Despite Burnout, There's Still Joy in Medicine

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Physician burnout is a persistent problem, particularly among residents. "Somewhere upwards of 50 percent of them can have substantial symptoms of burnout," says Lotte Dyrbye, Associate Director of the Department of Medicine Program on Physician Well-Being at Mayo Clinic. She sat down with Stephen Swensen, Lead Advisor for the NEJM Catalyst Leadership theme, to discuss just how widespread the problem is, what causes it, and what we can do about it. In other words, as Swensen says, "how we can get back to the core of the joy of helping people and families?"

"I think action is needed — action is very much a necessary piece," Dyrbye says. "There's a lot of conversation around physician burnout and its consequences to patient care." But the tide is shifting, she says, adding that she believes there is hope. "Many of those who are burned out do recover." Read or listen to the interview below.

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Steve Swensen: Good afternoon, this is Steve Swensen. I'm the [former] Medical Director for Leadership and Organization Development at Mayo Clinic. I'm here for NEJM Catalyst and today we have the opportunity to have a conversation with a great leader in health care, Dr. Lotte Dyrbye. She's a Professor of Medicine at Mayo

Clinic, and a well-published author and physician, [in the] burnout area, [as well as] researcher. She's the Associate Director of the Department of Medicine Program on Physician Well-Being at Mayo Clinic. So, Lotte, thank you so much for spending some time with us today.

Lotte Dyrbye: It's my pleasure, Steve.

Swensen: How did you get interested in professional burnout?

Dyrbye: I think my interest spawned back in early 2000 when Dr. Shanafelt published a study about how residents with burnout were more likely to have sub-optimal patient care practices. Things like discharging patients just to make the service more manageable, not fully discussing treatment options, those sorts of behaviors we're seeing much more frequently in residence. And it was really the first time that I started to think about professional burnout and what that meant. And when people were more likely to experience that during their career and it made us think about, as a group, well, when does this phenomenon of burnout start? Is it something that's unique to residents and physicians in practice, or could it possibly have its origins in medical school? And it was really that paper and that conversation with Dr. Shanafelt that started our very first research project, looking at burnout in medical students back in 2004 or so.

Swensen: So, beyond the well-being of medical students and residents and fellows, it sounds like you see a large opportunity to improve the care and experience of patients and families?

Dyrbye: Yeah, that's very much true. We typically think about patient safety and quality of care, looking at systems factors. But one of the aspects that hasn't been very well explored yet is the relationship between health care provider well-being and career satisfaction, and how that relates to quality of patient care. I think it's come to light more recently, as there have been published studies around burnout and quality of care, burnout and professionalism, burnout and intent to leave practice or actually reducing clinical hours. But how the phenomenon of professional burnout can be impacting, not only quality of care, but also access to care.

Swensen: So, how big, how pervasive, how widespread is this opportunity among our medical students and residents in America?

Dyrbye: Unfortunately, we see a very high prevalence of burnout in physicians. All specialty types with some specialties appearing to be at higher risk for having burnout. Particularly, those that are at the frontline of care. For example, general internists, such as myself — we have higher risk of burnout than other specialties.

> *When we look at residents, they also have a very high prevalence of burnout — somewhere upwards to 50 percent of them can have substantial symptoms of burnout."*

When we look at residents, they also have a very high prevalence of burnout — somewhere upwards to 50 percent of them can have substantial symptoms of burnout. And when we look at medical students, especially in the third and fourth years, or the years where they're more clinically engaged, we also see very high prevalence of burnout. And we see more burnout in physicians and in trainees than we would expect, based on national norms of other U.S. working adults.

Swensen: Fascinating. So we take what I think is a generalization — I hope it's true — enthusiastic, upbeat, mainly younger students in medical school, and put them through medical school and residency, and we sap that joy and enthusiasm, and a large proportion end up being burned out? So, what are the causes, what happens during those years of training, and is it different than for practicing physicians, like you just talked about? What are the drivers, the causes?

Dyrbye: Yeah, a really important point for us to remember is that when medical students matriculate . . . so the very beginning of medical school, they have mental health profiles that [are] better than other age-match U.S. college graduates. Even though they went through really rigorous college education and took the M-CAD and were very competitive in their process of applying to medical school, they had less burnout, less depression, better quality of life in multiple domains at matriculation than did other U.S. college grads.

But once they've been exposed to our environment, are acculturated to medicine, are exposed to our daily work lives, that switches, with higher levels of burnout, depression, worse quality of life, in our trainees, medical students and residents. And that persists out into practice. So, given that information, we think that the major driver has to do with the learning environment or the workplace conditions, more so than individual characteristics or personality traits. So, it's more what's going on in the learning and the work environment, that's really driving the burnout in trainees and in physicians.

