Empowering Trainees to Aim For Physician Wellness

Yul D. Ejnes, MD, MACP

Jennings and Slavin[1] describe burnout as "a maladaptive syndrome that results from chronic work stress." They add that it "is characterized by feeling emotionally depleted (emotional exhaustion) and/or having a distant or uncaring attitude toward patients and work (depersonalization or cynicism)."[1] Physician dissatisfaction, burnout, or any other term used for this phenomenon has been linked to increased job turnover and early career termination, reduced patient satisfaction, increased use of tests and specialist referrals, and higher rates of physician depression and suicide.[2,3]

Burnout affects physicians at all career stages, including medical students and residents. Much of the recent attention in the medical and general press has focused on physicians in practice. However, identifying and addressing burnout in the training years provides an opportunity to change the culture that contributes to this pernicious threat.

This issue of the *Journal of Graduate Medical Education* features 3 articles on resident wellness. From my vantage point as a physician in private practice for over 25 years, I believe the articles expand our knowledge about effective countermeasures for burnout, identify additional opportunities to improve physician wellness throughout the career continuum, and discuss challenges to achieving this aim.

In her systematic review, Raj[4] identifies several factors associated with resident well-being: autonomy, building of competence, strong social relatedness, sleep, and time away from work. I believe that most of these factors are relevant to late career physicians as well.

Ey et al[5] describe a comprehensive set of interventions to increase resilience in residents by teaching coping skills, reinforcing self-care, and modeling the use of mental health services. These interventions should be reproducible in other settings, including nonteaching settings. Bringing these services to small practices, which still make up a large, though shrinking, segment of the physician workforce, will be challenging. Professional societies are working on this, as evidenced by the American Medical Association's "STEPS Forward" program.[6] Health plans could join in this work, especially if provider wellness is adopted as a quality measure, as some have proposed.[7]

Cohen-Katz et al[8] report that a "culturally transformed" residency that supports wellness did not increase measurements of well-being. This is a reminder of barriers that result from a culture that has discouraged or devalued physician self-reflection and self-care, which are important to preventing burnout. Empowering trainees and practicing physicians to care for themselves without feeling like this is a tradeoff with caring for their patients is essential.

Less surprising is the observation from Cohen-Katz et al[8] that, while the residency changed its culture, doing so did not "change the nature of the work residents do." While it is important to destigmatize burnout and promote wellness by equipping physicians at all career stages with the skills and abilities to cope better with the realities of modern day practice, it is essential that we also change the often harsh realities of medical practice.

Physician "unwellness" has many root causes, many of them related to time pressures: insufficient time to spend with patients or inadequate time away from the office. Competitors for that time include "hassle factors," such as administrative burdens from insurers and the inefficiencies introduced by electronic health records, superimposed on the increasing needs of a sicker and more engaged patient population.[9] Additional influences are decreasing autonomy, increasing payment inequity, and greater physical disconnection from colleagues as professional work shifts from the hospital to the community.

Empowering physicians to take action to reduce burnout and increase practice satisfaction is expressed in calls by several commentators for society to value the well-being of physicians and other members of the health care team, in the same way that society values improving quality of care, the health of populations, and cost—the so-called "Triple Aim."[10] Some have recommended adding provider satisfaction to the Triple Aim and reframing it as a "quadruple aim."[11,12] This is not a novel concept, as it was considered, but ultimately

DOI: http://dx.doi.org/10.4300/JGME-D-16-00546.1

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/8/5/775/2217490/jgme-d-16-00546_1.pdf by guest on 26 October 2021

rejected, in the early 2000s, when what eventually became known as the Triple Aim was being developed (K. Kizer, personal communication, January 2016).

Some may argue that an increased focus on physician wellness is inconsistent with medical professionalism, in that it detracts from the primacy of the patient. However, this does not need to be an "either/or" choice. In fact, dissatisfaction and burnout increases the likelihood that physicians will engage in unprofessional behaviors, be less empathetic, and make errors.[2] Given the negative effects of burnout on quality of care and access to care, we have no choice but to address this issue for our patients.

