PERSPECTIVE: PART II

BURNOUT AS AN OCCUPATIONAL PHENOMENON: OUR CONVERSATION

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Inspired by *The New York Times*' opinion columnists who write The Conversation, an informal and brief dialogue on important issues of the time, we had our own conversation about physician burnout. The following exchange has been lightly edited for readability and flow.

Gaetan: Good morning, Dr. Leung. Or is it "good afternoon" in your part of the world? I really appreciate that you shared the recent *New York Times* Op-Ed by Dr. Richard Friedman in response to the World Health Organization's decision to upgrade burnout from a "state" to a "syndrome".[1] As Dr. Friedman points out, this is a complex issue that's particularly relevant to us as physicians and as educators, so I'm glad we're having this conversation.

Tiffany: Thanks, Gaetan. In a time when there is virtually a global clamor in medical communities everywhere about the daily burdens and challenges that doctors face, the WHO's declaration seems positive. At least these are the sentiments I gathered from the comments in reply to Dr. Friedmans' Op-Ed. So, I get his position: it's great that we can better measure burnout now, but at the same time, we should be prepared to avoid mislabeling difficult experiences and feelings that could be normal as the syndrome of burnout. What do you think—are we just complaining too much?

Gaetan: I don't think we're complaining too much. In some ways I don't think we're complaining enough. I do worry that shining a spotlight on burnout creates availability bias and may lead to misdiagnosis of both normal stress and depression, but I am more concerned about the root-causes of medical malaise than I am about the labels themselves. Diagnosing burnout tends to have the strange effect of focusing attention on the individual rather than on the system in which he or she practices. If a large percentage of patients treated at the same hospital developed a similar constellation of signs and symptoms, we wouldn't view those cases in isolation and we certainly wouldn't propose that each patient treat him or herself with a course of lifestyle modification. So why is it our impulse, when faced with growing numbers of struggling physicians, to prescribe mindfulness and resilience training?

Tiffany: I agree with you, it's not unlike a variety of other psychological disorders that have definite sociocultural, or biopsychosocial, components to them. To prescribe mindfulness and resilience training then is but a band-aid treatment for a complex problem. It helps to have these tools available, but isn't it better to prevent burnout and its potential consequences before it starts in the first place? I recently read a metaphor for prevention that could be applied and extended here:[2] if people were literally falling off a cliff repeatedly, sustaining injuries, experiencing reduced quality of life, and creating greater direct and indirect costs for society and our healthcare system, wouldn't we prefer to take a public health approach and put up a fence and warning signs at the cliff's edge, and adopt other interventions to prevent the bad outcomes?

Gaetan: I like it. "Upstream doctoring"[3] for doctors. It strikes me that one of the cardinal features of burnout is depersonalization, and if you asked me to name the biggest trend in healthcare today, I'm afraid that would be it. Although my physician scientist colleagues are brimming with excitement over the prospect of increasingly personalized medicine, the business of healthcare seems to be proceeding in the opposite direction—replacing touch with technology and faces with screens. I recently switched to a new primary care doctor and guess who greeted me when I arrived to check-in? A kiosk. Is it any wonder that physicians feel a sense of depersonal-

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ization when the system is literally replacing persons with machines?

Tiffany: You've raised a really interesting intersection of technology and humanism in medicine, where there seems to be a rising suspicion of technological applications replacing human interactions. I've also done check-ins at a kiosk, walking directly to a waiting room without any human interaction, but I think what matters most is that conversation between patient and physician. Does a video encounter convey enough verbal and non-verbal information to develop a trusting relationship and maintain the humanistic components? As a N-of-1, I can say from my experience at a prior job where I did predominantly video visits, I definitely felt like the interactions were more depersonalized and distant. Did it lead to burnout? Not by itself, but it was one factor in an accumulation of contextual work conditions that did. Whatever the acceptable label is, burnout or otherwise, it's a consequence of repetitively injurious and persistent systemic factors that lead to depersonalization, exhaustion, and a reduced sense of accomplishment.

Gaetan: Wow. Well said. So where does that leave us? I don't want to just throw up my hands and cry "systems foul." While I clearly don't think the solution lies in telling (or teaching) physicians to "buck up," I do think we have more agency than we realize, and that we ought to exercise it on an individual level while simultaneously advocating for broader reforms. Speaking of advocacy, I was heartened by Danielle Ofri's recent *NYT* Op-Ed, "The Business of Healthcare Depends on Exploiting Doctors and Nurses"[4] mainly for her willingness to speak frankly about the deep cynicism at the heart of the healthcare industry. Just as altruism has made doctors and nurses vulnerable to exploitation, politeness and professionalism have too often muffled our voices. I'm glad to see that's changing. I also want to break the cycle of "wellness retreats," which allow employers to nod at wellbeing without having to implement meaningful changes, and which pacify physicians while signaling that, on most days, we're still expected to go with the flow. I'm tired of going with the flow. Individually, I do think there are ways to limit exposure to those "repetitively injurious systemic factors." I can't ditch the electronic medical record, but I can spend less time obsessing over notes or guessing at the thought processes of consultants in the machine (I'm a big fan of office drop-ins). I can't ignore the quality metrics and institutional priorities that conflict with my values, but I can limit the extent to which they influence my practice. Most days, I can still find time to slow down and prioritize the personal interactions that make my work meaningful.

Tiffany: Completely true. It's encouraging to see that there's a growing recognition of the variety of factors at individual and institutional levels that contribute to this phenomenon of [insert *burnout* or other suitable term of choice here]. We've covered quite a lot of ground here! I'm reminded of the National Academy of Medicine's conceptual model of factors contributing to physician well-being.[5] Without delving too deeply into theory and philosophical underpinnings, it truly is helpful to organize and unify how we think about such a large-scale problem, so that we can work together to meaningfully sustain ourselves and the physician workforce going forward.

References

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