Swensen: Wow, so in this work environment, are there characteristics or drivers or specific things that you've learned through research and being an expert in this

area that's stand-out in that environment, that's different from the premed years that changed this whole, file from matriculation that's pretty good, to something that causes them to suffer, over the years?

Dyrbye: There are numerous contributors that have been delineated. If we think about the resident trainer, the resident trainee, as with physicians, excessive workloads. So, high patient volumes, frequent/erratic call, greater work hours, are associated with resident burnout, just like they are in practicing physicians. Residents also don't have a lot of autonomy and they experience work/home conflict and that contributes to their burnout. As does their educational debt. So, the more educational debt they have, the higher their risk is for having burnout, as well. Now, there are other factors that are related more to supervising physicians.

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So, if residents don't get timely feedback, if they have stressful relationships with their supervisors, if they feel that their personal needs are inconsequential and aren't being met. Those sorts of factors within the learning environment also contribute to resident burnout. Another interesting thing that we've uncovered is residents feel uncertain about their future, which you just imagine, in today's era of rapidly evolving health care reform and how we're delivering health care. Residents have a really hard time imagining what their practice is going to look like, once they're done with training. And the more uncertainty they feel about the future of the profession, the greater their risk of burnout, as well.

Now, we back it up and we look at the medical student, we look at the very, very beginning, one of the things that we've identified is that grading scheme, it makes a huge difference. So, if you look at year one and two of medical school and you examine things, like the number of hours they have to be in lecture, or small group, number of exams they have, how much vacation they have. Anything you can think about from a curricular structure point of view, the only factor that matters, is whether or not they're going to pass their grading scheme in the first two years, or not. The students in pass-only curriculum in years one and two have much lower risk of burnout. And perhaps more important, they have a greater sense of group cohesion or social support, which is really important in this area, where we're trying to form teams and teach students about interprofessional relationship building. So, with the medical students, it doesn't matter what

rotation they're on, it doesn't matter how many hours they're working in clinic, or how often they're on call, how many patients they're taking histories and physical exams on. I think the students want to work hard, they expect to work hard. But they need to do so in a supportive, well-organized environment.

Swensen: So the pass/fail grading schema. Am I correct that that promotes more social support because there's less competition than groups that are graded on a curve and only 10 percent get A's or something? Is that the cause of that?

Dyrbye: Yeah, we think it promotes more of a peer collaboration environment, which then comes with more social support. And it's interesting, studies using historical cohorts, have found that students perform just as well in step one and step two, they perform just as well in the courtships, with respect to grades, number of honors, shelf exams in the courtship years. So, even if you move to a pass only curriculum in the first two years, the students are still learning, they're still becoming competent. But it is helping to preserve their mental health and also building those very important relationships.

Swensen: That's really interesting, Lotte. So, I think you've already started to answer this question. Let's say you are now the dean of a major medical school that includes not only medical students but residents and fellows. And you had a pretty decent budget and the priority of yours is addressing burnout of these students, residents, fellows. It sounds like you'd move to pass/fail grading. But what else would you do, what else would you recommend to other leaders who wanted to have the wellness of their students and residents and fellows, to be in the best possible situation when they finish up their training and go into practice as board certified professionals?

Dyrbye: Yeah, I think that's a very important question, Steve. From my perspective, I think it's really important just to start with the shared framework that well-being of a trainee, trainee well-being, it's a shared responsibility of the individual trainee, as well as the training program, whether that's medical school or the residency, as well as the academic medical center, from a broader perspective, accreditation organizations and organized medicine. It really takes a multi-pronged effort. When we focus on just what should medical school leaders or program directors, leaders of GME, think about, I think there's a couple of what I think of as big buckets or big areas. One would be to think about wellness curriculum. So the students and the residents can benefit from learning about what are some of the self-care strategies that have been shown to be effective to promote resiliency, decrease the risk of burnout. And some of that can be framed within having personal wellness be part of core competency and have milestone frameworks around that. The

other big bucket for me is these new educational strategies, which include the pass only grading, like you mentioned. And also organizing students who are in very big medical schools into smaller learning communities, which is being done at several medical schools across the United States. Again, to promote group cohesion and social support, and also to provide opportunities for trainees to have meaningful patient care roles, which can give them a sense of value that they're contributing. That they're making a difference and they start to get meaning out of their work.

When we step back and think globally about having distress, not feeling well mentally, not performing optimally, who are the types of people that would be helpful to interact with, to help us get into a better place?"

