Transforming the Heart of Practice

An Organizational and Personal Approach to Physician Wellbeing

Dianne E. McCallister
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Editors

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Preface

We know that we are facing a critically important issue in professional burnout.

We care deeply for our patients and for our dedicated physicians and providers.

We dare to speak up about the issue and work diligently to find solutions.

We share what we've learned and what we've discovered to promote well-being.

We are the Coalition for Physician Well-Being, and this book is what we are about. We are not newcomers to the arena of physician dissatisfaction and dysfunction. We have been aware of, and working diligently to understand and address, the complex condition of physician burnout for well over a decade, long before it became widely known and popularized in the professional and mainstream press.

This book, *Transforming the Heart of Practice: An Organizational and Personal Approach to Physician Wellbeing*, is the culmination of 18 months of writing, editing, organizing, and preparing for publication a collection of essays exploring the issue of burnout from front to back, upside down, and inside out. Over 20 chapter authors have contributed to this volume, including physicians, psychologists, researchers, healthcare administrators, chaplains, professional coaches, and counselors. Some have experienced the desolation of professional burnout and have recovered to share their experience about the road to recovery and resilience. Some have spent a considerable portion of their careers in preventing burnout and promoting physician wellness. Some have done meticulous research to enhance our understanding of the issue and validate potential solutions. Some have ventured to work with physicians to make a difference, personally and organizationally. All are committed to contributing to the good of the discipline, collaborating in research, sharing best practices, growing the body, and encouraging each other in our support of balance and meaning—in pursuit of wholeness for physicians.

Part I of the book is intended to establish context, to provide a brief overview of the phenomenon of physician burnout, to establish its validity, and to make a case for the reason it has emerged as a critical issue in American healthcare. The opening chapter describes societal trends influencing a radical transformation in the healthcare industry. It elucidates the impact of burnout on the practice of medicine and upon individual physicians and providers, making a case for a concerted,

collaborative effort on the part of involved organizations and affected individuals to address the issue. The following chapter consists of a basic summary and analysis of existing research on professional burnout, cogently describing it as being in its "theoretical infancy," calling for a more precise definition of burnout, and emphasizing research initiatives designed for practical application. It then illuminates the downside impact of burnout on quality of patient care, staff morale, turnover, and organizational financial performance. The third article lays out why anyone who cares about healthcare should be concerned about this issue.

Part II provides a rationale for healthcare institutions (hospitals, physician groups, medical associations) to make a commitment to physician wholeness. We explore physician accountability and its role in monitoring physician clinical and professional performance, and we emphasize the necessity for mutual respect and trust in building a collaborative team of caregivers.

In Part III, we get down to brass tacks. We begin by addressing in a concise, step-by-step manner the persistent dilemma—What are we going to do about it? How do we get started? What is the first step? Who should be involved? Where do we go from here? We then take on the various elements of this "How to" curriculum, providing additional detail and personal experience direct from the frontlines of combatting burnout. Physicians are trained to be tough, independent, and resourceful. They are prone to ignore or deny their own needs for downtime, rest, recovery, and relationships, and they often fail to acknowledge personal signs and symptoms of burnout, depression, and social dysfunction.

Part IV focuses on developing and sustaining a healthy professional culture that is aligned with the mission of the organization. Essential elements of enculturation include understanding how medical education and training have formed physician attitudes and behaviors, how to help physicians and providers understand and accommodate organizational culture and mission, and how to incorporate intentional on-boarding and address what some might term "the soft stuff" of physician well-being. If the "hard stuff" might be defined as reengineering of the clinical workplace, or reprogramming the electronic health record to be more efficient and user-friendly, or organizing fully functional, collaborative clinical teams, then the content of these essays clearly belongs in the arena of "soft stuff"—mindfulness, collegiality, spirituality, and wholeness (biopsychosocial-spiritual health). But the old truism—"the soft stuff *is* the hard stuff"—applies here. The importance of this "soft stuff" to physician well-being cannot be overstated, and it is anything but easy to address. Initiatives designed to promote collegiality and "living in the moment," along with developing sensitivity, and providing access to personal and emotional resources are highlighted here. We share examples of several well-designed, functioning programs where these principles are being incorporated into practice.

Part V addresses head-on the spiritual component of physician wholeness. The first several chapters provide a social context and research basis in understanding the relationship between spirituality and well-being. Real-life experiences, narrated by doctors and their families, follow. They tell of struggles and successes, failures and faith, occasional self-doubt, and sometimes despair, along with busyness and rest, loneliness and companionship, courage and commitment, self-comprehension,

and service to others. In these true-to-life physician stories, you may expect also to encounter literary snapshots of "love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control, against which," as the early Christian leader St. Paul affirms in his well-known letter to the Galatians, "…there is no law" (Galatians 5:22–23).

Part VI concludes the book with two personal essays that poignantly express the nature of two common experiences affecting physicians that require uncommon insight, patience, and courage. About half of all physicians are women, and many young woman physicians experience the unique challenges of combining pregnancy, childbirth, and motherhood with the demands of active medical practice. Likewise, about half of all practicing physicians are experiencing signs and symptoms of personal and professional burnout. The final two chapters handle each of these topics with sensitivity, common sense, and uncommon grace.

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Part I

What Is the Problem?

Exactly what is the problem creating physician burnout, and what is the solution? If you have picked up this book, you likely know there is a problem and want to do something about it.

In 2004, a group of us noticed that physicians were losing their love of practice. We started to look into it. The healthcare world was changing quickly, sometimes in marvelous ways that improved the care available to patients. At the same time, distress among doctors seemed to be growing. The more we looked, the more we knew that the issue was real. Over time, we realized we needed to shift our focus from what was wrong to what was working: why were some physicians doing so well, and even flourishing? How could flourishing physicians and their approach to the profession guide us in helping all physicians thrive?

In this section, we describe the landscape in which physicians in America practice and lay the foundation for the solutions gathered in the sections to follow. There is need. There are implementable, effective solutions. Once solutions become clear, failure to act becomes the problem.

Chapter 1
Physician Wellbeing in Changing Times

John R. Combes

> *"What started out as important, meaningful and challenging work becomes unpleasant, unfulfilling and meaningless. Energy turns into exhaustion, involvement turns into cynicism and efficacy turns into ineffectiveness."*
> – Maslach C, Schaufeli WB, Leiter MP, (2001)

Introduction

Concern over physician wellbeing has garnered national attention, and this concern extends to all frontline clinicians delivering care in a rapidly evolving healthcare system. The question arises: why now? How can an entire professional field grounded in strong values, known for commitment and hard work, and dealing successfully with a variety of stressors be experiencing high rates of suicide and burnout? The answer may lie in the very rapid evolution of the delivery system responding to calls for higher value, more transparency and efficiency, and a move toward consolidation. While these external pressures alone do not underlie the loss of the sense of wellbeing, how the healthcare system responds through its efforts to redesign the delivery system can exacerbate the sense of loss if done without regard to the professional values and ethos of those delivering care in this new system. The challenge for both healthcare leaders and physicians is to create a participatory, collaborative redesign effort that recognizes the real external pressures of limited resources, public accountability, and high-value care for patients and populations while creating an environment where deeply held professional values are respected and flourish. Without this effort, we are destined to create a healthcare system that will neither serve the best interests of patients nor those to whom we entrust their care.

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Physicians and Healthcare Systems in Transition

Most health policy experts agree that the healthcare system as it is currently organized is financially unsustainable. More and more of the gross domestic product is consumed by healthcare. While in recent years the rate of rise in expenditures has decreased, costs are still escalating and threaten to resume their historic rate of increase over the next several years.

The risk for these costs is now increasingly borne by those receiving care, as well as the public in general. This has created a demand for value in care delivery. As in other industries, where the quality of products and services has improved over time while the cost for these products and services has decreased, there is a general call for the same to happen in healthcare delivery, where as much as 30% of all care is inappropriate or does not add to improved outcomes. This requires increased transparency and public accountability so that those bearing the cost for care can make informed decisions. In addition, healthcare delivery remains fragmented among organizations, practitioners, and care settings, making it difficult to achieve the efficiencies needed for a truly value-based delivery system. The lack of a system-wide information and technology infrastructure also contributes to the inefficiency and poor coordination of healthcare delivery leading to excess costs and consumer frustration with the entire healthcare system.

Large health systems have attempted to rectify these shortcomings by aggressively attempting to transform the way care is delivered. The increased employment of physicians, the rapid implementation of the electronic medical record, the embracing of value-based payment systems, and the creation of new delivery models such as accountable care organizations and bundled services have been an attempt to gain efficiencies, reduce waste, and improve coordination. While many of these changes have been needed and even desirable to transform the system, they have too often been done without understanding and respect for the underlying values and the intrinsic motivation of the caring professions who must deliver care in these new environments. This has led to internal conflict for the caregiver, with a resultant loss of meaning in work and a loss of a sense of professional autonomy and accomplishment. This disconnect from core professional values is a chief cause for the decreased sense of wellbeing and greater risk for burnout.

Burnout Defined

Christina Maslach defines job burnout as "prolonged response to chronic emotional and interpersonal stressors on the job…defined by the three dimensions of exhaustion, cynicism and inefficacy." She further defines these dimensions as (1) emotional exhaustion, feeling overworked and over-extended; (2) depersonalization/cynicism, unfeeling in response to patients or colleagues; and (3) inefficacy, decreased sense of personal accomplishment and success (Maslach et al. 2001).

These are the antitheses of the core values that motivate caregivers to join the profession. Because of this disconnect between values and work-life reality, high levels of burnout and disengagement are being recorded in many of the healthcare professions. It is estimated that greater than 54% of currently practicing physicians meet the criteria for burnout, with similar levels occurring in nursing. Burnout has significant consequences such as increased medical errors, poor adherence to standard protocols and procedures, less empathy, decreased patient satisfaction, increased risk of malpractice, increased physician and clinical staff turnover, and inefficient care practices including inappropriate testing. These effects not only work against efforts to transform care delivery and to succeed in a value-based environment but also promote professional disengagement at a time when their input and insight are essential in redesigning the healthcare delivery system.

The drivers of burnout are many. They include system changes, many of which are well-intentioned but poorly executed, e.g., EHR implementation. They also include some that are not so well-intentioned, e.g., nonrational insurance procedures to prevent patients from receiving appropriate care. There are personal drivers as well, such as debt burden from medical education and the pressures of family/work-life balance. Finally, and most importantly, we must not minimize the stress of the profession itself, particularly the sense of loss caused by death, disability, and failure to win over every illness. Failing to recognize and develop coping mechanisms for this type of stress can lead to loss of empathy—a core value of the profession (Privitera et al. 2015).

Because these drivers are multifactorial, there must be a diversity of solutions to help the profession tackle the challenge of burnout and disengagement. This requires both individual and organizational approaches focused on ameliorating the stressors and supporting the professional in creating the mental and physical space where wellbeing can thrive.

Crafting Solutions

Organizational Organizations can take several steps to create a work and learning environment where professionalism can flourish. This begins with redesign of workflow. The simple step of having routine patients have their labs drawn prior to the visit allows better decision-making by the clinicians and prevents lab results that are not returned to the office until after the visit from being lost or overlooked. Assigning a medical assistant to both the patient and physician to follow the entire visit, including prepping the patient and assisting with the documentation of the visit, can free the physician to improve the quality of her or his interaction with the patient and devote more time to educating the patient and enlisting them in their own care. Studies have shown that these modest increases in medical assistant staffing are more than compensated by increased physician productivity and increased capacity for more timely patient visits. Additionally, redesigning the clinical space so that clinician and patient engagement is facilitated by eliminated physical barriers

such as computer screens and desks where the clinician is forced to spend most of their time with their back to the patient can create a more meaningful encounter for both physician and patient.

Since healthcare delivery is increasingly a team activity, organizations can provide support to develop high functioning teams through training and simulation exercises. Learning and practice of communication and interpersonal skills can lead to mastery of these skills, particularly in difficult and stressful situations. Creation of high-performing teams can also lead to building up an internal support system for the team members.

Organizations can also play a role in helping to restore work- and family-life balance. Flexible and creative scheduling, part-time and shared positions, and mutual staff support for family obligations can provide a work environment characterized by individual respect and a demonstrable concern for creating a culture of wellness. While physicians pledge to place patient needs before their own self-interest, it is important for organizations to recognize that physicians' obligations to their family often compete with their patients' needs and create a level of stress that can become unhealthy. Organizations should provide all reasonable support and creative solutions to help their clinicians successfully manage this balance (Shanafelt and Noseworthy 2017; American Medical Association 2015).

Individual The individual professional also has an obligation to take steps to prevent burnout and maintain his or her health. Stress management begins by adopting healthy practices such as routine exercise and healthy diets in addition to being well rested. Employing meditation techniques and periods of reflection can help lessen stress (Nedrow et al. 2013). This may be done in a formalized program such as mindfulness-based stress reduction (MBSR) or in more informal small groups or self-care workshops. Connection to work is also essential to restoring meaning and joy in clinical activities. Programs such as the Accreditation Council for Graduate Medical Education's Back to the Bedside are an attempt to reconnect resident physicians with the patients they serve rather than perpetuating and experience of just being managers of clinical data and protocols.

Physicians should also participate in annual wellness surveys, including the Maslach Burnout Index (Maslach 2002), to establish a baseline level of burnout in their community and serve as a measure of the effectiveness of interventions and programs. In fact, organizations and their physicians should work together to use wellness as a quality indicator, establish an institutional wellness committee, distribute a wellness survey to the clinical staff, meet regularly with staff to discuss the data and potential interventions, implement appropriate interventions, repeat the assessment in the next year, and refine the interventions based on the new data findings.

Wellness and Professionalism

If one of the core ethical principles of the profession is non-malfeasance, or doing no harm, we as physicians have an ethical obligation to actively prevent and lessen burnout which harms not only ourselves but the patients we are privileged to serve.

As the delivery system rapidly evolves, physicians and other clinicians must take it upon themselves to be integral in the redesign and execution of the new system, a system which should support the meaningful work of its caregivers, maintain their sense of wellbeing, and foster continuous professional development and learning. Only then can the healthcare goals of patients and communities be met. Any newly reformed delivery system cannot diminish the profession or marginalize its members, distancing them from patients from whom they draw meaning. This inevitably leads to the burnout now being observed and results in more patient harm and dissatisfaction, outcomes which will be penalized in a value-driven environment (Wallace et al. 2009). Healthcare organizations and its clinicians have a responsibility to work together to achieve their mutual goals: a healthcare system where patients and communities achieve their full potential for health and their caregivers achieve fulfillment of the highest aspirations of their profession (West et al. 2014).

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Chapter 2
Research on Physician Burnout and Wellbeing: A Solution-Oriented Perspective

Richard J. Bogue and Nancy R. Downing

Introduction

If we believe that healthcare and our health systems are important, then we need to pay attention to the wellbeing and engagement of healthcare professionals. The work of health professionals drives all the clinical- and health-related processes in our health systems. If our healthcare professionals cannot consistently perform well, organizational leadership is not paying enough attention to the human factors in productivity, safety, and quality.

Research helps us pay attention. Researchers are reporting an escalating crisis of burnout. The prevalence, causes, and consequences of burnout have been extensively examined and reported. At this juncture, the field has barely begun to respond meaningfully and effectively to that crisis.

This chapter is not a systematic review of the hundreds of articles on physician burnout. Instead, this chapter aims to provide useful and easily digestible background for leaders of health systems and for healthcare professionals. We also aim to spark some additional clarity for research agendas in making progress against burnout with the hope of shifting the focus of research on healthcare professional burnout beyond description of the problem and toward solutions.

In this chapter, we emphasize the critical importance of distinguishing burnout or lack thereof from wellbeing and offer suggestions on how to move forward toward solutions. In brief, this chapter offers an overall paradigm to understand physician

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wellbeing and its relationship to burnout from a more practical and actionable perspective. To do so, this chapter proceeds in four steps: (1) summarize the current knowledge on physician burnout, (2) examine key concepts and definitions that can move the field forward, (3) describe systematic approaches toward solutions, and (4) offer ideas about ways to test, improve, and produce benefits using solution-oriented frameworks. At the end of this chapter, a reference list is provided.

Summary of Current Knowledge About Physician Burnout

There has been abundant research on the prevalence of, contributors to, and associated consequences of physician burnout. This section provides a quick summary of this research. Instead of extended review, we summarize three well-explored areas in physician burnout research, especially calling attention to emerging directions. We point readers toward useful resources, including references covering the three subsections of this section: (a) Prevalence of and Factors that Contribute to Physician Burnout, (b) Consequences of Physician Burnout for Physicians, and (c) Consequences of Physician Burnout for Patients. The references are found at the end of this chapter.

First, let us quickly define burnout. "Burning out" has long been used in reference to running out of fuel for combustion and, by the 1930s, electrical circuits (Etymonline 2018). In the early 1970s, "burnout" became a term in US vernacular referring to the consequences of drug overuse and other persistent stress, such as combat. Herbert Freudenberger is credited with coining the term "burnout" in a publication in reference to the emotional exhaustion among "helping professionals" (Freudenberger 1974). Freudenberger noted a syndrome experienced by people working with Vietnam veterans (Freudenberger and Marrero 1973) and in "free clinics, therapeutic communities, hot lines, crisis intervention centers, women's clinics, gay centers, runaway houses" (Freudenberger 1974, p. 161). According to Freudenberger, those most prone to the condition were dedicated, committed people who had a need to give and a wish to be liked. However, those afflicted also found it difficult to maintain personal and professional limits, leading to guilt, overwork, and emotional depletion.

Subsequently, Christina Maslach and Susan Jackson published the Maslach Burnout Inventory (MBI) (Maslach and Jackson 1981). MBI was originally designed for health and human service personnel, like social workers and physicians, with later versions for educators and others. The 22-item MBI has been translated from English into 38 languages and has been taken by hundreds of thousands of people, if not millions. MBI is widely considered the gold-standard measure of burnout.

A key aspect of the burnout syndrome as measured by MBI is increased feelings of emotional exhaustion (EE). EE has relatively consistently been the subscale of MBI that most closely associates with depression diagnosis (Schonfeld et al. 2018, pp. 218–219). As EE increases and emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological level; they either cannot do or internally struggle to do what they want or are expected to do as help-

ing professionals. They feel hopeless and unable to act. Another aspect of burnout syndrome is depersonalization (DP). DP means having negative, cynical attitudes and feelings about one's clients or patients. This callous or even dehumanizing perception of patients can lead caregivers to view patients as somehow deserving of their troubles. The third aspect of the burnout syndrome is reduced personal accomplishment (PA). PA refers to the tendency to evaluate oneself negatively, feeling dissatisfied with one's accomplishments, particularly with regard to work. For those interested in more extensive but general background on burnout measurement, refer to Maslach et al. (2009).

Prevalence of Physician Burnout

A long history of evidence documents the wide variety of stressors in the work of physicians, as well as estimates of the prevalence among physicians of burnout syndrome (Maslach et al. 2009). Karin Isaksson Rø (2010) provides a detailed summary of burnout prevalence studies using MBI and the more standard ≥ 27 cutoff on the emotional exhaustion subscale and ≥10 on the depersonalization subscale: "Using these cut-off values, the point prevalence of burnout in cohorts of working physicians has been found to vary widely" (Ro 2010). Among resident physicians, for example, estimates of burnout between 42% and 77% had been reported in a 2-year window (Gopal et al. 2005; Goitein et al. 2005; West et al. 2006; Martini et al. 2006). Using a different measure, Linzer and Poplau have recently estimated a much lower prevalence of burnout among family physicians (24.5%) (Linzer and Poplau 2017; Puffer et al. 2017).

Variation between nations appears to be substantial. In a general sample of US physicians, 58% reported high levels of emotional exhaustion, and 35% reported high levels of depersonalization (Deckard et al. 1994). At about the same time in Europe, the prevalence estimates were somewhat lower. In Italy and England, 27–35% had high scores on emotional exhaustion, while 19–28% had high scores on depersonalization (Grassi and Magnani 2000; Ramirez et al. 1996). An Australian study of anesthetists found 20% with high levels on the two dimensions (Kluger et al. 2003). One conclusion we can be modestly confident about across studies is that while modern medical practice is largely uniform across today's developed nations, US physicians may be particularly at risk for burnout among developed nations. This may be due to underlying factors in the overall system of care, rather than within medical practice itself, a topic we touch on a bit later.

In the USA, physician burnout, depression, and suicide have recently started to receive widespread acknowledgement as a national emergency (Goldman et al. 2015; Khan et al. 2015; American Foundation for Suicide Prevention 2015; Kishore et al. 2016). Some evidence indicates that the rate of burnout has been increasing on an alarming scale. For example, Shanafelt et al. (2015) reported an increase in physicians reporting at least one symptom of burnout (EE, DP or PA), using large comparable samples and comparable methods, from 45.5% in 2011 to 54.4% in 2014.

While variations across individuals, groups, organizations, and perhaps especially between specialties and nations, should be expected, there is legitimate cause for uncertainty about how to interpret published prevalence estimates for burnout. Consumers of burnout research should be very mindful that the level at which an investigator declares a survey respondent at high risk for burnout may vary from study to study, and this can have a large impact on estimates of burnout prevalence. Wide variations in reported burnout risk levels coupled with the use of different cutoff points for determining an individual as "burned out" raise questions about whether "many participants categorized as burned out [are] actually healthy" (Bianchi et al. 2015a). Eckleberry-Hunt, Kirkpatrick, and Barbera (2018) also call attention to these concerns.

This point begs for clarification, since reporting higher or lower rates of burnout may have a major impact on the perceptions of those of us using such information. "In a recent study, Dyrbye and colleagues used the Maslach Burnout Inventory to assess burnout and categorized participants with either an emotional exhaustion (EE) score ≥ 27/54 OR a depersonalization (DP) score ≥ 10/30" (Bianchi et al. 2015a). Since burnout is a multidimensional phenomenon, the usual procedure is to identify individuals at high risk of burnout only if they exceed the cutoff points for *both* EE *and* DP as cases of burnout (Maslach et al. 2016). Moreover, the usual cutoff point for DP is 13, not 10 (Maslach et al. 2016). This difference in cutoff points also increases the chances of one being considered as burned out. Bianchi and colleagues continue, "In our view, these inclusion criteria are excessively liberal and pose the risk of pathologizing normal fluctuations in daily levels of stress, fatigue, or motivation" (p. 1584).

Let us use a clear example to show how a researcher's choice to use different procedures or cutoff values has a major impact on reported rates of burnout. Table 2.1 below shows variations in procedures or cutoff points using the exact same data from a 2016 survey at a university medical center in the east-central USA. As shown in column A, 25.0% of those physicians were found to be at "high risk" for burnout using the "AND standard" recommended by Maslach and colleagues (column A). The more liberal "OR standard" (column B) determines an individual as burned out *if at high risk on any one MBI subscale*. Using the exact

Table 2.1 Percentages in professional group burnout using different criteria

	A (AND standard)	B (OR standard)	C DP ≥ 13	D DP ≥ 10
Nurse N: 535	122/535 = 22.8%	287/535 = 53.6%	168/535 = 31.4%	216/535 = 40.4%
Staff physician N: 396	99/396 = 25.0%	244/396 = 61.6%	124/396 = 31.3%	160/396 = 40.4%
Resident physician N: 121	47/121 = 38.8%	81/121 = 66.9%	54/121 = 44.6%	71/121 = 58.7%
Medical student N: 90	15/90 = 16.7%	47/90 = 52.2%	22/90 = 24.4%	37/90 = 41.1%

same data, this more liberal approach results in reporting more than twice as many staff physicians being at high risk of burnout (61.6%) and a rate more than three times higher for medical students. Keep in mind that these comparisons are of the exact same survey, same data, same people, and same responses, just using different criteria for determining "burnout." Also compare the rates of burnout across these groups using Maslach's standard of DP $\geq$ 13 (column C) versus using the lower cutoff point for DP of $\geq$10 (column D).

