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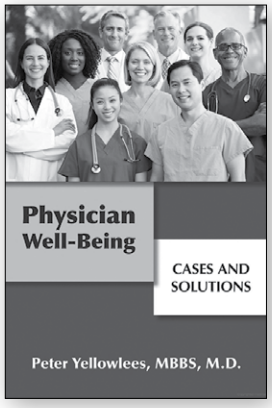
Physician Well-being: Cases and Solutions



By Peter Yellowlees; Washington, DC; American Psychiatric Publishing; 2020; ISBN 978-1-61537-240-9; pp 243; $55 (paperback).

Physician well-being has rightfully become a very important part of the discussion about today's medicine and its future. It is clear that many physicians are burned out and that many do not properly take care of themselves. As Peter Yellowlees, MBBS, MD, (who, among other responsibilities, is Chief Wellness Officer for University of California Davis Health) points out in the Preface to his book, physicians usually look after themselves well from a physical health perspective. They live longer than the general population because they apply to themselves the same advice they give to patients regarding behavioral causes of medical illnesses. Thus, they have fewer chronic cardiovascular and respiratory illnesses. This helps with relative longevity, though many physicians do not see a primary care physician regularly. However, as Dr. Yellowlees writes, the situation is quite different in regards to physicians' mental health. We know that most medical students are, at the start of medical school, "more resilient and less depressed than equivalent graduate students in other disciplines … However, within a few years this changes, and numerous studies have documented increasing levels of burnout and depression during medical school and residency. It is now widely accepted that 10-15 years after entering medical school, the average physician has twice the level of burnout of the average professional nonphysician, primarily caused by systemic and organizational issues" (p xii). Physicians also have higher rates of suicide, with females at twice the rate of community controls and males at 1.4 times the rate. Physicians have not been doing well lately. They are much distressed and burned out, which is also reflected by more physicians retiring earlier than they originally planned.

Continuing in the Preface (in my opinion, the most informative part of this book), Dr. Yellowlees notes that "the major reasons for physician distress are organizational and systemic and that physicians are not themselves primarily to blame, except for their past lack of insight and unpreparedness to ask for help with their own health care" (p xiv). The factors contributing to the distress are work hours, the current and worsening physician workforce shortage (namely in primary care and psychiatry), and the hours of unnecessary administrative work that could be done by others. Let's also not forget electronic medical records (EMRs) and the "malignant health insurance industry." As Dr. Yellowlees mentions, "I have never met a physician who told me that he or she went into medicine in order to spend 30% more of the working day on administrative requirements and clinical documentation" (p xv). That is all happening as the United States spends 18% of its gross domestic product on health care—more than other equivalent Western health systems—while delivering worse per-capita care than those systems. And all that while, when comparing medical notes, "U.S. doctors actually write between three and five times as much as European doctors, and for no obvious clinical benefit" (p 34). He also cites Dr. Darrell Kirch, President of the Association of American Medical Colleges, who warns of a major disruption of the health care system as we know it, with the increase in mergers and megamergers of systems, more physicians becoming career employees, the aging of the Baby Boomers with subsequent shortages of physicians (while Congress keeps the "temporary" cap on residency slots for 21 years). Dr. Kirch suggests that we need "1) more diversity within the health care professions, 2) organizational change to reduce burnout, and 3) improved medically driven leadership" (p xvii) all with "… less focus on economic bottom lines and more on clinical and well-being outcomes for both patients and providers" (p xvii).

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Dr. Yellowlees's advice to all is in this book. It contains 10 chapters that consist "of a long, detailed case description of a component of physicians' lived experiences, followed by a commentary examining the major themes and referencing key works or papers from the literature" (p xi). The chapters have titles that reflect their focus, such as Our Dedicated Dad; Health Care is a Team Sport; A Unified Mission; Trust, Mentoring, and Innovation; Pre-med: Vulnerability and Trauma; Medical School: Implicit Biases and Well-Being Curriculum; Residency: A Narcotic Addict's New Career; Cognitive Dissonance and Defining Meaning in Medicine; Medical Marriages: Caring for Each Other; and The Joy and Meaning of Medicine.

