The long dark night of the sports medicine soul

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When I first started as a medical student on the wards, I remember very strongly the words of the professor of medicine at the time, who seemed bored with clinical medicine. I can remember very clearly wondering how one could reach this cynical and world-weary state of mind and aimed from that formative stage of my medical career to avoid this end. I look back now, some 25 years down the road, and realise that I too have developed the same attitudes and wonder whether this is just me or whether there is inevitability about our medical life journey that leads us to this particular state of grace.

This struck home for me recently where, in my home city of Melbourne, there have been two junior registrars who have committed suicide during the past 12 months. This highlights the fact that medical practitioners and others in the healthcare industry have an increased risk of death from suicide. A recent literature review found that male medical practitioners may be twice as likely to commit suicide as other professional males in general, and female medical practitioners are four to six times more likely to commit suicide than other professional women.1 Obviously this is not only a tragedy for all the families and work colleagues involved, but also an incredible waste of talent and of the community’s investment in the individual’s healthcare training.

Unhappy doctors are a worldwide phenomenon.2,3 The Canadian Medical Association,4 in its statement on physician health and wellbeing, stated: “There are indications that physician stress is on the rise; increasingly, medical students, residents and practising physicians are voicing distress and seeking assistance in coping with stresses in their training, practice and personal lives”. There is no reason to suspect that sport and exercise medicine (SEM) physicians and trainees are not part of the worldwide trend in medical unhappiness—it is just that we haven’t asked!

WHY ARE DOCTORS UNHAPPY?

Increased professional demands may make it seem impossible to integrate personal life and professional life into a holistic state. Perhaps we are all bad time managers, but clinical practice seems a stressful business. Some physicians may even feel guilty at enjoying the occasional pleasures a personal life or sporting life can bring because it interferes with professional life.

Explanations for the decline in the health and wellbeing of physicians, and the documented increase in their work-related stress, may include:

- The political and economic uncertainty affecting specialisation, registration, insurance, practice location, remuneration, hospital closures and private practice business demands;
- The rapid pace of change in the healthcare system including the regulatory processes that govern day-to-day practice;
- Lack of respect within the workplace;
- The increasing tendency to litigation within the healthcare system by patients dissatisfied with their treatment;
- An unprecedented growth in medical knowledge and technology, and the accompanying ethical dilemmas;
- The needs and expectations of an increasingly (internet-) informed public;
- The large emotional component of physician practice;
- Avoidance of health maintenance as part of a healthy life. Patterns of inappropriate healthcare behaviour develop very early in doctors’ careers: young doctors give their own health a low priority;
- A tendency for physicians to aim for perfection, self-sacrifice and self-criticism. Although these personal characteristics often lead to professional success, they also predispose to depression and other stress-related illnesses;
- The physical and mental demands of providing urgent/acute specialist care in SEM to elite athletes and professional teams;
- Rural and remote practitioners who feel isolated with no “downtime” and have practical difficulties in sourcing locum cover;
- Female practitioners balancing competing professional duties with home, family and other obligations;
- Physicians from non-English-speaking cultural minority groups or indigenous backgrounds face additional social and/or regulatory barriers to practice;
- Junior doctors in training who have unrealistic rosters and excessive work hours, coupled with the added stresses related to the college examination process;
- The fact that SEM, particularly in a team physician role, is typically practiced on weekends or after hours adds to these demands within the sports medicine workplace.

Responses to the inevitable stress experienced by SEM, physicians and trainees must combine personal action and responsibility, and actions by the colleges and employing authorities that in turn support the practitioner in his or her chosen career.

WHAT ARE THE RISKS OF UNHAPPINESS IN MEDICINE?

There is a growing awareness within medicine that physicians and other healthcare professionals are at risk of burn-out, which in turn threatens the sustainability of healthcare in the broadest sense.4 A large percentage of dissatisfied doctors consider leaving the profession and feel that their occupation impacts adversely on their physical and mental health.6,7 In some cases, moving from a clinical to academic role is achievable but this is available to the minority of individuals. A developing specialty such as SEM can ill afford to lose even a small percentage of its number through these processes and still remain viable.

We all realise that a high proportion of doctors tend to aim for perfection and are self-sacrificing and self-critical.8 These factors may lead to professional success, but they also predispose to stress-related symptoms and, in some cases, burn-out. There is a widespread belief within medicine that being a committed doctor means working long hours and taking work home, despite increasing evidence that longer work hours do not equate to improved workplace efficiency.

In sports medicine it is widely seen that servicing a professional sporting team or an elite athlete squad is a prestigious role, even if that role involves long working hours, extensive travel, poor remuneration, critical and time-pressured decision making, ethical dilemmas and other negative factors. Similarly, to be a doctor at the Olympic Games, Commonwealth
Games or a World Championship is highly sought after despite long hours, sleep deprivation and limited opportunities to actually see many events. It is perverse that such lofty SEM goals result in some of the greatest workplace stresses that exist within our specialty.

There is a relationship between the reduced health and wellbeing of the doctor and a reduction in the quality of patient care. Doctors tend to avoid seeking formal healthcare for themselves, to continue to work when unwell, and to self-treat or at best seek informal "corridor consults" for themselves from colleagues. Only a minority of doctors have their own general practitioner. Doctors have difficulty in not only adopting the patient role but in treating doctors as patients. Doctors are more likely to receive inferior healthcare and to have major concerns about confidentiality.


Symptoms such as emotional exhaustion, work avoidance, cynicism, perceived clinical ineffectiveness or a sense of depersonalisation in relationships with co-workers, patients or both, may be indicators of burn-out.

It is important to realise that it is an inevitable state that both personal life and professional life will be affected by work-related stress. We should be as knowledgeable about the physical and emotional characteristics of excessive stress and burn-out in oneself and in colleagues as we are about musculoskeletal injury in our patients. Overcoming burn-out will not only help the physician and their family, but it will improve the quality of care of the physician's patients.

