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Editor's Forum

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Respect for the patient's autonomy with regard to health care decision making is regarded as a cornerstone of clinical care and ethics today. This central position of autonomy has supplanted the long tradition of medical paternalism. Yet in the clinical world of health care, serious conflict may occur between preserving individual autonomy and respecting other competing ethical concerns. The papers by Parkes & Kunyk and Gill & Byrne in this issue of *Health Ethics Today* address this conflict from very different vantage points.

Parkes & Kunyk present analysis and discussion about the ethical duty to protect populations from illness by having immunization policies in place while accepting that individual objections may occur. While sensitive to the basis of individual objections and "opting out" they recommend a mandatory immunization policy as being ethically justified because of the strong evidence in favour of population health benefits. They make clear policy recommendations and suggest a restrictive approach towards "opting out" as a balance between respecting individual autonomy and the health needs of the population.

In contrast Gill & Byrne raise the issue of excluding patients with mental illness from the current federal

legislation (Bill C 14) permitting physician assisted dying. The exclusion appears to be based on fears about the difficulty of distinguishing between mentally ill patients who lack autonomy on the basis of their illness and those genuinely making an autonomous decision to request assistance in dying. As psychiatry specializes in dealing with patients

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who may lack decision making capacity, resulting in frequent overriding of individual autonomy in the patient's interest, the expertise and experience of its practitioners should allay such fears. As such the autonomy of mentally ill patients requires the same respect as for other patients.

Physician health and welfare is not a subject receiving much public attention. Yet the statistics related to serious health problems including alcohol and drug abuse, marital strife and divorce, depression and suicide, show that physicians have among the highest rates of any profession. This lack of public discussion of these problems is surprising and ironic considering that physicians are responsible for assisting the population in avoiding such hazards. Brindley & Farnan describe the condition of "burnout" among physicians. Their diagnosis and prognosis of burnout is serious in its implications for physicians, for other health professionals, and for the public. A culture of toughness has been part of the tradition of medicine as a self-regulating profession and this has contributed to denial and secrecy concerning the problem. Recently this culture has begun to change with increased public accountability and professional acknowledgement of the problem. Medical supervisory and regulatory institutions now have formal reporting processes and health assistance programs for physicians (College of Physicians & Surgeons of Alberta, 2016). Early recognition of "burnout" among physicians and provision of assistance to them is key to dealing with the problem.

The diagnostic and therapeutic philosophy of modern medicine and health care is based on a biological basic science conception of health and disease. The clinical application of research findings from empiric and clinical studies influences the evolution of diagnosis and treatment. Care of the sick has long been understood to involve a great deal more than this simple diagnostic therapeutic process. The

nursing profession has always valued care as being central to all clinical encounters. Patients recognize and value the efforts of health professionals who treat them with respect and compassion. The paper by Fawcett & Mardon describes the development of western medical care with roots in philosophy, primitive pharmacology, a variety of spiritual beliefs, and overlap between these influences. Recognition of both physical and spiritual needs of patients today remains important even when diagnosis and treatment appear clear. They argue that an attitude towards religion as being contrary to science based health care is not supported by the beliefs or doctrine of Christianity. Specific questions about religious beliefs, cultural values, and what they mean to an individual patient and family, may be very important to the clinical care.



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Ethical and Policy Challenges with Vaccine Mandate: Whose Game of Russian Roulette?

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Perhaps indicative of our societal complacency regarding vaccines and preventable communicable diseases, it is jarring to read news reports of related outbreaks—and deaths. This was no less the case on April 29, 2014, when Alberta Health Services declared a measles outbreak effective for the Central, Edmonton, and Calgary zones. Over the course of the outbreak, 31 measles cases were confirmed. Thirteen of those cases occurred in Edmonton (Alberta Health Services, 2014).

In its first month, the outbreak enjoyed steady media coverage. Vaccine clinics popped up across Alberta centres and they were accessed, if not hammered, by concerned parents seeking to have their children immunized. News reports highlighted parents' frustration at backlogs created by surging demand for the measles vaccine (CBC Edmonton, 2014). With our respective backgrounds in immunology and public health, *we believe that the outbreak underscores the importance of increasing discussion about the ethical considerations of immunization policies.* Perhaps similarly sensing the need for debate, news reports covering the outbreak touched upon an oft-asked question: should vaccines be mandated in the interest of public health in Alberta? Currently, immunization is voluntary and, relative to other developed nations, Canada's immunization rates are low (Public Health Agency of Canada, 2011, 2012; UNICEF Office of Research, 2013). While some provinces require children to be vaccinated with MMR and DTaP prior to enrolment in school, exemptions are provided on medical, religious, and philosophical grounds (*Immunization of School Pupils Act, RSO 1990;*

Education Act, SNB 1997). Regardless of the rationale, our system has failed to achieve the breadth of immunization coverage required to suppress vaccine-preventable disease outbreaks.

