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Burning Out: Resilience Isn't Enough



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Insights

- Physician burnout is estimated to cost the health care system approximately \$4.6 billion dollars every year.
- System-related limitations and stolen autonomy were key precipitants of burnout prepandemic.
- Long hours, understaffed teams, and a disorganized system is leading to burnout during the pandemic.
- We propose a C.L.E.A.R. strategy to combat burnout during the second wave of COVID-19.

What is burnout? The Devastating Impact of Burnout in Healthcare

Burnout has emerged as a major problem at the forefront of the modern medical world. Several largescale studies and meta-analyses have reported that 1 in 2 medical trainees face burnout and that this rate does not change as new physicians proceed in their practice¹–⁴. Burnout is classically understood within three constructs; emotional exhaustion (EE), depersonalization (DP), and a sense of lack of personal accomplishment (PA)⁵. The effects of burnout are far-reaching, certainly affecting physicians' quality of life – associated with broken relationships, alcoholism, and physician suicide – but equally affects the health care system $^{6}-^{10}$. Studies indicate that burnt-out physicians provide poorer quality patient care and are associated with patient dis-satisfaction¹¹. Physician distress has also been linked to physician prescribing habits, test ordering, the risk of malpractice suits, and whether or not patients adhere with physicians' medical recommendations¹²–¹⁴. It is estimated that physician burnout has cost the health care system \$4.6 billion annually¹⁵.

Exhibit 1: Causes of Physician Burnout



Drivers of Burnout, Pre-Pandemic

It's not personal. Research around mediators of burnout have focused on individual characteristics, such as relationship status, gender, age, history of mental illness, among others to understand whether these differences between individuals make them more or less susceptible to burnout. Unsurprisingly, the literature has yielded inconsistent results. A recent systematic review of studies by our team investigating burnout among resident physicians found that no demographic characteristic was consistently linked to burnout (unpublished data). Conversely, personality attributes, such as being self-critical, perfectionism, neuroticism, engaging in unhelpful coping strategies, and idealism, appear to be related to higher rates of burnout¹⁶. It is even less surprising, therefore, that solutions targeting the doctor, such as promoting exercise, meditation, and hobbies, have not had a significant impact on burnout; a meta-analysis of 19 studies suggested that these strategies do not address the underlying problem¹⁷.



Exhibit 2: Burnout Among Residents (adapted from Naji et al 2020; unpublished data)

*Legend: Blue bars represent number of studies finding no association between studied factor and burnout. Orange bars represent number of studies finding that studied factor increases burnout. Grey bars represent number of studies finding that studied factor decreases burnout.



Early Promise From Phase II Results: Vaccines for COVID-19

Resilience is not enough. Often when discussing solutions to reduce distress and burnout, resilience training is proposed. Resilience is commonly understood as personal qualities that enable one to adapt to and thrive during times of adversity. Our OE poll respondents largely felt that resilience was not a significant determinant of burnout – only 9% felt this was a leading contributor (Exhibit 3). The literature supports this contention; a survey of 5,445 physicians in the US found that although high resilience was linked to lower burnout overall, physicians as a group did not want for lack of resilience¹⁸. Compared to the general population, resilience scores were higher among physicians, yet burnout among US physicians is dramatically greater than workers in other fields⁶. Most importantly, having resilience did not obviate the development of burnout; 392 of 1350 physicians (29%) surveyed had the highest possible resilience score but still reported having burnout¹⁸. A previous smaller study in the UK echoed these findings19: **doctors are more resilient than the general population, but still experience higher levels of burnout**.



Let's look at the system. Though challenging to uncover, numerous longitudinal and systematic studies have suggested that workplace and system factors, such as workplace efficiency and resources, workplace culture, stolen autonomy, control and flexibility, social support at work, and work-life integration are the drivers of burnout. Support for this comes from qualitative interviews and some interventions that have sought to change these system-related factors^{17,20,21}. The thought is that greater requirement for documentation, the often combative and toxic work culture, and extensive bureaucracy has turned medical practice into a series of checklists, ultimately stealing autonomy from physicians. To address these limitations, one department of family medicine at the University of Colorado instituted a model called ambulatory process excellence, APEX, which used medical assistants to gather data, reconcile medications prior to patient visit. The medical assistants also remained in the room to document the visit. With the implementation of APEX that reduced the operational burden of documentation, burnout rates dropped from 53% to 13%²².

Burnout Amidst COVID-19: An Epidemic Within the Pandemic

It is postulated that the COVID-19 pandemic has heightened the state of burnout among frontline healthcare workers^{15,23,24}. In addition to traditional causes of burnout, the increased risk of occupational exposure to infection, inefficient processes, and limited resources are additional stressors during the COVID-19 pandemic^{25,26}. A survey of 1,257 physicians and nurses caring for patients with COVID-19 in China found that frontline health care workers (FHCW) experienced more depression, anxiety, insomnia, and distress compared to providers not directly involved in the care of patients effected by the virus²⁷. An Italian study of 1,379 FHCWs found that 49% of respondents endorsed posttraumatic stress symptoms, nearly a quarter suffered from depression and 20% from anxiety²⁸. It is unclear if these rates represent a true increase in level of depression and anxiety compared to pre-pandemic studies which estimate that around 30% of physicians experienced the mental illness^{4,29,30} or rather that the higher levels of perceived stress among HCWs in COVID units is a sign of acute distress with yet unknown long-term mental health consequences. Similarly, another study of 180 health care workers on COVID-facing services found substantial levels of anxiety and stress that adversely influenced sleep and self-efficacy.