The level at which an investigator declares an individual at high risk for burnout has a large impact on estimates of burnout prevalence, as well as raising questions about whether "many participants categorized as burned out [are] actually healthy" (Bianchi et al. 2015a). Clinically, artificially high rates of burnout may lead to over-pathologizing, adding anxiety and stress to healthcare professionals who are already experiencing many stressors.

Factors Contributing to Burnout

The reference list of this chapter offers numerous studies identifying contributors to burnout. Many studies and many more factors that are mentioned in the body of this chapter may be found in the reference list, which is offered as a resource for your use. Here, we focus on one prime candidate for explaining the high and increasing rate of burnout among US physicians, possibly due to an overall shift in the practice of medicine especially in the USA.

A prominent candidate for factors contributing to an increase in burnout over time in the USA is reduced autonomy. It is widely observed that physicians had a higher degree of control over their own work in the past relative to the current situation in which practice models have largely shifted from independent practice to group and health system employment. Autonomy may have been reduced by this trend in a number of ways. Today's quality and safety management procedures require better documentation and regular performance reviews compared to peers. Payment methods require careful and extensive documentation in electronic health records. Lack of control over one's circumstances and lowered sense of autonomy or organizational justice may contribute to feelings of helplessness, inadequacy, failure, and burnout (Heponiemi et al. 2010; Balch et al. 2011; Lee et al. 2013a; Tucker et al. 2015; Lathrop 2017). In brief, lack of control or reduced autonomy may be contributing to lowered self-esteem and feelings of hopelessness throughout medicine and healthcare.

Two diagnostic criteria for depression are based precisely on persistent self-perceptions of (1) lowered self-esteem and (2) hopelessness. In other words, reduced personal control and autonomy, and the sense that one's work environment is rigid and unjust, may be an important underlying contributing factor to high and increasing rates of burnout and depression. The other four criteria for depression may be more clearly seen as physical symptoms, possible physiological signs, or expressions of lowered self-esteem and heightened feelings of hopelessness: (3) poor appetite or overeating, (4) insomnia or hypersomnia, (5) low energy or fatigue, and (6) poor

concentration or difficulty making decisions (DSM 5). Another lens through which to see that lack of control may be a critical underlying contributor to burnout is illustrated in a study by Blechter et al. (2018). They demonstrated that the burnout rate was much lower (13.5%) among 235 providers practicing in 174 small independent primary care practices in New York. The authors attributed this difference in large part to the greater independence and autonomy physicians experienced in independent practice.

Apart from possible general shifts in the practice of medicine, a huge corpus of research has identified additional contributors to burnout: job demands-resources, work-life balance, trait self-control, being on call, and social exclusion. Anything that can add stress can contribute to burnout. Scan reference list to see if anything catches your attention and sparks you toward a way for you to reduce the effects of a contributor to burnout on you, your colleagues, or a friend.

Consequences of Physician Burnout for Physicians

Many studies have referenced high suicide rates for physicians as a likely consequence of burnout (Frank and Dingle 1999; Torre et al. 2005; Gold et al. 2013). As early as 1996, a systematic meta-analysis of 14 international studies using data from 1935 to 1985 found male physicians to have 1.1–3.4 (95% CI) times higher risk of suicide compared to the general male population and female physicians to have 2.5–5.7 (95% CI) times the relative risk of the general female population (Lindeman et al. 1996). Subsequently, Schernhammer and Colditz (2004) conducted a similar multinational meta-analysis of 25 studies with data spanning 1935 to 1998, producing estimates that male physicians committed suicide at 1.21–1.65 (95% CI) times the rate for the general male population, while female physicians committed suicide at 1.90–2.40 (95% CI) times the rate as the general female population.

With respect to increases in prevalence of burnout and suicide among physicians, Shanafelt et al. (2015) reported a 10% increase in burnout from 2011 to 2014, but no evidence of an increase in suicidal ideation. This finding would seem to challenge the burnout-suicide association. But this result may also be due to some element of study design, as this was an uncontrolled, mass e-mailing to members of the AMA, using a link that could be forwarded to anyone and could be used multiple times.

This was also a time frame during which more attention had been called to burnout. Numerous scholarly papers were appearing during this time frame. One particularly notable illustration of the attention being called to physician burnout is the fact that *Time* magazine published three separate articles on physician burnout over 14 months in 2014–2015 (Sifferlin 2014; Oaklander 2015; Feldman and Greco 2015). Calling attention to burnout, and also avoiding the diagnosis of depression, may have produced a kind of social desirability effect whereby more physicians became willing to acknowledge burnout. While this may help explain the lack of a corollary increase in suicidal ideation, it also shows a potentially positive value of research and communication on burnout: we cannot effectively address a problem about which we are unable to talk openly.

Also, there may at the same time have been something in US society more broadly that was "raising all thermometers" toward higher levels of distress. Within the US population in general, suicide rates have increased sharply after 2006, in 2014 being 13.0 per 100,000 (Curtin et al. 2016). Andrew and Brenner (2016) report that, among physicians in the USA, approximately 400 physicians a year complete suicide, about 40 per 100,000, which would also represent an increase in the rate of suicide over earlier estimates. They drew on secondary sources to report that male physicians complete suicide 1.4–2.3 times the rate for the general population and female physicians complete suicide at 2.5–4 times the rate for non-physician females. They also report that depression rates among physicians are comparable to the general population but that medical residents experience notably higher rates of depression with "15–30% of them screening positive for depressive symptoms" (p. 1).

Apart from suicide and depression, research has long recognized other specific concerns for physicians' physical and emotional health. Factors include occupational hazards (Dorevitch and Forst 2000), lifestyle (Frank 2004), fatigue (Arora et al. 2006), motor vehicle accidents (Barger et al. 2005; Kirkcaldy et al. 1997), work environment (Chan et al. 2004), and psychological stress (Graske 2003).

There is also, perhaps surprisingly, evidence that an additional consequence for physicians is low rates of access to or use of the services of medical practitioners, psychiatrists, or psychologists. In one study, 1 in 16 American surgeons had experienced suicidal ideation in the prior 12 months, but only 26% of them sought psychiatric or psychological help (Shanafelt et al. 2011). This study also found a strong correlation between depressive symptoms with the incidence of suicidal ideation. Moreover, over 60% of those with suicidal ideation indicated they were reluctant to seek help due to concern that it could affect their medical license. An earlier study found that one in three physicians did not even have a regular source of medical care (Gross et al. 2000). Finally, when physicians are patients, they are known for a lack of good attention to their own health, along with a tendency toward self-diagnosis and self-doctoring (Brown and Schneidman 2004; Fromme et al. 2004; Kay et al. 2004). These ineffective responses to suicidal ideation and depressive symptoms demand better attention.

How can healthcare professionals be swimming in schools of caregivers and find, or seek, no care? This issue of the special under-tapped potential of care team members is addressed more fully in the section "Ideas for Producing Benefits Using Solution-Oriented Approaches". As part of untapping this great potential source of self- and other-care among care team members, we must find ways to make it safe for physicians, nurses, and others to report their distress and seek assistance. But where can we start opening up and acknowledging these needs?

The circumstances that lead to burnout and its consequences may be launched in medical school and perhaps especially in residency. Winkel et al. (2018) found that 30% of program directors in OB/GYN residencies were unaware of any wellness issues among their residents. Yet, 80% of residents in the same programs reported experiencing problems with wellness, and the likelihood of wellness problems increased as residents progressed through training. Dyrbye et al. (2015) summarized their findings related to this phenomenon as follows: "Only a third of medical students with burnout seek help. Perceived stigma, negative personal experiences, and

the hidden curriculum may contribute." (p. 961). This stark mismatch between residency program directors and faculty vis-à-vis medical students and residents is telling. Those of us who have worked long in academic healthcare settings, in teaching hospitals or academic medical centers, or who have had the unique pleasure of working with medical residents are quite clear that much of what is implicitly "taught" in medical school and in residency is cultural. Expectations *about how to be* a doctor are inculcated early and throughout whether faculty and program directors are aware of it or not. Some of these implicit lessons may contribute to burnout down the road.

Physicians are typically very dedicated to providing quality care "but they often do so at the expense of their own personal wellness" (Wallace and Lemaire 2009). The challenges of becoming, being, and excelling as a physician depend on an alloy of clinical knowledge, clinical skills, *and practiced humanism*, not denial of the physician as, first, a human being (Bogue et al. 2012). Bodenheimer and Sinsky recommend that "the Triple Aims of enhancing patient experience, improving population health, and reducing costs…be expanded to a Quadruple Aim, adding the goal of improving the work-life of healthcare providers, including clinicians and staff" (2014. p. 573). In the words of Fralick and Fregel (2014), "Physicians need to develop tangible strategies that encourage work–life balance and prevent burnout. If we don't, we will suffer. So will our patients" (p. 731).

Consequences of Physician Burnout for Patients

There are many studies documenting various kinds of harm to patients when physicians are overstressed, burned out, or depressed, so here we cover just a few different angles. Over 100 years ago, it was recognized that the quality of patient care is adversely affected when the care is provided by stressed, impaired, or depressed physicians (Osler 1909). It has long been known and well documented that when physicians are stressed, depressed, or impaired, the quality of care they deliver is diminished (Frank 2004; Heisler et al. 2002; Woolf et al. 2004; Wallace and Lemaire 2009; Beckman et al. 2012; Weng et al. 2011; Hall et al. 2016).

A classic 1993 study found that physician job satisfaction predicted patients' adherence to medical guidance (DiMatteo et al. 1993). Higher depersonalization burnout scores of physicians have been associated with lower patient satisfaction and longer post-discharge recovery time (Halbesleben and Rathert 2008). After a holistic physician wellness CME retreat, participating physicians experienced a jump in HCAHPS scores, relative to nonparticipants, throughout the following quarter (Paolini et al. 2014). Medical errors have been predicted by high depersonalization burnout scores (Tsiga et al. 2017). Welp et al. (2015) found that high emotional exhaustion burnout scores predicted patient mortality. The reference list includes additional examples.

The National Academy of Medicine, as noted above, has compiled a very extensive list of resources. The following link opens a page for finding sources on consequences of caregiver burnout in four areas (safety and patient outcomes, clinician health and wellbeing, turnover and reduction of work effort, and healthcare costs): https://nam.edu/clinicianwellbeing/effects/.

Key Concepts and Definitions for Moving the Field Forward

A significant challenge before us now is how best to define and identify physician burnout and how to target and test specific ways to reduce burnout in distinct physician settings. Over the past 8 years, the Coalition for Physician Wellbeing (ForPhysicianwellbeing.org) has been exploring the dynamic between active wellbeing, burnout syndrome, and the clinical diagnosis of depression. One thing we have discovered is that we need to get clear on our terms and definitions in order to develop better solutions.

Science is irrelevant when it lacks the potential for meaning in everyday life. Yet progress in science depends on definitions, including mathematical definitions. Definitions are not crucial to science for the reasons many laypersons imagine. Some people think scientists adopt definitions that scientists already assume are automatically correct and can be proven. To the contrary, definitions in the process of scientific discovery are essential because a suitably precise definition and its resulting "answers" must be knowable, testable, *and especially falsifiable*, or else we make no progress.

In research and practical applications related to burnout, certain critical ideas lack adequate and distinguishing definitions. I address here the relationships between two sets of terms: (1) burnout and depression; (2) burnout and wellbeing.

Before attempting to clarify these relationships between burnout, depression, and wellbeing, a critical underlying point must be made: *Physicians are human beings with lives outside of work*. This may seem obvious, but the literature on burnout largely ignores this point. An important factor in the burnout that physicians experience at work is how that experience affects their lives outside of work *and* vice versa. It is reasonable to assume that the effects of work-related stressors on relationships with spouses, children, and friends represent consequences of great importance. We also cannot afford to overlook how factors that are completely unrelated to work may affect one's resilience in the face of stressors encountered at work. Work is not a locked, cobwebbed box stowed in the attic but an element of life that a fully bio-psycho-social-spiritual human being experiences as part of life in general. We need a whole-person understanding of wellbeing to cast a brighter light on the examination of work-related burnout and especially so that we can identify and implement effective practices to reduce the stressors that lead toward burnout. You will find elements of this idea throughout this book, which may be the first book published in a collaborative manner to present a wide range of more humanistic approaches to issues of burnout and wellbeing. Refer to Chap. 23 of this volume, *A Philosophical Rationale for a Bio-Psycho-Social-Spiritual Approach to Wellbeing*, for a deeper exploration of the value of this underlying idea.

Burnout and Depression

This subsection aims to offer what we hope is a helpful perspective on the current state of the relationships between burnout and depression. Keeping in mind that there is not widespread consensus on "the current state" of these relationships,

several viewpoints are briefly covered here. Among these viewpoints are emerging studies on biochemical signatures that may be associated with burnout and/or depression signaling a possible way to disambiguate the relationships between these two maladies.

A more commonly encountered puzzle is that of measurement or determination of burnout vis-à-vis depression. Burnout is generally indicated by a survey response. Not all the surveys do the same work or even use the same standards, even though using the same terminology. As a consequence, one must pay careful attention even in identifying burnout using widely used and specific measures, as noted in the section Prevalence of Physician Burnout. Moreover, the field has not arrived at a clear enough consensus on the etiology and behavioral signs of burnout (beyond using the measures just noted) to clearly locate burnout in relation to depression. Depression, in contrast, is a medical diagnosis with quite specific experiential and physical criteria that do not seem to overlap well with many measures of burnout. Depression has tested, if not perfect, treatment pathways, whereas simply identifying the target of treatment for burnout lacks consistent specificity in the literature (we argue that the target of treatment should be stressors, not burnout). Finally, it may be the case that burnout is a more comfortable term for early or middle stages of an emergent ailment that is called depression once it reaches a critical stage.

Biochemical Markers

A relatively new area of research on *burnout* and *depression* is the study of biochemical signatures of these two, presumably different, phenomena. This area focuses on what we can learn about the nature of burnout and/or depression based on biomarkers. Some readers may find these studies interesting. For example, Orosz, Federspiel, Haisch, Seeher, Dierks & Cattapana examined the heart rate variability (HRV) and the brain-derived neurotrophic factor (BDNF) to identify differences and similarities between burnout and depression (2017). They identify similarities between burnout and major depressive disorder and also complications in interpretation. They recommend that instead of focusing on one or a few specific biomarkers, "future research should rather concentrate on elaborating indices for burnout and depression which integrate combinations of parameters found in genetics, neurobiology, physiology and environment" (p. 112). They suggest this research may lead to treatments for each of these "two mental health problems which are among the major causes for disability at work" (p. 119). Marchand et al. (2014) evaluated diurnal cortisol levels (five samplings per day on 3 days in 3 week) in association with MBI scores, finding strong associations between MBI emotional exhaustion scores and cortisol patterns. They arrived at the very interesting conclusion that cortisol levels may help identify lower and higher stages of burnout: "professional inefficacy may be the earliest warning signal culminating with emotional exhaustion that may dampen diurnal cortisol levels" (p. 27).

This last study about possible stages of burnout highlights both the important prospects for biochemical research into burnout and depression and also what we consider to be an important clue about how to go about identifying the best interven-

tions for different individuals. In brief, when is burnout something less, and when is it something more? That is, can we learn to "stage" burnout as progression toward depression, evaluated as depressive and treated as depression? Such a capability would be very useful when it comes to helping healthcare professionals with "stage-appropriate" interventions.

If burnout is actually depression, we must make it okay for healthcare professionals to be treated for depression without it affecting their careers. For administrators, discerning stage-appropriate interventions would enable investments of time, money, and other resources to best match the professional's state of need: prevention, primary care, acute care, or maintenance. Bianchi et al. (2015b, c) have asserted the following:

> The conditions under which the burnout construct was elaborated as well as the accumulated evidence on burnout-depression overlap cast doubt on the nosological distinctiveness of burnout. The current state of science suggests that burnout is a form of depression rather than a differentiated type of pathology. (p. 3)

Measurement or Determination of Burnout vis-à-vis Depression

So, when *is* depression actually depression? The relationships between burnout and depression are still being worked out. What we know with certainty is that burnout and depression are not the same thing for two primary reasons. (1) Depression is a diagnosis appearing in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM–5). Depression has specific diagnostic criteria. There are clinically recommended and tested treatment pathways for depression. At this time, the literature on burnout offers none of this. (2) The DSM has not been prepared to consider burnout as a distinct diagnosis, in part because the DSM describes emotional and psychological disorders of human beings, not one's ability to adapt to or manage stressors in specific work environments. There are no work environment-specific diagnoses in the DSM. We would argue that burnout is also not merely work-related—except by current definition—since the stressors of life are not restricted to work and some of the greatest stressors related to work are stressors that result from how work affects life outside of work.

The Maslach Burnout Inventory (MBI), as noted above, has been widely and frequently used, and represents the best "operational definition" for burnout. It has been validated in many different ways (Maslach and Lieter 2016). Let us for a moment focus especially on *face* and *content* validity. If an instrument is face valid, it means that a researcher or user is able easily to see that the instrument is about what it purports to be about. *Face validity* counts on "common sense": if it looks like a duck, it probably is. *Content validity* refers to whether the measure actually measures what it is expected to measure. Content validity is based on *the degree to which the items within a research instrument or measurement tool represent* ***the universe of content for the concept*** *being measured or the domain of a given behavior* (https://medical-dictionary.thefreedictionary.com/content+validity).

The MBI has strong *face validity* because it is designed to measure the three aspects that have been taken to define burnout: emotional exhaustion (EE),

depersonalization of clients/patients (DP), and reduced sense of personal accomplishment (PA). MBI also has strong *content validity* because it queries users about 22 specific behaviors or experiences and the frequency with which they are experienced. When researchers use the MBI, they have a high degree of confidence that changes in reported rates of burnout reflect changes in the prevalence of burnout. A secondary question is what that may mean for a given study in clinical terms or in the lives of physicians, their family members, or, of course, patients. However, care must be taken since even using the venerable MBI instrument, "burnout" has been indicated by different procedures or cutoff points and even by very different kinds of measures, as described above.

Some one- or two-question survey-based burnout indicators have been introduced and used, for example, by Shanafelt et al. (2012a) in their highly impactful AMA membership survey that 89,831 received, 27,276 opened (at least one invitation), and 7288 completed. These one- or two-item indicators of burnout are very efficient and correlate with MBI. Moreover, their face validity would seem to be easy to discern.

Yet, while such measures may correlate with "burnout" as measured by MBI, they still may or may not be measuring the same phenomenon. In brief, measuring *the frequency of occurrence of signs and symptoms of burnout*—as with the gold-standard measure MBI—may or may not mean the same thing as a measure of *a willingness to self-identify as burned out*, even if correlations are quite high. This may be particularly true during an era in which a concept like burnout is very highly visible. Given that physicians have been told 40–50% of them are positive for high risk of burnout, it is not surprising that general self-ascription measures correlate with more precise behavioral measures of burnout. *Two different kinds of measures* are at work here and may or may not be measuring different but correlated phenomena: *one is based on a set of specific behaviors/experiences and their intensity in three dimensions*, while the *other is based on a willingness to identify with one or two general and self-ascribed categorical selections.* Regarding psychological disorders, and specifically burnout and depression, recent research has demonstrated that a multidimensional approach gives more accurate and useful information, as done, for example, by Riley et al. (2018) who compared MBI scores with scores using three-item reduced scales for each of the three dimensions of burnout as measured by MBI.

On the other hand, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM–5) 9 (APA 2013) entry on depression includes specific behavioral diagnostic criteria, extensive clinical guidance, and tested treatment modalities as provided in the Appendix to this chapter. To clearly express the similarities and the gap between burnout, which is defined as above by surveys, and depression, the specific criteria for diagnosing depression are provided here verbatim from DSM-5:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

(Note: Do not include symptoms that are clearly attributable to another medical condition.)

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The episode is not attributable to the physiological effects of a substance or another medical condition.

(Note: Criteria A–C represent a major depressive episode.)

Burnout and Wellbeing

Burnout and wellbeing are not two ends of one continuum. This section sets out to explain why these two terms should not be used as though they are on one continuum and also to offer a model and some ideas about how better to discern between burnout and wellbeing.

Many authors appear to see burnout and wellbeing as on the same continuum, as though wellbeing is merely the absence of burnout. Mayo's Wellbeing Index, for example, asks seven general questions directed toward stressors—corollaries of or contributors to burnout—such as "During the past month, have you felt burned out from your work?" and "During the past month, have you felt that all things you had

to do were piling up so high that you could not overcome them?" (Dyrbye et al. 2013b). The Wellbeing Index appears to be useful for identifying physicians experiencing certain types of work-related distress. However, given its emphasis on sources of distress, the Wellbeing Index may lack face validity as an index of wellbeing.

Linzer's Mini-Z purports to measure sources of distress at work—and does so—thereby offering better face validity. Mini-Z allows ratings that may have negative or positive valence, such as "My control over my workload is…," with possible responses from poor to optimal. Yet the Mini-Z also reflects the idea that a physician's wellbeing is dependent almost entirely on her or his work experience and especially the electronic health record (EHR): three of the ten items are about documentation and EHR (Linzer et al. 2016; Linzer and Poplau 2017). The EHR can indeed be frustrating, but it is difficult to imagine that, given the whole of one's life—the quality of intimate relationships and friendships, the prospects of one's children, and the health of everyone you care about—EHR could possibly account for one-third of all of life's stressors. Moreover, there is evidence that frustrations with electronic documentation may be generational (Decker et al. 2012) and may become increasingly less salient as users, systems, and vendors find ways to reduce or eliminate frustrations (Menachemi et al. 2010). On the other hand, it is not uncommon for EHR to require health professions to click or write notes in four or five different screens for items such as one prescription. Healthcare organizations must insist that their vendors improve ease of use for EHR users, which may result in fewer EHR-related stressors.

In contrast to the idea that wellbeing and burnout are on the same continuum, the very first principle in the *Constitution of the World Health Organization* affirms that "health is a state of complete physical, mental, and social wellbeing *and not merely the absence of disease or infirmity* [italics added]" (World Health Organization 1948). That is, wellbeing is a construct on its own terms. It is its own thing. In what follows, we attempt to extract wellbeing from the burnout dimensions and to frame wellbeing as the things you and/or those around you think and do to reduce the stressors that can lead to burnout.

The confounding of wellbeing and burnout among physicians is particularly surprising given the fundamental nature of the medical model: assessment, diagnosis, and treatment. I cannot think of any diagnosis that recommends more or less of the disease as the treatment. Treatments are not on the same continuum as disease or discomfort. Tylenol is not on a continuum with headache. Insulin is not on a continuum with diabetes. In contrast, treatments stimulate, interfere with, increase, or decrease some aspect of functioning in order to avert, manage, mitigate, or eliminate disease. Burnout and wellbeing do not belong on the same continuum.

