

 An audio interview with Dr. Stuart Slavin is available at NEJM.org

ical education, the Association of American Medical Colleges, the U.S. Medical Licensing Examination, and the American College of Graduate Medical Education — will have to band to-

gether if we want to change this culture. I believe it is imperative that we do so before another precious life is lost.

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1. Dyrbye LN, Thomas MR, Massie FS, et al. Burnout and suicidal ideation among U.S. medical students. *Ann Intern Med* 2008;149:334-41.

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Breaking the Stigma — A Physician's Perspective on Self-Care and Recovery

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My name is Adam. I am a human being, a husband, a father, a pediatric palliative care physician, and an associate residency director. I have a history of depression and suicidal ideation and am a recovering alcoholic. Several years ago, I found myself sitting in a state park 45 minutes from my home, on a beautiful fall night under a canopy of ash trees, with a plan to never come home. For several months, I had been feeling abused, overworked, neglected, and underappreciated. I felt I had lost my identity. I had slipped into a deep depression and relied on going home at night and having a handful of drinks just to fall asleep. Yet mine is a story of recovery: I am a survivor of an ongoing national epidemic of neglect of physicians' mental health.

In the past year, two of my colleagues have died from suicide after struggling with mental health conditions. On my own recovery journey, I have often felt branded, tarnished, and broken in a system that still embroiders a scarlet letter on the chest of anyone with a mental health condition. A system of hoops and

barriers detours suffering people away from the help they desperately need — costing some of them their lives.



Last year, I decided I could no longer sit by and watch friends and colleagues suffer in silence. I wanted to let my suffering colleagues know they are not alone. I delivered a grand-rounds lecture to 200 people at my hospital, telling my own story of addiction, depression, and recovery. The audience was quiet, respectful, and compassionate and gave me a standing ovation. Afterward, hundreds of e-mails poured in from people sharing their own stories, struggles, and triumphs. A floodgate of human connec-

tion opened up. I had been living in fear, ashamed of my own mental health history. When I embraced my own vulnerability, I found that many others also want to be heard — enough of us to start a cultural revolution.

My years of recovery taught me several important lessons. The first is about self-care and creating a plan to enable us to cope with our rigorous and stressful work. Personally, I use counseling, meditation and mindfulness activities, exercise, deep breathing, support groups, and hot showers. I've worked hard to develop self-awareness — to know and acknowledge my own emotions and triggers — and I've set my own boundaries in both medicine and my personal life. I rearranged the hierarchy of my needs to reflect the fact that I'm a human being, a husband, a father, and then a physician. I learned that I must take care of myself before I can care for anyone else.

The second lesson is about stereotyping. Alcoholics are stereotyped as deadbeats or bums, but being humbled in your own life changes the way you treat other

people. An alcoholic isn't a bum under a bridge or an abusive spouse: I am the face of alcoholism. I have been in recovery meetings with people of every color, race, and creed, from homeless people to executives. Mental health and substance-abuse conditions have no prejudice, and recovery shouldn't either. When you live with such a condition, you're made to feel afraid, ashamed, different, and guilty. Those feelings remove us further from human connection and empathy. I've learned to be intolerant of stereotypes, to recognize that every person has a unique story. When we are privileged as professionals to hear another person's story, we shouldn't take it for granted.

The third lesson is about stigma. It's ironic that mental health conditions are so stigmatized in the medical profession, given that physicians long fought to categorize them as medical diagnoses. Why do medical institutions tolerate the fact that more than half their personnel have signs or symptoms of burnout? When mental health conditions come too close to us, we tend to look away — or to look with pity, exclusion, or shame.

We may brand physicians who've had mental health conditions, while fostering environments that impede their ability to become and remain well. When, recently, I moved to a new state and disclosed my history of mental health treatment, the licensing board asked me to write a public letter discussing my treatment — an archaic practice of public shaming. Indeed, we are to be ashamed not only of the condition, but of seeking treatment for it, which our culture views as a sign of weakness. This attitude is

pervasive and detrimental — it is killing our friends and colleagues. I've never heard a colleague say, "Dr. X wasn't tough enough to fight off her cancer," yet recently when a medical student died from suicide, I overheard someone say, "We were all worried she wasn't strong enough to be a doctor." We are all responsible for this shaming, and it's up to us to stop it.

The fourth lesson is about vulnerability. Seeing other people's Facebook-perfect lives, we react by hiding away our truest selves. We forget that setbacks can breed creativity, innovation, discovery, and resilience and that vulnerability opens us up to personal growth. Being honest with myself about my own vulnerability has helped me develop self-compassion and understanding. And revealing my vulnerability to trusted colleagues, friends, and family members has unlocked their compassion, understanding, and human connection.

