENCED BY DOCTORS, AND MANY OF THE ELEMENTS OF STRESS MANAGEMENT AND RESILIENCE COVERED IN THE “BASICS” SERIES OF ARTICLES.

Taking the podium, I looked at my audience, and, to my surprise and pleasure, saw that the room was full. Beyond full, actually, as delegates were standing at the back of the room, in the doorway, and in the corridor outside.

Before the presentation, and while planning the content, I was concerned that surgeons — professionals very focused upon the art and science of their craft — would have little interest in the “soft” nature of my talk. Turns out I couldn’t have been more mistaken. They listened attentively, asked questions, and offered comments that revealed their interest in their own wellbeing.

But when I introduced the topic of spirituality, they became quiet. It wasn’t the silence of discomfort or dismissal; it was more like private thirst transformed into a collective hush. I had entered into the domain of the

soul, terrain seldom knowingly navigated by doctors in the context of their day to day work.

This is my experience nearly every time I present the idea that an exploration of one’s spiritual understanding and practice is a vital component of personal resilience.

What is spirituality?

I choose to adopt a broad based concept that encompasses both secular and religious perspectives and can be widely accepted.¹ Thought of this way, spirituality is a complex and multidimensional aspect of human experience.

Philosophical aspects deal with finding meaning and purpose in life. Experiential, emotional and social aspects relate to feelings of connectedness, love, and caring for others, inner peace and equanimity.

The transcendent component of spirituality relates to the awareness of a universal life force, a guiding “power greater than ourselves,” God or a cosmic consciousness of our understanding.

Spirituality is not purely religion. But for many, spiritual benefits, practices and comforts are obtained through religious affiliation, ritual and faith.

Secular life is rich with transcendent opportunities as well, as many find spiritual fulfilment in art, music, nature, meditation and philosophy, to name a few.

In his book, *Spirituality and the Healthy Mind*, Marc Galanter depicts spirituality as a large tent that can

ing a protective effect on physical and emotional wellbeing among healthy individuals.⁴

Two examples that have been studied are acceptance and altruism, both of which can be said to have aspects that are spiritual in nature.⁴

Many hardy individuals cite acceptance as an important contributor in their ability to tolerate stressful situations and circumstances. Not to be mistaken for resignation (and its attendant helplessness), acceptance of life’s difficulties and personal challenges fosters willingness to seek appropriate help, support, and creative solutions, including connection to others and the transcendent. This

“ I HAD ENTERED INTO THE DOMAIN OF THE SOUL, TERRAIN SELDOM KNOWINGLY NAVIGATED BY DOCTORS IN THE CONTEXT OF THEIR DAY TO DAY WORK. ”

house diverse views of transcendence with room enough for the secular and the religious.²

Spirituality and resilience

There is evidence, summarized in various reviews, that spirituality and religious commitment is associated with positive physical and mental health.³

Attitudes and beliefs influenced by spirituality also provide a framework for understanding adversity and making sense of tragedy, as well as hav-

ing a fundamental concept in 12-step recovery programs widely accepted to be spiritual in nature (but not religious, at least by most who subscribe to them.)

Altruism, the philosophy and practice of helping others, has been associated with both successful adaptation to stressful environments and the ability to find meaning in illness or tragedy. An example is the “survivor mission,” when the individual turns personal adversity into activism, or the practice of helping like affected others. Mothers Against Drunk Driving (MADD) is an

example of the first; the mission of recovering alcoholics in AA to “carry the message” (Step 12) is an example of the second.

And, in a study that looked at the competencies of physicians who were identified as having a resilient approach to their personal and professional lives, spirituality was cited as an important contributor.⁵ In this article, such qualities as self-awareness, acceptance, and a sense of contribution in their work are specifically mentioned.

mind is an open mind. And an open mind is one that is willing to explore and adopt new ideas, attitudes and practices.

- *Give of yourself* — Medical practice is a form of giving, of course, but also our livelihood. Donate medical services. Join a community board. Become a big brother or sister. Coach a sports team. Give for its own sake.
- *Be mindful* — Mindfulness refers to a meditation practice that cultivates present moment awareness.⁶ Medi-

“ EVERY DAY WE JOIN WITH OUR PATIENTS, LISTEN TO THEIR STORIES, OFFER THEM OUR EMPATHY AND UNDERSTANDING, ALONG WITH OUR SKILL. ”

Spiritual practices that enhance resilience

- *Be humble* — It’s hard to imagine accessing true spirituality without humility. And humility can be difficult for some doctors — especially those who have been conditioned with “white coat hubris” to see themselves as separate from others, fiercely independent, arrogantly eschewing new ideas and values that don’t conform to their world view so influenced by medical training. Humility permits a different perspective of self — one that acknowledges vulnerability, interdependence with others and with a universal power greater than ourselves. A humble

tation might be thought of as a form of deep, attentive listening. Mindfulness meditation teaches how to remain focused in the present, alert, aware and unhurried. Some meditative techniques enable physical relaxation and a clear and peaceful state of mind. Meditation practice fosters mental discipline and improved powers of concentration that can tame the wild horse of unbridled thought. Meditation helps us to connect to the core of equanimity unaffected by personal problems that resides within each of us. Mindfulness meditation training is popular and readily available.

