Improved antiviral treatment has transformed HIV for many people into a more manageable illness than it had been. But HIV providers—whether nurse practitioners, counselors, or physicians—still face sobering realities and an ever-expanding maze of challenges, including rising infection rates and HIV treatment failure. As the epidemic has grown and evolved, providers have been called on not only to maintain cutting-edge medical competence, but also to muster the combined skills of social worker, health care advocate, spiritual leader, and liaison with third-party insurance carriers. Add to this concerns about the medication adherence of their patients, insufficient reimbursement or funding for their services, and a seemingly shrinking pool of colleagues committed to the cause of HIV care, and it is easy to see why HIV providers are at risk of burning out.

**Burnout**

Burnout is a state of physical, emotional, and mental exhaustion. It results from intense involvement with people over long periods of time in situations that are emotionally demanding. Any combination of the following symptoms can signal burnout: emotional exhaustion; impaired cognitive function; depersonalization (impersonal, detached dealings with others); diminished sense of accomplishment; impaired work performance; increased physical symptoms of stress; spread of emotional distress to home life; poor organizational morale; and increased interpersonal conflict.

When burnout happens, everyone involved in the collaborative health care team, the essence of HIV care, suffers. Because the attitudes and emotions of key players in any relationship system tend to be "contagious," a provider's sense of well-being affects more than his or her own resilience, morale, and behavior. It also affects the resilience, morale, and behavior of both colleagues and patients, and may even decrease the likelihood that patients will adhere to treatment.

For nearly 25 years, the clinical staff at Sotile Psychological Associates has served as personal counselors to more than 1,000 physicians and countless allied health professionals. Both clinical and research data suggest that burnout is related less to number of hours worked than it is to personal emotional management style. Many providers find that their efforts to be all things for all people result in coping habits that stress, rather than bless, the very people they are trying so hard to please. Research has also shown that those providers who show traits of insecurity, low self-esteem, dependency, social anxiety, a history of depression, the tendency to obsessively worry, passivity, and social withdrawal are at particular risk of burnout.

**An In Vivo Look at Burnout and HIV Care**

*In Vivo* is a workshop designed to promote collaborative care in HIV medicine and enhance the quality of life for HIV providers by rejuvenating the passion, agility, and vision that brought them into HIV care. *In Vivo* uses the language of antiviral treatment to describe the condition of burnout. The best HIV providers become so intent on helping others that they develop a style of coping that leads to a *resistance* to their own symptoms of wear-down. Specifically, these supreme caretakers go numb to awareness of their own needs in deference to caring for others.

At first, *tolerability* for the consequences of this way of living—loss of sleep; poor self-care; delay of personal gratification and play; and relationship tensions at home, to name but a few—is high. But the
Burnout. No one likes to consider it. Yet, the conditions for burnout are always present, just as anyone, failing to breathe for long enough, will faint. Everyone faces the possibility of submitting to job pressures rather than to the needs of body and spirit.

HIV care—with its ever-changing medical, psychological, and social stresses—resembles an exceptionally oxygen-poor environment. Add to this list the place of HIV care in the ailing U.S. health system, and it is clear that providers who want to avoid a fall need to remember to breathe deeply.

Observing from outside the HIV hothouse, Wayne Sotile is well placed to assess the composition of the air inside and to describe a way to monitor stress and respond to it. He emphasizes the factors over which providers have control and which can sustain a commitment to work without compromising a commitment to self.

At the same time, Lawrence Goldyn, a private practitioner with a large HIV practice, implicates, in particular, conditions that may lie outside a provider’s control. He elaborates by confronting a condition that normally dares not whisper its name: money.

We looked askance at Goldyn’s first draft: how could a physician, even living in one of the most expensive regions in the world, legitimately complain about salary, especially at a time when cuts to government-funded health care, disability, and AIDS programs threaten the lives of people with HIV? But this question ignores the root of the problem.

Whether we like it or not, in our society, different jobs are valued differently and receive different compensation. If we continue to value the contributions of health care providers as highly as we have in the past—and the frontline work of people like Goldyn surely deserves such recognition—then society should compensate these jobs appropriately. The real culprits here are not “overpaid” health care providers, but multimillion-dollar-earning corporate executives and tax-cutting politicians who are willing to gut health care for votes.

According to employee surveys, however, salary levels are not the prime motivator of job satisfaction. Improving the salaries of health care providers can be only one component of burnout prevention. Further, the systemic solutions our health care system would require to boost job satisfaction seem distant in a society where, for example, no prescription drug benefit for senior citizens has been enacted despite the fact that Congress and two successive administrations have avowed that this benefit is crucial.