The first chapter examines "the medical environment and the culture of physicians in contrast with family perspectives and some of the unintended consequences" (p 24). It discusses Dr. Glen O. Gabbard's "compulsive triad" of the doctor's personality—"doubt, guilt, and an exaggerated sense of responsibility, working synergistically with the ethical obligations of the Hippocratic Oath, which, while covering many positive aspects, contains nothing about self-care or the care of other physicians" (p 16).

The next chapter focuses on 2 major issues: a) the need for organizational and systemic changes to reduce physician burnout, and b) the importance and widespread occurrence of stigma of psychiatric disorders among health professionals and the roles of medical boards and licensing authorities in making this stigma worse. This chapter is followed by 2 chapters addressing problems in a large health care system and a multidisciplinary clinic; focusing on effective ways of introducing change within a clinical environment; understanding why these ways would create changes that help to reduce burnout and improve patient care and safety; mentorship in this setting from both the mentor's and the mentee's perspective; and the importance of working more efficiently (using Stanford Wellness Program and also using EMRs and telepsychiatry more effectively). The text includes good tables titled "Tips for Mentors" (p 93) and "Tips for Mentees" (p 94). It also includes a table on how to use technology to stay sane (eg, set clear boundaries with patients, avoid playing "phone tag," refrain from writing letters and notes after hours, and use mobile technology to work anytime anywhere [really?]). More advice in the book focuses on the advantages of telepsychiatry, such as increased variety, increased time with patients, increased collaboration and teamwork, increased flexibility, and reduced costs in the office environment. I was disquieted by some of the statements included in this advice. For instance, "It is much easier to type up notes while talking to the patient, because in the telemedicine consultation it is possible to maintain good eye contact while using two or more screens simultaneously to type notes out of the sight of the patients, with little interference in the relationship" (p 96) (really?); "Patients can be seen literally anytime, anywhere and are no longer tied to the typical 8 A.M. – 5 P.M. clinic day. Evening time and weekend clinic suddenly become an option…" (p 97) (speaking of burnout?); and "Many physicians prefer working from home, where they can simultaneously, for instance, look after their children, save travel time, and reduce the cost of an office…" (pp 97-98) (as one of my female colleagues noted, "How can you simultaneously work and look after your children?").

The next 3 chapters focus on "solutions needed to improve the onboarding of physicians in the early years of their career, starting first in pre-med before focusing on medical school and residency" (p xix). The medical school chapter describes a moving case of a student who dies of suicide, while the chapter on residency uses a scenario of a resident with opioid abuse to address the culture of residency, the need for the availability of good treatments for residents, and other issues.

The last 3 chapters cover areas such as alternative medical careers and use of information technologies and telemedicine to help physicians work differently and less stressfully; medical marriages (this chapter's narrative may be good for those never exposed to marital therapy) and physicians being poor personal finance managers; and finally, how medical societies can support and enhance physician well-being.

The topic of this book is important and interesting. The book is filled with a good amount of valuable information. However, I am not enthusiastic about the narrative framework used. Narratives frequently are useful to illustrate important points. But the narratives are too long and wordy, and one gets lost in reading

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them at times (I admit that some are more crisp, but those are exceptions). I was a bit disquieted by some of the advice provided. The heavy reliance on technology as an answer to many ills worries me a bit for a couple of reasons: a) the demise of the humanistic part of patient care, and b) the big unknown—EMRs were introduced to us as a great help, yet many see it as a scourge now. Last but not least, while I understand the enthusiasm, I am not sure about the wide audience, as I am not clear who the audience would be. Thus, as far as a recommendation, the book leaves me ambivalent about what to say.