To translate the basic medical model into the domain of the burnout malady and wellbeing, we propose a simple but testable model as a first step toward systematic and comparable understanding and research on interventions and their effects on the stressors that can contribute to burnout. This high-level and simple model does not attempt to handle all the complexities of biological, psychological, social, or spiritual contributors to or resolutions for burnout syndrome. This model also does not attempt to clarify the biochemical and psychological associations between burnout and depression. The following simple model is intended only as a way to encourage

consistency for discovery of stressors that add to burnout risk, wellbeing interventions that may have the most impact on stress reduction, and efforts that have the most impact on burnout as determined by standard measures, such as the Maslach Burnout Inventory. Rothenberger's systematic review and framework for action (2017) sets the stage for distinguishing malady from prevention and cure:

> To restore balance and achieve physician wellbeing, we must first acknowledge that no one person or institution is to blame for the physician burnout epidemic. It is the unintended net result of multiple, highly disruptive changes in society at large; the medical profession; and the healthcare system. (Rothenberger, 574)

I propose that stressors are these *INPUTS* to which Rothenberger alludes and that the unabated persistence of these stressors can lead to the *OUTPUTS* of burnout and depression. Studies should seek to identify and formally measure specific stressors using accepted methods. I further propose that *averting and/or recovering from burnout or depression* requires intervention, that is, *PROCESSES* that manage, mitigate, or eliminate stressors. Following this line of thought, I define *wellbeing as deliberate mindfulness and active practices that inhibit, mitigate, or manage the stressors that otherwise may accumulate to become burnout.* Interventions should be conceived as specific steps to eliminate certain stressors, reduce others, and to improve management of other stressors. In Fig. 2.1, I propose that any and all steps that are part of the PROCESS of protecting a person from stressors or reducing extant stressors are comprised collectively as *WELLBEING.* That is, wellbeing means actively being well by means of *mindfulness* and *specific practices*, just as we are mindful to reduce infection risks through specific practices. By managing or mitigating stressors, the overall load of stressors can be reduced. One concrete metaphor for this distinction between causes and cures is found in the fact that harmful

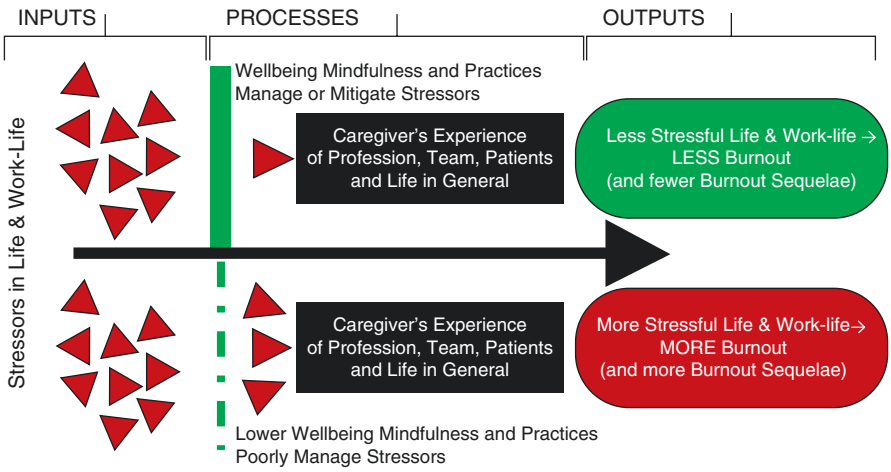

Fig. 2.1 Wellbeing as mindfulness and practices that prevent or reduce the caregiver's experience of stressors, helping avert burnout and its consequences

levels of bacterial load can be reduced by certain practices, leading to better handling of the load by the whole physical person.

The stressors experienced by any given individual may accumulate from a wide variety of sources across the spectrum of a bio-psycho-social-spiritual whole person. A whole person, therefore, must actively identify, and sometimes seek help to identify and address, the bio-psycho-social-spiritual means of managing or mitigating stressors. In brief, identifying, adopting, or augmenting one's own assets for managing or mitigating stressors, in alliance with family, friends, care team members, and health professionals, should be considered a regular part of one's primary care and disease prevention regimen. Healthcare organizations should consider shifting from passive wellness programs to mindful (well-conceived and personalized), active, and ongoing whole-person primary care for and among all healthcare professionals.

Figure 2.1 illustrates a simple systematic conception of the relationships between stressors, wellbeing, and burnout. Starting at left, stressors are assumed to be *input* in the lives of everyone. Stressors exist and occur in everyone's experience, perhaps substantially more in certain groups, such as physicians.

However, individuals can become better managers of stressors through the *processes* that I refer to as wellbeing mindfulness and wellbeing practices. Wellbeing means actively managing or mitigating more of the stressors in one's life in ways that work for that individual. Wellbeing *processes* to manage or mitigate stressors can be adopted by individuals, families, groups, teams, or organizations. In research or interventional studies—whether the interventions be regular team debriefings to review traumatic events on the unit, easy access to counselors, flexible scheduling, required minimum vacations of at least 2 weeks every 6 months, or the use of scribes—practices that may enhance wellbeing must be defined precisely. In this way, comparisons across studies are facilitated, advancing learning for all.

Imagine! What if the residency program directors mentioned above could gain a more honest view of the stressors being experienced by their residents? What processes could they implement? What would health systems do differently if they realized they can gain benefits for their health professionals, their patients, and likely their bottom line by taking the fourth aim of The Quadruple Aim as seriously as they take the also essential processes of documentation, billing, and coding?

But even excellent wellbeing practices cannot mean targeting burnout directly. "Burnout" is merely a name for *a syndrome resulting from persistent exposure to stressors*, and it cannot mean *eliminating* all of one's stressors. The mere process of breathing includes the production of "free radicals and other ROS (reactive oxygen species) that are derived…from normal essential metabolic processes in the human body…leading to cell damage and homeostatic disruption. Targets of free radicals include all kinds of molecules in the body" (Lobo et al. 2010. p. 118). As noted by an early scholar and researcher in the study of stress, Hans Selye:

> Complete freedom from stress is death. Contrary to public opinion, we must not—and indeed cannot—avoid stress, but we can meet it efficiently and enjoy it by learning more about its mechanism and adjusting our philosophy of life accordingly. (1973, p. 693)

As to *outputs*, failing to practice wellbeing allows more and a greater variety of stressors to affect one's life with greater persistence, leading toward the experience of burnout and perhaps even depression. Interventions that help healthcare professionals successfully practice wellbeing reduce the quantity, variety, and persistence of stressors and therefore the likelihood of burnout and its many possible sequelae.

In brief, wellbeing is the process of managing or mitigating stressors, and not the mere absence of burnout. Burnout is not the actual target for treatment. *The process of averting or reducing burnout is based on identification and intervention to manage or mitigate the stressors one experiences—whether the experience is at work, at home, or elsewhere.* Disciplines, organizations, units of organizations, teams in units, social groupings, families, and other allies at work and outside work can be activated to be mindful of wellbeing and to test and adopt practices that help professionals experience fewer and less persistent stressors.

At AdventHealth, Dr. Bogue had the excellent opportunity to lead an expert panel through the process of developing a Physician Wellbeing Self-Assessment Tool (PWSAT). PWSAT is not just a measurement tool. It is also intended to provide a tool to self-reflect and become more mindful about wellbeing practices that a given individual can adopt or amplify to manage or mitigate specific stressors and, therefore, to avert or reduce burnout. PWSAT is comprised of four independent ten-item scales that produce four scores based on an individual's own self-assessment of wellbeing practices in each of four different domains of the whole person: biophysical (BIO), psycho-emotional (EMO), socio-relational (RELA), and religio-spiritual (SPIR) wellbeing. Contact Dr. Bogue for more information: rjb@courageoushealthcare.com.

Systematic Approaches Toward Solutions

Better active support for physician wellbeing is the reply we need in response to burnout. As noted above, however, the targets we must have in mind are the stressors. Burnout is a syndrome generated by persistent unmanaged or mitigated stressors, and the way to avert burnout is to better manage or mitigate the stressors that generate burnout. Effective wellbeing-generating responses are vital not only for physicians themselves but also for all of us who entrust ourselves and our loved ones to health systems. Administrators, nurses, other healthcare staff, and the general public also benefit when physicians are present and more fully engaged in their work. The goal of research into physician wellbeing must therefore go beyond support for physicians. As physicians thrive in their life and work, so too will the systems and the teams in which they fulfill their calling. Active efforts to promote wellbeing will enhance results for all those to whom the systems intend to provide care.

With this in mind, this book includes numerous chapters describing one or another approach to advancing wellbeing, from the certification program Medicus Integra to St. Vincent Health Systems Life-Centered Mentoring Program and numerous others. Action steps are being taken within many organizations. These

include medical schools and health systems such as AdventHealth, Baylor Scott & White, Loma Linda University Medical Center, Marian University College of Medicine, Mercy Health Network Des Moines, St Vincent Health (IN), and Virginia Tech University's Carilion Clinic. Each of these systems has used the PWSAT to assess care provider wellbeing as part of their larger efforts to understand burnout and wellbeing and to conceive action steps that make sense in their respective organizations.

But many other organizations have used different measurement and planning tools, begun providing better and confidential access to mental health counselors, and/or have expanded wellness programs to assist physicians and other health professionals toward wellbeing. The remainder of this subsection and the reference list provide a number of notable resources that you can access online.

- For over a decade, Mayo Clinic has been making an impressive ongoing investment in a productive in-house research unit—Program on Physician Wellbeing—focusing primarily on prevalence and contributors to physician burnout, coupled with efforts to reduce burnout (https://www.mayo.edu/research/centers-programs/program-physician-wellbeing).
- Cleveland Clinic has developed excellent programming addressing patient care quality and provider burnout with an emphasis on the skills of empathy (https://newsroom.clevelandclinic.org/2018/05/23/cleveland-clinics-patient-experience-empathy-innovation-summit-draws-national-experts/).
- Kaiser Permanente maintains calendars of events and other items intended to protect provider wellbeing, with programs run by region (https://permanente.org/road-physician-wellness/).
- The Accreditation Council for Graduate Medical Education (ACGME) has affirmed that "[N]o one organization can have the level of impact needed to create culture change" (Nasca 2016). ACGME hosted its first National Symposium on Physician Wellbeing in November 2015 and has established an online compendium of guidance and resources to help promote wellbeing and avert burnout from the beginning of one's journey as a physician (https://www.acgme.org/What-We-Do/Initiatives/Physician-wellbeing).
- The American Medical Association established its Steps Forward program to offer supportive tools (https://www.stepsforward.org/modules/physician-burnout). The StepsForward website includes free CMEs on burnout and/or wellbeing that can be downloaded and delivered locally.
- The American Psychiatric Association also offers wellbeing resources https://www.psychiatry.org/psychiatrists/practice/wellbeing-and-burnout/wellbeing-resources.
- The American Nurses Association with "Healthy Nurse, Healthy Nation" (2019) and National Nurses United (2019) have both called increasing attention to burnout among nurses.
- Stanford has recently established a program called WELLMD (https://wellmd.stanford.edu/).

- The National Academy of Medicine has compiled, over the past 2 years, perhaps the most extensive list of studies on potential contributors to burnout and related issues within its Knowledge Hub, which is found at https://nam.edu/clinicianwellbeing/.
- The Agency for Healthcare Research and Quality provides evidence, clinical guidelines, recommendations, and resources on the wellbeing of healthcare professionals (https://www.ahrq.gov/professionals/clinicians-providers/ahrq-works/burnout/index.html).
- Even more broadly focused, the American Management Association has produced a tidy summary of burnout symptoms and strategies (2017).
- The Coalition for Physician Wellbeing has oriented its work solely around solutions that promote wellbeing since its launch in 2011. More recently, the Coalition established itself as the first membership association focused specifically on advancing physician wellbeing (https://www.forphysicianwellbeing.org/). The Coalition includes a number of experts and has established a highly valued recognition program for healthcare organizations that widely implement and sustain physician wellbeing programs: Medicus Integra. Consider joining the Coalition or sending a team to the Coalition's annual meetings, which serve primarily as open and collaborative exercises in sharing best practices for promoting wellbeing.

Many of these systematic efforts at the level of hospitals, health systems, associations, or governmental agencies have documented promising results. These efforts are sowing many different seeds, producing a creative bounty of potential approaches to promoting wellbeing, and mitigating the stressors that can lead to burnout. Assessment of the relative value of these approaches remains difficult to formalize due to a lack of rigorous and/or consistent definitions, burnout cutoffs, and study designs. This deficit is exacerbated by the fact that health systems are very busy places that must advance their wellbeing agendas without slowing down their work on behalf of patients. But, together, as a field, as the science progresses on biochemical indicators, survey measures, and especially interventions and their efficacy, progress will accelerate toward identifying and demonstrably managing or mitigating the stressors that contribute to burnout and depression among healthcare professionals.

Ideas for Producing Benefits Using Solution-Oriented Approaches

The evidence on burnout, depression, and their consequences has far surpassed, for a long time, any threshold for deciding that something needs to be done about it. Nonetheless, the study of physician wellbeing is in its theoretical infancy. As a field, we have conducted many exploratory studies, particularly studies determining the

extent of burnout for physicians, as well as studies identifying likely contributing factors. In addition, numerous studies have identified consequences of job dissatisfaction, stress, and burnout. A number of good efforts to reduce physicians' risk of burnout have been launched. Even with all that, there is much to do. What follows is a quick review of some ideas for moving the field forward, toward solutions.

Including All Healthcare Professionals

There is a high degree of interdependence in the provision of healthcare. That is, physicians are highly dependent on others for the outputs and outcomes of their work, and vice versa. In the hospital setting, two-thirds of the items in the HCAHPS patient experience/satisfaction scores are highly relevant and highly sensitive to nurses' roles (Bogue 2012; Kennedy et al. 2013). Yet, only recently is research emerging on burnout prevalence, contributors, and consequences of burnout among nursing professions (Hart et al. 2014). Given the high degree of interdependence among healthcare professionals, research and interventional studies on burnout should include all members of the care team, with attention to differences in what solutions might work best for different professions and their collective capacity for being part of the solution. Focusing on the outcome measures of these interprofessional studies and interventions on improving patient care, safety, and quality may accelerate progress in optimal ways.

Adopting and Testing Systematic Theoretical Approaches

For learning and progress *against burnout* and *toward practices of wellbeing*, the field needs competition in theory development. Progress in theory testing and improvement depends on testing theoretical relationships between key constructs by the use of consistent and precise definitions, measures, and procedures such as those enumerated above. In Fig. 2.1, we posit theoretical and testable relationships between stressors, wellbeing, and burnout, where wellbeing is mindfulness and active practices for managing or mitigating the stressors that may otherwise accumulate to create burnout. This kind of inputs-processes-outcomes dynamic is one simple way to permit systematic learning across studies. Input, process, and outcome is not unlike the logic of subjective and objective findings, assessment, and plan as long taught for healthcare professionals as SOAP notes. A basic theoretical approach does not need to be complex, particularly when an area of study is still largely pre-theoretical. Let's get started in being explicitly systematic, perhaps using basic interventional models like inputs (stressors)-processes (wellbeing practices)-outcomes (burnout, depression, other consequences), and reporting the effect sizes of specific and well-defined wellbeing interventions.

There are many theoretically valuable questions we need to be asking. Rather than considering low burnout risk to mean the same things as wellbeing, I urge us to define wellbeing as an active state of mindfulness and practices for managing or mitigating stressors. This perspective introduces the idea of *treatment* in response to *malady*, solution in response to a problem—a key dynamic in medicine and other

problem-solving arenas. Here, wellbeing is seen as better management of stressors to reduce the likelihood of burnout.

Additional questions with potential for conceptual clarification may spark progress as well:

- Are burnout and wellbeing similar across healthcare professional groups? If yes, does this open the possibility of more productive interdisciplinary or team-based efforts to study and improve wellbeing?
- Does "wellness" more clearly refer to corporate wellness programs, while wellbeing focuses on specific practices that extend far outside the workplace and that take into account the individual's various relationships (with self, others, the material world, and the transcendent)?
- To mention just two contrasts associated with personality: are passion and trait self-control possible mediators in predicting wellbeing (Briki 2017)? Can extraversion and neuroticism in youth predict mental health 40 years later (Gale et al. 2013)?
- Can we recognize the importance of financial matters without conflating access to resources (wealth) with the fundamental bio-psycho-social-spiritual aspects of being human? In other words, can using the internationally recognized framing of relative wealth as "financial welfare" be helpful in respecting that finances matter, but that finances are extrinsic and not an inherent aspect of a human being and may therefore be related to but distinct from bio-physical, psycho-emotional, socio-relational, and religio-spiritual experience? (Pouw and McGregor 2014).

This quick touch on considerations and opportunities for definitional clarity and systematic efforts to advance theory and practice around burnout and wellbeing is just that, a palpation. Advancing underlying constructs remains a high priority if we wish to accelerate progress in knowledge about burnout and wellbeing.

Staging of Burnout to Better Target Burnout Interventions

One of the central features of modern medicine is the ability to identify the stage of a pre-disease condition or of a disease, and to target treatment to that particular stage. We check blood pressure, for example, and make different recommendations or take different actions based on that information. The nature of the treatment for blood pressure control or reduction and related conditions depends on the level of blood pressure, the persistence of higher levels, comorbidities, and other factors like the patient's age. The field needs to learn how to do this with respect to burnout and depression.

A strong relationship between high scores on the MBI emotional exhaustion scale (EE) and depression diagnosis, as in Schonfeld et al. (2018) and noted in many studies that include both depression diagnosis and the MBI. However, depression, unlike burnout, is a DSM-5 diagnosis. DSM provides diagnostic criteria and information about appropriate interventions. Preliminary research demonstrates there may be behavioral associations in communicative behavior with stages of EE (Ferren et al. 2017; Penwell-Waines et al. 2017). Can we imagine training and systems by which members of a care team recognize stage-specific behavioral signs of EE and/or depression in their colleagues and initiate appropriate care steps?

There remain many unanswered questions that interested parties should consider when developing initiatives concerning burnout, depression, or wellbeing. What are the most appropriate steps for intervening against earlier stages of depression? How can those in need of assistance to restore wellbeing be identified prior to approaching crisis?

Openly Addressing Depression

If we are to help identify and ensure proper supportive interventions for the healthcare professionals we know and care about, we need to learn more about the staging of burnout and to make it safe and permissible to openly address depression. To do this, it is imperative that we recognize the critical importance of acknowledging and treating depression and other mood disorders before they proceed toward potentially disastrous outcomes. All medical societies and healthcare organizations need clear policies for providing restorative support for healthcare professionals headed toward or diagnosed as depressed. These policies must provide a pathway of confidentiality, complete protection, and/or restoration of the professional's rights, privileges, and duties.

Adopting Optimal Approaches to Accelerate Progress

The highest form of evidence in scientific inquiry is a systematic review and formal metanalysis of multiple randomized clinical trials (RCTs) (Barton 2000). To date, there are precious few RCTs on interventions addressing burnout. In 2018, Wiederhold, Cipresso, Pizzoli, Wiederhold & Riva reported that "from an initial search of 11,029 articles [studies about intervention on physician burnout], 13 studies met full criteria and were included in this review. Of the 13 studies presented, only 4 utilized randomized controlled trials" (p. 253).

There are some good reasons for this low rate of RCTs on physician burnout. First, if burnout may signal or contribute to suicide risk, randomly withholding treatment from medical staff members may not be ethical. As an illustration, in the early stages of the HIV plague in the USA, HIV infection constituted a much higher risk of death than burnout. The federal government authorized treatment with AZT without first going through RCTs because the risks of morbidity and mortality were too high. Second, physicians in a health system, hospital group, or practice cannot easily or effectively be randomly allocated to intervention versus nonintervention or intervention *A* versus intervention *B*. Physicians working together every day would likely learn from each other about alternatives, contaminating results to some extent. Also, since one intervention might appear more appealing, or as though it requires more resources than the other, healthcare organizations are understandably reluctant to provide intervention *A* to some physicians and not to others. If one intervention is a better fit for the organization's culture than an alternative intervention, this could harm morale and a sense of affiliation to the organization's culture. In addition, it simply costs extra time and effort to design and manage traditional RCTs,

given the needs for random allocation at the level of individuals to intervention and control groups, or to one of two or more groups for alternate interventions.

If we cannot make rapid progress using RCTs within one organization, what might be an optimal approach to accelerating development, testing, and refinement of interventions to increase wellbeing? In prior burnout or wellbeing intervention research, studies have demonstrated the value of longitudinal cohort designs that last at least 2 years (Jones et al. 1988; West et al. 2006).

Efficiencies can be gained, organizational cultures respected, and the odds of grant or other funding increased by means of collaborative, multi-site longitudinal studies, as the longitudinal cohort study (LCS) model below illustrates (see Fig. 2.2). Cohort studies can be especially valuable in interventional and dosage studies or any research involving impacts over time (Caruana et al. 2015; Wiederhold et al. 2018). Collaborative LCS design can overcome many of the challenges inherent to RCTs noted above, though randomization is sacrificed. In a collaborative LCS program of research, each organization in a collaborative would deliver to a central research team the same outcome measures on the same timing (e.g., burnout and/or wellbeing measures and patient experience scores every 172 months). However, each organization would design and implement one or more interventions suited to their culture, resources, and challenges, ideally over set periods of time (e.g., 6 months for each intervention tested). Comparing the effect size of each intervention on the same outcome measures over the same amount of time would provide a reasonably rigorous assessment of the value of each intervention. This approach would be strengthened if enough information about each organization is gathered so that differences in organizations can be controlled for. Such differences might include bed size, staff composition, patient demographics, and service mix. With at least two data points for each intervention, the collaborative systems involved could gain a great deal of insight into the effectiveness of different interventions.

Cohort studies can evaluate a sequence of different possible improvements (Monteleoni and Clark 2004). As illustrated in Fig. 2.2, collaborating across organizations can accelerate learning by facilitating adoption of a Rapid Cycle Quality Improvement (RCQI) approach. HRSA recommends RCQI as a way of systematically evaluating different interventions in a relatively short cycle (AHRQ 2018). For example, healthsystem1 could test and measure the effects of intervention *A* for a year and then intervention *B* for a year. During the same year, healthsystem2 could test and measure the effects of interventions *B* and *C*. Healthsystem3 could simultaneously test and measure the effects of interventions *C* and *D* and so on. Optimally, to achieve a more longitudinal perspective, the outcome measures would be gathered for at least 6 months after all interventions were completed. Through this means, a collaborative of ten health systems could (a) invite all their physicians, (b) participate in two different interventions, (c) contribute data for evaluating which of ten different interventions work best. Over the course of 3 years, and with good collaboration, a collaborative could achieve design, institutional review board (IRB) processes, intervention periods, data aggregation and analysis, and reporting to leadership teams. Ten collaborating health systems might arrive at the two most effective and cost-efficient wellbeing-generating interventions and identify five or more interventions unworthy of further study.