It's been said that for every complex problem there is a simple solution, but this is usually wrong. Similar to the difficulties met in tackling obesity or tobacco use at the policy level, there is no simple, one-dimensional solution for improving immunization rates. Mandate is widely perceived as a potential solution to low immunization rates and outbreak. However, we argue that mandate alone is not the preferred single solution for improving vaccination rates, in part because of its failure to respect certain individuals' values, needs and situations.

Mandating vaccination is comfortably at home in a rat's nest of ethical issues. A key problem is the high value Western culture assigns to personal autonomy. If those advocating against mandates are not strictly opposed to vaccination, chances are they're objecting to infringement on their personal freedoms. In the interests of public health, is it ethical to enforce immunization in defiance of culturally entrenched respect for certain individual liberties? Conversely: is it ethical to respect individuals' autonomy despite consequent risk to others who may not be able to protect themselves from disease? The answer is not entirely clear. If vaccines are mandated for all but the medically exempt, the reasoned result is better coverage, fewer outbreaks, and reduced outbreak-associated costs. But unlike other mandatory safety measures—seatbelts, for instance—vaccines lend

themselves to ideological rejection. Religious and philosophical objections are legally valid grounds for exemption from childhood vaccinations in Canada and many US states. Perhaps unsurprisingly, exemption rates are inversely correlated with the complexity of seeking exemption, and states that acknowledge philosophical objections to vaccination have higher exemption rates than states that allow only religious exemptions (Ciolli, 2008; Omer, 2009).

Philosophical objections frequently stem from misconceptions, as evidenced by the wealth of online material decrying vaccines on the basis of unreliable information on their efficacy and safety. A prime example is the continued use of the counterargument that vaccines are linked to autism, despite overwhelming evidence to the contrary (Mah, et al., 2010). Marketed vaccines are safe and effective; however, anecdotal evidence to the contrary is a powerful driver of public opinion (Betsch & Sachse, 2012). Ideally, misinformed philosophy should not constitute acceptable grounds for exemption. In a time when Google is the go-to broker for health information, such exemptions place the public at risk. On the other hand, in a culture of scepticism, total mandate may be viewed as a Big Brother-esque act of authority—also not a desirable outcome. Ethical challenges manifest in either course of action.



Mandated vaccination programs that do not allow exemption for legitimate religious conviction implicitly reject the validity of the beliefs associated with the religion in question. For some people, this may mean not only a rejection of their ideals but

also of their identities in some part. If policy aims to respect spiritual identity, it would be unethical to deny religious objectors the right to exemption. However, a challenge presents itself therein: how is it determined when religious objection is legitimate and not falsely claimed? Furthermore, is respect for religious or philosophical identity more important than protecting vulnerable populations from harmful diseases, or ensuring that decades-long investments in disease eradication are not wasted?

Communities characterized by secular rejections of immunization are often hotbeds for outbreaks of otherwise rare diseases. While exemptions are uncommon on average, they tend to concentrate in these communities, amplifying risk (Mah et al., 2010). In 1993, poliovirus was isolated from stool samples of members of a religious community in Alberta. The strain was linked to an outbreak in a related non-vaccinated religious community in Netherlands, and originated in India (Shemo et al., 1995). Measles outbreaks still occur annually in Canada and the US, and typically start in unvaccinated communities, especially when members had traveled to areas where the disease is endemic. While immunization rates against polio—and, to a lesser extent, measles—are currently very good (Public Health Agency of Canada, 2011), it is troubling that a virus close to eradication can still hitchhike around the globe in the bodies of travellers who refuse vaccination.