Importantly, those who reported a strong social support network had a lower degree of stress and anxiety, and a higher level of self-efficacy³¹. These stressors are not unique to COVID-19, fears of transmission, social isolation, ostracism by family were cited in the SARS epidemic^{32,33}, AIDS epidemic³⁴, TB epidemic in South Africa³⁵, and the Ebola epidemic in West Africa³⁶. And yet, as while caring for COVID patients and in my discussion with colleagues, I have also felt that the pandemic has inadvertently provided opportunity to find fulfilment in medicine once again. Physicians and frontline workers have demonstrated impeccable altruism and selflessness and in turn have been widely recognized and applauded. Working in an uncertain time without medical guidelines and a vast pool of knowledge to draw from has also created opportunity for autonomy, competency, and fuelled our academic curiosity through research. But most importantly, the pandemic has allowed for a unique opportunity to reflect upon the limitations of our profession and make deliberate changes that will promote fulfillment and reduce burnout in our practice as physicians.

With a potential second wave on the horizon, we need a C.L.E.A.R. strategy to fight the pandemic of burnout.



Communication: As a young resident working on COVID Units and ICUs, one of the most frustrating factors contributing to my exhaustion was the lack of clear and transparent communication from hospital leadership. Code blue protocols, policies on personal protective equipment (PPE), flow of COVID patients, among others, were aspects of our work that changed daily. We would often find out this information in pieces from colleagues or overhear a conversation at the nursing station. Lack of prioritized communication to the frontline not only erodes trust in leadership, but also makes HCWs feel undervalued and contributes to added stress, anxiety, emotional exhaustion, and to burnout overall. In fact, poor communication and support is an independent predictor of adverse mental health outcomes among first responders in medical disasters³⁷. For the remainder of this first wave and as we prepare for a second wave, health care institutions should develop a consistent platform through which pertinent pandemic related information is communicated and accessible to all frontline medical workers.

Less rigidity: In our OE poll, 26% of respondents felt that flexibility and control over schedules is a good strategy to combat burnout (Exhibit 4). This idea is echoed in the pre-pandemic literature on burnout. A 2017 study showed that physician input in scheduling was among the few organization-directed solutions to achieve a reduction in burnout¹⁷. This type of intervention ultimately allowed physicians the flexibility to incorporate individual practice styles and balance work and life. In the context of a pandemic, flexibility over scheduling is oft limited, however incorporation of physician preferences and previous commitments could minimize burnout.

Enhance protection: Much has been said about the effect of lack of PPE and stress; the fear of contamination and infecting loved ones were among the drivers of stress and anxiety among health care workers on the frontline. Yet, PPEs not only directly precipitate workplace stress, but represent the lack of investment in the health and safety of physicians working in the pandemic. Although endorsed by only 5% of our OE poll respondents (Exhibit 4), peer and mental health support has been shown to be efficacious in reducing burnout^{38,39}. To this end, driven by the tragic suicide of a New York City physician caring for COVID patients, Gulati and Kelly⁴⁰ proposed implementation of programs to protect physicians. We reiterate these here:

- Establishing a COVID-19 Clinical Ethics Committee that physicians can consult for critical clinical decisions, such as withdrawal of care, liaising with families, and experimental treatments, among others.
- Physician peer groups providing an informal 'safe-space' aimed to reduce professional isolation

Autonomy: With the advent of EMRs, best practice guidelines, and focus on efficiency-based medical practice, physicians experience a profound lack of control over their clinical practice. Specific requirements are in place for the amount of time spent with patients, the mounting burden of required documentation, and increased surveillance in the form of metrics. These have all compromised autonomy and is often identified as a principle precipitant of burnout. Healthcare institutions should prioritize reducing administrative burden, funding initiatives that improve workplace efficiency without adding to the workload of physicians, and encourage clinical volition.

Relatedness: According to Hartzband and Groopman, relatedness is the psychological feeling that one belongs, has interpersonal attachments, and is connected to the social organization. In this construction, physicians want to be valued and recognized for their efforts to provide patient-centered care¹⁵. To this end, 38% of respondents of our OE poll agreed that one way to circumvent burnout would be for leadership to be supportive and compassionate toward FHCWs (Exhibit 4). Mentorship and peer support programs geared toward providing a sense of community and recognizing positive contributions may circumvent burnout during a possible second wave. As such, healthcare institutions should prioritize funding for and creation of such professional support and community building initiatives.

EXHIBIT 4: WHAT CAN HOSPITALS DO TO COMBAT BURNOUT?



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