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Navigating Minority and Gender Discrimination, Substance Use Disorder, Financial Distress, and Workplace Politics: Lessons for Work-Life Wellness in Academic Medicine: Part 2 of 3

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Part 2: Medical/Surgical Specialties (Cases 7-12)

In this second installment of the three-part series of manuscripts addressing a range of complex work and personal issues, the authors explored case scenarios with clinicians who work in the fields of general surgery, orthopedic surgery, anesthesiology, neurology, radiology, and otolaryngology. The medical specialty identifiers informed baseline understanding of the demands of that particular profession but were less pertinent than the specifics of each case. In this manuscript, the authors explored the topics of navigating a lawsuit and professional burnout, personal finances, substance use disorder, demands of clinical work and workplace politics, diversity and inclusion, and dealing with major personal illness. The authors provided practical steps to help the readers deal with similar situations and provide insights to support clinicians on how to manage these complex situations.

Case 7 (Authors: Heather Farley, M.D., Julia MacRae, M.D.)

Surgery: A 48-year-old female general surgeon was exhibiting several signs of burnout including irritability, fatigue, and interpersonal conflicts with her colleagues. She was demonstrating atypical behaviors (for her) such as arriving to work late and becoming delinquent on her charts. The surgeon had been approached by several colleagues who stated that she seemed "not herself" lately. Student and resident evaluations, which were typically stellar, also reflected her recent lack of enthusiasm and engagement.

Contextual Features: The surgeon was known to be a compassionate surgeon with an impeccable service record who recently had been named in a lawsuit after a patient succumbed to multi-system organ failure following an emergent bowel resection.

Solutions/Suggestions for Handling the Current Crisis: The surgeon was experiencing a range of emotions in response to the lawsuit including shame, guilt, self-doubt, fear, and uncertainty. She did not feel safe opening up to colleagues about her situation (and, in fact, she ay not be clear on what she can share legally with her colleagues). Ideally, someone this surgeon trusts would assess her openness to seeking and receiving support. For example, an opening could be "I see something's going on, and I know this isn't normal for you. I really care about you. Would you like to share what's on your mind? I don't have to be the person you open up to, but I can connect you with resources to help."

If the trusted colleague knows that the lawsuit is part of the problem, there are many support options for this surgeon. Shame can be a barrier to seeking help.[1] Normalize her experience by letting the surgeon know that this is a common experience for over 60% of surgeons,[2] and that she is not alone. Using language such as "I have been through something similar. There are some great resources to help navigate this extremely stressful time" can open the door for the surgeon. Her institution's wellness program or risk management department may be able to facilitate finding another surgeon to talk to (not necessarily about the details of the case, but about managing the inevitable toll that it takes on the physician). Connecting the surgeon with a mental health professional who can assist her in coping with and processing the emotional impact of the case can be very beneficial. Online resources[3-5] such as articles, videos, message boards, and podcasts also can be helpful ways of getting support and information in a confidential fashion.

Much of the stress of a lawsuit stems from fear of the unknown.6 The first thing that malpractice attorneys often advise anyone served with a lawsuit is "Don't talk to anyone about it". That may prevent the surgeon from seeking the support she needs. The surgeon should be encouraged to talk to her legal team about exactly what to expect (and the timeframe) of the lawsuit, as well as to clarify exactly what it is permissible to discuss and with whom. Many attorneys recognize that it is acceptable and encouraged to discuss the emotional ramifications (but not the case details) with trusted sources. The surgeon's legal/risk management team can reassure her that they have extensive experience with this scenario and communicate a "We've got this!" attitude. Fear of losing a career (and an identity) also can come with a lawsuit. The surgeon should be encouraged to discuss with human resources personnel and/or her legal team how facing a lawsuit might impact licensure and employment. She may be encouraged to hear that most physicians continue to have a successful career after facing or even losing a lawsuit. Preparation returns agency and control to the physician and empowers them to work through not only the legal aspects of the case, but also the emotional response.[7]

Negativity bias will tend to make the surgeon focus on the lawsuit

as a reflection on her competency, while disregarding her many years of successfully treating patients and teaching students. A healthy strategy involves avoiding isolation and seeking the support and counsel of colleagues and experts who can affirm the physicians' worth and value to her medical community. Coaching and simulation exercises may help boost her clinical confidence.[8]

Finally, the surgeon's colleagues could recognize that it may be difficult to juggle a full clinical and teaching schedule along with the added work and stress of the lawsuit. Discussing with leadership or human resources personnel ways to shift responsibilities temporarily can lessen the feelings of being overwhelmed.