Measles and polio are examples of diseases caused by pathogens that only infect humans. In part, this makes them candidates for eradication, much like smallpox. Looking back on our experience with smallpox, it's clear that as long as the right socio-political factors are in place, disease eradication can be achieved by implementing effective immunization, quarantine, and surveillance strategies (Fenner et al., 1988). Economically, there is a strong case for disease eradication. For example, polio eradication is expected to generate global savings exceeding US\$ 1 billion per year (Aylward et al., 2000). Vast resources have already been expended on eradication attempts for diseases like smallpox and polio, and to relax on vaccination requirements now would be a

colossal waste of time, money, and effort. As it is, each outbreak that starts in an unvaccinated cluster of individuals represents an opportunity for human-only pathogens to mutate, creating a small chance that the right genetic events may occur to generate a new strain of measles or poliovirus that can subvert global immunity. It's like a game of Russian roulette with higher stakes than a single life. In view of the health risks posed by persistent pools of human-restricted pathogens, it may be justifiable to deny personal freedoms by mandating immunization against pathogens for which eradication is an achievable outcome.

It may not be justifiable to mandate some other vaccines, though. Take influenza: it cycles not only through humans, but through birds and swine as well. Because it exists in non-human hosts, genetic events that alter the antigenic identity of the virus are common and cannot be controlled by vaccinating humans. Indeed, genetic changes are often *required* for influenza host switching. While a vaccine may confer immunity to an influenza strain one year, it probably won't work against the next mutated variant, which is why the flu vaccine frequently changes based on whichever strains are forecasted to pose the greatest risk in the upcoming season. Some would argue that as vaccines against influenza and other pathogens not restricted to human hosts cannot completely suppress their respective diseases, it is unethical to risk the social consequences of mandating these vaccines. Others endorse the value of such an approach for its life-saving potential—is even one preventable death an acceptable trade for autonomy? It is important to note that within some health care institutions it has been policy to mandate influenza vaccination of health care providers. (Perinatal Hepatitis B is another interesting example of vulnerable populations being vaccinated—we automatically immunize the newborn in this clinical setting.)

The most detrimental consequences of mandate are perhaps socio-political. Regardless of individuals' stances on vaccination, there is the threat of revolt against the concept of being forced by health

authorities to act one way or another, as was observed in the end-stages of smallpox eradication when there were few visible cases of the disease (Greenough, 1995). Thus, mandating vaccines against diseases that the public no longer perceive as a significant threat could generate widespread mistrust for public health agencies, undermining the credibility and success of future public health efforts. This could reduce the impact of education initiatives, increase operational costs, and compromise the success of future vaccination efforts—all foils against a positive state of public health (Taylor, 2009). The risk of such a blow to public health efforts is powerful enough on its own to seriously challenge the notion of mandating vaccines without careful consideration of pertinent socio-political factors.

Adjusting delivery of vaccine-related education to better leverage the growing influence of popular media on public perception may be a more ethical way to combat misinformation and increase immunization status than total mandate of certain vaccinations. Mandate for all public is ethically untenable because it could undermine the credibility of future public health efforts by generating resistance. However, we believe the moral imperative to play no role in putting vulnerable individuals at risk of preventable disease is greater than the imperative to respect autonomy; therefore, we *suggest that mandate with no allowance for non-medical exemption may be defensible and effective at select bottlenecks, for example: school enrolment, employment in healthcare facilities, international travel to select destinations, and immigration.*

In consequentialist terms, we believe this course of action is ethically justifiable because its positive outcomes outweigh the negative effects of potential backlash, which would likely be less intense than in the case of mandate for all individuals. At the very least, mandate should cover MMR and DTaP-IPV because measles and polio are potential candidates for eradication. In any case, we advocate for continued delivery of vaccine education which includes risk / benefit analysis as a means of building trust between health care professionals

and the public, which we believe is the most ethical, straightforward path to successful public health programs. Furthermore, as new generations take increasing personal responsibility for their health, health care professionals need to learn effective ways to use online media to deliver health education and messaging, rather than struggle to make traditional methods work.

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Physician Assisted Suicide in Psychiatric Patients

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In February 2015, the Supreme Court of Canada ruled that Canadians have the right to physician assisted suicide (PAS, Carter vs Canada). This ruling is expected

to become effective June 2016 and has raised a lot of questions both within the medical profession and the public at large. One such question is whether

this right to assisted suicide should be extended to psychiatric patients. Requests to psychiatrists for PAS from patients suffering from unbearable mental illness are not uncommon in countries where PAS is legal such as in the Netherlands (Ganzini, et al., 1996). Many argue that the psychiatric population is more vulnerable to misuse of PAS stemming from this legislation and even proponents of allowing PAS for terminal illnesses worry about extending this right to patients with mental illness. However, in this new age of medicine with its emphasis on autonomy, isolating the psychiatric population from accessing their right to PAS is to dis-empower them. The arguments made to enact this legislation for patients suffering from incurable somatic illnesses can be applied to the psychiatric population with incurable mental illness as well.