Unfortunately, despite our best attempts, students continue to report perceptions of being mistreated or being harassed, so we do need to continue to work on promoting a culture of no tolerance of harassment. And also, just working on developing our faculty, to raise awareness, and helping them also facilitate a positive learning environment. Beyond that I would say, it's really important to implement screening tools. It turns out, it's really hard for us, even as physicians, to self-assess our level of distress and see how close are we to the edge, so to speak. Even as physicians and skilled diagnosticians, it's really hard to hold that mirror up to yourself and say, how's my level of fatigue, how is my burnout, how is my stress? How is it compared to peers? So, I think, thinking about how can we help trainees self-assess their level of well-being would be another important part. And the fourth big area that I think about is access to care, which continues to be a huge public health problem. And certainly, also, a problem, even for us, within the walls of medicine. The willingness to access care and barriers to that, and then also just the ability to be able to get the mental health care that's needed.

Swensen: And so the access to care would be for young professionals who either self-identify or become aware of their situation through these screening tools? And you're talking about burnout, not depression, and the access to care would be with a psychologist or psychiatrist or some counseling?

Dyrbye: Yeah, I do think that would be helpful. When we think about professional burnout, that is different than depression. But when we step back and think globally about having distress, not feeling well mentally, not performing optimally, who are the types of people that would be helpful to interact with, to help us get into a better place? And some of those people are going to be mental health providers. They might be, as well, your primary care physician, it might be the

program director, or the dean of student affairs. It's going to take a variety of individuals to help a person come from a spot of not being well, to being pulled back or guided back into a spot of a better mental health profile.

Swensen: Very interesting. Dr. Dyrbye, when I listen to those recommendations and what you do as a dean, I'm thinking that most of them involve time and attention [and] programs. And in this share of responsibility you talk about I'm not seeing a huge capital budget here. So, is that a fair interpretation of what you've shared with us? That this is not a terribly expensive way to address a very important issue for patients and for providers and students, but is more about time and attention of leaders and not so much about throwing a lot of money at it?

Dyrbye: I do think it needs to be a thoughtful strategy. And any sort of strategy should engage the trainees in addressing what are some of the local drivers of burnout? Some of these risk factors are going to be beyond the control of even an academic medical center. But there are some factors that are going to be within local control. So, identifying what those are, with help of the trainees, getting their perspective on what [are] some of the low hanging fruits, what are ways to build more social support, or how can we address work compressions better? What are the opportunities within the curriculum, or within the training program, to make work life or learning on the job better and more effective? So, I think we need to engage the trainee in those conversations and step up to our own responsibilities, figure out what is in our sphere of influence. And then, nationally, work on the other issues that are driving some of this.

Swensen: You mentioned about this culture of harassment and tolerating some attending physicians' behaviors that promote burnout and disengagement of students and residents. How can organizations identify opportunities to help attending staff increase their mutual respect and improve the ways they interact, or what would you recommend in that space if you're in charge?

Dyrbye: You want an important comparative stick? Continue with 360 evaluations. Because for these physicians, they're probably themselves struggling with their interactions with a variety of members on the allied health professional team. So responding to that feedback, I think, is very important. The medical students and residents also fill out learner or faculty evaluation forms. Similarly, it's very important to look at those and to address themes. But I have to admit, there's been a lot of work and a lot of effort going on in this space about how do we get students and trainees to talk about or to report when do feel like they're harassed and belittled, rather than just anonymously saying it on an end of graduation survey? Because that's really hard to act on. And although there's been a lot of effort in the field, we continue as an organization or as a culture to

make a difference, so we need to just continue to partner with our trainees to identify some novel ways of monitoring and responding to reports of harassment, and how can we better deal with sub-optimal role modeling by faculty. But this is, unfortunately, an area that continues to be challenging.

Swensen: One thing we haven't talked about is medical errors and preventable harm and the second victim area. So, on a regular basis, there are patients in a country who are harmed by systems and processes and human factors and medical errors that competent, conscientious, hardworking students and fellows and staff make. And [of] most of those harm events for patients and families, there's a second victim of the providers that are involved in the care that also have some influence on their emotional well-being. How does that play into burnout?

Dyrbye: We know from Colin West's longitudinal work that was published in JAMA a few years ago is there's a bidirectional relationship between perceptions of having committed a major medical error, and well-being. So, what I mean by that is if you perceive that you've committed a major medical error, that is associated with subsequent distress across multiple domains, whether you look at burnout, depression, quality of life. So, if you think you've committed a major medical error, it's highly likely, if we were to assess your mental health, two to three months down the line that it would be worse. But we also know that residents who have burnout are also much more likely to subsequently perceive that they've committed a major medical error.