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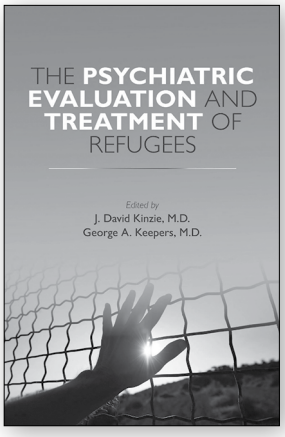
DISCLOSURE: Dr. Balon is a member of the American Psychiatric Association Publishing Editorial Board.

The Psychiatric Evaluation and Treatment of Refugees



Edited by J. David Kinzie and George A. Keepers; Washington, DC; American Psychiatric Association Publishing; 2020; ISBN 9781615372263; pp 200; $48 (paperback).

The matter of migration and refugees has received a lot of media attention—not just in the United States, but all over the world. As noted in the first chapter of this small book, according to the United Nations High Commissioner for Refugees, in 2019, there were "66 million forcibly displaced people, of whom 22 million are refugees, more than half from Syria, Afghanistan, and South Sudan" (p 1). However, migration is nothing new. It "has been a part of the human condition since the beginning of time" (p 1). People migrate for various reasons: to find freedom, escape adversity, and gain a better life. The United States has been a country built by and open and welcoming to immigrants, and people have migrated to this country for all these reasons.

In the United States, the patterns and numbers of immigrants have changed throughout time, reflecting changes in public support and government policies. Immigrants represented 15% of the total US population in the 1920s, only 5% in the 1970s, and 15% at the present time. Many of the refugees and asylum seekers have been traumatized and faced psychological struggles in their countries of origin or during their migration. They need to be evaluated and treated for possible psychological consequences of their struggles, and probably for mental disorders in general, because the mental health services in many of the countries from which they come are inadequate.

J. David Kinzie, MD, and George A. Keepers, MD, put together a team of psychiatrists with expertise and experience in caring for refugees to write this small volume to guide others in evaluating and treating refugees. A lot of the material presented in this volume is based on more than 40 years of experience working with refugees at the Intercultural Psychiatric Program at the Oregon Health & Science University led by one of the editors, Dr. Kinzie.

In its 13 chapters, the book discusses various issues of the care of refugees, such as psychological and psychopharmacologic treatments, specific matters in the care of children and older refugees, training residents to treat refugees, and other interesting topics, including the description of the Oregon Model (the Intercultural Psychiatric Program).

As noted in the first chapter, "Despite the conditions that refugees experience prior to resettlement, there currently is no clear evidence that the prevalence rates of mental disorders among refugees in the initial years of resettlement are significantly higher or lower than those

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in the host population, with the exception of psychosis and PTSD. However, over the long term, among the resettled refugees, the rates of depression and anxiety disorders seem to be higher than those in the host populations, while the rates of PTSD continue to be higher than those in the host populations" (p 6). Importantly, torture is a prominent factor in the development of PTSD. This chapter provides a great overview of diagnostic and cultural issues, including the refugee screening process, their countries of origin, and their arrival in the United States; assessment of refugee mental health in the clinical setting; and general treatment issues. The text emphasizes that when an interpreter is present during the assessment, "it is important for the examiner to also be aware of variations in nonverbal behavior that occur cross culturally" (p 9). One also should be aware of the refugees' barriers to access to care, such as language, lack of knowledge about treatment options, and lack of familiarity with the American health care system. One of the vital aspects of evaluation and care is thus thorough education of the patient and family, especially when discussing "common posttraumatic symptoms in order to reduce personal and social stigma" (p 13). The next chapter provides an example of a diagnostic interview with a refugee. It emphasizes that "The diagnostic interview of refugee psychiatric patients is difficult, requiring a gentle, slow approach to promote trust and set the relationship for long-term care" (p 28).