Several countries around the world have legalized assisted suicide in cases of constant or unbearable suffering such as the Netherlands and Sweden. Although likely fatality is often used as a distinction between somatic and psychiatric illness, the latter can produce just as much suffering as any somatic illness. In practice, the right to PAS has been extended to those patients with not only imminent terminal illnesses but to those with incurable illnesses causing unbearable suffering. With the latter determining factors in mind, certain psychiatric illnesses would meet the criteria for PAS. To limit the use of PAS to only non-psychiatric patients is to suggest that the suffering of psychiatric patients is somehow not as severe as that of patients with terminal somatic illness.

The issue here, however, does become complicated by the traditional focus of psychiatry on suicide prevention. In many cases, suicide prevention is a priority within the psychiatric patient population, when dealing with conditions likely to include thoughts of suicide. But there are also cases where patients suffer from constant incurable agonizing anxiety or depression. If it can be established, by a psychiatrist, that a patient is experiencing severe suffering constantly from an incurable mental illness then that patient, if decision making capacity

(competence) is established, should be provided the option of PAS. This provision of PAS would be in keeping with options provided to patients afflicted with any form of incurable illness which causes severe intractable pain and suffering.



Of course, a higher level of competence must be demonstrated in end of life decisions as opposed to other medical decisions that do not have such permanent consequences. As such, any patient seeking assisted-suicide should have formal capacity assessment done to ensure they understand the consequences of their decision as well as some of the alternatives that could be offered (Ganzini, 2000). Mentally ill patients, just as patients suffering from a somatic illness, may have the capacity to make end of life decisions. Only a full formal capacity assessment should be allowed to assess such a patient's capacity. If the capacity to make an end of life decision is demonstrated, the right to PAS should be extended to empower psychiatric patients.

It is important to note that a patient in the throes of any severe psychiatric illness may be temporarily not competent to make such decisions. For example, any acute psychosis will result in a patient not being able to make rational decisions in line with their own beliefs and values. However, once these episodes recede the patient should be given the same opportunity provided to other patients while they are in a state of remission. As with any important medical decision, a thorough capacity assessment done by a professional is key to determining whether or not a patient's decision is truly their own and in line with their beliefs and values. Of course, there are fears that an extension of the right to PAS for psychiatric patients will provide the opportunity for misuse or abuse in the capacity assessment away from the best

interests of the patient. It is fundamentally wrong, however, to deny rights from individuals out of fear that other individuals will erroneously apply or abuse those rights. The capacity assessment should be bound by regulations (as should the entire PAS procedure) to minimize the potential for abuse of PAS. It is the government's responsibility to minimize potential for abuse of any law while maximizing the rights of Canadian citizens with respect to all of its laws. The legislation for the right to PAS is no exception as it extends patient's rights to a new procedure under the Canada Health Act.

Finally, to make PAS unavailable for competent psychiatric patients is to override or take away their autonomy. Respect for patient autonomy lies at the center of the doctrine of informed consent upon which the patient – physician relationship is based. Patient autonomy allows patients to reject or accept life-saving treatment. The Supreme Court of Canada decision in Carter appears to expand the decision-making capacity of the patient to include a request for PAS. However, if we are to justify the right to doctor-assisted suicide for any patient, whether they are physically or mentally ill, it cannot be solely on the basis of a single assessment of capacity as the results would not be in keeping with ethical medical practice. This is because autonomy may fluctuate, may be situation or task specific, or simply have certain limitations with respect to self-harm and harm to others. All patients, suffering from both somatic and mental illness, need to display competence to make choices that are in line with the values that they describe or have displayed in their lives. Thus, autonomy is established only on the patient's proof of their capacity to make their own decisions in order to prevent patients from making decisions that would harm themselves or go against their values.

Looking specifically at psychiatric patients, assessments of competence are routine practice for psychiatrists. Whereas it is may be possible to understand a somatic patient's competence after a brief interaction, psychiatric patients often need a more thorough assessment before allowing them full control in their medical decisions. These routine formal assessments of competence make psychiatrists well equipped to perform similar assessments for psychiatric patients requesting PAS. If patients do not

display competence, it is common for psychiatrists to override patient wishes made in their incompetent state. This legally supported clinical practice to override patient decisions is shown through involuntary hospitalization of psychiatric patients with psychosis where they risk being a danger to themselves or society. As psychiatrists commonly override potentially dangerous decisions made by patients lacking competence, there is additional security in extending the right to PAS to competent psychiatric patients. If the psychiatric patient is regarded as having the capacity to make end of life decisions, why withhold an option that would be granted to a non-psychiatric patient in the same situation?