Many physicians fear that showing vulnerability will lead to professional repercussions, judgment, or reduced opportunities. My experience has been that the benefits of living authentically far outweigh the risks. When I introduced myself in an interview for a promotion by saying, "My name is Adam, I'm a recovering alcoholic with a history of depression, and let me tell you why that makes me an exceptional candidate," I got the job. My openly discussing recovery also revealed the true identity of others. I quickly discovered the supportive people in my life. I can now seek work opportunities only in environments that support my personal and professional growth.

The fifth lesson is about pro-

fessionalism and patient safety. We work in a profession in which lives are at risk, and patient safety is critically important. But if we assume that the incidence of mental health conditions, substance abuse, and suicidal ideation among physicians is similar to (or actually higher than) that in the general population, there are, nevertheless, many of us out there working successfully. The professionals who pose a risk to patient safety are those with active, untreated medical conditions who don't seek help out of fear and shame. Physicians who are successfully engaged in a treatment program are actually the safest, thanks to their own self-care plans and support and accountability programs.

Instead of stigmatizing physicians who have sought treatment, we need to break down the barriers we've erected between our colleagues who are standing on the edge of the cliff and treatment and recovery. Empathy, unity, and understanding can help us shift the cultural framework toward acceptance and support. Mentally healthy physicians are safe, productive, effective physicians.

The last lesson is about building a support network. My network has been the bedrock of my recovery. You can start small and gradually add trusted people, from your spouse and family to friends, counselors, support groups, and eventually colleagues. Then when you fall flat on your face, there will be someone to pick you up, dust you off, and say, "Get back out there and try it again." A support network can also hold you accountable, ensuring that you remain true to your own personal and professional standards.

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Without question, my own successful recovery journey has made me a better physician. My newfound perspective, passion, and perseverance have opened up levels of compassion and empathy that were not previously possible. I still wear a scarlet A on my chest, but it

doesn't stand for "alcoholic," "addict," or "ashamed" — it stands for Adam. I wear it proudly and unapologetically.

When a colleague dies from suicide, we become angry, we mourn, we search for understanding and try to process the death . . . and then we go on doing things the same way we

always have, somehow expecting different results — one definition of insanity. It's way past time for a change.

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Adopting Innovations in Care Delivery — The Case of Shared Medical Appointments

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Transformative innovations in care delivery often fail to spread. Consider shared medical appointments, in which patients receive one-on-one physician consultations in the presence of others with similar conditions. Shared appointments are used for routine care of chronic conditions, patient education, and even physical exams. Providers find that they can improve outcomes and patient satisfaction while dramatically reducing waiting times and costs.¹ Patients benefit from interacting with their peers and hearing answers to questions that may be relevant to them. Doctors avoid repeating common advice, which improves their productivity and enables higher-quality interactions with individual patients. Increased system capacity reduces waiting times even for patients who opt for traditional one-on-one appointments. Shared appointments have been used successfully for over 15 years at the Cleveland Clinic, in the Kaiser Permanente system, and elsewhere.

Shared service delivery isn't a new concept. Group interventions

are common for primary prevention (e.g., encouraging smokers to quit) and secondary prevention (e.g., helping patients with chronic obstructive pulmonary disease to avoid complications). Group-based programs such as Alcoholics Anonymous and Weight Watchers allow people to acknowledge that they have a problem and start working toward solutions. PatientsLikeMe connects patients to peers with similar conditions. Mental health support groups — for people with depression or anxiety, for example — are common. Yet these interventions are rarely led by doctors.

Given the effectiveness of group interventions, why aren't doctors routinely using them to treat physical and mental conditions? We believe four crucial components are missing: rigorous scientific evidence supporting the value of shared appointments,² easy ways to pilot and refine shared-appointment models before applying them in particular care settings, regulatory changes or incentives that support the use of such models, and relevant patient and clinician

education. Such enablers are necessary for any highly innovative service-delivery model to become standard.

First, like most delivery models, shared medical appointments aren't easily amenable to randomized, controlled trials. Patients like to decide for themselves how they'll see their doctor. And unlike a study drug and identical placebo, shared and one-on-one appointments differ visibly from one another.

In the social sciences, randomization is often impractical. Researchers can't randomly provide schooling to some children and deny it to others to estimate education's effect on earnings. Social scientists have cracked this selection problem by exploiting sources of "random" variation in the treatment variable. For example, whether a child's birthday falls before or after an arbitrary cutoff date often determines the age at which he or she can enter first grade. This policy creates random variation in years of education among children who drop out after the compulsory schooling