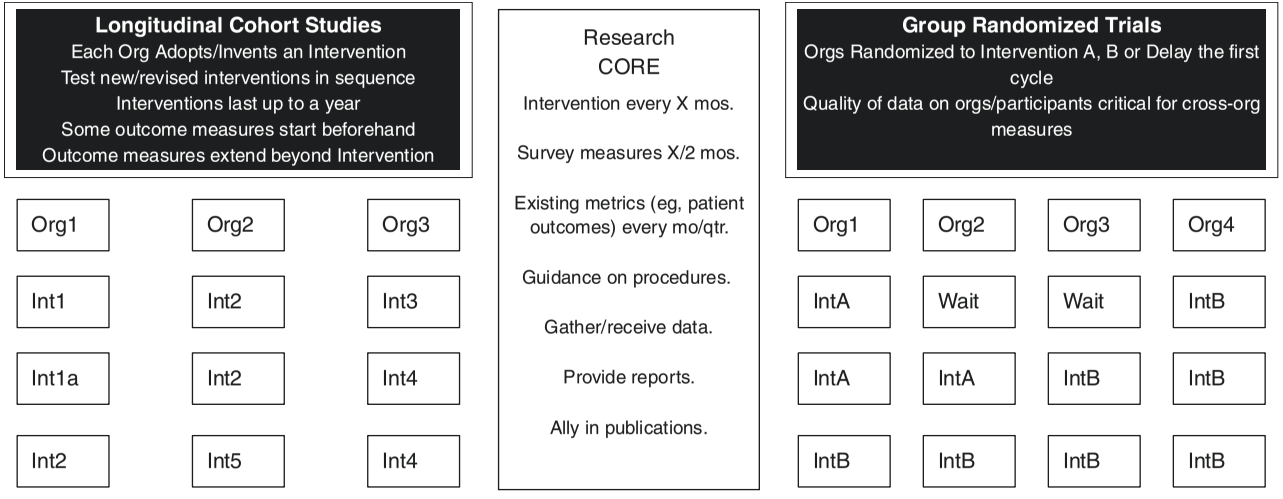

Fig. 2.2 Example of multi-organizational longitudinal cohort study designs that could accelerate progress in addressing burnout

A related but even stronger design option may be available to very stable collaborations. Illustrated below, group-randomized trials (GRT) would achieve randomization (at the group level) and controlled tests of different interventions (Murray 1998). Organizations would first participate in designing or selecting a set of interventions to test. Again, each organization would gather and deliver to a central research team the same outcome measures on the same timing. Some organizations would be randomly selected to receive 6 months of intervention *A*, while other organizations receive 6-month intervention *B* or *C*, and still others receive interventions only after a 6-month delay. By working through interventions *A*, *B*, and *C*, as well as no intervention, as above, many environmental/systemic factors (like shifts in payment methods or EHR requirements) could be accounted for in the process of comparing interventions to each other. GRT still is not an RCT, which has advantages of randomization at the level of individual physicians. GRT requires the use of special analytic approaches yet restores randomization to group-level trials and could provide a very robust series of interventional trials to improve physician wellbeing, better mitigate stressors, and, thus, reduce burnout. These authors, other authors in this book, and other researchers in burnout and wellbeing would no doubt be interested in aspects of developing, managing, and evaluating wellbeing interventions in a collaborative model using RCQI.

Conclusion: Making a Difference in Everyday Practice through Authentic Engagement and Advocacy

Authentic engagement requires empathy for self and other (Melnick and Powsner 2016). Theoretically, two physicians, facing equivalent stressors, may experience different amounts of stress and different levels of burnout risk based, at least in part, on the amount and quality of their self-care (Schmitz et al. 2012; Rabatin et al. 2016; Winkel et al. 2018). Gaining competency in wellbeing should modify the sequelae toward less burnout, a happier life, as well as more effective patient communication and care outcomes. In short, wellbeing is an active state in which one engages in the mindful adoption of practices that inhibit, ameliorate, or avert the accumulation of stressors that can lead to burnout (Gagnon et al. 2016; Shanafelt et al. 2016).

The Coalition for Physician Wellbeing has been actively promoting wellbeing, understanding the prevalence, causes, and consequences of burnout, and seeking pathways toward improved wellbeing since 2011. The Coalition recognizes physicians as whole persons, with biophysical, psycho-emotional, socio-relational, and religio-spiritual aspects. These aspects of a whole person are affected by home life, work life, as well as surrounding contexts. The Coalition and its members have been active in many ways in promoting wellbeing. As you can see by the many examples in this book, the Coalition emerged early among those recognizing the challenges across the nation that must be addressed to improve physician wellbeing.

As a collective of professionals invested in improving wellbeing and averting burnout, readers of this book can build capacity to advocate for improved wellbeing for healthcare professionals. Figure 2.3 illustrates the advocacy process. It suggests steps individuals and groups can take to improve healthcare professional wellbeing

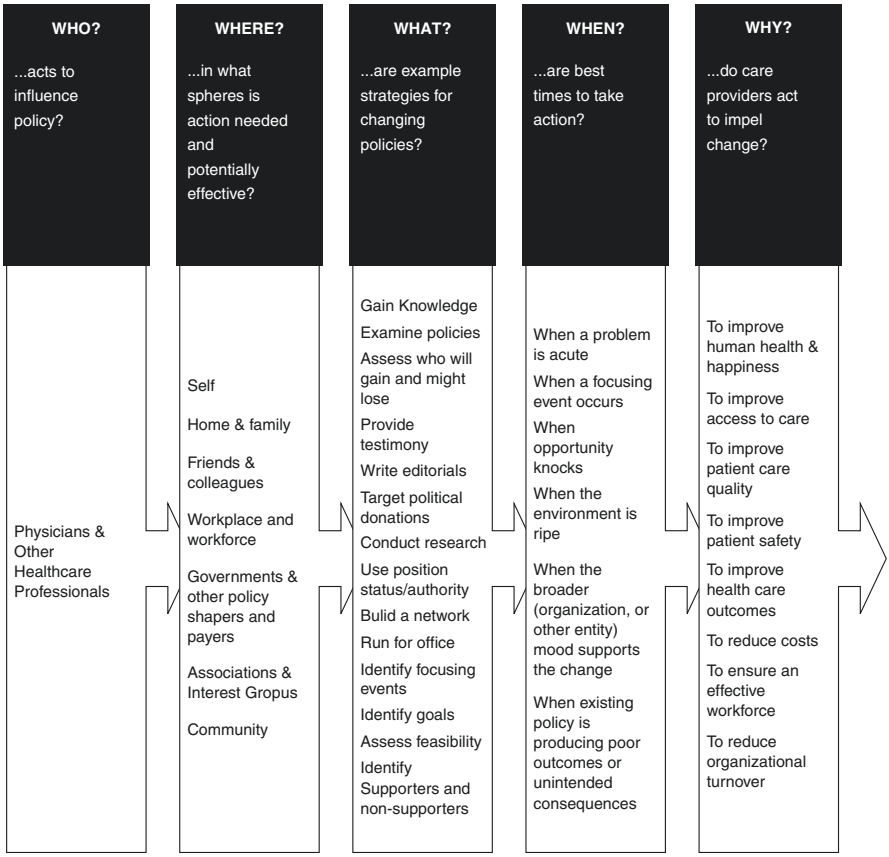

Fig. 2.3 Steps for making a difference

and reduce the many negative consequences suffered by physicians, other healthcare professionals, their families…and their patients (O'Grady et al. 2016). Use the figure in committees or action groups on wellbeing to identify best ideas about how you and your allies can move forward an agenda of healthcare professional wellbeing.

If one of your aims is to help address and reduce the healthcare professional burnout, there is much more to explore, read, and discuss than can be covered in this brief summary. Even with the entire contents of this rich book, many more possible directions remain unexplored.

You would not have read this chapter unless you can imagine that change is needed to improve healthcare professionals' wellbeing for, by, and with healthcare professionals. So, consider where can you make a difference. Consider whether the setting in which you want to act is a health system, a group practice, a federal agency, an insurance company, or even providers' homes.

Wherever you want to make change happen, imagine strategies you can see yourself advancing. Identify general ideas or specific steps you think would make a posi-

tive difference for physicians or for all healthcare professionals. Consider assets you have to make a difference. Identify assets you will need to move your idea forward and how you can evaluate it.

In closing, Fig. 2.3 provides a map for action, steps for making a difference. This tool for policy advocacy and change can help healthcare providers and their allies to explore how they might make a difference in burnout and wellbeing. The need, the interest, and the questions are all there. It is time for the healthcare community to move forward, using clear and consistent definitions to test potentially useful theories about methods for strengthening the wellbeing of physicians and other care team members.

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Chapter 3
Why Should We Care?

Herdley O. Paolini

Introduction

Why should you care about physician burnout? There are many reasons. One stands out among the rest: Your health is at risk.

It is not breaking news that the majority of physicians today are burned out and overwhelmed. Many studies have documented the pervasiveness, symptoms, and root causes of physician dissatisfaction and burnout (Deckard et al. 1994; Benzer 2001; Linzer et al. 2001; Shanafelt et al. 2012). Physician burnout—the hallmark of which is emotional exhaustion, low sense of accomplishment, cynicism, and detachment—directly affects quality of care, safety of patients, treatment outcomes, patient satisfaction, nurse turnover, hospital staff morale, and financial performance. It occurs at alarmingly high rates (Shanafelt et al. 2003; Ofri 2013).

As stated succinctly by Dyrbye and Shanafelt (2011), "Physician burnout is threatening the foundation of the U.S. medical healthcare system."

The most recent Medscape Physician Lifestyle Report places physician burnout at a higher prevalence and greater severity than just a year ago, with the highest prevalence at 53% and greatest severity of 4.3 on a 5-point scale, depending on specialty (Physician Lifestyle Report 2015). This is consistent with a Mayo Clinic published study that placed mean physician burnout in 2014 at 54%, with a specialty-specific range between 39% and 71% and with every specialty's prevalence increasing since 2011 (Shanafelt et al. 2015). The consensus is that physician burnout has reached a critical, if not epidemic, crisis level. In addition, in a recent survey in the United States, 60% of physicians reported that they were considering leaving their practice, and 70% reported knowing at least one colleague who left their practice due to low morale (Sikka et al. 2015).

So, how can there be a question if we should care?

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A Moral Imperative

If we think about physician burnout and well-being as an individual issue, and in addition, if we think about it as something that we can isolate from the clinical and organizational environment, we might sheepishly justify ignoring this issue. Of course, it would still be morally wrong to ignore it, in the same way that it would be wrong to ignore any other health issue impacting a group in the general population. More than 400 physicians committed suicide last year—the equivalent of an entire medical school class. Physicians fall victim to burnout in significantly higher numbers and severity than members of other professions. All this has major implications for the health of the population. Yet, despite the ample evidence that depression, suicide, and substance abuse disorders are more prevalent among physicians than the general population, the well-being of physicians consistently receives low priority.

It seems reasonable to assume, though, that we all understand that physicians, who are in the front lines of healthcare delivery, are a major influence on the quality, outcomes, and overall success of that delivery of care. So it is difficult to justify why the epidemic of physician burnout has received little attention and band-aid approaches at best, often categorized or dismissed as a "feel good" program for physicians.

The Problem of Denial

The question today is not *if* organizational dysfunction related to physician burnout exists. That is a given in current US healthcare. In spite of that reality, significant denial still exists within the healthcare sector despite repeated research findings that demonstrate high percentages of practicing physicians today experiencing diagnosable burnout.

One of the difficulties in addressing this problem within individual health systems is its "silent" nature. Physicians tend by nature and training to be highly resilient individuals who work in a culture of medicine that does not condone public complaints. The result is an epidemic of burnout that is analogous to hypertension: a silent disease that unless proactively diagnosed reveals itself only after progression to serious and sometimes fatal consequences.

Denial generally exists as much or more within the medical community than within administration. Senior leaders—with or without medical credentials—tend to be removed from the day-to-day realities of medical practice, deal with a wide range of priorities, and are themselves coping with unprecedented levels of industry and organizational change. In addition, medical leaders come from the same culture of pervasive denial.

Cost and Quality

Physicians are more than just cogs in the healthcare machine. Just think of the power of the physician's pen or the reality that they are on the front lines and responsible for critical points in the care of the patient. They can unconsciously undermine an initiative because they are emotionally and physically maxed-out and thus do not understand the meaning of it, do not experientially see how it will be helpful, and cannot be meaningfully enlisted.

Physician burnout directly affects quality of care, patient outcomes, staff morale and turnover, and financial performance. The "triple aim" of healthcare—better patient outcomes, improving population health, and reducing costs—was first introduced in the literature in 2008 and has become healthcare's Holy Grail (Berwick et al. 2008). Unfortunately, the triple aim appears as elusive as its counterpart in mythology. This should be no surprise given that, on average, more than half of the key players in healthcare are exhibiting a range of burnout symptoms.

Is it possible for physicians to deliver personalized, relational, compassionate care while they are dissatisfied, burned out, and disengaged? Is it possible to achieve the results that are needed as it relates to the physician-patient relationship by deploying a quick script or course on the "right words to say, eye contact, and sitting down with the patient," regardless of the physician's state of mind or health? The results of cognitive attempts, quick fixes, and the teaching of new skills have so far not been encouraging. Most current patient experience improvement programs fail to connect the dots between the patient experience and the emotional state of mind of the care provider. We believe this is because we try to train a physician in technique when what we desire is a compassionate presence. For that, we need physicians who are experiencing their own wellness, who can access the language of caring, and who will find a way to be resilient in maintaining their health, wellness, and satisfaction in the midst of the overwhelming, ever-changing business of medicine.

The desired shift from "volume to value" continues to elude us. Are the high rates of physician burnout and distress an overlooked but critical issue? A "fourth aim" to address caregiver burnout has been proposed (Sikka et al. 2015; Ruddy et al. 2016; Bodenheimer and Sinsky 2014). Rather than a fourth aim—an afterthought—this aim is so essential to the triple aim that it is a prerequisite. It should be the first aim.

We will continue to fall short of achieving the triple aim if we do not proactively attend to the health and wellness of physicians rather than simply reacting to extremes of physician distress. In addition, our success in achieving all of the aims will depend on our ability to provide physician leaders with the core skills and holistic wellness to achieve such transformation.

Healthcare Transformation

Why is physician wellness of crucial importance as we face this unprecedented change in healthcare?

Unless we address the issue of burnout and all of its causes and work toward a culture of wellness for caregivers and patients alike, we are not going to have the foundation we need to achieve the required changes. After all, what could be more patient-centered than ensuring that those who provide care are not only clinically competent, but emotionally and physically well?

Let's be clear though: Addressing burnout is not just a matter of addressing how many hours one works, how many bureaucratic tasks one has to weed through, how many barriers one has to jump through in order to care for patients, reducing the number of clicks in an EHR, or providing better pay. While these are necessary components, any comprehensive approach also needs to address the damage that may have been done by physician training and the ongoing effects of medical and organizational culture.

Medical training includes a hidden curriculum from which physicians often learn such things as valuing expertise and reductionism over whole-person care; embracing independence and invulnerability as opposed to teamwork, collaboration, wholeness, and connection; and saying nothing in order to survive rather than expressing concerns when deviations from care quality occur, when communications with patients are inadequate, or when the physician and/or team members are treated with disdain, disrespect, or dismissal.

Many physicians carry emotional scars from these experiences. At best, the formal curriculum of medical training generally lacks any process for gaining the emotional intelligence skills of self-awareness and self-management. Most of the feedback is focused on the mastery of the technical and cognitive skills of becoming a physician, as well as self-sacrifice and stamina, rather than the interpersonal skills necessary to be a healer. This education system takes young students who score higher on important measures of emotional wellness than their equivalent peers pursuing other academic endeavors and statistically ends up lowering their emotional wellness (compared with their peers) by the end of medical school (Brazeau et al. 2014)

The culture of medical practice must also change if physician wellness is to be effectively addressed. The present system produces a culture that advocates self-sacrifice at the expense of self-care: a culture that aspires to and talks a lot about teams, collaboration, and inter-professionalism but often invests little time or resources in the development of these; a culture that frequently models leadership as a command-and-control function; a culture that can drive physicians to ignore their own humanity and disconnect them from their own experiences, thus severing them from the very self-awareness they need to function in a high-complexity environment.

Nevertheless, physicians are not victims. Instead, they are often co-creators of this unfortunate reality. They are co-creators by (1) continuing to accept the "status

quo" and expecting that the leadership of our healthcare systems and our political structures will fix the problem; (2) buying into the professional drive that leaves important parts of themselves out of their professional and personal lives; (3) perpetuating a culture of "silent suffering" while denying their own humanity; and (4) ignoring self-care as imperative to calibrating themselves in order to sustain this most meaningful but most stressful work.

Physician Leadership

Physicians today need skills that were not developed in their medical training and that are often in direct opposition to what they were taught. These skills are essential in aiding the integration of their learning and development, and in readying physician leaders for the essential tasks of envisioning, enlisting, and actualizing change. All physicians are leaders—for better or worse. Both formal and informal physician leaderships are needed for healthcare transformation. Contrary to popular opinion, leaders are not born. They are formed. This process involves a personal inner journey, one involving the courageous development of self-awareness through a reflective process that instructs as to how one's strengths and shadows are affecting one's ability to inspire, enlist others, and create collaboration for needed change. Formal leaders need to be effective in their position to enlist collaboration in creating disruptive innovation and transformative change. But informal leaders (i.e., all physicians) need to be effective in both collaborating in the creation or innovation and change and taking ownership by operationalizing it. If physicians are not taking ownership of their leading role, even without realizing it, they will be barriers to much needed change initiatives.

Consistent with the popular definition of insanity (doing the same things while expecting different results), management often continues to try to go around physicians, run over them, or "carrot and stick" them, all while getting the same negative results. One physician in a senior management position told me, "I don't understand why (our) physicians can't find purpose and meaning on my agenda." He demonstrated the frustration experienced by those who attempt to lead without the necessary formation in the skills that inspire, gain others' respect, and enlist others into collaboration.

Sadly, attempts to address these real challenges often ignore proven principles of leadership development and holistic personal growth. The MBA-style approach to physician leadership development, which focuses mostly on management theory and practice, does not adequately address the inner transformation needed to change mental models and habits of relating to self and others. The content is not sufficient because it does not support the clinician experience and sustainability of the work, and often does not reflect an understanding of the physician worldview and the physician starting point relative to leadership and teamwork.

More foundational leadership formation is supported by the latest neuroscience research—in particular, the neuroscience of leadership and teamwork. Advances in

functional MRI technology have identified why inspiring and supportive relationships are crucial. These relationships help to activate parts of the brain that make it possible to be open to new ideas and to be more socially oriented toward others. What this means is that instead of seeing this type of leadership as "soft science," we would do well to understand how we are "hardwired" to connect. That connection matters at every level, especially when attempting to change deeply embedded patterns and overcome immunity to change.

Developing physician leadership and teamwork skills is an ongoing formation process that requires deliberate, consistent, and explicit implementation based on the physician worldview, principles of adult learning, and dynamics of behavioral science. It must be highly experiential and take advantage of small-group dynamics and collegial relationships. It must incorporate the physician's individual context into the process. It must create a safe space for learning that acknowledges the vulnerability involved in transformative learning. It must provide ongoing mentoring and professional coaching. It must focus on the emotional well-being and personal integration of individual physicians as a foundation from the very start.

Financial Implications

Physician burnout, low physician engagement scores, and financial risk go hand-in-hand. A 2017 calculation by the Institute for Physician Integration based on Advisory Board provider survey data for an East Coast hospital highlighted the degree of financial exposure this can create. The data indicated 15–35% of the employed physician population was considering other employment options. Given a $200,000 conservative minimum average cost to replace a physician, the financial risk for that institution was calculated at three to seven million dollars of exposure per 100 physicians on staff. This conservative calculation included neither lost revenue nor operational costs associated with lack of engagement, misalignment, and barriers to integration.

A 2013 study conducted by an outside consultant while I was responsible for the hospital-based physician support program at Florida Hospital, Orlando, calculated the direct financial benefit of that program to that health system to be in excess of five million dollars over the previous 2 years in cost-avoidance alone. At the same time, difficulties involved in quantifying benefits, such as avoidance of revenue loss, reduced absenteeism, employee (particularly nurse) retention, employee and patient satisfaction, and other business and human resource measures were acknowledged as significant factors left out of the quantification. More important, the program was credited with rescuing the careers of more than 100 physicians over the previous 10 years (Jernigan 2013).

We have long seen the link between the program's results and standard measures of patient outcomes, physician satisfaction, nurse satisfaction, and the quality of healthcare delivered by the institution. However, proving cause-and-effect relationships, although in theory possible, presents daunting obstacles in terms of the costs

of data collection and analysis. The cost-avoidance metric, on the other hand, can be tracked at reasonable cost with a credible methodology based on the program's clinical data and the real costs experienced by the hospital when compelled to replace physicians. That metric will always underestimate the financial value of the program to the hospital but still more than justifies the program investment.

Taking Solutions to the Next Level

Burnout has traditionally been seen as an individual problem, but in fact it is a workplace issue. The prevalence of burnout in physician populations, coupled with the leadership and interpersonal relationship skill deficits that are the legacy of medical school and residency training, have enormous implications for health systems. Clinical integration, patient and employee satisfaction scores, and the physician leadership needed for the transition to value-based compensation will remain at risk until physician well-being is addressed.

Given the forces shaping the training and practice of medicine today, it is remarkable that so many of our physicians have managed to persevere in the art and science of medicine. Nevertheless, clinical data and experience are pointing to the dire consequences of leaving the wellness of physicians to chance.

Prevention and physician wellness must become even more robust and comprehensive as we continue this period of unprecedented change in healthcare. Changes in healthcare cry out for a more holistic and integrative approach to developing physician leadership, changing medical staff cultures, and building stronger bridges of trust between healthcare leaders and physicians.

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Part II

What Is Our Physician Culture Now and What Does It Need to Be?

Gardeners know that when a plant is not doing well, it is usually wise to consider changing the soil. We change the soil, not the plant. We look at our physicians and have their wellbeing guide us in determining what needs to be amended in the soil in which they live. Are there elements vital to a physician's engagement missing? The science of the physician environment is evolving, but there are some basics that increasingly appear to be "must haves." This section explores the "must haves."

Physicians, like all people, do not thrive in a toxic environment. If certain physicians, due to status or economic impact, are allowed to behave poorly, the entire medical staff will suffer. It is important to consider whether an organization has empowered the medical staff to deal with behavior that does not align with the cultural values.

In addition, inclusion of physicians in the strategic planning of the hospital is critical. This is the place where they send their patients and/or care for their patients. Physicians tend to stay at one institution for a majority of their career, and certainly for longer than the average administrator. They yearn for a voice in the ongoing plan. Their wisdom is a great asset to the administrative team.

Finally, transparency and integrity in data is essential in negotiations and other interactions between medical staff and administration. Building trust is good for individuals. It is also good for the institution. As one physician puts it, "Just tell me yes or no. The long, slow no is disruptive to my practice."

Chapter 4
Preventing Burnout Through Physician Integration: An Organizational Approach to Physicians That Can Improve Physicians' Personal Work-Life Integration

Dianne E. McCallister, Barbara Couden Hernandez, Doug Wysockey-Johnson, and Ted Hamilton

Introduction

A new paradigm for the hospital/physician relationship is in order. The concept of hospital or practice/physician "alignment" is fraught with danger—the danger of "misalignment," or even the sense that inherent alignment is lacking. The true goal, we believe, is integration rather than alignment. An integer is a whole number that cannot be divided. The reality of hospitals and physicians is that integration is inherent; we depend upon one another, and our patients' best interests depend upon us being a whole, non-divisible unit. In an age when headlines announce physician and administrator burnout, our 10 years of research led us to propose a prescription of health and integration to increase physician well-being.

We have come to the conclusion that the physician well-being paradigm must move away from work-life balance, which most anyone in a professional role will likely admit is an equation that simply does not balance. Instead, we believe a focus on professional/personal integration as the way forward, creating a meaningful whole out of all the important aspects of an individual's life.

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In this discussion, we present a method that has helped us improve the personal integration of physicians' lives by intentionally creating structures in our organizations to integrate the life of the organization with the physicians who honor us with their participation in our hospitals. The concept has four components which together create a relationship that is a win/win for the physician and the hospital, and is certainly in the best interest of patients and staff alike.

The structure has now been piloted in two distinct hospitals: one a not for profit and one a large, publicly traded healthcare company. In both instances, double-digit increases in patient satisfaction scores emerged in the first year with no increase in FTEs for the hospital and no additional committee responsibilities for the physicians. All programs within the structure are based on evidence. In both hospitals, the "side effects" of this work have been improved patient care metrics, better engagement, and decreased behavioral incidents reported by staff in the occurrence systems. We have also done the work of determining the baseline "well-being" of the physicians at the publicly traded institution a year into the work and prior to the start of the last piece of the structure: facilitated meetings for physicians to discuss topics important to their personal lives and their practice of medicine.