As practice of medicine moves away from paternalism, the field of psychiatry cannot be left behind. The same arguments brought up to give the right of assisted suicide to patients suffering from somatic illnesses can be applied as well to psychiatric patients. Due care must be taken of course to ensure that the wish to end one's life is not a transient thought, is not related to underlying depression or other psychiatric illness, just as would occur with any patient suffering from somatic illness. Transient thoughts of suicide may be more prominent in the psychiatric patient population so this may present a difficulty in practice, but it does not outweigh the moral justification to extend the same rights to end of life decisions to competent psychiatric patients as to other patients.

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Burnout in Physicians: Another “*Inconvenient truth*”?

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Introduction

Psychological burnout is difficult to define precisely and its incidence is imprecise. However, given that approximately 30% of Surgeons (Campbell, et al., 2001), 40% of General Practitioners (Bakker, et al. 2000), and 50% of all type of Canadian Physicians have reported “burnout” (Boudreau, et al., 2006; Executive Summary Physician and Family Support Program, 2002), this is not an issue to be dismissed just because it is complex. The goal of this article is to help understand the basics, and for each of us to be a non-judgmental resource. The overall goal is to increase resilience, retain staff, maximize safety, and protect patients. Otherwise, when it comes to burnout, everybody pays.

But what is burnout?

The term originated in the 1970s and is usually understood to be an emotional condition that includes mental and physical fatigue (Burnout Psychology, 2011). It is also often associated with exasperation or frustration, especially when dedication fails to produce the hoped-for results. Sufferers of burnout also report a loss of ideals and commitment (Cole & Carlin, 2009). They also report a loss of concern or respect for others. This can manifest as insensitivity, scorn, cynicism, even contempt (Senior, 2006).

Physicians have the highest reported rate of burnout of any studied profession, and it has been described in all levels of medical practitioners (including trainees; Campbell, et al., 2001; Krasner, et al., 2009). There may even be a higher incidence in younger

rather than older practitioners, which has been attributed to unrealistic expectations amongst the young (Campbell, et al., 2001). Burnout is also not clearly associated with particular medical or surgical specialties. It is also worth emphasizing that this is categorically not an affliction unique to physicians. For example, approximately 40% of all Canadian workers report burnout (Executive Summary Physician and Family Support Program, 2002). The common theme is whether people believe their work is valuable and valued, both by the individual and by others (Fields, et al., 1995).

Burnout has been defined as the opposite of “engagement” (Maslach & Leiter, 1997). If engagement equals “energy” and “involvement”, then burnout equals “emotional exhaustion”, and “depersonalization” (Maslach & Jackson, 1981). These dimensions are captured by the Maslach-Burnout Inventory. There is also a non-validated but shorter test for compassion fatigue (which is typically described as a lessening of compassion over time; Compassion fatigue, 2011). Links for tests exist for those humble enough to self-test, or concerned enough to help others (Burn out self-test, 1996-2011; Pfefferling; et al., 2000).

Why do so many physicians burnout?

We physicians should accept a few “*inconvenient truths*”. Firstly, even the most challenging diseases become routine over time. As such, once the novelty has gone, we risk simply being left with the stress and long-hours. In addition, while we may still expect a single physician to know and do “everything”,

the complexity of modern medicine makes this impossible (Gawande, 2009). There are over 13,000 diseases and syndromes, over 6,000 drugs, over 4,000 procedures, and over 5,500 medical journals indexed by Medline (Gawande, 2009; Collections of the National Library of Medicine, 2011). In short, we need to accept that it is impossible to be completely up to date in all areas.

The same traits that may be suited to the clinical arena can become vulnerabilities elsewhere (Gabbard, 1985). For example, physicians are known for our competitiveness; our dedication, and our emotional remoteness. We are also quite used to postponing gratification (Gabbard & Menninger, 1989). However, assuming that we can also postpone attending to our personal relationships may be dangerous. After all, interpersonal relationships can be a prime source of happiness and resilience. If ignored or mismanaged they can also be an additional source of exasperation and despondency.