> *We have to remember that not all physicians or health providers are burnt out. Many of those who are burned out do recover. But nonetheless, there's a serious issue that's facing health professionals."*

So, we think that it's a complicated relationship that goes both ways. And as you point out, physicians, we tend to be very attentive to detail, very thorough, very committed to our patients. And when we perceive we've had a role in a major medical error, it really hits home. And it's hard to let go of and often results in substantial stress, which leads to burnout, as well as other forms of mental health problems. I'm not sure that all organizations think about that. Organizations have lots of processes in place for, okay, how do we communicate this with the family? How do we work on identifying what went wrong? How do we remediate that to make the chances of this happening again smaller? But where in that whole cycle or flow chart is there, let's make sure we address the excessive self-blame that can happen with the team members who are involved?

Swensen: Thanks, Lotte. I'd like to end with just a more of an upbeat approach to this dreadful problem. And so, when you look at all of the different professions and careers and work opportunities, one might make an assessment that there should be so much joy in this helping profession. Health care is all about healing and caring for people in need that are in pain that have cancer or heart disease. It's a wonderful, professional opportunity to find joy and meaning and purpose in one's work. And from a distance, someone might conclude that the burnout rate in health care should be so low because of this opportunity to have all of the gratification and gratitude, meaning, purpose, and joy in helping families and patients, either heal, get better, or deal with a condition. And yet, the health care profession has the highest levels of burnout, doesn't it? So, in the beginning, you talked about getting back to the core of the joy of helping people and families?

Dyrbye: I think there still is an enormous amount of joy in medicine. We have to remember that not all physicians or health providers are burnt out. Many of those who are burned out do recover. But nonetheless, there's a serious issue that's facing health professionals. I think action is needed — action is a very much a necessary piece. Patients deserve and they should be receiving care from committed, competent, professional physicians who are enjoying what they do.

We know that physicians who find meaning in their work are less likely to have burnout. So, getting back to meaning, how do we get more meaning and joy out of our everyday interactions with patients? And one of the things that's getting in the way is the electronic health record and how that is interfering with our ability to connect with our patients, spend the time with them that we want to be able to spend. So, I think that there is hope. There's a lot of conversation around physician burnout and its consequences to patient care. I see that the tide is shifting, change is going to come, and we're going to work hard on being able to make a difference.

Swensen: Outstanding, Dr. Lotte Dyrbye, Professor of Medicine at Mayo Clinic, thank you so much for your time today. And thank you on behalf of NEJM Catalyst for your work to help bring back joy in work for people who need that help. Thank you very much.

Dyrbye: Thanks a lot for talking to me, Steve. It was a pleasure, thank you.

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Intermountain Healthcare

Stephen Swensen is the Medical Director for Professionalism and Peer Support at Intermountain Healthcare. He is also a Senior Fellow of the Institute for Healthcare Improvement, where he co-leads their Joy in Work Initiative. Learn more about Stephen Swensen...

Liselotte Dyrbye, MD, MHPE

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DISCUSS

HIDE 1 RESPONSE

+ ADD A RESPONSE

Ann Carroll MD

Sleep deprivation:
(1) Is universal in almost all physicians.
(2) Deteriorates physician health and accelerates markers of the aging process (HBp, diabetes) over time. (If University of Chicago pioneering sleep research is to be believed.)
Certainly the civilian and government labor regulatory bodies negatively sanction private employers whose work demands employee sleep deprivation. These regulations are toughening even as we discuss this.
Physicians and the Military are the only vocations in which sleep deprivation is expected, as the vocational goals take priority.
Over time, the cost to the MD of years/long prolonged work hours is by nature to include burnout. BO is but a collection of dysfunctions.
Read the pro/con discussions on excess training hours in NEJM and JAMA. Even now policy makers recommend work weeks in excess of federal law. Never do the 'pro' discussants weigh the health of the MD, his family, his proficiency when measurably sleep deprived (bp, ekg r-r interval, insulin resistance, transient mental decline -- in the midst of providing patient care).
Most MDs have vivid memory of such. As resident, a night RN called me to assist a sleep deprived surgeon --

whom I found at bedside 'reading' a patient's chart upside down.
He was groping to comprehend what to do for his patient with a torn bleeding liver. She had already received over 200 units of blood. He had no idea who his patient was, nor what to do next.
That was vivid. How many millions of mortal medical errors have been committed while sleep deprived?
You first.

July 14, 2016 at 7:14 pm REPLY

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