Case 8 (Author: David Rogers, M.D.)

Orthopedics: A 50-year-old male orthopedic surgeon was an experienced and well-respected joint replacement specialist who was unable to perform surgery for several months during the COVID-19 pandemic and was eager to get back to work. He requested weekend and evening operating room (OR) time to address his backlog of cases. He was becoming increasingly irritable at work and even was written up for disruptive behavior in the OR. He stated his duty was to his patients who needed their operations completed and he would not quit until he had provided the best and most timely care to all of them. The OR staff was struggling to provide extra OR time to him given obligations to his colleagues, and was exhausted by excessive overtime for OR nurses, and they voiced their concerns to hospital administration.

Contextual Features: The surgeon had four children, two who graduated from college, but one was in college now and one was a junior in high school. He lost a great deal of revenue during the pandemic and was concerned about paying for college tuition for his children.

Solutions/Suggestions for Handling the Current Crisis: One conceptual model of wellbeing represented this state as being one of balance between challenges and resources.[9] This surgeon's situation was a result of an increase in financial demands related to his goal of providing a college education for his children and a lack of staff support for him to do the clinical work that would alleviate his financial shortfall. Resolving the situation will require a combination of approaches, deployed in the short and long term, that would restore balance between challenges and resources.

A first step in addressing the situation might include meeting with the operating room administrative leadership to explore options that would increase the availability of staff. While the financial benefit to the surgeon is obvious, it is also likely important to system leadership given the importance of procedurally derived revenue for academic medical center programs. During this meeting, the surgeon could be put on notice that his disruptive behavior must stop given its negative consequences to the staff and his own career.[10] Ultimately, having staff resign due to his behavior only compounds his problem. However, this notice should be combined with an acknowledgement that there are systems contributions to these behaviors that will be addressed as the modifies his behavior.[11]

This would be a good time to introduce coaching, counseling, or peer mentorship and other stress management approaches. Ultimately, the surgeon's individual well-being was his greatest asset in meeting his families' financial needs and may be a powerful motivation for a surgeon to seek wellness help.

The need for clinical revenue has caused some centers to develop highly production-oriented compensation programs for proceduralist physicians.[12] To maximize this source of revenue, proceduralists are incentivized to be clinically busy and are substantially penalized when they are not, even if through no fault of their own.

Systems leaders need to strike the right balance where clinically generated revenues are used to maximize efficiency in addition to subsidizing research and education. Finally, the chronic under-resourcing of operating rooms in academic centers combined with highly individualized compensation programs can create a competitive culture that pits surgeons against each other vying for the limited access to the operating room. The loss of collegiality that results from this combination places surgeons at risk of burnout.

Another long-term solution is for the surgeon to consider his priorities and approach to helping his children. Surgeons are well compensated and so it likely would be surprising to anyone that a surgeon is experiencing stress that is due to financial concerns. Starting a career in adult mid-life means that surgeons sacrifice many years where savings can accrue through compounding interest. This surgeon would be well-advised to gain a fundamental understanding of personal finance that addresses the unique opportunities and challenges for surgeons.[13,14] He might seek guidance from a financial planner to maximize his plan for saving for his children's college education and involve his children in these conversations. It would be regrettable if the surgeon spent weekends and evenings in the operating room motivated to pay for his children's college education at an expensive elite institution when they would have been content with a less expensive option that meant that they could spend more time with him before leaving for college.

Case 9 (Author: Elizabeth Lawrence, M.D.)

Anesthesia: A 38-year-old male anesthesiologist (Dr. P) who worked primarily in an out-patient surgery center, enjoyed a successful career with significant control over his job and personal life. The chief of anesthesiology received a cryptic text message: "Fentanyl missing, Dr. P. missing." Recovery room nurses had noted that Dr. P.'s patients seemed to be waking in excessive pain, although much more fentanyl was ordered for his cases compared with others.

Contextual Features: The anesthesiologist recently moved out of his family home and had defaulted on his mortgage and car loans. He stopped responding to messages from his partners and his wife had declined his requests to see his children because she did not want them to "see their father like that".