Physicians may be celebrated for their “perfectionism”. However, this is often accompanied by a need for external validation (Hewitt & Flett, 1991). We also commonly accept the “myth of invincibility” (McKevitt & Morgan, 1997) and this can discourage us from seeking help. In addition, we rarely say “no” and nor do we encourage others to say “no”. In fact, medicine commonly follows the mantra of “the better we do, the better we are expected to do” (Myers & Gabbard, 2008; Flett & Hewitt, 2002). Clinicians are often expected to teach (also a high burnout pursuit), and then to research, and then to administer, and often at the same time. We also share the “myth of the imposter”: believing that while others have got their lives under control, we are underperforming (Clance & Imes, 1978). The way most people mitigate this fear is to try harder and to do even more. This can in turn result in further exhaustion and resentment.

We also often compare our insides (i.e., *how we really feel*) with others’ outsides (i.e., *how they appear*). In addition, medicine is a profession where overwork is the norm, and where our identity comes primarily from being a physician (rather than say as a parent or spouse). Many of us also feel “uncomfortable” when

outside of work. We are also used to being on-call and therefore used to blurring the lines between work-life and home-life. In short, we promote an unfortunate combination of compulsiveness; self-doubt, and an exaggerated sense of responsibility (Gabbard, 1985; Gabbard & Menninger, 1989).

Burnout probably develops gradually, but its speed and severity is likely worsened by stressful environments; inadequate support; long and irregular work hours; sleep-deprivation, and disillusionment (Campbell, et al., 2001; Bakker, et al., 2000; Boudreau, et al., 2006; Executive Summary Physician and Family Support Program, 2002; Burnout Psychology, 2011; Krasner, et al., 2009; Freudenberger & Richelson, et al., 1980; Maslach & Leiter, 1997; Cole & Carlin, 2009). Burnout may result from a *disconnect* between an individual and an organization in one or more of six areas: workload; control; reward; community; fairness, and values (Maslach & Leiter; 1997; Maslach & Jackson, 1981). As a result, efforts should focus on these areas. Efforts should also include both the individual and the organization within which they work.

Strategies to Reduce Burnout

Burnout appears to be mitigated if employees and employers share common values, and where leadership is seen to be supportive and collegial. The concept of “fairness” is particularly important, as is the chance to resolve perceived inequities, and a sense that all are “sharing the load” (Senior, 2006; Krasner, et al., 2009; Freudenberger & Richelson, 1980; Maslach & Leiter, 1997). To use a Canadian analogy we all have to drag the toboggan up the hill. Chronic stress is also intrinsic to burnout (Senior, 2006; Justice Potter Stewart, 1964; Campbell, et al., 2001; Bakker, et al., 2000; Boudreau, et al., 2006; Executive Summary Physician and Family Support Program, 2002; Burnout Psychology, 2011; Krasner, et al., 2009; Freudenberger & Richelson, 1980; Maslach & Leiter, 1997). As such, Stress Management classes, confidential counseling, life-coaches, and time-off might help. Leaders can also trial no-meeting weeks and no email weekends. After all, getting the most out of staff does not always mean getting the best out of the staff (Senior, 2006).



Those that apply for time-off should be supported rather than being made to feel inferior, lazy or guilty. After all, the idea of a “sabbatical” or a break from work has existed for thousands of years. With this in mind, the sabbatical could be typical rather than exceptional, and, given our poor insight, we suggest it be mandated. Regardless, if we can schedule parental leave then we can do the same for sabbatical leave. Many professions accept that career changes are typical, and perhaps even desirable. However, if we do contemplate career change we should beware the tendency to pick another altruistic pursuit. Unfortunately, this is the same type of profession that led to burnout in the first place (Senior, 2006).

We also need to focus on internal strategies, after all, “*happiness is an inside job*” (Boorstein, 2007). In a similar vein, Alden Cass argued: “*happiness is reality divided by expectations*” (Senior, 2006). This means we need to set *realistic* personal goals. In addition, we need to be mindful in order to set *deliberate* personal goals. This means self discipline in order to avoid: “*money over memories*”, and “*professional growth at the expense of personal growth*” (Duncan, 2010). We must not neglect what we enjoy, or what is meaningful, or focus on being noticed rather than being fulfilled (Gabbard, 1985). While anathematic to some physicians this means exploring our beliefs, and challenging our fears.