Background

The structure of this program centers on four basic realms of work:

1. *Quality and efficiency of operations***.** This is the *basic/fundamental work of assuring that patient care and service* and the efficiency of the systems with which the medical staff interacts are constantly being surveyed and repaired to produce high-quality processes and outcomes. Quality and efficiency are crucial. To put it simply, without this basic work the rest of the program parameters are not effective.
2. *Culture of the organization and medical staff***.** To quote a common aphorism, "culture eats strategy for breakfast." Culture includes such aspects of organizational life as shared expectations for behavior, communication of expectations to all medical staff during on-boarding and re-credentialing, consistency in accountability for behavioral deviances, recognition for behavior that exemplifies shared values, and intentional programs to thank those whom patients and staff appreciate. Another critical aspect of culture is the provision of voice for the medical staff. This includes basics in communication plans and methods as well as intentional inclusion of physicians in structures such as strategic planning, dyad leadership models, and intentional systems to gather concerns and ideas. Finally, transparency between administration and physicians, as well as between physicians themselves, is key to a successful culture for physician integration.
3. *Learning environment***.** Physicians are lifelong learners. Remaining on the "cutting edge" of the science and art of medicine is also seen as positive to job satisfaction. In this area, the traditional CME/post-graduate training is not the only

important element. In addition, it is important that the culture of the organization recognize not only those physicians who publish but also those who take time to serve through media/social media in structured forums. It is important to recognize this work. It is also vital that the publications/recognitions are well communicated to the medical staff at large. It enhances pride in the work of the organization and inspires others to publish.

4. *Physician personal integration***.** The cliché of the physician as a poor patient is based on reality. This final level of physician integration catalyzes all the others. The integration by physicians of their emotional and spiritual selves and their views of themselves as physician is the heart of this work. This final level of physician integration is critical for all the other elements. Proven structures within the hospital and medical staff can provide a basis for this work, thus improving the physician's personal integration while accelerating the work of all the other dimensions. These structures must include a method to understand the emotional and spiritual inclinations of the medical staff and programs and communication acknowledging and accommodating those inclinations as much as possible. In our experience, facilitated discussion programs with peers strongly correlate with prevention of burnout. Finally, the habit of sending cards or other acknowledgments of personal landmarks (birthdays, births, and deaths) to members of the medical staff from administration and medical staff leadership reinforces a sense of community and caring for physicians.

Programs

We have developed successful programs in each of these areas. Many of these programs have been used in multiple hospitals with great success. Establishing structures in each of the four basic areas is paramount to success; isolated programs will not flourish without the support of the other areas and will thus fail to achieve the desired outcomes. We will review a few examples of structures that help to execute the goals and objectives in each realm of the work.

Quality, Service, and Business Efficiency

1. *Physician Connection Team* (PCT)—Based on a model developed by the Studer (TM) group, a PCT is a team of hospital staff who round on every physician to find what is working well, to seek suggestions for whom to recognize for helping the physician, and to discover an issue to tackle that would improve the physician's work experience. The team has 2–3 business days after rounding on a doctor to refer the problem to the appropriate area, capture the follow-up plan, and relay the information back to the physician. Every month, the group meets to go over the issues they have gathered and to look for systemic trends. An

important follow-through is then given to leadership as a process improvement project. When leaders in the facility receive a topic for improvement, they are given a timeline for completion and are held accountable to that timeline.

Collected physician recognitions create the framework for a thank you note in which the physician who recognized that person is credited and the person who is being recognized is thanked for their work. This model begins a positive cycle of closed-loop communication that improves both physician and staff morale. The issues collected are reviewed at appropriate medical staff meetings to maintain transparency and to help the general medical staff understand that the organization is focused on efficiency in their practice.

2. *Simple Issue Collection*—A "hotline" method of gathering physician concerns provides busy physicians with a communication tool to share systems and processes that are not working. We find that the majority of these hotlines create awareness of problems that would not otherwise be recognized by routine surveillance. The key to the success of simple issue collection is twofold. First, the problems must be delegated and solved in a time frame designated by the hospital. Second, the "closure of the loop" back to the physician must be completed so the physician is aware of the response. The issues submitted by physicians are collected and then shared with medical staff leadership, thereby increasing the awareness that physician efficiency and voice is held in high esteem by the organization.
3. *Quality*—Good physicians are deeply invested in the appropriate care of their patients. Prioritizing a quality agenda with clear goals and clear metrics of progress is therefore fundamental to physician integration. Encouragement of occurrence reporting, effective peer review focused on improving the quality of care provided by all physicians, and physician involvement in process improvement processes are essential.
4. *Service*—The patient experience in a given facility is an important driver of both physician satisfaction and business volume for the physician. Consistent, structured work to improve the patient's experience with both staff and physicians is another fundamental of physician satisfaction. In interviews with hundreds of physicians over the past decade, the vast majority have expressed some version of "wanting to help people" as a reason for their career choice. A satisfied patient provides gratitude back to caregivers. That gratitude reinforces physicians' own deepest reasons for being in this demanding career.

Culture

The most fundamental culture issue is the creation of clear expectations for the hospital and medical staff. Misunderstandings will abound until both employees and physicians are aligned as to the "behavioral norms" of the health system culture. Behavior norms can be established and communicated in several different ways.

1. *Code of Conduct*—Per The Joint Commission (TJC), there must be a Code of Conduct, but a document alone does not create expectations. Cultural reinforcement of expected behavior is what gives life to the concept.
2. *Orientation*—Formal orientation to the mission, vision and values, and behavioral norms of the organization is key at on-boarding. We also use this valuable time to get to know the physicians through structured group discussions. This sets the ethos of the culture as one that cares about them as individuals.
3. *Accountability*—It is necessary to have structures firmly in place that create feedback on deviances from the norm. These structures must be transparent and uniformly applied across the medical staff and employees.
4. *Recognition*—Our research has shown that 99% of the people on our medical staffs are good citizens. Recognition for those who exemplify the behavioral norms of the culture is a powerful positive reinforcement to the culture as a whole. Both written notes and other public recognitions are effective and are appreciated by the majority of the medical staff.
5. *Transparency*—In order to have a strong culture, there must be transparency in relation to how decisions and judgements are made. In addition to clarity on mission and values, it is important that the communication be clear and that "yes means yes and no means no." Even when it is necessary to say "no" to something that is important to a physician, delivery of a clear and transparent message develops trust.
6. *Ethics*—An ethics committee that is active, well trained, and available to guide in difficult situations and a high level of ethics and transparency in business transactions generally promote a strong positive culture.

Learning Environment

Most physicians love to learn and to excel in their work. Additionally, most specialty societies and many states now require ongoing education. These factors, coupled with the explosive increase in research and medical knowledge, make intentionality in providing education a key factor to physician integration. Structures that support this area include the following:

1. *CME*—This can be provided through in-person conferences or online opportunities. Increasing the flexibility in availability increases the engagement of off-campus and night-shift physicians.
2. *Multidisciplinary learning*—Multidisciplinary rounds, "medical moments" at the start of a shift, service line case conferences, and huddles all present opportunities for physicians to be both teacher and student and to create additional teamwork and open communication that can provide learning throughout the care process.
3. *Graduate medical education*—Many high-performing physicians enjoy the opportunity to teach medical students, residents, and fellows. Establishing

opportunities to support this desire can vary from maintaining a residency program to establishing affiliations and medical staff office structures that facilitate visiting students and residents.
4. *Personal development*—Physicians are key contributors to the service lines and cultures of hospitals. Leadership skills are often not covered in depth in medical training. Formal leadership training classes prioritize the culture of teamwork and give physicians satisfaction by improving their effectiveness in an increasingly team-based profession.
5. *Library*—Whether provided online or in a room, physicians identify an available library as important both to assuring the quality of the patient care and improving physicians' enjoyment of their work.

Physician as a Person

This is an area we have spent the last 10 years researching while also developing pilot programs to support the work. The hospital/medical practice is the place where physicians spend a majority of their waking hours. We do not think of work/life balance as the end goal. As in most professions, there is not a realistic way to balance that equation and have a viable income. Instead, we believe work-life integration should be the goal. We define work-life integration as creating a meaningful whole out of many individual components. Several evidence-based methods are available to support physicians in achieving this goal.

1. *Facilitated Discussions*—Early research in a medical group in Nebraska suggests that a facilitated discussion with peers is more effective than any other structure in improving physician well-being. Partnering with Lumunos, a 90-year-old faith-based nonprofit that for the past 10 years has been supporting the physician vocation (physicians.lumunos.org), we created a facilitated discussion program for medical staffs. The groups, open to all medical staff members, meet with a trained facilitator once a month for an hour. The facilitator uses topics identified by the medical staff as important to create the core for the next month's conversation. In multiple different medical staffs, the confidentiality and collegiality of these conversations created a dynamic that literally changed the culture. In implementing these groups, we initially focused on the "good guys/gals" of the staff, as they are the ones who generally take advantage of this opportunity. The topics range from personal to professional.

   This reinforcement of what is best about the culture decreases the frequency of deviance from cultural norms among the rest of the medical staff. It is said that it takes only the square root of the active members of a group to change a culture. In our experience, this has been true. In a medical staff of 200–300 physicians, we generally see 15–20 physicians participating in at least two 1-hour discussions a year at these meetings. In one hospital, we experienced a 90% decrease in the occurrence of behavioral issue after a year of the program.

2. *Email Discussions*—Many of our medical staff are unable to come to on-site meetings. We use an email version of the topics, sent out weekly, to engage the physicians off-site. Physicians have responded with great enthusiasm to this mode of connection as it allows them a moment of self-reflection at a time convenient to their schedule. Our facilitators are then available to respond to email thoughts sent back to them from the physicians.
3. *Meaning In Medicine* (*TM*)—This structure involves a gathering of a small group of physicians to talk about a topic in medicine at a physician's home. We use our facilitators to help guide the discussions. These gatherings are also reported by members of the group to be meaningful and to contribute to well-being.
4. *Physician Vitality*—Loma Linda University has developed a robust program to actively support the physical and emotional health of their students, residents, and faculty. The program spans the continuum mentioned above. In addition, the Loma Linda programs provide reflective feedback to simulated difficult patient situations and organize rounds geared to the spiritual and emotional needs of patients. These opportunities help students and attending physicians address their own reactions and they also inform structured responses to areas of need in the community. One constructive program resulting from a startling need that was uncovered at Loma Linda is a program for women students and residents in abusive marriages.
5. *Spiritual Acknowledgement and Support*—We have diverse medical staffs whose spiritual lives are key in their personal integration. An inventory to assess the cultural and spiritual needs of the medical staffs and assurance that the necessary resources are available for all physicians to have the ability to engage their spirituality are both important. Most of these needs are basic: a quiet and private place to meditate/pray; an acknowledgement that their traditions and spirituality are an important aspect of their lives. Chapters 17 and 18 in this volume address attentiveness to spiritual needs in multi-faith contexts.

In this article, we provide a high-level overview of structures we have deployed in different combinations at multiple institutions. At the two institutions where we have data, we have seen double-digit increases in physician satisfaction within a year of implementation. In addition, we have been privileged to hear numerous poignant stories of physicians who point to this work as "changing their lives." We invite you to use this model to create an integrated environment for the physicians in your community.

The Coalition for Physician Well-Being is an organization formed 6 years ago to study what helps physicians thrive and integrate their lives to a meaningful whole, rather than limiting our focus and study to the causes of burnout. We know that it is an honor and privilege to be a physician and to be trusted to be a part of the most personal aspects of the lives of the people we serve. We continue to work to provide research and leadership to our field because we imagine a future in which all physicians have the structures and support to be whole persons in caring for the patients we all serve together.

Chapter 5
Physician Accountability and Medicus Integra©

Ted Hamilton

Medicine is, at its center, a moral enterprise grounded in a covenant of trust.

– Stern and Papadikis (2006)

It's a sad and scary story culminating in a nearly million dollar fine and revocation of a medical license. It is also the end of a story that began with poor academic performance in residency training, followed by arrest for possession of cocaine and charges of inappropriate use of drugs. This doctor's medical career was associated with dozens of malpractice suits and peer review findings of multiple unnecessary operations. Charming and financially successful, his career ended abruptly following two decades of "chronic and dangerous malpractice" (Jones et al. 2005).

How could this happen? How could it have been allowed to continue for so long? Who was responsible for monitoring this doctor's performance? How could it have escaped the attention of medical staff peer review? How could his specialty's professional society and board have missed what was happening? How could his license to practice have been renewed time after time? How could he have obtained professional liability coverage? Who was looking out for his patients?

This is a particularly egregious case. It doesn't happen every day, does it? Yes and No. Yes, the magnitude of this true story is breathtaking, but it is mistaken to conclude that "it" doesn't happen every day. In 2014, a dozen doctors a day had their medical licenses limited, suspended, or revoked, for a total of 4043 serious disciplinary actions across the country. Is our system of physician accountability adequate? If not, what is needed?

A quick search of the Internet reveals a multitude of similar stories, sharing substance if not scope: unnecessary procedures, fraudulent billing practices, inadequate record-keeping, lack of professionalism, incompetence, and deception in advertising. Most of the time, it didn't come as a surprise; someone knew about it. Generally,

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this behavior does not go unnoticed, but it is often denied, ignored, or overlooked. Those who are in the know fail to take responsibility for confronting and reporting aberrant behavior and initiating corrective action. In that failure, we neglect our patients, our profession, and our troubled colleagues.

This is not a new problem. In 1803, Dr. Thomas Percival wrote, "Let both the Physician and Surgeon never forget that their professions are public trusts…which they are bound by honor and probity to relinquish as soon as they find themselves unequal to adequate and faithful execution" (Percival 1803). Dr. Percival seems to call for self-monitoring, encouraging his physician colleagues to be aware of their limitations and have the foresight, integrity, and courage to take responsibility for their own practices and behavior.

Some 80 years later, the Supreme Court of the United States argued for medical licensure to afford the protection of society by the State, finding that "[f]ew professions require more careful preparation by one who seeks to enter it than that of medicine…comparatively few can judge of the qualifications of learning and skill (the physician) possesses" (Thompson and Robin 2012). Another four decades passed before the Health Care Quality Improvement Act was signed into law, establishing the National Practitioner Data Bank and encouraging low-risk peer review among physicians. This resulted in growth of oversight by health professional regulatory agencies to improve the quality of patient care (Thompson and Robin 2012). Over 200 years have passed since Dr. Percival's call for a greater sense of personal responsibility in the interest of quality patient care. Efforts have been made and continue to be made to hold ourselves accountable as individual physicians and as a profession.

In the spring of 1974, I applied to the state of North Carolina for my first license to practice medicine. By that time, I had already experienced the influence of organized efforts to ensure accountability in medicine. I had been accepted to medical school four years earlier by virtue of sound performance in my undergraduate studies, an acceptable score on the Medical College Admissions Test (MCAT), and attestations of good character and citizenship. In the course of my medical school career, I had passed National Boards Part One covering basic science and Part Two over the clinical sciences. During my internship, I also passed Boards Part Three, and upon successful completion of one year's post-graduate training, I was eligible to apply for licensure. I made a cursory, required, in-person appearance before the Board in session at Pinehurst, North Carolina. In due time, I received my license and went to work in a small mountain hospital with a total of three doctors on staff.

A medical license in the United States is an undifferentiated license to practice medicine. It is the responsibility of state medical boards to protect the public through licensure of medical professionals, establishing standards for medical practice, and removing incompetent and unfit physicians. Among the most common reasons for suspending, restricting, or revoking a medical license are unprofessional conduct, negligence, substance abuse, fraud, and sexual misconduct (Thompson and Robin 2012). On average, about 10–12 physicians lose their licenses each day in the United States, a total of just over 4000 in 2014 out of some 900,000 practicing physicians in the country or less than one-half of 1% overall (Chaudhry et al. 2012).

Following 3 years of medical practice and having fulfilled continuing medical education requirements, I qualified to take the examination for certification by the newly established American Board of Family Practice (ABFP). It was a 12-hour written examination spread over 2 days. Within a few weeks, I received notification that, having passed the exam, I was now a board-certified family physician. The ABFP was the first specialty board to require periodic re-examination to retain certified status, so I took (and passed) boards a total of five times over the next 30 years or so.

Specialty boards have matured and grown in sophistication over the decades. Today, their emphasis is on ongoing education, continuous assessment, and comprehensive review. Some specialty boards are moving toward a model termed "Maintenance of Certification" or MOC. MOC addresses six distinct elements of practice, including the following (Thompson and Robin 2012):

- Medical knowledge
- Patient care and procedural skills
- Interpersonal and communication skills
- Professionalism
- Practice-based learning
- Systems-based practice

Not all doctors are happy with the MOC method of accountability, citing the significant time commitment to complete the requirements, the financial cost of the process, the relevance (or lack of it) to an individual practice, and questionable overall efficacy of MOC outcomes. In addition, some complain about the amount of revenue generated by the governing organizations (Tierstein 2015).

Notwithstanding physician concerns, there remains a sense that professional societies rightly own a significant responsibility for physician accountability. Dr. Edmund Pelegrino writes, "…Physicians (must) justify the claim to the moral integrity that patients expect. The present dilemma provides an opportunity for professional medical associations to shift the balance from self-interest to the interests of patients" (Pelegrino and Kelman 1999).

There are those who argue that the malpractice tort system in the United States provides a reasonable check on irresponsible medical practices. However, despite well-publicized lawsuits and large financial penalties and settlements, the data fail to demonstrate a significant impact of professional liability on physician practice and quality of care. "The societal goals of malpractice litigation are compensation of those wrongfully injured, identification and discipline of bad doctors, and consequent improvements in the quality of medical care…The malpractice tort process does little to accomplish any of these goals" (Jones et al. 2005).

Today, physician accountability has entered the public arena. Publications including *Consumer Reports* and *ProPublica* publish comparative data on physicians and medical practice. The Center for Medicare and Medicaid Services (CMS) provides a readily available online service to CMS recipients, *Physician Compare*, designed to give consumers comparative information regarding selected elements of preventive and therapeutic practice for physicians who provide care to CMS patients.

The most personal, direct, real-time, and practical agent for assessing physician performance remains the hospitals, clinics, and related practice settings where physicians care for patients. Beginning with the documentation of credentials, health, character, experience, and prior practice history at the time of application for privileges, organizational responsibility includes quality and safety of care, patient experience, professionalism, and work performance standards, all within the purview of a formal peer review process.

Professional peer review is not an easy process. The reasons are complex, but the essence of this challenge is most clearly demonstrated by relationships. How can I hold my longtime mentor accountable? How can I question the surgical skills of my close friend? What gives me license to ask my practice partner about her marriage, or her health, or her lack of attention to her medical records? What will be the reaction if I question the appropriateness of care provided by one of my most faithful referral sources? And what if my suspicions are mistaken? What if my former colleague threatens legal action? It is difficult for physicians to hold each other accountable.

But this is our responsibility. We must do it because we know. We know our calling. We know good care and professional behavior when we see it. We know when skills are slipping, we know when cognitive abilities are failing, we know when behavior is aberrant. We know our duty. If we don't do it, others will and, in fact, professional accountability is being taken out of our hands.

Medicus Integra©, a survey-based recognition program sponsored by the Coalition for Physician Wellbeing, is designed to help hospitals and physician groups develop an intentional, comprehensive, and coherent approach to physician wellbeing. Physician accountability is a core construct of the Medicus Integra© philosophy, as evidenced by the pervasive presence of accountability principles throughout the survey criteria:

- We believe that lifelong learning is an essential requirement for delivering quality patient care, and we support efforts to facilitate the dissemination of accurate clinical information and current best practices at every level of training and practice.
- We believe that monitoring the quality, safety, and personal experience of patient care is essential to improve care and reduce inappropriate variability, and we support efforts to refine the applicability, precision, and timeliness of data collection, analysis, and communication.
- We believe that the nature of medical practice with ever-increasing specialization and geographic isolation contributes to professional isolation and fragmentation of care, and we support efforts to promote physician collegiality and teamwork across the clinical spectrum.
- We believe that physicians have a responsibility to protect patients by caring for themselves and for each other, and we support efforts to bolster the integrity and effectiveness of medical peer review through leadership training, professional mentoring, peer coaching, and sound partnership with administrative colleagues.

"Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interest…Physicians are called upon to discuss, defend, and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed" (Stern and Papadikis 2006).

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Chapter 6
Respect

Ted Hamilton

What I did was wrong. I know it now. I knew it then. But I chose to do it anyway. I was a junior medical student on surgery rotation at a community hospital that was affiliated with the medical school. My attending physician seemed to delight in demeaning medical students under his supervision. He asked questions that students would not have been expected to answer adequately. He criticized their admittedly immature and awkward surgical skills in a humiliating manner. He rarely demonstrated real interest in their learning. Assisting him at surgery was an exercise in fear, inadequacy, and shame. So, one day, I simply stayed away. I didn't show up to assist at a scheduled procedure. I knew I wasn't really needed, and I was unwilling to subject myself to another dreary episode of abuse.

The surgeon confronted me following the procedure, and I told him why I had chosen to ignore my responsibility. The incident was reported to the school, and I had opportunity to discuss it with the dean. I can't recall that it had a detrimental effect on my assessment for that rotation, but it had a lasting impact on my training experience. I had been treated with disrespect and had responded in kind.

A 2008 study out of Wellington, New Zealand, was designed to explore factors contributing to professional relationships between doctors and nurses working in rural primary care clinics. At the time, New Zealand healthcare was responding to several major restructuring initiatives that placed the entire system under considerable stress. A total of nine doctors and nine nurses were interviewed. "The importance of mutual respect for each other and importance of trust in ongoing professional relationships (not only between doctors and nurses, but also between nurses and nurses, doctors and doctors, and/or with other team members) were prominent in the talk of both nurses and doctors. Notions of respect and trust occurred and re-occurred in the talk of all but two of the interviewees" (Pullon 2008).

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It became clear as the New Zealand study progressed that the concepts of respect and trust are closely associated with each other and are significantly related to professional competence. In fact, the notion of competence seemed to underpin interprofessional respect. As one nurse stated, "respect and competence go hand in hand." A doctor acknowledged that if nurses are competent in an area of practice, they have "a right to professional respect from doctors." Competence was discerned to be a prerequisite, but not a guarantor, for the development of respect and trust. "Trust," the article concluded, "had to be developed and earned between individuals" (Pullon 2008).

The New Zealand article included the diagram below (Fig. 6.1), illustrating the author's perception of the relationship between competence, credibility, respect, and interprofessional trust.

If this diagram is correct, a predictable sequence can be identified in the development of interprofessional respect and trust. Professional competence, demonstrated over time, contributes to credibility, which in turn builds mutual respect, eventuating in interprofessional trust.

Writing for the American Association of Critical Care Nurses, Cynda Rushton states that, "[d]emonstrating respect is the hallmark of excellence in critical care practice," adding that, "[c]ritical care nurses have identified respect as a key

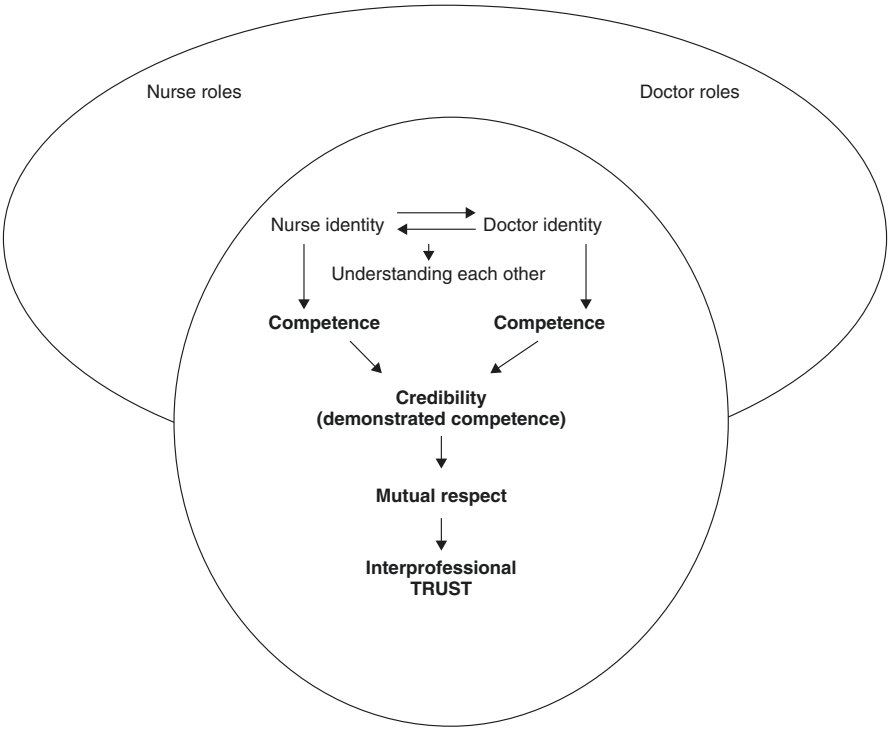

Fig. 6.1 The development of interprofessional trust

component of communication, collaboration, and in valuing the contributions of nurses" (Rushton 2007).