I appreciated the next chapter on psychological treatment, which focused on narrative exposure therapy. It discusses several important concepts, such as stigma, cultural humility, and vicarious traumatization, through several case examples. It also emphasizes that "Refugees are often reluctant to talk about trauma and torture. Furthermore, many refugees do not distinguish between symptoms and traumatic experience" (p 43). The following related chapter discusses psychotherapy of post-immigration stress, again using several case examples.

The chapter on psychopharmacology unnecessarily veers into psychobiology, but also provides some practical clinical tips. Examples of these tips include facts such as "Africans tend not to adhere to the regular appointment time, although they usually come in the same day.... Many patients from rural areas in Asia and Africa are illiterate and cannot read the labels of medicine and need repeated explanations and reminders to take medicine. A pill box is very helpful.... Many patients from Asia believe that American medicine is too strong and cut the dose in half. Most have no understanding of the long-term use of medicines and stop taking them as soon as the prescription is finished or as soon as they feel better." (p 64). The author also shares his good experience with using tricyclic antidepressants, such as imipramine or doxepin, combined with prazosin or clonidine in the treatment of depression, insomnia, and nightmares.

The chapter on the Oregon Model emphasizes some of its unique features, such as its inclusion of full-time ethnic counselors and case managers (eg, Vietnamese staff for refugees from Vietnam), who serve as interpreters for the psychiatrists in treatment sessions with patients in their own ethnic group. Interestingly, the psychiatrist provides not only evaluation and medication, but also psychotherapy (usually supportive) and letters of support for government medical assistance or citizenship application. The chapter on children and adolescents includes several very good clinical cases. The book also includes a chapter on asylum seekers, which addresses victims of torture and female genital mutilation.

I also liked the inclusion of a chapter on training residents to treat refugees. The text emphasizes that psychiatrists need skills for distinguishing "normal suffering" of refugees, such as demoralization, loss of identity, and loss of dignity, from psychiatric illnesses. "Demoralization, ambiguous loss, and loss of identity are three normal syndromes of distress that are particular sources of suffering for many refugees" (p 148).

Finally, the chapter on ethical issues in the field of refugee mental health is worth mentioning. One of the special issues pointed out here is when the patient is found to be a perpetrator of human rights abuses. Such a situation could be so abhorrent that the clinician cannot continue, and a referral should be made elsewhere (p 171).

The positive features of this little book are its clinical orientation, practicality, wealth of shared

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experience by some of the authors who have been taking care of refugees for decades, and the wealth of case examples. Are there any weaknesses? Some chapters could have been more elaborate, and experiences from host countries other than the United States could have been included. Nevertheless, this is a very useful book for anyone who is evaluating and caring for refugees' mental health.

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BOOKS RECEIVED

The following books have been received or otherwise obtained and will be reviewed by selected individuals, the courtesy of the sender is acknowledged by this listing

Professional Well-being: Enhancing Wellness Among Psychiatrists, Psychologists, and Mental Health Clinicians. By Grace W. Gengoux, Sanno E. Zack, Jennifer L. Derenne, Athena Robinson, Laura B. Dunn, and Laura Weiss Roberts; Washington, DC; American Psychiatric Association Publishing; 2020; ISBN 978-1-61537-229-4; pp 298; $55 (paperback).

A Psychiatrist's Guide to Advocacy. Edited by Mary C. Vance, Katherine G. Kennedy, Ilse R. Wiechers, and Saul M. Levin; Washington, DC; American Psychiatric Association Publishing; 2020 ISBN 978-1-61537-233-1; pp 458; $59 (paperback).

The American Psychiatric Association Publishing Textbook of Anxiety, Trauma, and OCD-Related Disorders, Third Edition. Edited by Naomi M. Simon, Eric Hollander, Barbara O. Rothbaum, and Dan J. Stein; Washington, DC; American Psychiatric Association Publishing; 2020; ISBN 978-1-61537-232-4; pp 721; $155 (hardcover).