Managing rather than eradicating burnout

It may help to conceptualize “burnout” as a chronic rather than an acute condition. This means that we should not be looking for a quick-fix. This chronic model also emphasizes that we need long-term symptom management- or the prevention of

“flare-ups”- rather than outright cure. This is important for those physicians used to solving problems rapidly, or by simply “trying harder” (Myers & Gabbard, 2008; Flett & Hewitt, 2002; Clance & Imes, 1978). This is also why the relief gained from a short break is unlikely to last if we return to the same stresses and triggers. If this is not understood then the sufferer merely amplifies their unhappiness with additional shame (i.e., disappointment that one cannot easily get over their burnout) or with resignation (i.e., assuming that this is how they will feel for the rest of their career). In addition, when we do take a break we may not truly rest: taking work on vacation; running on a treadmill while listening to podcasts; checking emails; or frequently phoning-in *just in case* (Senior, 2006). In short, we need to learn that doing *less* can achieve *more*.

“Work/life balance” (Duncan, 2010) offers a key strategy to revitalize, to rediscover joy, and to maintain perspective. This can mitigate burnout, build up resilience, and extend our working life. However, balance is also difficult to define and therefore easier to ignore. In Medicine, we understand that there are times when work will dominate. However, balance means that later on family and hobbies should also dominate. As Todd Duncan emphasizes in his book “*Life on the Wire*”, this might be the best chance of achieving a satisfying career without sacrificing family, and a happy family without sacrificing career. This requires effort and persistence. It also requires humility and insight. Regardless, it is worth it for our own health and that of our patients.

This article is adapted from a more in-depth book chapter in the 2012 *Annual Update in Intensive Care and Emergency Medicine* (Springer Publishing, Editor Jean Louis Vincent). We would refer readers to this expanded source.

Full references on e-edition only.

Table 1. What is burnout?

• Mental and physical fatigue
• Loss of ideals; cynicism
• Sense of purposeless (“what’s the point”)
• Insensitivity towards others
• Sense that you are underappreciated
• Loss of respect/concern for others

Table 2. Strategies to reduce burnout

Organizational Strategies
• Stress Management/counseling
• Increase work-place socializing
• Time-off/Sabbaticals
• Programs in self-awareness/mindfulness
Individual Strategies
• Setting deliberate/realistic goals
• Dividing career into thirds (learning; earning; returning)
• Accept your limitations (“you can’t know everything”)
• Strive for balance/“purposeful imbalance” (Duncan, 2010)

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Religion and Medicine

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There are perhaps two basic human reactions to the world that will always orient our species towards religion, and, curiously, they are in something of a tension with each other. One is a sense of wonder at the world and a wish to interpret the numinous experience that it elicits, and the other is repulsion at the suffering and dysfunction within that same world.

The impulses towards both aesthetic contemplation of and a remedy for the ailments of the universe are also what drive people towards the physical sciences, and as a result science and religion are always wavering between being allies and being opponents. Stephen Jay Gould, 2011 (p. 274) famously called religion and science “non-overlapping magisteria” which pronounced on two different and safely unrelated realms, but a topic like medicine throws this simple explanation into question: What about when religious practices threaten to replace medicine, or medicine is perceived to make religion obsolete? A historical survey is necessary to understand better what the relationship between medicine and religion has looked like, and what it could be.

There are two different components to medicine: The

treatment of symptoms and the diagnosis of the cause of a disease. The former has probably been practiced since time immemorial, and it is probably futile to try to pinpoint when, in murky pre-history, our freshly sentient ancestors began observing that consuming certain plants usually occasioned the end of a period of suffering. The latter problem, though, begins to come into relief in ancient Greece, where science as we recognize it began to take recognizable shape. On the one hand, we have the work of writers like Galen and Hippocrates, who saw the cause of diseases as being physical and biological. Galen, drawing an analogy to Aristotle’s observation of the four elements, posited that human health was predicated on the proportions of humours in the body, a theory we still homage when we speak of a melancholy temperament or a sanguine personality.

On the other hand, there was the cult of Asclepius, the mythological slain-and-reborn physician god whose temples treated patients with chamomile tea, mud baths, and even surgery, in the service of putting them into an ecstatic trance where the deity was expected to personally heal their illnesses (Lawson, 2004, p. 28). No doubt many of the treatments at the Asclepieia, as they were called, happened to be

effective, but the fundamental philosophy was that the cause of disease lay in the realm of the supra-cosmic, where the cure was also to be found as well.