Innovations in how care is delivered can reduce burnout at all career stages. Sinsky et al[13] describe practical ways by which medical offices can make practice more joyful through workflow redesigns that reduce the practice hassles. My experience with practice transformation parallels their findings. Greater delegation of tasks to other members of the patient care team, "smarter" use of the electronic health record, and previsit planning are just a few of the tools that I have used to increase satisfaction and regain control over how I spend my time.

This new approach to managing workflow requires another cultural change that must begin in training, a shift from the traditional mindset of "If I don't do it myself, it won't get done or get done right," to comfort with delegating tasks to other members of the patient care team who are qualified to perform them. This is at the core of the patient-centered medical home model that many practices, including my own, have adopted.

Transforming practices into models that support physician wellness demands adequate resources. At all system levels, physicians must advocate for those resources. We also must insist that provider experience be valued as a key metric, whether in evaluating health care organizations (insurers, hospitals, physician groups, etc) or initiatives that potentially add to the workload and time demands of physicians. Therefore, to be effective, we must train residents to be leaders and advocates for the profession, as well as educate them on the "alphabet soup" of organizations and entities that can help or hinder this work.

Teaching and supporting trainees (and practicing physicians) in the development of resiliency must occur in parallel with improving the work environment. In addition, building on the work presented in this issue of the *Journal*, expanding our understanding of physician burnout, and developing programs to increase the resilience of physicians will give agency to physicians to make practice more rewarding and achieve the other 3 goals of the "quadruple aim."

References

1. Jennings ML, Slavin SJ. Resident wellness matters: optimizing resident education and wellness through the learning environment. *Acad Med*. 2015;90(9):1246–1250.
2. Cassalino LP, Crosson FJ. Physician satisfaction and physician well-being: should anyone care? *Professions and Professionalism*. 2015;5(1):1–12.
3. Blackwelder R, Watson KH, Freedy JR. Physician wellness across the professional spectrum. *Prim Care*. 2016;43(2):355–361.
4. Raj KS. Well-being in residency: a systematic review. *J Grad Med Educ*. 2016;8(5):674–684.
5. Ey S, Moffit M, Kinzie JM, et al. Feasibility of a comprehensive wellness and suicide prevention program: a decade of caring for physicians in training and practice. *J Grad Med Educ*. 2016;8(5):747–753.
6. American Medical Association. STEPS forward program. https://www.stepsforward.org/. Accessed September 1, 2016.
7. Wallace JE, Lemaire JB, Ghali WA. Physician wellness: a missing quality indicator. *Lancet*. 2009;374(9702):1714–1721.
8. Cohen-Katz J, Sternlieb JL, Hansen SE, et al. Developing emotional intelligence in the residency learning environment: a case study in cultural transformation. *J Grad Med Educ*. 2016;8(5):692–698.
9. Shanafelt TD, Dyrbye LN, Sinsky C, et al. Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clin Proc*. 2016;91(7):836–848.
10. Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. *Health Aff*. 2008;27(3):759–769.
11. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med*. 2014;12(6):573–576.
12. Spinelli WM. The phantom limb of the triple aim. *Mayo Clin Proc*. 2013;88(12):1356–1357.
13. Sinsky CA, Willard-Grace R, Schutzbank AM, et al. In search of joy in practice: a report of 23 high-functioning primary care practices. *Ann Fam Med*. 2013;11(3):272–278.

Yul D. Ejnes, MD, MACP, is Clinical Associate Professor of Medicine, The Warren Alpert School of Medicine, Brown University.

The author would like to thank Michelle L. Rossi, MD, and Audrey R. Kupchan, MD, for their insights and thoughtful review of the manuscript.

Corresponding author: Yul D. Ejnes, MD, MACP, Coastal Medical Inc, 75 Sockanosset Crossroad, Suite 100, Cranston, RI 02920, 401.946.6200, fax 401.275.1992, yul_ejnes@brown.edu

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/8/5/775/2217490/jgme-d-16-00546_1.pdf by guest on 26 October 2021