In this atmosphere, Sotile’s procedure for taking advantage of the capacities we all have is, forgive me, a breath of fresh air. Whether providers can and will follow his advice remains to be seen.

durability of the capacity to tolerate this way of living without untoward side effects is insufficient. Soon, stamina for dealing with the interpersonal needs faced at work and home starts to dwindle.

Gradually, caregivers adapt to subtle, negative changes in relationships and in their own emotional management strategies. They grow accustomed to maladaptive levels of conflict, unhealthy self-care habits, or both. Like some HIV mutations that seem to be no threat at first, these subtle changes can suddenly manifest into greater levels of resistance: the minor adjustments that used to serve to help you “bounce back” after a period of exhaustion no longer work. For example, taking one weekend off no longer rejuvenates, or usually effective efforts at reconciliation fail and personal relationships linger in tension.

Too many months or years living under too much strain can lead even the most compassionate individual toward a sort of psychological mutation: compassion fatigue and burnout prompt a switch from empathizing with to resenting the very people to whom all this caretaking effort has been devoted. The result is that frustration and irritation escalate, contaminating both work and home relationships. At this point, salvage therapy is indicated. Only a major revamping of life strategies will restore and revitalize exhausted coping reserves.

Of course, for both HIV care and the management of coping patterns, the best strategy is to avoid getting to the point of needing salvage therapy. This feat requires emotional management strategies that prove to be durable, potent, and without unwanted side effects that will undermine relationships.

The response to this situation—the HIV caretaker cocktail—emphasizes honing skills to promote effective communication with patients, collegiality and collaboration among peers, and intimate connections within a provider’s personal life. This cocktail is based on a model for stress resilience called effective emotional management.\(^3,6\)

Among its strategies are: disrupting burnout “dominoes,” taking responsibility for communication, respecting mind, body,
and spirit, balancing achievements and expectations, taking time to grieve, and being an ambassador of collaboration.

**Disrupt Burnout “Dominoes”**

Think of each of the symptoms of burnout listed above as being a single domino in a continuous line. The goal is to disrupt any one of these dominoes with healthy choices.

The sooner in the coping progression a person substitutes a healthy act of self-nurturing or collaboration for one of damaging self- or other-neglect, the better. The main risk to avoid is staying emotionally “numb” and plowing onward.

**Take Responsibility for Communication**

In many ways, effective emotional management hinges on being a clear communicator, one who is able to generate deep levels of trust, compassion, and mutual respect in relationships. Consider how this might work, both in patient care and when dealing with colleagues and loved ones.

**In Patient Care.** Medical patients who rate trust and communication with their physicians as excellent are four times more likely to believe they have received excellent health care than those who do not.7 Physicians who are deemed by their patients to be effective communicators tend to interact with others using a combination of receptivity, authority, and appropriate humor to ease tension. They also show respect for patients: they introduce themselves and everyone in the room and orient the patient before doing any physical examination, and they make time to ask not only about the patient’s physical health, but also about problems of daily living, relationships, and feelings.8

Be sure to listen for the deeper level of what a patient’s behavior is telling you. Is failure to adhere to treatment indicating despair and hopelessness about the disease, confusion about the regimen, lack of effective coping strategies for managing treatment side effects, or life problems that require additional support? Compassionate communication may not solve every medical problem, but it will lighten the distress of both patient and provider.

**With Colleagues and Loved Ones.** Marital researchers such as John Gottman of the University of Washington have shed light on three communication strategies that can “divorce-proof” relationships with loved-ones and colleagues alike.9 First, get into the habit of offering others five positive interactions for every one critical interaction. Second, avoid the lethal progression of: starting a conversation with an accusation or criticism; reacting with defensiveness that ignores the other person’s feelings; engaging in challenging interchanges; and then abruptly cutting-off communication.

Third, let “repair attempts” count. Here, two concepts are helpful. Remember that during any discussion, appropriate uses of humor, affection, and agreement can cool escalating tensions. If the other person does the same, let his or her actions calm you. Even if a disagreement remains unresolved at the end of a conversation, never underestimate the powers of apologizing, forgiving, acknowledging that your relationship is bigger than the size of the issue at hand,10 and affirming the other person’s importance to you. It is not unresolved issues, but the failure to confront these issues, that creates relationship dysfunction.

**Respect Your Own Mind, Body, and Spirit**

Pay attention to the fundamentals of self-care. Regularly engage in healthy pleasures, without mind-altering substances: only by regularly taking “recess” will you eventually learn to relax without feeling guilty.

