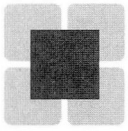

WILLIAM S. WILKE, MD, EDITOR

HIGHLIGHTS FROM MEDICAL GRAND ROUNDS

PHYSICIAN JOB SATISFACTION: REVERSING THE DECLINE

PHYSICIANS today are finding less satisfaction in their work. Even though physicians still get a sense of fulfillment from diagnostic challenges, financial security, and patient gratitude, many feel a growing sense of failure. Radetsky[1] noted that in this era, "a deluge of new clinical information is eroding one's sense of professional mastery, money ceases to compensate for the time and toil (of medical practice), and the gratitude of patients is often mixed with fear and suspicion."

Practitioners, educators, and medical leaders need to acknowledge this phenomenon and understand its roots and the opportunities it presents to improve the health care system.

DISSATISFACTION GROWING

The problem of physician dissatisfaction seems to be growing steadily over time. A 1966 study of Case Western University Medical School graduates found that 98% would stay in their present career and only 2% would change.[2] In 1982 a similar study found that 90% of the graduates were happy with their career and 10% would change.[3] By 1989, a Gallup Poll of 1000 practitioners found that 61% would stay in their present career, 14% definitely would not go to medical school again, and 25% probably would not go again.[4] And in 1991 a survey of American College of Physician members found that 60% would stay in their present career, 21% would choose a different specialty, and 19% would select a different career altogether.[5]

■ Highlights from Medical Grand Rounds present take-home points from selected Cleveland Clinic Division of Medicine Grand Rounds lectures and other educational presentations at The Cleveland Clinic.

Major sources of physician satisfaction, cited in a 1979 study, were diagnosis and successful therapy (53%), service to humanity and good physician-patient relationships (50%), and respect and appreciation from patients and community (29%).[6] As for irritants, time pressure was the number-one complaint (47%), while other sources of dissatisfaction were therapeutic failure and patient-related problems (26%) and office details and paperwork (24%). If this study were done today, the last figure would no doubt be much higher.

THE DIFFERENCES BETWEEN MISERABLE, UNHAPPY, AND HAPPY

A study by Reames and Dunstone[7] found two types of dissatisfied physicians. One group felt their problems were unsolvable; they felt powerless and feared financial loss and malpractice suits. At the same time they exhibited (perhaps most tellingly) an overdevotion to medicine. Medicine was all there was for them. As they had problems in their medical practice, they felt trapped.

The second group of unhappy physicians found their practical problems solvable, but they were still unhappy. These physicians felt they had mastered the business of medicine, but they were still very concerned about threats to the doctor-patient relationship. They felt that they were being told how to practice and how much time they could spend with patients. A common coping mechanism for these physicians was to work harder and longer; consequently, fatigue was a very common problem.

In contrast, satisfied physicians had made an internal adjustment. It was as if they said to themselves, "I may not be able to change the outside world, but I can change my own attitude on the inside." Because they felt they had good relationships with their patients, these physicians felt (rightly or

wrongly) some security against malpractice suits. They kept medicine in perspective and had more balance in their lives.

SOME SKILLS TO INCREASE HAPPINESS

To be happier and more effective, physicians need to develop a set of skills that are not usually taught in medical school.

Set realistic goals. If you expect that you can prevent diabetic nephropathy in every patient, you are setting yourself up for failure, since many aspects of patients' care and compliance are beyond your control.

Listen before speaking. Many physicians fail to listen when proposing a treatment plan. Active listening can increase satisfaction for the patient and physician by creating a closer bond between them.

Negotiate. Physicians need to foster partnerships with their patients and share responsibility so that responsibility for treatment and care is not all on their shoulders. This mutual negotiation can also improve a patient's motivation to do the things that are in his or her own best interests.

Learn time management skills. Set boundaries on how many hours you work and do not always let the demands of medicine crowd out everything else. Time management also applies at the level of the patient encounter. If you can negotiate an agenda up front (as Beckman and Frankel suggest),[8] you can get more control of that 10- or 15-minute clock.

Take care of yourself. Physicians are terrible at this. Dispel the myth of the iron man and superwoman. Learn how to become a team player rather than going it alone. Support is particularly vital in coping with mistakes and with complicated patients.

In addition to these inner adjustments, physicians must pay attention to the institutions where they work. They must examine the values that are communicated and cultivated at their office and hospital. A healthy work environment includes respect for the personal experiences and needs of workers instead of just treating them as objects to be moved around. Staff and colleagues should be encouraged to seek help for problems, rather than be made to feel shame and humiliation.

To improve their sense of satisfaction, physicians must accept responsibility for their own happiness and not simply blame Congress or the insurance companies. These two institutions introduce many hassles into physicians' lives, but we cannot give them too much power over us. By working on skills that foster relationships and that strengthen self-care skills and by creating work environments that are supportive and respectful, we can create a real health care revolution. We cannot change the entire system all at once. But we can confront these issues within our own practices, our own departments, and in our own exam rooms. In humanizing care for patients and their families, we rehumanize ourselves.

ANTHONY L. SUCHMAN, MD
University of Rochester, NY

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CARDIOVASCULAR DISEASE IN RENAL FAILURE: RISK ASSESSMENT, SCREENING, TREATMENT

END-STAGE RENAL DISEASE (ESRD) imposes an extremely high death rate, approximately half of which is due to cardiovascular disease. Studies with relatively small numbers of patients are elucidating the clinical factors that identify ESRD patients at highest risk of cardiovascular disease and are suggesting possible strategies for intervention. Nevertheless, this work is still in its infancy, and much remains to be done. Poignantly, because of the high risk in this population, studies need not be large to demonstrate statistically significant results.

A LARGE POPULATION AT HIGH RISK

According to the United States Renal Data System, the US population of approximately 240 000 ESRD patients is growing by about 9% annually, as