Solutions/Suggestions for Handling the Current Crisis: The description of Dr. P indicated that he was impaired. Impairment is a functional classification that depends on whether a physician can safely and effectively care for his patients. Illness, in contrast, is simply the presence of a disease.[15] A physician can be acutely ill, be recovering from an acute illness, or have a chronic illness without being impaired.

Several major professional societies have published guidelines and considerations on caring for the impaired physician, recognizing

that, in addition to the duty to care for the physician-patient, there is a duty to prevent harm to patients.[16-18] These guidelines highlight the distinction between impairment and illness to ensure that care of a physician-patient focuses on therapeutic responses rather than disciplinary interventions.

The prevalence of substance use disorders (SUD) in U.S. physicians is 10 to 15% and is comparable to that of nonphysicians.[19] Physicians traditionally have been thought to misuse alcohol and prescription medications such as opiates and benzodiazepines more commonly than non-physicians, but more recent data suggested that alcohol is the most commonly abused substance.[20]

Almost all states have physician health programs (PHPs) to respond to physician mental and physical illness, including SUD. These PHPs serve the dual purpose of protecting the public from harm while offering confidential support to impaired physicians. The aim of these programs is to enable the physician to resume the safe practice of medicine. PHPs help to coordinate diagnosis and evaluation, the creation of a personalized treatment plan, treatment, drug and alcohol testing, connection to groups of other physicians in recovery, and ongoing monitoring and support.[21]

PHPs serve as an alternative to disciplinary action for physicians and other health professionals.[21] PHPs have a "safe harbor" provision and generally do not require reporting of the names of enrolled physicians to the medical board. The safe harbor provision stipulates that so long as the physician follows a signed PHP contract for treatment and monitoring, licensing sanctions will be deferred. A recent narrative review[21] and a recent meta analysis[22] concluded that as many as 75% of physicians enrolled in PHPs achieve and sustain remission, a success rate much higher than that in the general population.

The American Medical Association Code of Medical Ethics makes clear that colleagues of an impaired physician have an ethical obligation to intervene to help the physician and to protect the physician's patients.[17] The American College of Physicians position paper on the impaired physician provides a stepwise plan on how colleagues can and should intervene.[16] When a physician is ill but not impaired, and when there is no risk of a patient being harmed, colleagues can encourage the physician to contact the local PHP and to explore other resources for evaluation and support. When there is the possibility of imminent harm to a patient or harm is known to have occurred, colleagues need to report the physician to clinical supervisors and medical licensing boards. Finally, if a colleague is undecided about whether a physician is impaired, consulting a clinical supervisor or perhaps someone from the local PHP is suggested.[16,23]

Dr. P's substance use disorder already reached the stage of impairment as his patients were waking up in pain and he was not meeting his professional responsibility to respond to messages. The Chief of Anesthesiology should speak with Dr. P, share her concern, and require Dr. P to contact their local PHP. Had Dr. P's illness been identified while he still was caring for patients safely, the Chief would have discharged her duty by taking those steps. Given that harm already was occurring, however, the Chief must inform her supervisors and the medical licensing board of Dr. P's situation. The most positive outcome would be for Dr. P to receive the care he needs through his PHP without sanctions as long as he commits to and follows his treatment contract with the PHP, and that over time he regains the ability to practice medicine safely and effectively.

Case 10 (Author: Chantal Brazeau, M.D.)

Neurology: A 37-year-old gender non-binary neurologist has a thriving practice in an academic setting caring for a wide variety of patients in their outpatient office. The teaching hospital where they have privileges recently had had a falling out with the other group of neurologists providing the majority of the call coverage for the busy stroke service. The hospital was looking to this physician's group practice to provide this medical coverage but the Medical School chairman and clinical group were unwilling to scale back the physicians' time at the outpatient practice to accommodate this request. This left the physician facing several days per month of long office days, nights answering pages, and occasionally having to come into the hospital, followed by another long office day. They loved their work and did not want to leave the practice, but felt unhappy with their work environment and know this was not a sustainable situation.

Contextual Features: The private neurology practice recently was acquired by the health system, requiring a re-work of contracts, the same process by which the other neurology group became displeased and ended negotiations with the health system.

Solutions/Suggestions for Handling the Current Crisis: In this situation, there were several competing issues: The hospital leadership and the departmental chair both wanted to maintain the same level of patient services in their respective clinical areas competing with how much realistically can be expected of fewer physicians and the impact on each physician; the academic physician balanced this increased clinical load, related sleep deprivation and duty to patients with teaching, scholarly and other academic responsibilities while maintaining their personal health.