The dictionary and thesaurus illuminate the word "respect" as follows:

- Respect (n): high esteem; courteous or considerate treatment. (Morehead 2006, p. 604).
- Synonyms: appreciation, dignity, regard (Princeton Language Institute 2005, p. 707).

These particular definitions and synonyms suggest a number of thought-provoking questions for healthcare providers:

- Do my interactions with others—patients, colleagues, nurses, staff, residents, and students—communicate a sense of honor and esteem?
- Are my words and actions consistently courteous and considerate?
- Do I express appreciation for the skills and contributions of others?
- Do I treat others with dignity, even in awkward and sensitive circumstances?
- Do I acknowledge the contribution of all members of the team (including patients and families) as valuable?
- If asked to assess and comment on my personal attitude and behavior, how would my associates, colleagues, and patients respond to the above questions?

Respectful behavior is not always easy. It may not seem to be the most efficient way to handle an emergency situation. For some people, respectful words and actions don't come naturally. The truth is that some individuals and some situations are just difficult.

David M. Boyd, MD, tells the story of a patient whom he cared for as a medical student "in the most decrepit hospital in the roughest neighborhood" of a major American city. "Zeus," as Dr. Boyd calls him, was "a mammoth character standing 6 feet 8 inches and weighing nearly 400 pounds." His diabetes was out of control, gangrene had developed in the few remaining toes of his right foot, and he was eating a Snickers bar (a staple of Zeus' diet) when Dr. Boyd first walked into his room. Insulin management was instituted, he had surgery on his toes, and he was encouraged to give up smoking.

Zeus had lots of visitors, as many as 15 a day. Dr. Boyd was impressed with Zeus' ability to forge lasting relationships, until he stumbled upon the realization that Zeus had simply transferred his illicit drug business from the city street to his hospital room. Young Dr. Boyd blew up, "How dare you! Pack up and get out!" Contrite and apologetic, Zeus pleaded for mercy, took out his cell phone, made a call, and within minutes, his "business associate" arrived to remove the paper bag containing Zeus' remaining pharmaceutical inventory to a location outside the hospital.

"Over the next ten days," Dr. Boyd relates, "we formed a respect for each other." Boyd learned more about Zeus: about his drug-ridden childhood and adolescence; about the old battered Cadillac that served him as home and business office; about his fast-food nutritional fare and access to gas-station restrooms for personal needs. "The bond that formed between Zeus and me was unanticipated, but undeniable,"

Boyd writes. When Dr. Boyd was attacked on the unit by a schizophrenic male patient with advanced HIV, it was Zeus who came to his aid, pegging the unstable and violent patient in the middle of the forehead with a flying Snickers bar, before giving the candy bar to the now subdued patient as a reward for returning to his room. A few days later, Zeus was discharged from the hospital, but not before reassuring Dr. Boyd, "I put a good word out there for you, doc. No one will mess with you. See ya" (Boyd 2011).

> "As physicians, we affect every single person who walks into our office, whether we realize it or not. More importantly, however, every single person we see affects us, shaping who we are, and sometimes even changing the course we thought we were on. Not everything in medicine is as it seems, not everyone fits nicely into a standardized treatment regimen, and sometimes the most unconventional of situations requires the most unconventional of treatments. We are treating people, not diseases, and sometimes that requires us to shift our focus." (Boyd 2011, p. 81)

An article from the *Nursing Science Quarterly* describes "feeling respected-not respected" as applying to patterns of relating with managers, colleagues, other health professionals, patients, and family members of patients. Participants in a study underlying the article spoke about feeling respected when "feeling listened to," "feeling revered for their knowledge," "being honored," or "feeling trusted." By contrast, they described feeling not respected when they were "disregarded, not revered, not trusted, not supported, or not recognized" for their contributions. Likewise, they felt not respected when they "overheard hurtful conversations" or persons "speaking in a tone of voice that is demeaning" (Bournes and Milton 2009).

> "Listening is what matters. That's respect." (Bournes and Milton 2009)

Disrespect can have an adverse impact on practice economics. Karen Childress writes, "Here's something you can take to the bank: it's less costly to keep the patients you have than it is to constantly be looking for new ones to fill the appointment schedule." Urologist Neil Baum, MD, agrees that there's not much that can be done about patients moving away or changing insurance providers, but "when dissatisfaction results in patients leaving (a practice), doctors need to know about and solve (the issue)." Practice manager Bill Bristow says that patients rarely leave because of quality of care concerns, "It's the wait time, the rude staff, the inability to get on the schedule." Internist Audrey Corson adds that patients who leave do so because "they didn't feel paid attention to, that the doctor didn't give them enough time or wouldn't answer their phone calls" (Childress 2011).

It all comes down to patients' perceptions of a lack of respect on the part of physicians and other caregivers. Unanticipated wait times, rudeness, delays in scheduling, lack of time and attention, and communication failures—whether intended or not, whether avoidable or not, and whether incidental or habitual—these behaviors communicate disrespect for another individual, a failure to convey honor and esteem, and a failure to treat others with courtesy and consideration.

> "The key is to not have patients leave the practice because of simple misunderstandings, poor office policies, or for reasons you never know about. Whenever patients leave your practice, find out why and then fix the problem that caused them to vote with their feet." (Childress 2011, p. 54)

I'll never forget Dr. Muehler (not his real name). I was assigned to his general surgery service as a first year family practice resident in the early 1970s. Dr. Muehler was short of stature, but large in virtually every other way. He was a busy and accomplished surgeon working at the peak of his career, confident, assertive, rarely mistaken, and never in doubt. He was a good teacher, demanding, but professional, in his approach to young physicians. With patients, Dr. Muehler was direct and authoritative, somewhat paternalistic, occasionally abrupt, but, overall, considerate of their needs and desires.

Ward rounds with Dr. Muehler were very different: an experience not easily forgotten, a daily primer in the practice of disrespect. His approach to nurses and other support staff was condescending, rude, and humiliating. He regularly and routinely blamed the unfortunate rounding nurse for every mistake or break in protocol, real or imagined. He did so publicly, in a loud voice, using language liberally laced with profanity, and clearly intended to intimidate the entire unit. Nurses sought to avoid Dr. Muehler. Failing that, they tried to ignore his excesses to the extent possible. It was never easy. His blustering and blistering behavior was an ongoing burden to nursing morale and, ultimately, a detriment to patient care. That was 40 years ago, and, while I recall my time on Dr. Muehler's service with appreciation, I have no respect for his treatment of nurses and staff. I'd like to think that the behavior exhibited by Dr. Muehler would no longer be acceptable in hospitals and clinics today, but would be firmly and professionally addressed.

Dr. Lucian Leape, adjunct professor of health policy at Harvard School of Public Health, would disabuse us of the idea that disrespect is a problem now relegated to the past. Writing in *Academic Medicine*, Leape and others recognize disrespect as an ongoing threat to patient safety because "it inhibits collegiality and cooperation essential to teamwork, cuts off communication, undermines morale, and inhibits compliance with and implementation of new practices." He identifies nurses and students as being particularly at risk, but avers that "disrespectful treatment is also devastating to patients…and contributes to turnover of highly qualified staff" (Leape et al. 2012a).

> "We propose that disrespectful behavior is the 'root cause' of the dysfunctional culture that permeates health care and stymies progress in safety…A culture of disrespect is harmful for many reasons, but it is its effect on patients that makes it a matter of urgency." (Leape et al. 2012a, pp. 845–846)

According to Leape, disrespectful behavior may be classified in six fairly distinct categories, as follows (Leape et al. 2012a).

- Disruptive behavior: Inappropriate conduct that that interferes with delivery of quality care. Examples include profane language, loud arguments, demeaning comments, and simple rudeness.
- Humiliating treatment of subordinates: Abusive, demeaning treatment of nurses, residents, and students, including belittlement, harassment, intimidation, and being ignored.
- Passive-aggressive behavior: A pattern of resistance to performance expectations, for example, unwarranted criticizing, blaming others, refusing tasks, and failing to follow through.

- Passive disrespect: Uncooperative behaviors, such as showing up late to meetings, failing to maintain current medical records, and resisting safe practices.
- Dismissive treatment of patients: Failing to answer questions, explain procedures, or communicate in a manner patients can comprehend.
- Systemic disrespect: Prolonged wait times, duplicative documentation requirements, difficulty obtaining accurate and timely information, and self-protective response to medical errors.

However disrespectful behavior is classified, we've all experienced it, and we all know it when we see it. And we know that our behavior has consequences that directly impact patient care. Kathryn Kaplan, describing the current healthcare environment as "relationally depleted," writes that "health care providers who respect one another simply do better than those who do not" (Kaplan et al. 2010, p. 496). Lucian Leape states, "Without mutual respect and a sense of common purpose, people cannot and will not work effectively together." He proposes that "creating a culture of respect is the essential first step to becoming a safe, high-reliability organization… Mutual respect," he emphasizes, "must be the explicit expectation" (Leape et al. 2012b).

> "…Respect is like air. If you take it away, it is all people can think about." (Patterson et al. 2002, p. 71)

What does respect look like when dressed in scrubs and armed with a stethoscope? Earlier in this article, I used the words honor and esteem, courtesy and consideration, and appreciation and acknowledgement to describe respect. Cynda Rushton, writing from the perspective of a critical care nurse, explains it this way, "Respect is expressed in how we care for our patients and their families…when we give individuals respect, they experience a sense of worthiness, of being seen and heard. We demonstrate respect by our words, deeds, and behaviors, when we honor another's choices, preferences, and boundaries for privacy" (Rushton 2007).

How do we go about creating a culture of respect in our hospitals and clinics? This is not the place for a detailed treatise on culture change. Suffice it to say that incorporating a culture of respect requires commitment from the top down and throughout the organization. No one gets a bye. Doctors, nurses, and administration—everyone must be on board. While strategies and tactics will vary from one institution to another, planning and intentionality are essential. Policies and procedures must be developed and operationalized. Education and training must be deployed so that everyone understands the focus and direction. Champions should be identified and acknowledged and detractors and dissemblers held accountable. Persistence and reinforcement are essential. Progress should be regularly measured and reported to appropriate committees and ultimately to the board of directors.

I began this chapter acknowledging the importance of respect and trust in building a safe, effective, and productive healthcare team. I sought to help us understand the nature and contribution of a culture of respect in healthcare and to explore the

character and importance of trust between and among healthcare professionals. Respect in all its dimensions is at the very foundation of excellent health care.

> "Respect is foundational to all…relationships. Every encounter with patients, families, and our colleagues is an opportunity to demonstrate respectful engagement, communication, decision-making, and understanding. In our relationally-depleted healthcare environments, we must strive to create a workplace that creates authentic and respectful norms among patients, families, and healthcare professionals." (Rushton 2007)

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Chapter 7
Trust

Ted Hamilton

Trust in another person is essential for human coexistence.
– Hillen et al. (2011)

My shift begins at 11:00 AM. Activity is picking up in the emergency department at Mountain Memorial Hospital.

My first patient is a 17-year-old boy who was thrown from his mountain bike while negotiating a sharp downhill turn between two boulders. He is alert and responsive despite having fractured his helmet upon hitting the ground. He is complaining of pain in his right shoulder and mild shortness of breath. An exam reveals multiple abrasions and contusions on his right arm and right thorax.

My second patient is a 57-year-old business man from Florida who experienced the acute onset of crushing, left-sided chest pain, shortness of breath, sweating, and dizziness while fly-fishing along the bank of the mountain stream that runs through our alpine valley village. He called 911 and the EMTs responded within minutes, administering oxygen, aspirin, and sublingual nitroglycerin, while also forwarding an EKG to the ED, revealing typical ST-segment elevation in the anterolateral leads.

My third patient is a 37-year-old mother of three whose family flew in yesterday from New Orleans for a week-long vacation in the mountains. She complains of the gradual onset of moderate, throbbing, bifrontal headache, nausea, weakness, and dizziness, beginning a couple of hours after landing. Because of her symptoms, she has had little to eat or drink in the past 12 hours, and hardly slept at all last night.

It's not an atypical morning in the ED at our small mountain hospital. Three patients with three distinct presentations: all on vacation and all presenting with acute, potentially serious, symptoms and signs. All have placed their trust in our team.

Trust implies both vulnerability and risk, as exemplified by my three patients. They are each vulnerable because of their illnesses and injuries, their inability to care for themselves without the assistance of others, and their lack of clinical knowledge,

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skills, and resources. They are each at risk due to the potentially serious nature of their conditions, their lack of experience with our hospital and healthcare team, and their lack of options for care in their urgent time of need.

So here are my three patients, sick and hurt, away from home and familiar surroundings, placing their trust in our team to care for them. Trusting in our education and training, our experience and skills, our resources and commitment. Trusting in our willingness and ability to communicate effectively and work together collaboratively. Trusting that we will be able to relieve their pain, accurately diagnose the etiology of each illness and injury, and provide prompt and appropriate treatment.

Trust is a simple word. *Webster* defines trust as reliance on the integrity and veracity of a person, or confident expectation (Morehead et al. 2006). Roget's *Thesaurus* supplies these synonyms: assurance, confidence, expectation, faith, and reliance (Kipfer 2005).

But trust is an elusive concept to define with scientific precision. Trust has been described by one author as "challenging and far from straightforward" (Goold 2002). Another suggests that trust is an "ambiguous scientific concept" (Hupcey et al. 2001). A third uses the words "a complicated, multidimensional construct" (Pearson and Raeke 2000). Researchers often opine that the lack of a clear, unified definition makes it difficult to compare research studies on the topic of trust. Having said that, we all have an intuitive understanding of trust; we know it "when we see it" and when we experience it, when we have opportunity to place our trust in others, and when others view us as persons worthy of trust.

A useful definition, minor variations of which are frequently found in medical literature, states that trust is the expectation of the patient that (caregivers) act in a manner that keeps the patient's best interest as a priority (Graham et al. 2010).

To seek the patient's best interest is a noble aspiration, even a moral obligation (Dinc and Gastmans 2012), some would propose. But this lofty intention is not easily operationalized in the healthcare milieu of the twenty-first century. The economics of medical practice demand levels of caregiver productivity and efficiency that place significant pressure on the quantity and quality of time and attention devoted to each patient. While most physicians attest that the practice of clinical medicine and the opportunity to care for patients remains meaningful and fulfilling, many decry what they perceive as encroaching bureaucracy with its twin burdens of increasing operational complexity and burdensome documentation. Time is compressed and relationships are compromised.

The precise definition of trust may be subject to some debate, but there is no disagreement as to the importance of trust in the delivery of safe and effective medical care. Although expressed in various ways, the underlying message is clear and consistent.

- "Trust is an *important* aspect of physician-patient interaction, both in terms of compliance and…outcomes" (Ommen et al. 2008).
- "Trust is an *essential* element in physician-patient interaction fostering…adherence and improving…outcomes" (Thum et al. 2012).
- "Trust is at the *core* of building an effective patient-physician relationship" (Jones et al. 2012).

- "Trust is…particularly *central* to the patient-physician relationship" (Pearson and Raeke 2000).
- "Trust is a *fundamental* component of the patient-doctor relationship" (McKinstry et al. 2008).
- "Trust is a *key* component of the patient-doctor relationship" (Berrios-Rivera et al. 2006).
- "…Trust is an *essential* element in nurse-patient relationships" (Rogers 2005).
- "Trust is *essential* to human relationships and is critical to both human development and life itself" (Dinc and Gastmans 2012).

Important. Essential. Central. Core. Key. Fundamental. It's difficult to escape the conclusion that trust is at the heart of relationships that contribute to quality medical care. How are trusting relationships between and among healthcare professionals, patients, and families established and nurtured? How do we create a healing environment founded on mutual trust?

An article by Pearson and Raeke (2000) states that "there is not a single published article to date of a successful intervention that has measurably improved patients' trust in their physicians." A 2008 article from the Cochrane Collaboration agrees: "It is not clear if there are interventions known to be effective in enhancing patient trust in physicians" (McKinstry et al. 2008). Given the lack of a unified definition, and the difficulty agreeing on standard measures of trust, perhaps it should not come as a surprise that there is little proven and published information regarding interventions that reliably establish trust. It may be helpful to note that not everything that is deemed true can be proven, and that some things considered proven may not ultimately meet the test of truth.

While not constituting scientific proof, the medical literature is replete with references to what might be termed contributors to, or determinants of, trust. Demonstrating a significant thread of consistency and broad agreement, the following Table 7.1 lists a sampling of these trust-promoting dimensions of provider behavior.

Table 7.1 Behavioral characteristics contributing to interpersonal trust in the clinical setting

Fiscella et al. (2004)	Graham et al. (2010)	Pearson and Raeke (2000)	McKinstry et al. (2008)	Thom and Campbell (1997)
Competence	Competence	Competence	Competence	
	Communication	Communication	Communication	Communication
	Caring	Compassion	Compassion/ empathy	Caring/ understanding
Honesty			Honesty	Honesty
Confidentiality		Confidentiality		
		Dependability	Dependability	
		Reliability	Reliability	
			Partnership	Partnership
Acting in patient's best interest	Continuity of care		Respect	Listening

Competence, communication, and compassion/caring, each present in four of the five references, appear to constitute essential components of trust-building behavior. Honesty is referenced in three of the articles, while the concepts of confidentiality, dependability, reliability, and partnership each show up twice.

Competence is often tacitly assumed in the clinical encounter. Skirbeck (2009) writes that "Trust prevails in a taken-for-granted-manner in normal consultations." The three patients profiled at the beginning of this chapter have a right to expect that the healthcare professionals on duty in the ED have been properly educated and trained and are competent to manage their presenting injuries and illnesses. A moment of crisis affords a patient no opportunity for assessing the qualifications and capabilities of healthcare providers. Degree-granting institutions, certifying boards, licensing bodies, medical staff reviewers, and hospital boards of directors each play an essential role in assessing and confirming the competence of health professionals. Healthcare professionals also have a responsibility to each other, and to our patients, to monitor provider performance and to uphold safety and quality standards.

Peer review processes exist to provide ongoing vigilance for instances of clinical performance that provoke questions regarding competence. Often fraught with thorny personal, professional, legal, and financial issues, medical peer review is never an easy process. Trust is critical. Patients must be able to trust that the system will work to assure their safety. Practitioners must be able to trust their colleagues to do peer review work with honesty, sensitivity, and confidentiality. Administrators and boards of directors must trust that the outcome of peer review will reflect the values and maintain the integrity of the institution, not to mention that peer review processes and determinations will be defensible in court.

Communication is an essential determinate of trust. Open, honest, clear, and effective communication provides a foundation for building and maintaining trust. Trust deteriorates in the absence of honest and straightforward communication. One author states, "Sharing information, admitting mistakes, speaking with good purpose, and giving and receiving feedback are examples of behaviors that build communication trust" (Reina et al. 2007). Another writes, "…the ability to communicate clearly and effectively…implies being willing to listen and really hear what is being shared" (Rogers 2005).

Compassion, caring, empathy, and understanding create an environment conducive to effective communication. A familiar quotation, variously attributed to Theodore Roosevelt and to author John Maxwell, states, "People don't care how much you know until they know how much you care" (Goodread 2018). While the substance of that quotation is subject to debate, especially in a setting that requires immediate application of skilled intervention, when "how much you know" is critically important, it nevertheless emphasizes the fundamental importance of relational aspects of the clinical encounter.

> "Never forget that I am a human being." Anonymous intensive care patient (Thum et al. 2012)

Competency. Communication. Compassion. Honesty. Fiscella writes, "Patients base trust in their physicians on a belief that their physician is honest and competent, will act in their best interest, and preserve their confidentiality" (Fiscella et al. 2004). A physician may be renowned for clinical expertise, articulate and fluent in communication, and possess a congenial bedside manner, but if not perceived to be honest, truthful, and forthcoming, the physician will have difficulty gaining the trust of colleagues and maintaining the loyalty of staff and the confidence of patients.

It is more challenging to objectively assess the benefits of trusting relationships between and among caregivers, patients, and families than it is to measure the clinical response to a new antibiotic or innovative surgical technique. However, a growing body of evidence attests to the therapeutic benefit of a trusting relationship, as illustrated in the following Table 7.2.

These references reveal a consensus that trust contributes to treatment adherence, patient satisfaction, and continuity of care, and thereby to improved health and clinical outcomes. Conversely, mistrust or broken trust may contribute to dissatisfaction with care, failure to follow treatment plans, and disappointing clinical outcomes.

Cathy Goodwin is a PhD, author, and marketing consultant who occasionally contributes customer book reviews on Amazon. In 2009, she reviewed the book, *Trusting Doctors: The Decline of Moral Authority in American Medicine*. Identifying herself as an "ordinary person," she closes her review with the following words, "If doctors keep people waiting for hours, expect patients to tolerate a degree of rudeness not accepted elsewhere, and continue to use the word 'patients', they are creating expectations. Simple failure to meet these unrealistic expectations may account for erosion of trust…" (Lee and Lin 2009). While Goodwin does not elaborate on "these unrealistic expectations," her point is clear. Relationships are dependent upon common, everyday behaviors that demonstrate dignity and consideration and build mutual respect and trust.

Trust has been defined by one author as "the process by which barriers to cooperation and compliance are overcome" (McKinstry et al. 2008). Another sees it as "the basis for improved collaboration and excellent clinical outcomes" (Rogers 2005). It is perhaps most cogently stated by Reina, "Trust influences communication, and communication is the lubricant for collaboration" (Reina et al. 2007).

Table 7.2 Therapeutic contribution(s) of trust in the clinical setting

Lee and Lin (2009)	McKinstry et al. (2008)	Fiscella et al. (2004)	Hillen et al. (2011)	Berrios-Rivera et al. (2006)
	Patient satisfaction	Patient satisfaction	Patient satisfaction	Satisfaction with care
Treatment adherence	Treatment adherence	Treatment adherence	Treatment adherence	Treatment adherence
Self-efficacy	Continuity of care	Continuity of care		Preventive care
Clinical outcomes		Improved health	Participation in clinical trials	Health outcomes

My patients—the 17-year-old mountain biker with his fractured ribs and clavicle, the middle-aged executive with an acute anterior myocardial infraction, and the young mother experiencing altitude sickness—all deserve the best care that we are capable of providing, combining competence, confidence, respect, and trust, leading to clear and open communication and effective collaboration, and contributing to the healing process.

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Part III

How to Get Started?

To quote a common aphorism, "The smallest good deed is better than the grandest good intention." Another way of framing that in this context might be: anything you put into place will help some physician. In this section, we hope to share with you the inspiration that we have received across the years along with a framework to help you choose one strategic project as your first step.