Moreover, although recognition of the symptoms is important, the question arises as to what action you can take if professional impairment is recognised in you or in a colleague (eg, role of local medical boards). How many of us are familiar with the existing care pathways for impaired doctors in our own countries?

W H A T C A N W E D O A S I N D I V I D U A L S ?

We know we should be in good mental and physical health when seeing patients, but with the demands on our time, our own health often comes a distant second. Working in the public health system there is a high risk of burn-out due to work overload, excessive on-call time and high demand for doctors in certain regional areas or in particular specialties. In part, the culture of the medical system appears to reward self-sacrifice and the mistaken belief that being a committed doctor means working long hours and taking work home.

There are some simple rules that we can all follow to try and improve our own health:

- Establish and maintain regular contact with a GP;
- Develop a regular exercise programme;
- Incorporate health maintenance as part of professional life;
- Adopt a balanced lifestyle—time for self, family and friends and professional life;
- Establish or participate in local professional support networks such as mentoring programmes, professional supervision or formal professional groups;
- Use your colleagues for support, and maintain and work on relationships with partner/friends;
- Recognise that our professional and personal life will be affected by work-related stress and learn to recognise the physical and emotional characteristics of excessive stress and burn-out. Find out about action you can take if professional impairment is recognised in a colleague (eg, role of local medical boards);
- Develop the skills of effective time management—making realistic schedules and not over-committing yourself (at work or at home);
- Take control of your work hours. This may be achieved through tactics such as scheduling breaks, taking days off, striking a balance between the hours of paid work and job demands, putting holidays in your diary months ahead, and avoiding taking work home;
- Humour is therapeutic: surround yourself with fun and humour daily;
- Act today, tomorrow may be too late.

When I reflect on my personal situation I know I don't exercise sufficiently, am overweight, over-commit my time and work excessive hours. However, I owe it to my family, my patients, my colleagues and even to my employers not to ignore my physical and mental wellbeing. A few years ago, after a self-diagnosed minor health scare, I did establish contact with an excellent general practitioner whom I continue to see regularly and whom, very importantly, treats me as a patient not just a colleague.

W H A T C A N B E D O N E I N T H E W O R K P L A C E ?

Balancing the demands of work and home effectively are a high priority for most female and male physicians and trainees. Female physicians/trainees are at particular risk of work-related stress as they may retain the primary role for managing the household.

Often the work environment offers little support for women physicians. There can also be harassment at work. Women may experience inappropriate sexual comments and behaviour, which may not be overt or intentional but are still demeaning. Female physicians are vulnerable to high rates of verbal abuse and physical assault by male patients and other healthcare workers.

More and more women are having their own children during their medical training. This is because many students are entering medical school at an older age as postgraduate students. Unlike public hospital training where there are workplace industrial awards with employee benefits, including parental leave and provision for part-time training, SEM training in the private system offers little financial protection for this eventuality. Physicians and trainees need to be self-insured for health problems, disability or other reasons that may limit their ability to practice. Trainees need to be educated about these needs throughout their period of training and as they develop their consultative practice as an integral part of their professional development. It may be a radical step, but continuing professional development (CPD) points could be awarded for effective individual financial and insurance arrangements.

However, those exercising these benefits may feel guilty because their colleagues will have an increased workload in covering them (particularly as some hospitals do not employ locums for parental leave and private practices simply do not offer this benefit). Furthermore, these physicians and trainees may experience criticism and disapproval from colleagues, and even their supervisors, for taking parental leave. Similarly, workplaces need to allow staff to provide quality parenting through flexible workplace practices that support the work-family balance.

W H A T C A N T H E S E M C O L L E G E S D O ?

It is critical that SEM colleges and faculties recognise the health issues of fellows and trainees as a matter of priority. At a college level, the importance of physician wellbeing needs to be highlighted in all areas and also should be incorporated into the new SEM curriculum. Part of SEM physician training should concentrate on self-care and maintaining wellbeing.
WARM UP

Possible roles that a college may play in a supportive educative structure may include:

- Including sessions on physician well-being at annual scientific meetings as well as annual registrar meetings;
- Recognising that the participation of physicians and trainees in wellness educational activities, such as supervision and mentoring programmes, is a component of CPD and should be rewarded through the CPD points structure;
- Investigating ways to reduce stress associated with the college examination and assessment processes;
- Ensuring that during the accrediting of SEM facilities for training positions, consideration is given to “wellness” issues for trainees. This includes on-call requirements, mentoring, trainee advocacy, flexible work hours, professional support, the availability of part-time and job-share options, and personal impacts such as accommodation. The college also has a key role in supporting trainees in the resolution of inappropriate or unsustainable working environments and expectations;
- Raising the “profile” of self-care, wellness and lifestyle in training and CPD policy;
- Including material in supervisor workshops regarding trainees developing health maintenance activities/strategies;
- Recognising and responding to the specific needs of overseas trained SEM physicians and trainees, especially those working in regional settings and “areas of need”;
- Supporting the development of professional networks, peer support activities, and mentoring and clinical supervision programmes within the college;
- Within the existing team physician courses and programmes, recognising this issue as a priority and developing educative strategies to prevent this from occurring in this high-risk group.

CONCLUSION

Many factors predispose doctors to difficulty in maintaining their mental and physical health. Physicians need to be more perceptive in recognising burn-out in our colleagues and ourselves and, more importantly, know what to do once this is recognised. Health maintenance and self-care principles need to be incorporated in the SEM curriculum and perhaps into CPD programmes. Identification of specific issues at an individual, college, workplace and system level that contribute to these causes will also help structure preventative measures.


REFERENCES

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