The physician could begin to address this unsustainable situation by considering how to navigate the competing demands at the systems level and the personal level. What argument could the physician make to get the attention of the hospital leadership and department chair? What are the risks to the organization by continuing to expect the same level of clinical service with fewer physicians? Are there motivating factors or compelling arguments (the "burning platform")[24] that would motivate the hospital to find physicians (e.g., locums) to cover the added on-call load, or the chair to allow a reduction in the outpatient practice?

One argument is quality of care. Burnout has been linked to increased medical errors, decreased quality of patient experience and other measures of quality.[25] Sleep impairment has been linked to increased burnout and increase in clinically significant medical errors.[26] Quality of care could be impacted in both the hospital service and the outpatient practice if the physician experience burnout or has insufficient sleep. In addition, various people (stakeholders) who are impacted by the work environment may be supportive of physician well-being. The physician could seek key stakeholders who could

relay the message to hospital and department leadership that this is an unsustainable and risky situation. These stakeholders could include chairs of other departments, leaders in graduate medical education or of various health professions (e.g., nursing), or quality, patient experience and operations.

While approaching hospital and departmental leadership, the physician should consider that change is difficult; in this case, a change toward incorporating physician well-being in decisions about clinical operations. It would be helpful to speak to the hospital and department leadership at the same time and acknowledge their uneasiness, show data to support compelling arguments rather than express direct opposition, and note discrepancies between organizational values and real risk of negative impact of this situation. This can set the tone for constructive problem solving.

During this time of increased clinical demand, the physician was navigating a variety of teaching and scholarly responsibilities. Despite doing their best to uphold professional duties, there is a point when the physician may reach their emotional and physical limit. To prevent getting to that point, the physician may need to review and delegate and/or postpone less time sensitive work or home responsibilities. The goal is to free time for self-care, and basic needs including nutrition, sleep, exercise, and spending time with their loved ones. Self-care will be crucial, and ultimately, organizational systems changes will be essential in solving this situation.

Case 11 (Author: David Rogers, M.D.)

Radiology: A 49-year-old male radiologist worked in a large hospital and was the Program Director for a small radiology residency program. His love of clinical work was balanced by his love of teaching and publishing a series of highly cited papers in high impact journals. He and his husband, an internal medicine physician at the same hospital, have been married for 10 years and have adopted three young children. They are well respected physicians and teachers in their institution and are involved community members. Recently, a few office staff members have been overheard making insensitive comments about the couple, including offensive remarks about their involvement in the LGBTQ groups on campus. They are both deeply hurt but feel loyal to their workplace.

Contextual Features: The couple's school-age son was the target of inflammatory remarks by a classmate's father, a local dentist, at a recent school event.

Solutions/Suggestions for Handling the Current Crisis: This is a complex social situation that involves multiple parties. At the individual level, this physician educator was being subjected to negative comments by members of the work group related to the physician's identity. The physician's son has been subjected to offensive remarks by another health care professional in a social setting which surely would be a source of distress. To address this complex situation will involve efforts that are both proactive and protective and occur at multiple levels.

A proactive approach for the workplace would include involvement in national organizations that are promoting diversity in the workplace. In this case, the challenge of diversifying radiology has included a review of discrimination faced by LGBTQ radiologists with some suggestions for overcoming barriers to change.[27,28] This information is important, and it also may be helpful to join national groups focused on issues of diversity and inclusion for both practical wisdom and the social support from people facing similar challenges.

The effort to effect changes at the local organizational level could begin by helping the leader understand the importance of diversity and inclusion. It is well established that diversity of perspective amongst the physician workforce is fundamental to excellence in the academic medical mission and efforts to create a climate of safety for everyone will be critically important in recruiting talented individuals and allowing them to be engaged fully in their work.[29] Effective change in the individual work group would best be accomplished in collaboration with human resources to achieve a balanced approach. The physician is entitled to work in an environment that is free from discrimination. However, there is a power hierarchy that must be minded so that a physician's actions toward the staff are not seen to be retaliatory. A human resources specialist may be an ally in efforts to effect change in the work group through training that promotes inclusivity and provides information about behaviors that are illegal in the workplace. Individuals who persist in these activities should be advised that they would face sanction or termination if they persist in unacceptable behaviors which is part of the protective aspect of this overall approach.