Modulate times of work and worry with pockets of loving connection with others. Finally, embrace a belief in something bigger than yourself. Be it your god, your family, your profession, or your love of nature, regularly partake of rituals that connect you with aspects of your life that remind you that there is meaning beyond your stress.

**Balance Achievements and Expectations**

Learn to feel good about what you are able to accomplish—both in patient care and self-care—and help others to do the same.

**In Patient Care.** Shape hopeful and adaptive attitudes toward the side effects of HIV treatment. First, help patients to move beyond interpreting their symptoms or side effects as signs of failure, punishment, or suffering. Rather, suggest that they apply the “three C’s”: this is a Challenge that I am Committed to meeting, and I will learn strategies that will help me to Control my reactions. Second, many patients normalize side effects that might be ameliorated. You will discover this only if you delve beyond the “everything is fine” patient response.

**In Self-Care.** Physicians themselves have offered the following tips about how to take care while being a medical caretaker:3
Clearinghouse: Burnout

References
Landon BE, Reschovsky J, Blumenthal D. Changes in career satisfaction among primary care and specialist physicians,
Physician Burnout and the Social Contract
Lawrence Goldyn, MD

In 12 years of private practice as an HIV doctor, I have buried more patients, friends, and colleagues than most doctors do in a lifetime. I practice in a private setting where insurance reimbursements are low and decreasing, and my costs and the burden of insurance and managed care bureaucracies are increasing. I carry a large debt from medical school that will be paid off when I am 80, and I live in one of the most expensive cities in the world.

HIV Treatment and HIV Doctoring

I came to HIV medicine with my eyes wide open. This is my second career. I had left San Francisco to teach political science in the late 70s, and returned as a medical doctor in the late 80s. Coming back reminded me of the accounts I had read of European refugees of World War II on their return home after the war. Everything had changed; it seemed as if everyone I knew was dead.

I had gone to medical school with the specific intention of serving my community, which had been devastated by HIV. Before the arrival of triple combination treatment, my job involved keeping a person with HIV alive and symptom-free as long as possible, with the understanding that failure was inevitable, and that the doctor-patient relationship we had built up would pay off when my patient and I had to make difficult decisions about when to let go. In my gut death still felt like failure, but I could reason with myself that I had done my best against a foe that was fated to win. I consoled myself with the thought that I had provided my patient with a dignified death.

In this setting doctors worked hard. Patients often showed up in the office very sick, in need of immediate hospitalization. This meant that a long day would be longer yet, and that the emotional and dramatic intensity of the day would be screwed up yet another notch. A doctor crawled into bed exhausted, hoping the pager would not go off again, feeling that he or she had put in a day of noble work serving the community, mitigating suffering in a little corner of the universe.

HAART (highly active antiretroviral therapy) has changed much of this. Where patients have access to HIV drugs the threat of death still lingers, but at least it is not snarling at the door. HIV is becoming a disease we manage, much like other chronic illnesses. I can honestly tell most of my HIV patients that with a little luck they will probably live long enough to die the same common heart attack, stroke, or cancer death that awaits their uninfected peers.

Managing HIV Care

As HIV becomes a more managed disease, the frustrations of management come to the fore, in terms of both complex medical treatment and the challenges of health insurance and managed care. Managing HIV now requires understanding nearly 20 drugs—with many more on the way—and wading through complicated resistance pitfalls.

Unlike the bad old days, when doctors were thrilled to have any HIV medication, HIV providers now have to function as pharmacology experts, knowing not only how HIV drugs react with each other, but also their effect on the myriad of other medications their patients take. We have also had to hone our skills as molecular biologists:


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See also references cited in articles in this issue.
we have to know how dozens of molecular changes in the virus affect its susceptibility to specific drugs. Even in the face of this arsenal of new drugs, HIV—replicating and changing at an unbelievable rate—still provides more than its share of surprises.

The good fortune rendered by HIV treatment advances makes it particularly hard to talk about one other set of challenges: financial stressors. This is something that doctors do not like to talk about with others, however, it seems that we talk about little else among ourselves. We do not want to be seen as persons who are “in it for the money”—although there are some among us who are—and a commitment to professionalism makes it “unseemly” to air the topic of finances, particularly since doctors are perceived as being well paid.