Keeping the training and approach of physicians foremost on our minds, our hope is that by sharing how other organizations have approached the journey, the task will seem less daunting. A year from now, perhaps you can share with us the new element you've added to your repertoire.

It is our experience that physicians are deeply grateful when an organization does something for them as people, even if they do not participate or need the offering. The very fact that the organization values them as humans with needs that should be met inspires trust and more wellbeing. Physicians know instinctively that when their colleagues are well, it aids their own wellness by association.

Most of us learn the hard way that perfection is the enemy of good. We hope these roadmaps will help you decide where to start on your organization's journey to wellness and engagement. You may not find the perfect path on the first try—or ever. We are confident you will find a good path, and a good path is better than no path.

Chapter 8
A Single Step and a Thousand Miles

Ted Hamilton

A journey of a thousand miles begins with a single step.
– Laozi (604-530 BCE), *Tao Te Ching*, Chap. 64

Doctors are unhappy. This problem is apparent and well-publicized. There is no longer any question about that fact nor about its growing magnitude. Physicians are disheartened about the practice of medicine, disenchanted with their careers, and discouraged about the future. In growing numbers, they are leaving medicine early, changing careers, and even taking their own lives.

Medical schools, residency programs, physician practice groups, hospitals, and healthcare systems are scrambling to find answers, to learn what can be done to stem the tide, and to turn around this disturbing trend. The existing research provides little help in this regard. However, it is clear that something must be done, and there is growing recognition that institutional initiatives together with personal effort on the part of physicians are more effective than either in isolation.

The Coalition for Physician Wellbeing has been working in this arena for almost a decade. We offer the following simple guide to help organizations take the first steps toward alleviating physician burnout and promoting physician wellness.

1. *Take the first step (together)*

   If you are a physician who is deeply concerned about the wellbeing of your colleagues, step up. Step up first to the senior executive team of your organization and identify a well-respected, well-placed ally who will come alongside and commit to working with you to address this issue. Likewise, if you are a healthcare executive who first becomes aware of the importance of this issue, find a physician who gets it, who is willing to do something about it, and who enjoys the respect of the medical staff. Engage with that physician champion.

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The value of this dyadic structure cannot be underestimated. The physician champion brings commitment, collegial contacts, and credibility. The executive contributes essential relationships, responsibility, and resources. Together, one plus one equals far more than two in terms of potential. Together they can begin to develop a process and move it forward.

2. *Build a team of fellow travelers*

   Identify like-minded people who will agree to serve on an action group that will meet periodically to devise a plan for moving forward and agree to support implementation of the plan. The physician wellbeing committee need not be too large, perhaps 8–10 individuals. The size is less important than the composition and level of commitment. The membership of an effective committee may include any, or all, of the following, depending on the nature of the organization:

   - Physician champion (see #1)
   - Senior executive (see #1)
   - Practicing physician(s)
   - Medical staff administrator
   - Senior chaplain
   - Behavioral health professional
   - Physician relations liaison
   - Chief medical officer
   - Others as interested and appropriate

   This action group should meet on a mutually agreeable, regularly scheduled basis. Minutes should be kept and progress tracked and routinely reported to the medical executive committee or its equivalent.

3. *Establish reliable lines of communication*

   The best-laid plans may be crippled in the absence of reliable information. Many organizations are more adept at one-way (top-down) communication than at two-way information exchange. To put it more succinctly, we are often better at speaking than listening. An important early task for the physician wellbeing committee is to assess the signs, symptoms, and vital signs of the medical staff and its constituent physicians. What is the status of our organizational wellbeing? Are there indications of stress and dissatisfaction? Are there smoldering issues that need to be addressed?

   Any number of strategies may be used to open communication channels that may have become corroded and unreliable, including formal surveys, focus groups, open-door practices, and administrative hot lines, to mention a few. The single most important communication commitment is to a rapid, reliable response to identified issues. That doesn't mean that every issue is immediately resolved. What it does mean is that someone hears and responds in a meaningful manner every time, without fail.

4. *Provide coaching and counseling*

   The phenomenon of burnout, while pervasive in the medical profession, shows up most commonly in a few predictable ways, including stress disorders,

relational problems, and mood disorders including anxiety and depression. The frequency and severity of symptoms exhibits along a classical bell curve, from merely aggravating to severely disabling.

Doctors make poor patients, often ignoring or denying early symptoms, then self-diagnosing and self-treating, then engaging in sidewalk consulting with a trusted colleague, before finally seeking professional help the old-fashioned way (or not).

A growing number of organizations are finding value in making "employee assistance programs" (EAPs) more acceptable and accessible to physicians. Coaching and counseling services have demonstrated success in stabilizing difficult situations and providing professional support when needed. It is important to structure these programs in a manner compliant with federal regulations on physician compensation (Stark laws).

5. *Facilitate collegiality*

   Modern medicine, with increased specialization and fragmentation as physicians migrate to exclusively outpatient or inpatient practices, has served to separate and isolate physicians from each other. The physician lounge, which once proved a "professional square" for doctors to meet, eat, decompress, and relax with friends and colleagues, is no longer practically accessible for many doctors. In addition, many physician lounges have recently provided a venue for public posting of physician metrics, comparing individual performance versus peer performance in quality, safety, and patient experience—not a welcome experience.

   Providing a "safe place" for physicians to meet, share experiences, and commiserate over common concerns contributes in real, albeit sometimes subtle, ways to a culture of physician wellbeing. Another time-proven technique for promoting physician collegiality is *Finding Meaning in Medicine*, a program created by Dr. Rachel Naomi Remen, which consists of small groups of physicians meeting together periodically to share a meal and relate personal experiences around a common theme.

6. *Re-engineer the physician workplace*

   A relentlessly escalating burden of regulation and bureaucratic scrutiny has placed increased demands upon physician time and practice efficiency. The electronic health record (EHR) has reduced clinical productivity and encroached on personal time.

   It will take concerted effort on the part of physicians, information technology professionals, and practice managers to creatively design structures and processes to relieve practitioners of time-consuming, nonclinical activities and increase clinical efficiency and productivity.

7. *Design and deploy intentional physician on-boarding program*

   The standard on-boarding program for physicians is minimal at best in most hospitals and practice groups, consisting primarily of credentials, privileges, background checks, verification of practice history, and introductions to risk management, compliance, and other required programs.

Despite the fact that physicians may well be spending most of their waking hours within the confines of the office or hospital, little attention is given to becoming acquainted, orienting to the mission, vision, values, and culture of the organization, and making acquaintance with physician leaders and executives who can answer questions and solve problems. A creative, thoughtful, impactful on-boarding program is a small investment that has the potential to pay huge dividends in mutual understanding, organizational fit, and career satisfaction.

8. *Invest in leadership training for physicians*

   Physicians are clinical and organizational leaders by default. After all, they write the orders, do the procedures, and direct the staff. But their clinical training does not include a leadership curriculum, so they learn by observation and imitation of more senior physicians, and the leadership behavior they come to model may be less than desirable or productive.

   High-performing healthcare organizations are learning the value of well-designed leadership training for physicians. Combined with intentional opportunities to work in a dyadic manner with senior executives on issues of mutual interest and importance, leadership training contributes to better program design within shorter time frames and routinely produces a better product.

9. *Encourage physician-led teamwork*

   The traditional clinical model of the physician as authoritarian "captain of the ship" is slowly yielding to a more inclusive, collaborative model of physician as "captain of the team." Mounting evidence demonstrates the benefits of the team model. Physician-led clinical teamwork has been repeatedly shown to provide superior clinical outcomes, shorten hospital length of stay, reduce cost, increase patient satisfaction, and enhance staff morale.

   Initiation of the team model requires a team effort in its own right. Physicians, nurses and nurse leaders, administration, and related disciplines, such as pharmacists, respiratory therapists, social workers, and chaplains may be included in program planning and implementation.

10. *Embrace the physician's family*

    Three relationships of high value and importance to physicians include (in no particular order) patients, colleagues, spouses, and families. The nature of clinical work with its long hours, urgencies, and emergencies often, and inescapably, places families in a subordinate place of priority in a physician's life.

    The physician wellbeing committee, in consultation with physicians and their families, can collaborate to seek institutional solutions to unpredictable demands and stresses on physician families. Simple measures, such as thoughtful scheduling of required meetings, occasional family-oriented social events, family retreats, and counseling for families in distress are initiatives that have proven beneficial.

Do Something. Today. Make a Start. Make a Difference.

In an interview with Dr. Brent James of Intermountain Healthcare, W. Edwards Deming, American quality expert, stated that culture change does not require

participation of a majority of any group. It only requires the involvement and support of "the square root of n" members of the group. For example, if the active medical staff of a physician group or hospital is 225 physicians, only 15 supportive, committed physicians, working together with executive support, are capable of moving culture in a tangible way.

Engage physician and executive champions, form a physician wellbeing committee, and get underway. Do something. Learn, grow, create, and develop.

You'll make a difference in the lives of physicians and in the life of your institution.

Chapter 9
Physicians, Heal One Another: A Letter to Healthcare Administrators

Peter J. Weiss

The greatest healing therapy is friendship and love.
– Hubert H. Humphrey, Jr.

If you are reading this, you are probably not a doctor. Most likely you are an administrator with responsibility for physician practices or for supporting the medical staff. That can be a tough job in the best of times, but in healthcare today it is especially hard. You, along with your physicians, face relentless pressure to improve service, achieve better clinical outcomes, and lower costs—all while trying to adapt to the latest government initiative designed to force you to change faster. It is a highly stressful environment, for everyone.

As a group, physicians are not handling it all that well. Burnout is epidemic. Divorce and depression are common. Suicide is less so, yet physicians take their own lives at a much greater rate than the population average. It is a crisis. Pretty much everyone agrees on that. But what kind of crisis is it? Many see it as a crisis for the healthcare industry, or their particular healthcare system: "We're losing key workers. How can our hospital recruit and retain physicians?" That is a valid perspective, but I would like to offer you a different view. I suggest you see this a humanitarian crisis. Doctors are first of all people, and these people are suffering.

In my experience as a healthcare administrator, I have found that it is easy to overlook that suffering. In our business meetings, concerned with driving performance, we often refer to "the physicians" or "the medical staff" as a single entity, and we focus on how this supposed entity functions in "our" clinical or business processes. Individual physicians may be seen primarily as units of economic production, and "the physicians" as an operational tool to be used for our purposes. This doctors-as-objects approach results in an "us" against "them" dynamic that only further alienates the already too-stressed doctors.

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Let us agree, physicians are first people—many of whom are not emotionally well—and we want to help them. Unfortunately, helping people is hard, maybe impossible if they do not trust us. You and I are not perfect. We are also people, with our own issues. How is it we can help others? What is our model? How do people get to a place of despair? How do they get out? Each in her or his own way perhaps, but usually it is with help.

Within the spiritual understanding of the Christian tradition, we understand that God creates us as individual persons, but individuals designed for community. People are inherently social beings. It is our nature to need each other. God plans for us to love and support one another, bear each other's burdens, and help each other to face our individual issues.

We get in trouble when we ignore our natural need for help and companionship. Too often our pride prevents us from accepting love and support from our friends. Unwilling to admit our weaknesses or imperfections, we hide our personal problems and our emotional pain, putting up a good front. We say things like, "I'm fine" and maintain outward appearances even as our interior life is falling apart.

Usually it is when we cannot open up, when we try to "keep a lid on it," and when we try to handle it all on our own that our problems worsen. When, finally, the truth is revealed (as it almost always is), it often comes as a great emotional relief, and we can begin to make forward progress. Not without pain of course, but secrecy and self-reliance are typically major impediments to becoming well. When we overcome these barriers, there is new hope.

This can be likened to the physical processes our body uses to eliminate harmful substances. The intestines, liver, and kidneys work together to remove waste and toxins routinely through bowel movements and urination. Occasionally we eat spoiled or toxic food and promptly vomit it right back up. Some things just need to come out of us, and the sooner the better. So, it is with the recurring toxic feelings and thoughts that take us downhill internally. We need to get them out in the open by revealing them to someone else.

Difficulty revealing problems is universal, but it may be especially hard for doctors. There are several reasons for this. The fierce competition for medical school slots increases the selection pressure for acceptance of driven overachievers who pride themselves on their ability to produce top results despite difficulty. Physician training puts a premium on being right. After all, "lives are at stake," and the culture is frequently less than compassionate or even overtly hostile. Lastly, revealing a potential practice impairment—for example, severe anxiety and sadness, poor concentration, or heavy drinking—might result in a report to and action by the professional licensing body.

If you assume that about half of your medical staff is experiencing toxic emotions and other symptoms of burnout, I do not think you will be far off. It is also a pretty safe assumption that most of them have not been able to be completely open about it with anyone. Could you help them talk to someone about how they are feeling? They are unlikely to be vulnerable with you or another administrator. The chaplain might possibly work, but your best bet is another physician.

Observing how people change, the most powerful therapeutic relationships seem to be those of shared experience. Relationships in 12-step programs such as Alcoholics Anonymous or Overeaters Anonymous are prime examples. Not only do these programs work, they seem to be the most (perhaps only) reliable method for overcoming addictions. PatientsLikeMe and Weight Watchers are examples of other groups connecting individuals with shared experiences and goals, and faith-based "small groups" have helped many troubled souls toward wellbeing.

Nothing helps people to listen and feel accepted like the knowledge that the teacher has been there too. The group becomes a "safe space" to reveal oneself. Personal stories shared among the group members are both inspirations and sources of information on what works and what does not. In a setting of love and acceptance, many are able to hear the call to change, act on it, and become well. Whether it is a 12-step group or just a close friend, this "like helps like" phenomenon works. It is powerful. Healing happens in relationships.

> *Friendship is born at that moment when one person says to another: "What? You too? I thought I was the only one."*
>
> – C.S. Lewis

It works for physicians too. Unfortunately, there is no "Physicians Anonymous," and although a doctor may have many professional colleagues, he or she might have few who are close personal friends. Speaking personally, when I was first in practice, I enjoyed numerous friendly relationships with my partners and associates but had no true confidants among them. Your physicians may be in the same boat, and perhaps you can change that.

What could you do to foster close personal relationships among physicians? How could you nurture a healing community (even a tiny one) among your medical staff? I know it sounds like a tall order. You might be wondering, "Should that be *my* job? Am I qualified to do that? Is it even possible?" These are reasonable thoughts, but do not let them stop you. It is nobody's job, but it is a need. There is no harm in trying to meet the need, and who knows what good you could do?

You do not have to have all the answers. Honestly, I do not think you even need to have any of the answers. I believe that the right attitude, trial and error, and persistence will take you far. "Physicians as objects" is a big part of the problem, and a basic mental shift to seeing stressed out human beings rather than objects is the beginning of the solution.

Consider starting by identifying one or more physicians to help you. There will be a few at your institution who are known for being compassionate and being at peace. They have faced adversity and, having grown through it, are prepared to help others along the way. Show them this essay. Better, give them a copy of this book and ask them to help you strategize an approach to physician wellbeing.

There will be no shortage of ideas, some of which will be straight from the other pages of this work. These physicians themselves could serve as informal mentors and coaches, or they could help identify and introduce an outside resource to serve the medical staff (the number of physicians turned coach is rapidly increasing). Beyond funding this activity, the organization should be hands off. Privacy and trust are essential.

One excellent idea is “Finding Meaning in Medicine”, a free program developed by the Remen Institute for the Study of Health & Illness (RISHI) whose mission is “to contribute to healing the culture of health care through innovative educational programs and the formation of supportive communities.”

The program consists of monthly discussion meetings, perhaps with a light meal, where physician colleagues engage in deep reflection and conversation on the experience of being a physician. Individual stories often serve to introduce and illustrate the selected topic, and RISHI has found that “over time, the dialogue within a supportive community of colleagues can have the positive effect of deepening each person’s heart connection to their day-to-day work and to their patients, as well as to their connection to the lineage of medicine and healing.” Find out more at www.rishiprograms.org.

You might also think about the team-building approach you and your firm take with the non-physician staff. Most healthcare administrators work hard to help subordinates find connection and belonging, even intimacy, with the others on the team. What are you doing for them? How could you apply it with the physician staff? For example, many organizations use the Gallup “Q12” Employee Engagement Survey, which includes the following as “Q10”: “I have a best friend at work.” Gallup has this to say about this sometimes-controversial query:

> This item [Q10] also points to the issue of trust between coworkers. When strong engagement is felt in a workgroup, employees believe that their coworkers will help them during times of stress and challenge. In this day of rapid-fire change, reorganization, mergers, and acquisitions, having best friends at work may be the true key to effective change integration and adaptation. When compared to those who don’t, employees who have best friends at work identify significantly higher levels of healthy stress management, even though they experience the same levels of stress. (Item 10: I Have a Best Friend at Work 1999)

Organizational or work unit activities associated with improving this item might include such things as short “ice breaker” or “get to know you” activities at business meetings, regular staff retreats, and encouraging taking lunch together. All of these could have application within your physician community.

I will not continue with more ideas as every organization is different and you can develop plenty of them with your team. You are tackling tough issues together with physicians every day. Take a step back from the issues. See “the physicians” as people, people who could use a friend; simply act to meet the need. Get some help from your own friends, colleagues, and supportive doctors. Structure the work to facilitate relationships. Create environments that encourage intimacy and caring. It does not have to be perfect, just genuine. Do more of what works and less of what does not. Try new things from time to time. Then, just keep at it.

Let me know if I can help.

Reference

Item 10: I Have a Best Friend at Work. (1999, May 26). *Gallup Business Journal.* Retrieved from http://news.gallup.com/businessjournal/511/Item-10-Best-Friend-Work.aspx?g_source=ABOUT_THE_Q12_I

Chapter 10
How Doctors Are Wired

Dianne E. McCallister and Ravi S. Chari

Introduction

If we want to address physician well-being, it makes sense for us to first think about how physicians think and what drives their engagement with their profession. While it is clear that in many dimensions physicians are not uniform, the shared education and training of physicians instills certain consistent characteristics that serve as foundations to engagement and enjoyment of the profession. We have discovered that attention to the needs and preferences formed by these characteristics when crafting an approach to physician well-being improves the likelihood that more physicians will benefit from our physician well-being program.

Getting the basic structure of physician work in shape is foundational for any physician well-being program. Developing systems and processes that support, rather than impede, the workflow and efficiency for physicians must be a top priority. Once that foundation is in place, we find it helpful to orient our thinking around three different habits and characteristics of physicians as loci for our work. Physicians tend to be truth seeking, problem solving, and competitive. These habits of truth seeking, problem solving, and competition have been developed through years of training designed to improve outcomes for patients within a complex diagnostic and treatment algorithm.

This is all to say that physicians approach situations in a specific way. The first imperative we learn is to "do no harm." To achieve this, physicians orient themselves to seek the truth in data, to render diagnoses, and to plan treatment. Physicians are also trained to approach diagnosis and treatment from a problem-solving

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perspective, drawing upon algorithms and experience to do the detective work necessary to correctly diagnose patient needs and treatments. Finally, physicians enter the profession striving to be the best. They have a history of delaying gratification and striving to be given the opportunity to attend medical school, and obtain a residency and fellowship in the best programs. This kind of striving requires an achievement orientation. Given that physicians are wired to be truth seekers, problem solvers, and competitive, any program oriented toward physician well-being needs to both acknowledge and build upon these habits, realizing there are both gifts and the perils in a life and vocation shaped by these three characteristics.

There is a feedback loop here as well. As system leaders, attention to the way physicians are wired also provides insight to improve the basic, foundational systems and processes that support the needs of practicing physicians. Barriers to excellent patient care can be minimized through this attention and attendant frustrations reduced. Open dialogue increases mutual understanding, paving a path to more rewarding work encounters for our physicians as well as for our staff. In the end, the patient wins if appropriate interventions produce improved efficiency.

It is vital to keep in mind that the same traits that make physicians great in their field, if they become excessive, can also lead to burnout. By providing structures and processes that feed the need for truth, that allow problem solving to be done efficiently and effectively, and that lead to a feeling of success, we can engage physicians in their greatest strengths and help them feel professional satisfaction while also improving the quality of care that patients receive. Providing quality care reinforces physicians in those strengths, thus reciprocally improving their ability to engage. It is our experience that a focus on these three physician characteristics supports our physician partners in their work with administrative teams, which in turn can produce remarkable changes in our organization's ability to consistently deliver high-quality, efficient care with ever-improving service.

In this article, we explore each of these three aspects of physician hardwiring and consider how to draw upon these characteristics for improvements in the quality of patient care and the level of physician satisfaction.

Truth Seekers

Physicians, almost without exception, are drawn to the field of medicine by a sense of curiosity about the way the body functions: the science behind the intricate processes of normal function, as well as the pathology and pathophysiology that occur when these complex processes go awry. This innate curiosity is reinforced and augmented through the multiple educational layers that include training in biology, chemistry, pathophysiology, statistics, and scientific research methods. Further, medical students are taught to critically analyze any data presented to them and to think independently of the data and information as presented to assure themselves that the conclusions others have drawn have scientific merit, are reproducible, and are not biased by other factors. Students master independence in their reasoning and

are urged to go to primary sources whenever possible. The human inclination to "take someone's word for it" is considered a cardinal offense if there is no evidence to back up the assumptions.

Another primary foundation of medical training is the idea that as a physician, one must probe beyond the obvious complaints a patient presents in order to understand the other symptoms and background history that allows an informed diagnosis. This practice is woven into the fabric of the physician by didactic and experiential classes addressing appropriate history and physical examination, laboratory analysis, and interpretation of radiologic evidence. Open-ended questions and diagnostic algorithms become tools to discern the truth amidst a myriad of information—some important and some extraneous to the ultimate diagnosis.

Additionally, physicians are trained to weigh the possible benefits of an action versus the potential side effects of intervention. Emphasis is placed on the importance of considering the downstream consequences of every action as an integral component of knowing the truth. Drug side effects, possible procedural implications, and the cultural factors inherent to the patient's life view are some of the important truths the physician in training is taught to acknowledge prior to taking action.

Thus, the support of physician curiosity, the need for data, and time to consider the pros and cons of decisions are all vitally important to the well-being of physicians. In developing programs aimed at physician well-being, physicians will feel disengaged and frustrated when we try to make changes without presenting data that support a need for change. We must expect and encourage them to question the data we offer in order to create confidence. We must also be thorough in our processes to evaluate the downstream consequences—particularly the affect on patient safety—of any changes the organization makes. Physicians will actively resist change out of a sense of protection of their patients and workflow if we have not considered the "side effects" of changing a system or process. When physicians are engaged, they will ask for data, risk analysis, and process flow. We must see it as a positive dynamic in the conversation and even anticipate the need. Making critical data and decision rationale transparent in the changes we suggest will improve physician satisfaction with the processes and will also help that change proceed more smoothly.

In the past 5 years, our system's need to address sepsis in a standardized fashion became a key clinical priority. ICU and Emergency Medicine physicians were gathered at a market level and given the evidence-based data regarding the 3-hour bundle for sepsis care. These two groups were then given the current outcomes for patients with the diagnosis of septic shock and severe sepsis to compare to the outcomes in the studies. Based on this, the groups created standardized order sets to use across the market and developed best practices for workflow in coordination with the Intensive Care and Emergency Department nursing teams. Their work was then rolled out across the entire market, resulting in a 60% decrease in sepsis mortalities and a 3-hour bundle compliance that exceeded the initial 60% goal. This collaboration across competitive groups also created a platform for learning that was used to sustain this work and address other key clinical initiatives.

Problem Solvers

Physicians are trained as scientists and change agents. Interviews with hundreds of physicians show that almost universally, they went into the profession because of a love of science combined with a desire to help people (McCallister 2018). In other words, knowing the truth is not enough. The physician feels compelled to solve the problem for the patient or the organization.