As a physician-educator, this individual has an opportunity to affect the needed culture change in academic medicine and this is a significant opportunity given the lack of attention given to the LGBTQ physician experience or specific LGBTQ patient concerns in medical education.[30] Such a curriculum can focus on the concept of intersectionality in better understanding and appreciating other individuals, to include those who identify as LGBTQ.[31] It also would contain information about the corrosive effects of microaggressions faced by many groups including those that identify as LGBTQ.[32] In addition to helping advance the culture, this kind of open discussion also may help LGBTQ medical students who are reporting discrimination at a time where they are extremely vulnerable in the learning continuum.[33]

While the physician educator would be helping others, it might be helpful for him if his son could see his efforts to help and also that healthcare providers who identify as LGBTQ deserve respect and support and have much to offer medicine and the communities that they serve. This physician parent needs to reach out to his son's school leadership to offer support for positive change while putting him or her on notice that bullying by a parent at a school function cannot be tolerated.

Case 12 (Authors: Eliza M Park, M.D., Anna Cassidy)

Otorhinolaryngology: A 48-year-old female has a busy academic practice. She had National Institutes of Health (NIH) funding and was an admired teacher to the students and residents at her prestigious institution. She recently had been diagnosed with breast cancer. She will need to take time off for treatment and was worried about the progress of her research and her upcoming promotion to Professor. She felt as if her entire world was crashing down.

Contextual Features: Her husband of 22 years recently died after

a long battle with colon cancer. She remained the sole breadwinner for the family and had two children in college, one in high school, and another in grade school.

Solutions/Suggestions for Handling the Current Crisis: What does work-life balance look like when faced with life's most important existential challenges? The physician in this case had cultivated the rare balance of clinical, research, and educational success. How does this individual hold on to her multi-faceted and rewarding life when it is challenged in every direction? She cannot be expected to continue at her prior pace, but how does one adapt to life when life happens? The culture of academic medicine offers few easy answers.

Nearly every physician will find themselves wondering whether it is possible to be invested in both their career and their family or home life. Time, energy, and attention are finite resources that everyone must use judiciously. Sometimes, personal and professional priorities conflict and there is inadequate institutional support for resolving them. This tension becomes particularly acute for junior and mid-career faculty when they have (and cherish) family caregiving roles. A career in academic medicine can be deeply meaningful and fulfilling work. It also can be stressful, time-consuming, and challenge psychological and physical health. The truth is that balance is difficult, and it is unique for every individual and family. Yet, the risk for physicians is to prioritize professional life at the expense of other life priorities. When individuals make choices misaligned with their core values, they risk personal unhappiness and burnout.

Academic institutions fare no better. Withholding support for dual personal and professional roles means further perpetuating existing gender disparities among men and women in academic promotion, limiting the diversity and breadth of the physician-scientist workforce, and more broadly, promoting the unrealistic pursuit of work at great personal cost.[34] Women currently represent less than a quarter of all full professors in academic medical centers and only a third of NIH research project grant applicants.[35,36] The physician in this example is an extraordinary asset to her discipline, science, and to the next generation of physicians. What are the ways her institution can demonstrate their support when relentless productivity is the benchmark for success?

When so much of life is out of control, one can naturally wish to move toward what is controllable. This deeply committed individual needs hope for her future and anchors to her present. She cannot afford to wait for long-term institutional cultural change. She needs her mentors, department chair, and others, to advocate for her now. The losses and new challenges that this physician faces are both valid and outside of her control. In these circumstances, what is her highest goal? What is most important to her and most important to her right now? Prioritizing her own health and that of her family will likely require disappointing others. Can this physician provide the same compassion she has provided to her patients, her trainees, and her research to her own needs? Who will help her with this? When tragedy strikes, it is extraordinarily difficult to care, let alone advocate, for one's own needs. In this example, the cumulative pressures occurred at a time when the physician was mourning not only the death of her husband, but also the life she previously had imagined for herself and her family.

Physicians are not immune to life's losses, pain, and illness. Crises like serious illness force difficult personal choices, yet institutions should not be the driving force for unnecessary ones. While competition for scarce federal funds remains largely unchanged, institutions can do more for their faculty. They can acknowledge the immense pressures that individuals face and provide tangible support and resources. Even when such policies exist, the existing data suggested that broader organizational forces discouraged many from actually using them.[37] Tangible support requires clarity about what is available, what are viable alternatives, and an expectation that they will be used.

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