As a group, we are. But primary care doctors make far less than most people think. In the San Francisco Bay Area, for example, HIV providers make between $90,000 and $120,000 a year. Moreover, HIV doctors often graduate with enormous debt—as high as $150 thousand—the servicing of which affects our career choices and undermines what for many was the initial motivation to go into medicine: to help others. The result is that many doctors feel less inclined to take an uninsured patient, or to spend three months volunteering in a clinic in India, let alone offering a half-day at a free clinic down the street. I spend far too much time worrying about the efficiencies of running a small business. Affording retirement is problematic: in my case it will likely involve leaving the city that I had little time to enjoy while I worked in it.

The financial stress of being an HIV doctor is hard to bear, because it feels part of a broken social contract. Like a police officer, I am never really off duty. If someone drops on the sidewalk in front of me, I am expected to do something, even if I am on vacation, even if I am on my way to my mother’s 80th birthday party. In the past, when doctors were better paid, this obligation was seen as part of the bargain. Now, feeling less financially secure, we might balk at what seems an unfair deal.

But most of us still fulfill our part, just as we care for our patients when we are paid insufficiently, because it is our ethical obligation to do so. Insurance companies have no such qualms. Hospitals, particularly private ones, are also fundamentally business driven. Government, a major player in health care funding, is controlled by political considerations. As the only player motivated primarily by a sense of ethical duty, the doctor is left holding the bag.

Conclusion

A doctor learns early in his or her medical career either to manage stress or prepare for a rough ride. Throughout my career, wise advisors have offered good counsel: protect your personal life, and protect your mental and physical health. I have instituted this advice in the following ways: I do not take work home with me—my patients are in my thoughts enough. I spend as much time with my partner as I can—which is by all civilized standards far too little. When I am not on call, my pager is off. My patients know that help is available all the time, but it will not always be from me. I protect my lunch break and always try to leave the office for a while. My exercise and gym hours are sacred. When I am on vacation, I instruct my office to call me only if the building has burned down.

I also protect my mental health by reminding myself how lucky I am. I live in the world’s favorite city. I am surrounded by a few people who love me and many who respect and admire me. I enjoy good health—and nobody is shooting at me. I like my work and will never be unemployed, and my daily work helps others. In the broad course of human history, this catalogue describes a very fortunate person indeed.

Those of us who provide HIV care in San Francisco are a lucky lot in so many ways—first and foremost because our patients are doing so much better. But morale is eroding, and there are very few new doctors joining our ranks in private practice. The epidemic continues. It requires more time, thought, and effort than ever. There is a health care crisis in the United States caused by growing numbers of uninsured people, increasing complexity of treatment, and skyrocketing costs for care and malpractice insurance. Everyone wants the latest technology, but nobody—individuals, governments, or health insurance companies—wants to pay for it. In this context, the tools physicians use to keep spirits up will not work forever.

Authors

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Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rmarks@itsa.ucsf.edu or to Editor, FOCUS, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.
Physician Stress Related to Work Overload

A French study of 670 physicians caring for people with HIV found that levels of stress and satisfaction were related more to work overload and management responsibilities than to HIV-related factors.

Participants responded to questions about work characteristics, and stress, satisfaction, burnout, and psychiatric distress. All participants worked at least once a week in a hospital and had direct contact with HIV-infected patients; two-thirds worked in a hospital full time. Seventy-three percent were specialists, 18 percent were department heads, 33 percent were hospital unit heads, and 20 percent were involved in AIDS non-governmental service organizations.

Clinical work accounted for an average of 76 percent of the doctors’ time, but HIV care was not the main activity of most of the doctors. The majority of the doctors had been working with people with HIV for more than five years; 14 percent had worked in the field before 1985. Forty percent of respondents were female, and the average age of the doctors was 42 years.

While work stress was at least moderate for the majority of respondents, HIV care did not itself contribute to overall feelings of stress. Forty-one percent rated their work as very stressful, 38 percent as moderately stressful, and 21 percent reported low job stress. Doctors with more HIV-related work were neither more stressed nor less satisfied than doctors with less HIV work.

Fatalistic attitudes towards job stressors strongly predicted burnout in a cohort of 445 nurses specializing in HIV care, while internal styles of coping such as expression of feelings, patience, and problem-solving techniques reduced the likelihood of burnout.

Nurses completed an anonymous survey of work history and workload, Maslach Burnout Inventory predictors of burnout (emotional exhaustion, depersonalization, and lack of personal accomplishment), locus of control (whether respondents attribute events to internal or external causes), and ways of coping. Eighty-four percent of the sample was female, and the average age of participants was 44 years, with a range from 23 years to 74 years. The nurses provided direct care to an average of 20 to 30 patients per week.

