Recovery From the Burnout Epidemic: How the Academic Community Can Help

Abigail Ford Winkel, MD, MHPE

Physician burnout weighs heavily on the medical community. Decades of research have illustrated the devastating impact of burnout on individuals, patient satisfaction and outcomes, workforce turnover, and costs.[1] Burnout appears to take its grip during medical training. The Accreditation Council for Graduate Medical Education has placed a spotlight on wellness, stating that "psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician . . . programs, in partnership with their sponsoring institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence."[2] The magnitude of the problem and the momentum of efforts to address it have resulted in a rush to interventions without a robust and complete understanding of this complex problem.

A recent review of interventions to address burnout demonstrated that current efforts to address burnout are heterogeneous. They range from creating mindfulness-based stress reduction, to setting up new staffing models, instituting formal debriefings around work-related stressors, conducting workshops, and incentivizing exercise programs.[3] The good news is that many of these interventions seemed to work, which supports an organizational approach to address the sources of distress in our working environment. The bad news is that it is impossible to determine from the existing research which interventions work best or why they work. We have not yet defined what it means to thrive in the medical work environment or how that construct could be measured.

Burnout research has its flaws. In a recent article, Eckleberry-Hunt and colleagues[4] examined the literature on burnout research and identified important concerns. While a gold standard for measuring burnout exists—the Maslach Burnout Inventory–Human Services Survey[5]—this tool is not always used or interpreted correctly. Even in well-designed studies, identifying burnout does not necessarily lead to a solution. A wealth of other quantitative methods exists to measure aspects of professional satisfaction, compassion fatigue, fulfillment, engagement, and patient experience. Researchers have proposed novel metrics to quantify how physicians spend their time at work and at home.[6] The multitude of tools for intervention and measurement hints at the many questions that remain in this arena, such as: What does it mean to thrive? What does it take to get to that place?

In this issue of the *Journal of Graduate Medical Education* (*JGME*), Abedini and colleagues[7] investigate how residents recover from burnout. They use a novel approach to the subject. We have not examined recovery from stress and burnout in medicine, although this subject has been examined in other professions.[8] Abedini et al[7] used a qualitative approach to explore the question, which allowed them to discover something about the phenomenon that they had not hypothesized a priori. To understand how residents recover from burnout, they distinguished between 2 types of burnout: *existential* and *circumstantial*. While *circumstantial* burnout might improve without intervention when a particularly difficult rotation ended or a program changed its duty hours structure, *existential* burnout needs a more deliberate examination of meaning and professional place—even mental health services. The researchers found that burnout may not be a single homogeneous construct; it could contain subtypes that may not respond to the same treatment.

These insights help us to know what questions to ask in future studies, including what aspects and items to measure in quantitative studies. As we explore this territory, we need to call on a variety of tools in our research. Qualitative research must be performed and reported with the same rigor that is used in quantitative research; maps exist to help education researchers find their way in this arena, including several guides published in *JGME*.[9–11]

A realist approach to educational research does not just ask if an intervention works, but it also asks "what works, for whom, in what circumstances, in what respects, to what extent, and why."[12] This type of study will need to build theory on how physicians develop resilience and recover from burnout as well as which interventions (directed toward medical

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professionals and the surrounding environment) are likely to be the best use of our resources.

Internal and external forces contribute to the problem of burnout, along with cultural forces that push us to behave in ways that may not be in the best interests of ourselves and our patients. There are mismatches between physician effort and work structures as well as between reward systems and institutional values. These are problems we may not be able to fix. Yet, there are paths forward that we can choose to promote wellness in the face of difficult circumstances.[4] At the same time, it is important that we not mistake the need to take action with the conclusion that we understand the problem. We must collect evidence as we go in order to learn how thriving works for learners and practitioners at different stages of development, even as we try to fuel interventions.[4] Learning from those who have successfully recovered from burnout is an important step in this direction.

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Abigail Ford Winkel, MD, MHPE, is Associate Professor and Vice Chair for Education, Department of Obstetrics and Gynecology, New York University Langone Health.

Corresponding author: Abigail Ford Winkel, MD, MHPE, New York University Langone Health, Department of Obstetrics and Gynecology, NBV 9E2, 550 First Avenue, New York, NY 10016, 212.263.8683, fax 212.263.8251, abigail.winkel@nyumc.org