What is of interest to us today is that Galen complained that both he and Hippocrates were not widely studied in his day (Nutton, 2001, p.17). It is tempting and all too easy to speculate about why the Greek everyman may have favoured the ceremonial certainty of an Asclepian rite to the treatment of a proto-scientist. There is a level of control with superstition that is missing from either religion or science, a cause-and-effect thinking which is more confident than the measured tones of genuine science. This is doubtless what attracts people to pseudo-scientific “cures” today, and it is an impulse which was not eradicated when Christianity was introduced into the world.

The Christian religion combines, in a way, features from both these schools of thought. It postulated an ordered and even somewhat independent universe, structured around reason—God was identified with the Stoic *logos*, the logical principle of the cosmos—which was governed by natural laws rather than by the whims of warring and parochial deities. This theological idea was the necessary prerequisite for the birth of modern science, presupposing as it does the stability and predictability of the natural order. Yet it also held that the same God who had ordered all of this could personally intervene in the material universe, and not infrequently did, in particular in the form of miraculous healings, performed by Christ Himself and by His followers.

There is no evidence that the early church interpreted the fact that God was frequently curing all sorts of ailments by way of direct and supernatural intervention as a licence to jettison medicine altogether. Colossians 4:14 records that St. Luke was a “beloved physician”, and certainly the Gospel attributed to him exhibits the precision we recognize from a medical doctor. Moreover, 1 Timothy 5:23 has St. Paul telling the young bishop to drink wine as a medicine for his stomach. Yet James 5:14-15 urges the sick to be anointed by their elders and hope for healing. This verse is the warrant for the Sacrament

of the Anointing of the Sick (formerly known as “the last rites”), and taken in tandem with the rest of the evidence of the New Testament suggests that the primitive church believed in the use of doctors and medicine, but systematically remained open to the prospective of a sudden supernatural intervention.

Certainly, the Christian Church historically never had any great problem with the use of medicine as such, except insofar as it was engaged in a propaganda war with the old paganism. The earliest hospitals were the initiatives of monasteries, the gardens of which supplied the ingredients for the remedies prescribed by the texts on medicine being translated into Latin from Greek and Arabic (Koenig, 2000, p. 387). To the extent that there was any conflict between the Church and “medicine”, it perhaps took the form of the witch-hunts, wherein it is possible that the folk medical knowledge possessed by certain women, such as midwives, was interpreted to be a form of sorcery. Certainly this would be a continuation of the traditional connection between a kind of pagan magic and the use of medicine; the Greek word for “sorcery” in the New Testament is *pharmakeia*, with its obvious etymological link to our *pharmacy*. Yet even these cannot generally be called “ecclesiastical” projects; the witch-hunts were usually an initiative of the common peasant, and opposed by the Church officials, who often opposed them less on humanitarian than on theological grounds: Witchcraft had no real power in a world ruled by Christ. But it was hard to purge the people of this paranoia, even after the Council of Paderborn in 785 decreed the death penalty for all witch-hunters.



The common Christian was still, no doubt, a baptized pagan, and their pagan desire for certainty, for control, and for superstition was carried over into their Christian customs. Relics were widely thought to possess healing qualities, healing was thought to be promised to those who made certain pilgrimages, and specific saints were linked to specific diseases and ailments, promises that not even the most medically-advanced monk could make in good conscience. Yet the Church herself was always steadfast: Scientific, medical treatment was to be sought as well as supernatural healing. Ironically, Galen, who criticized the Christians of his day for believing in miracles, only gained prominence and respect in the Medieval era, because his orderly worldview corresponded better with the Christian vision than the pagan one (Nutton, 2001, p. 24).

There is a certain banality to saying that religion and medicine need each other to a certain degree. Without medicine and science, religion can become an attempt to fix the problems of society by means of magical and unreliable rituals; without religion and a high view of human dignity to guide it, medical science can become cold and dehumanizing. But

more to the point, both superstition and a ruthless kind of science are a desire for control. A sound medical diagnosis and a prescription to trust in God's healing power both necessarily require one to let go of their desire to be in complete control: The acceptance that nothing is ever certain or guaranteed is as hard a lesson for the devoutly religious as it is for the atheist. Yet a certain willingness to relinquish is necessary for both the votary who must set aside their prayer beads and submit to an X-ray and for the dedicated technician anxious to find a panacea for the world's diseases. Patience is still a virtue, as is hopefulness.

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