- *Pray* — Prayer is communication.

Prayer is a form of reminder. Prayer is a request for help. When we repeat a prayer, we are guided by its words and intent.

- An example is the Serenity Prayer, adapted from the original attributed to theologian Reinhold Niebuhr, so often repeated at Alcoholics Anonymous and other 12-step meetings: “God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.” Prayer can also be an expression of gratitude, a pause to quietly say “thank you.”
- *Walk on uneven ground* — I think that most of us crave connection to the natural world. I suppose God exists on the frenzied sidewalks and high between the skyscrapers of our cities, but somehow it’s easier to appreciate nature’s soothing message while walking down a forest path, in a country meadow, or along the ocean shore.
- *Join a spiritual/religious community* — Tolerant, respectful religious communities connect people with common spiritual ideas and practices. They provide social support, a sense of purpose and belonging, and, of course, a means to understand and communicate with the God of their understanding. Find a community that supports values that matter to you. Join it and get involved.
- *Play* — Imagine the many ways you can and have played. Remember the exhilaration of downhill skiing, the satisfaction of smacking a baseball into the outfield, joking with your

friends on the golf course. I think play is a form of spiritual experience. Make time to laugh and have fun.

- *Enjoy music* — Music carries messages of meaning to us through lyric, tune and rhythm. Music can soothe or invigorate. Music bypasses our conscious, rational thought to reach into memory and the stirrings of our heart. Listen to music. Make music.
- *Read* — There are many ways to enrich our lives through reading. Along with the scripture of sacred texts, contemplative literature and poetry open the door to reflection and philosophical thought that nourish the spirit.
- *Create* — Write a story, grow a garden, build a cabinet, compose a song. Paint a picture or cook a meal. Rejoice in your personal creativity — it’s an expression of the soul, a gift.
- *See life through the lens of awe and wonder* — Other people do. I have heard Rachel Naomi Remen, American physician and author of *Kitchen Table Wisdom* and other works, suggest that we view our work as a novelist or film producer would, replete with the richness and human drama that service through medical practice affords.

Every day we join with our patients, listen to their stories, offer them our empathy and understanding, along with our skill. This is one way to find meaning in our work again, to recapture the soul of medicine.⁷

Whether we are aware of it or not, there is healing — for our patients, and ourselves.

Conclusion

This article, and the five preceding articles in the BASICS series, offers but a few strategies that doctors can use to enhance their personal resilience.

We have discussed attending to our primary physiological needs, such as nutritious eating and getting enough rest, and examined some ways to confront perfectionism and other attitudes and thinking styles that hold us back.

ers. Even so, busy doctors often lament that there isn't enough time or opportunity in their lives to implement all, or even many, of these suggestions. Patients, after all, come first. However, maybe patients don't come first — maybe our health is equally as important as that of our patients.

So, leaving the last word to Wayne and Mary Sotile, maybe all we have to do is a little. One or two doable stress managing, resilience enhancing choices per day might be plenty. "Do sweat the

“ THIS IS HOW WE TAKE RESPONSIBILITY FOR OURSELVES, RESTORE OUR INTEGRITY, HEAL TOGETHER, AND CELEBRATE THE MANY REWARDS OF BEING A DOCTOR AND A WHOLE PERSON IN OUR DEMANDING WORLD. ”

We have been reminded about the social aspects of resilience involving family, friends and community. We reviewed using our intellectual abilities to make good occupational choices and to understand and cope with change in our lives.

And, finally, we explored some ideas about spirituality, its importance to our resilience, sense of wholeness, and how leading a more spiritual life can remind us of the things we love about being a doctor.

Even in this brief series of articles, many suggestions have been offered. Most are likely viewed as common sense, some already utilized by read-

small stuff," the Sotiles say. Even small changes can have large rewards.⁸

This is how we take responsibility for ourselves, restore our integrity, heal together, and celebrate the many rewards of being a doctor and a whole person in our demanding world.

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