Respondents who attributed events and problematic situations to external causes were more likely to use external coping strategies, and those who used external coping were more likely to experience emotional exhaustion, depersonalization, and a lack of personal accomplishment. Those who reported using more proactive, internal coping strategies reported experiencing lower levels of burnout, however an internal locus of control did not predict internal coping. Older nurses were significantly more likely than their younger counterparts to use internal coping strategies, while younger nurses had perceptions of heavier workloads and less confidence in their ability to control or change the situation.

Burnout in Substance Abuse Settings
Shoptaw S, Stein JA, Rawson RA. Burnout in substance abuse counselors: Impact of environment, attitudes, and clients with HIV. *Journal of Substance Abuse Treatment.* 2000; 19(2): 117–126. (Matrix Center, Santa Monica, California; Friends Research Institute, Santa Monica; and University of California, Los Angeles.)

A variety of factors—ranging from a lack of professional support to working in a methadone clinic—predict burnout in substance abuse settings, according to a study of 134 substance abuse counselors.

Researchers assessed risk factors for burnout, using the Maslach Burnout Inven-
tory, program characteristics, job characteristics, workplace support, and counseling self-efficacy. Thirty five percent of respondents worked at drug-free clinics, 50 percent at methadone clinics, and 15 percent at the Salvation Army. Forty-four percent were male, and the average age of the sample was 40 years. Race and ethnicity included 42 percent White, 31 percent African American, 16 percent Latino, 2 percent Asian, and 5 percent multiracial.

High levels of occupational support significantly reduced emotional exhaustion and depersonalization, and increased feelings of personal accomplishment. Organizations with formal and informal support structures, such as weekly lunches promoting peer support, had fewer counselors reporting high levels of burnout. Counselors who worked at methadone clinics reported larger caseloads and less client contact than those at other treatment centers. Feelings of stress, lack of efficacy, and general pessimism were common among methadone clinic counselors.

For all respondents, emotional exhaustion was correlated with lower self-efficacy, less support, and more depersonalization. Depersonalization was correlated with greater numbers of clients, working in a methadone clinic, lower self-efficacy, and less support. Counselors who reported feelings of personal accomplishment had higher levels of self-efficacy, greater support, and fewer HIV-infected clients. Self-efficacy—instilled through trainings that strengthened counseling skills and self-perceptions—was a deterrent to burnout.

Distress among HIV Buddies


Approximately one in four emotional support volunteers working with people with HIV surveyed in a British study suffered from burnout. This rate was lower than that reported in a similar sample of HIV health care workers in London, perhaps due to the fact that health care workers spend more time with clients with HIV.

Researchers surveyed 267 “buddies,” 193 of whom were currently in budding relationships (requiring at least weekly contact). They asked about amount of time spent with clients, client health, motivations for volunteering, anxiety and depression, and frequency and intensity of feelings of emotional exhaustion, depersonalization, and lack of personal accomplishment. The majority of respondents were young, White gay men or heterosexual women. The average time spent volunteering was 5.3 hours per week, with 95 percent spending less than 12 hours per week.

Emotional exhaustion and depersonalization among buddies corresponded to declining client health. Depersonalization also increased among buddies who did not feel emotionally close to clients. While a sense of personal accomplishment increased with time spent buddying, so did emotional exhaustion. Higher levels of education were related to emotional exhaustion, and volunteers who were working or going to school full-time (77 percent) reported greater emotional exhaustion than those who were unemployed. Buddies who were unemployed or homemakers (12 percent) reported greater feelings of personal accomplishment from volunteering.

Volunteers who felt dissatisfied with their emotional support volunteer training were more likely than those who were satisfied with training to experience burnout, anxiety, and depression. Peer support decreased feelings of emotional exhaustion, anxiety, and depression. Only one motivational factor for volunteering correlated significantly with burnout or psychological distress: the desire to gain more personal control over HIV correlated with higher anxiety levels.

Next Month

Research on factors related to HIV risk is increasingly implicating a history of childhood sexual abuse as a central factor, particularly among men who have sex with men. In the April issue of FOCUS, Jay Paul, PhD, a leading researcher in this area, working at the University of California San Francisco, reviews the literature on the effects of sexual abuse on adult psychology and behavior, outlines general approaches to treatment, and emphasizes the aspects of treatment that can be implemented on the front lines at AIDS service organizations doing HIV prevention.

Also in the April issue, Mary Curry, LISW and James Bristol, LISW of the Southwest CARE Center in Albuquerque discuss the relationship between childhood sexual abuse and health-seeking behaviors such as medication adherence.