Physicians experience frustration when there are obvious problems that are not being solved. They spend their patient time as experts who find the truth and then create a prescription to improve the situation. Physicians are likewise trained to have a huge fund of knowledge that is readily available because the physical conditions often demand an immediate response in order to be effective. A 2-month research project is not an acceptable response to a person having a heart attack or experiencing a stroke. "Time is heart/brain" is a slogan for a reason.

Physician engagement in process change improves when the creation of a timeline of expectations for change is both transparent and frequently updated. This is due to the wide discrepancy in time between medical and business decision processes. For very good reasons, business decisions and processes frequently proceed at a glacial pace compared to the work in an ICU, operating room, or even an outpatient office. The visibility of a time frame helps physicians reset their expectations from quicker time frames to the slower pace of organizational change.

Importantly, physicians become most engaged when they assist in the development of solutions. As key stakeholders in patient care, physicians contribute perspectives crucial to a well-rounded solution to processes and challenges surrounding patient care, thus improving the chances of success. In addition, ownership in the process increases the likelihood of rapid deployment and sustainability of the chosen changes and a shared pride among the team when care improves.

A recent goal across our system was to decrease the time on a ventilator for ICU patients. Intensivists were gathered to create a best practice pathway which included multidisciplinary rounds, daily weaning trials prior to rounds, and early ambulation. The pathway was rolled out to individual facilities, along with the evidence behind the changes. The teams at each facility met to customize the pathway to the unique patient populations and staffing at the hospital. By engaging the intensive care physicians at a national, process-making level, and then again at the facility level, the vent days per case across the company were decreased. The shared data set across the company also allowed individual facilities to reach out to other facilities of a similar size and patient population who had best practices to learn additional processes for improvement.

Competitive

For better or for worse, physicians are competitive with themselves and with one another. As a profession, we share a goal of continuous improvement. Providing individual data setting and an individual physician's work in the context of local or

national benchmarks contributes to a self-awareness that converts to a sense of accomplishment or a platform for action. Seeing progress in their own performance is a source of personal satisfaction for physicians. Conversely, lack of progress can be demoralizing to this highly self-critical group.

In training, physicians have a level set to compare self to a larger group and therefore have a gauge for self-awareness. Unfortunately, in many specialties there is a paucity of controlled comparison data to afford the practicing physicians this same mirror. As a result, when out in practice there is a natural bias to a more subjective experience of one patient/one physician, which can lead physicians to an inflated sense of success when patients do well or an unjustified sense of failure when patients have complications or die. Given this reality, sharing individualized data that is risk-adjusted and comparable is a gift the organization can give the physician. It is particularly important that the data are risk adjusted though, since the patient's own physical status affects the data in ways that no physician can control. This data is more likely to lead to action when presented in the context of best practices that have been effective as this can help those with lower scores develop a clear plan of how they can improve.

Harnessing the competitive nature of physicians can produce a win for the patients too, as their physicians learn from one another. Drawing on competitive instincts can also hasten change, as those physicians recalcitrant to change have a new perspective on how they compare to a larger cohort. Physicians gain personal confidence as they see their data shift with the implementation of new processes or techniques, and the transparency helps to create trust.

Across our 170-hospital system, we identified a key need to find data useful to discovering best practices and accelerating change. New clinical guidelines suggested that, with two possible exceptions, mortality was increased if blood was given to those with a hemoglobin greater than seven. With the goal of shifting to the new blood usage evidence, we set a goal that 55% of all transfusions would meet the new clinical guidelines of a hemoglobin of seven or less. To support this change, we leveraged the EMR to obtain the hemoglobin at the time of transfusion. At the hospital level, we created the ability for the ordering physician to attach this information. This data was then shared with the Chief Medical Officers at each facility to allow change management at the individual physician level. With the assistance of the Blood Bank specialists, education was offered to help physicians learn a new practice and to compare each physician to his or her peers in a non-punitive fashion. With these interventions, most of our facilities were able to achieve the goal, or to discover and change processes that were not supporting the practice of the physicians. Patient care improved throughout the engagement of this competitive drive to achieve best practice results.

Summary

By understanding and incorporating the three physician characteristics of truth seeking, problem solving, and a competitive spirit into an approach to clinical improvement across a 170-hospital system, we have seen improvements in

mortality, complication, hospital-acquired conditions, and other key health outcome measures (e.g., length of stay, utilization rates, and costs). We have committed personnel and resources to create a learning community that improves results for patients and increases efficiency for staff and physicians. Most importantly, we have accelerated the engagement, involvement, and ownership of the physicians as we share the journey toward improved patient outcomes.

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Chapter 11
Organizational Opportunities to Enhance Physician Learning

Barbara Couden Hernandez

The capacity to learn is a gift;
The ability to learn is a skill;
The willingness to learn is a choice.

–Brian Herbert
–Herbert and Anderson (2000, p. 134)

I remember sitting on the leather-covered exam table and staring around the large drafty office that extended from the side of Dr. Woodford's home. Bottles of rubbing alcohol and iodine stood on the rolling surgical table under the window. A bespectacled Dr. Woodford sat down on the oak desk chair and leaned toward me, smiling kindly. This was our doctor in small-town USA during my growing up years. After he officially retired, Dr. Woodford continued seeing patients 3 days per week, charging two dollars for an office visit and three dollars for a house call.

I often recall Dr. Woodford fondly as I discuss bedside manner with medical students, realizing how hard it is to teach the enduring value of warmth and therapeutic presence. Yet so much has changed since Dr. Woodford's life and times. Forty years ago, it was estimated that medical literature was produced at the rate of 1 article every 26 seconds, which would require physicians to read 5000 journal articles daily just to stay current (Chalmers and Tröhler 2000; Garba et al. 2010). In 2017, it is virtually impossible to read a fraction of medical literature in one's own specialty because of the explosion of online literature, open access journals, organizational websites, and medical blogs. Yet in order to support ethical, safe, and evidence-based practice, lifelong learning is necessary. In this chapter, I explore physician learning opportunities that can be offered by healthcare organizations as a critical aspect of the Medicus Integra© award evaluation process.

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Medical Trainee Education

Learning begins in medical school when new students are told that during the next four years, they will feel as if they are "trying to drink water out of a fire hydrant." In addition to basic science, medical education involves cognitive, affective, and behavioral knowledge and skills. Educators have long recognized that acquiring information is not a simple process but consists of several steps according to a model called *Bloom's taxonomy* (Ramirez 2017). The first step is *acquiring knowledge* about a topic. Medical students learn differential algorithms, treatment protocols, and patient examination skills. The second learning step is to be able to *apply the facts* to real patients, which begins during clerkships. *Reviewing and evaluating effectiveness* of knowledge application takes place during daily patient rounds and continues through internship and residency. Learners observe the way in which their mentors manage clinical work and observe the effectiveness of their exemplars. Performance evaluations, in-training examinations, and ability to pass licensing boards *validate the quality of learning*. Most residents begin to *develop their unique approach* to patients and identify practice preferences based on modeling and on their own emotional intelligence and experiences with patients. Hospitals can use Bloom's taxonomy steps to develop continuing medical education (CME) programming to meet the needs of their medical staff through informational presentations, case studies, evaluation methods, validation of application as the result of quality improvement projects, and subsequent care protocols.

It is exhilarating for doctors fresh out of residency to realize that their formal education is finally behind them, but the need for continued learning becomes apparent as they face situations to which there were only abstract allusions in medical school: participating within a practice or hospital group, negotiating policies and procedures, learning to use sometimes unwieldy practice systems. They find themselves needing to adhere to ethical principles and compliance regulations while delivering cost-effective care to a diverse patient population. Thus, graduation from school represents only the threshold to the world of lifelong learning in medicine.

Learning Opportunities for Practicing Physicians

Onboarding Orientation

Educational opportunities during physician onboarding can help new doctors understand organizational structure, practice strategies, and systemic technological use. Presentations about the organization's peer review process can help physicians become oriented to their new institution and clarify the expectations regarding

their performance, behavior, and participation in the life of the institution. This is very important education, particularly for physicians just out of their fellowship or residency.

Medical Literature

Reading journals is probably the most common form of physician learning because it is the most accessible and time efficient. Physicians need to have access to a located or virtual medical library that allows them to download journal articles to their computer or electronic device. Patients have certainly discovered the world of online medical advice and, as a result, many have expectations about their condition and treatment that may or may not be accurate. It is estimated that over a third of health-related facts in the public press exaggerate or otherwise inaccurately portray findings of medical studies (Sumner et al. 2014). This confuses the general population, who then challenge their doctors with their alternative treatment ideas. It becomes important for physicians to stay abreast of medical developments by critically evaluating medical literature for evidence-based best practices. Numerous articles, phone apps, and websites are available to help physicians scan articles and rapidly identify take-home points in the limited time they have. Hospitals may provide physicians with a list of these resources or discounted pricing for memberships, CME, or electronic educational access.

Continuing Medical Education

Each medical organization should have a CME coordinator or office, whose tasks include maintaining the required standards for physician education by the Accreditation Council for Continuing Medical Education (ACCME) and providing educational offerings. Some small hospitals with modest resources may need to partner with other organizations or hospitals to offer CME events based on need assessments at each institution. A quick online survey or agenda item in a medical staff committee can identify desirable CME topics and physician interest in attendance.

Physicians typically attend professional conferences for CME and for networking with others in their specialty. Presentation titles frequently include words such as *advances*, *developments*, and *update* or allude to *new horizons* in medicine such as dealing with the newest superbug, pursuing a career in medical informatics, learning about entrepreneurial aspects of solo practice, or forging global alliances. Some conferences offer CME for Maintenance of Certification (MOC) courses, allowing physician maximum efficiency and cost-effectiveness. Many physicians are inspired to incorporate the new techniques and practice ideas they've learned into their current settings. It is fruitful to invite conference attendees to teach modules on a topic or to report findings from their most recent conference to their colleagues when they return home.

Leadership Education

Physicians are engaged in continual learning, sometimes out of necessity but also for the love of learning and even emotional survival. Physicians who are well liked and have good reputations are often invited to take leadership positions even though they may know very little about leading others. They may have no interest in leadership but are prevailed upon because they are respected by their colleagues. It is demoralizing to hold significant responsibility but lack skills to carry through those responsibilities. Physicians who acquire leadership training feel more confident and have reduced stress and burnout due to their newfound ability to resolve complex practice, business, and financial issues (Angood 2016).

Women leaders are perceived and utilized quite differently than male leaders by administration, colleagues, patients, and hospital staff (Hofler et al. 2015) and, therefore, should have gender-sensitive leadership training that includes mentorship by other women in leadership (Murphy 2017).

The American Hospital Association's Physician Leadership Forum (Combes and Arespacochaga 2012) has identified leadership training as an essential physician skill in order to transform medical practice. Their publication, *Next Generation of Health Care Delivery*, calls for strong interpersonal skills and the ability to operationalize good customer service, cultural sensitivity, and emotional intelligence in teams. Indeed, these skills require education and mentorship and are vital learning elements in the Medicus Integra© award evaluation.

Medical Humanities

A growing area in medical literature pertains to medical humanities. More and more physicians have been writing about the things they wished they had learned before assuming responsibility for patients, what they have learned from their patients, what they have learned about themselves, how they survive the vicissitudes of medicine, and how they experience the intersection of medicine and spirituality. This literature is instructive for many physicians at a deep emotional level. For example, oncologist Jerome Groopman poignantly described a sense of cognitive and emotional disorientation as a new oncologist, facing a career of breaking bad news to patients: "While I was well prepared for the science, I was pitifully unprepared for the soul. I was in over my head. …the subjects of hope and despair were not part of our curriculum" (Groopman, 2005, p. 21, 23). Other authors have articulated cognitive, emotional, and gender-related aspects of medicine in books such as *How Doctors Think* (Groopman, 2007), *What Doctors Feel* (Ofri, 2013), and *Changing the Culture of Academic Medicine* (Pololi, 2010). Such books and similar articles that describe physician behaviors in the practice of medicine help doctors think objectively about themselves and reflect candidly about their own practice. Dr. Stephen McPhee at the University of California at San Francisco routinely shared poetry with his patients at the end of life and gave poetry readings to physicians for CME, illustrating the value of using art and expression to deepen human experience.

Finding Meaning in Medicine (Bornstein 2013) and *Balint* groups (Crossman 2012) offer rich affective learning experiences in the narrative medicine tradition. CME developed around this type of experiential learning is one way physicians can enrich both their professional and personal lives.

Whole-Person Care

Whole-person care, or the biopsychosocial-spiritual approach to patient care, is a model that is heartily embraced by many Christian faith-based medical institutions. The idea that physicians can attend to the physical, emotional, social, and spiritual aspects of their patients arises from the example of the healing ministry of Jesus Christ, who taught (mental), healed (physical), comforted (emotional), and moved freely within the context (social) of those whom He sought to serve. Most world religions encourage care of the sick, helpless, and marginalized, so similar ideas and commitments can be integrated into the practice of medicine by people of all faiths. We are also learning that it is simply good science, since the relationship of patient and provider often proves significant to the wellbeing and survival of very ill patients. Many physicians who have not learned about holistic or whole-person care in medical school warm quickly to the idea of treating their whole patient in context, particularly when CMEs on the topic are available.

Wellness Education

Physicians want to learn how to build resilience and maintain their own wellbeing. With burnout rates between 40% and 70%, it is important for hospitals to frequently offer evidence-based interventions and best practices by several different methods. Experiential and didactic CME might include conferences, brown bag lunch seminars, journal clubs, and videos on topics such as mindfulness-based stress reduction, self-management, conflict resolution, or spiritually informed interventions to increase a sense of meaning and purpose. A number of hospitals in the Dignity Health network use physician formation training to integrate spirituality with leadership, resilience, and whole-person care (Doyle and O'Toole 2011).

Teaching Opportunities

The Medicus Integra© award evaluation team will be interested in evidence that physicians in healthcare institutions have opportunities to teach. This may include presentations for ancillary staff and nurses, residents, or community lectures. Hospitals with residencies are required by the Accreditation Council for Graduate Medical Education (ACGME) to offer specific lectures to promote patient and physician

safety and enhance professionalism and general wellbeing (ACGME 2017). Faculty or supervising physicians can participate by providing lectures that meet ACGME and CME requirements so physicians at the same venue may attend.

Conference presentations or participating in Schwartz Center Rounds©, whole-person care presentations, or other multidisciplinary forums are important experiences. Collaborative or multidisciplinary team use in patient care both appear to be the wave of the future and are excellent topics for CME (Cade et al. 2017).

Recognition for Scholarly Contributions

Finally, it is often self-reinforcing for organizations to publicly recognize the learning-related achievements of their physicians. Accomplishments such as publications, research outcomes, grant awards, certifications, or academic rank advancement should be announced to stakeholders in some way. Weekly newsletters, posters, hospital websites, medical staff meeting agendas, or public relations/marketing materials of the organization are possible venues for these notices. Physicians are typically grateful for the educational resources and recognition they receive from their employing organization(s).

Conclusion

The opportunities to provide learning venues for physicians at the workplace are numerous. The list of things that doctors are called upon to know well is staggering: how to manage patient flow, office and hospital policies and procedures, third-party payer regulations, electronic medical documentation, patient care legislation, best practices in one's specialty, leadership skills, team collaboration, and whole-person care. Additionally, there is that enduring art of medicine that my Dr. Woodford knew well: beneficence, kindness, communication skills, self-care, work-life integration, resilience skills, and integration of values and spirituality in patient care. There are many ways to support learning opportunities and resources for our physicians of whom so much is expected.

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Part IV

What Models Have Worked in Other Places?

Acceleration of Change in the realm of physician wellbeing prompted the formation of the Coalition for Physician Wellbeing. Monthly webinars, break-out sessions at annual meetings, and collection of best practices from surveys for Medicus Integra© promoted pilot projects at hospitals across the country. While research continues to develop to help target model to outcome, a number of projects have been validated by use in facilities and through feedback from the facilities' physicians. The surveys reveal that the fact that the organization cares enough to do *anything* provides a feeling of support to the physicians on the medical staff – whether or not they take part in the program. In this section, we share a few of the practices that have worked for others in the hope that they might provide you with a template for implementation or spark innovative programs in your organization. Any step forward is a positive change for the overall culture.

Chapter 12
Physician Wellbeing as a Matter of Mission: What We Have Learned at AdventHealth and Through the Coalition for Physician Wellbeing

Ted Hamilton

"It's rare to hear, 'I care about you as a person.' That's the message I heard."
—Survey Response to AHS Conference on Physician Wellbeing.

Introduction

I remember him yet, striding down the center aisle to a front-row seat in the amphitheater, for our first anatomy lecture. Matt entered medical school with the full intent of becoming a pathologist. He possessed a small library of anatomical slides, with which he was already quite familiar. Matt was a serious student who graduated near the top of our class and went on to complete his residency and fellowship at a prestigious university medical center. Over the course of his 30-year career, Matt became an internationally renowned neuropathologist, publishing over 700 articles, authoring several textbooks, and lecturing around the world. On a recent Monday morning, Matt inexplicably failed to appear for work. Authorities discovered his body 2 days later in his home. The cause of death, officially undisclosed, was suspected to have been self-inflicted.

Matt is not alone. In response to life challenges that they perceive as overwhelming, many physicians simply give up. We will never know for sure what circumstances might have contributed to Matt's untimely demise. We do know that many physicians are disillusioned with the practice of medicine, disheartened by lack of control over their personal and professional lives, and despairing of hope for the future. In short, they're burned out.

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Webster defines burnout as "the point at which missile fuel is all burnt up." Alternate definitions include "damage caused by overheating" or "a state of emotional exhaustion." Somehow, all three definitions seem applicable to the malaise and discontent experienced by many physicians. Some are simply worn out, beaten down by encroaching bureaucracy, increasing demands of clinical documentation, and ever-present concerns about medico-legal liability. Some are working beyond the point of exhaustion, with long days and frequent call, trying to meet patient needs, sustain economic security, and achieve productivity standards. Many are emotionally exhausted, having yielded personal need for rest, recreation, and relationship to the relentless demands of medical practice.

The Maslach Burnout Inventory is a well-respected and widely used tool for the assessment of burnout. It consists of a series of self-assessment questions designed to address three indicators of burnout: depersonalization (impersonal attitude toward patients and others), personal accomplishment (self-perception of influence and effectiveness), and emotional exhaustion (feelings of strain and fatigue). Unpublished data from our own research, conducted on a random, nationwide sample of about 1500 physicians, revealed that 25% of respondents were, by their own admission, at high risk of depersonalization. Almost a third admitted that they would not choose a medical career if they had a chance to do it over. And more than 40% of responding physicians assessed themselves as at high risk of emotional exhaustion.

A large study, reported in a 2012 article in *Archives of Internal Medicine,* described the prevalence of burnout among physicians as "alarming." It noted that Primary Care physicians (family medicine, general internal medicine, emergency medicine) appear to be at highest risk. Unfortunately, the authors conclude, there is little evidence on how best to address the issue (Shanafelt et al. 2012).

Dr. Davidson is a mature, experienced family physician with a thriving practice in a small resort town. He is a physician leader, having held numerous positions of medical responsibility, most recently Chief of Staff. In addition, he is a devoted husband and father and a pillar of the community, supporting worthwhile causes and serving on various boards and committees. Dr. Davidson recently confessed, "I'm angry." He went on to say that this was not normal for him, describing himself as usually content and satisfied. "But," he explained, "for about six months now, I have noticed that little things bother me more than before. I have a short fuse. I find it difficult to be patient with other people. I seem to be near a boiling point much of the time." Although unusually self-perceptive, Dr. Davidson didn't understand what he was experiencing, nor did he quite know what to do about it.

Not infrequently, it falls to others to bring evidence of the risk of burnout to a physician's attention. Dr. Greer has been a practicing gynecologist/obstetrician for about 8 years. She has a 2-year-old child and has tried to balance her personal and professional priorities. But recently one of her partners retired, resulting in increased demands for patient care and call. "Yesterday," the hospital administrator said, "she blew up at staff in an unacceptable manner." Her remaining partners are concerned about the risk of burnout and fear "that her patients will get the idea that she doesn't care and will not want to see her."

Symptoms and signs of burnout include marital and family stress, substance abuse, auto accidents, health issues, depression, and suicidal ideation. Inevitably, physician burnout surfaces in the workplace, compromising relationships with patients and staff and endangering the quality and safety of care. Often unaware of their own symptoms, and insensitive to their impact on others, physicians are prone to stoicism and denial, carrying on with routine responsibilities until the personal burden is overwhelming, or maladaptive behavior can no longer be ignored.

Fortunately, there is growing awareness within the medical community of the issue of professional burnout. A substantial body of recently published research attests to the scope, prevalence, severity, and deleterious impact of this condition. Chapter two in this volume offers an overview of that research. Hospitals and professional organizations are beginning to acknowledge the problem and seek solutions.

Adventist Approach

About a dozen years ago, AdventHealth, a faith-based, 46-hospital system, with facilities in 10 states, began a journey, under the direction of concerned administrators and physician leaders, to address the issue of physician burnout. The first step was to create what has become known as the Center for Physician Wellbeing (CPW). Staffed today by two full-time clinical psychologists, CPW provides a range of preventive and therapeutic services for staff physicians, including counseling, seminars, retreats, coaching, and training. Counseling services are private and confidential. Initial visits are provided without charge to the client. Over the past decade, some 1000 physicians have accessed the counseling resources of CPW, resulting in over 10,000 visits for a variety of complaints and conditions, including, most commonly, anxiety and depression, marital and family stress, anger and boundary issues, and addiction and substance abuse. Over 90% of referrals to CPW are voluntary and self-initiated.

It is clear that CPW has been instrumental in relieving symptoms, restoring relationships, enriching marriages, and salvaging the careers of many physicians. While it is difficult to calculate a precise cost-benefit ratio for CPW services, it has been estimated that the cost to a healthcare institution of replacing a full-time physician who leaves practice or moves away approximates at least $250,000. At this rate, the recovery and retention of only two or three physicians who might otherwise have been lost to the practice of medicine more than covers the annual CPW budget. The Center for Physician Wellbeing is a prime example of the principle of “doing good and doing well,” providing a worthwhile benefit to physicians, while saving careers, improving patient care, and generating a measurable return to the institution.

Recognizing that physician leadership is essential to the establishment of a successful initiative to promote physician wellbeing, AdventHealth sponsors an annual conference designed to inspire and equip physician leaders for this work. The 2-day Conference on Physician Wellbeing, now in its ninth year, brings together about 90

physicians and an equivalent number of senior executives from around the company, for 2 days of motivation and education in a collegial setting. Consisting of plenary sessions, smaller breakouts, and table discussion, the conference is intended to be practical, providing readily applicable programs, tools, and resources for local implementation. Topics and issues addressed over the years have included communication and collegiality, purpose and meaning, margin and balance, marriage and family, spirituality and service, and AdventHealth mission, vision, and values.

Physician response has been gratifying, as illustrated by typical responses to the standard conference survey. "Administration looking out for physician well-being was eye-opening." Another wrote, "Very refreshing…focused on emotional wellbeing and patient care." From others: "New insights to use in reflecting on my own personal and professional situation"; "It's rare to hear, 'I care about you as a person. That's the message I heard.' " And, finally, "The highlight was experiencing physicians bonding through candid discussion, hearing each other, and being heard. One colleague shared how impressed he was with the conference and how much it helped him. He told me his staff was asking him why, after being back to work for a week, was he still relaxed? They asked him what meds he was on!"

This work is essentially relational. The task of engaging physicians and promoting physician wellbeing is critically dependent upon building healthy relationships. Without attempting to narrowly prioritize the relationships of highest importance to physicians, the top three arguably include marital & familial, collegial, and patient relationships. Successful initiatives will take all three into account, not just conceptually, but logistically, in terms of scheduling programs around call and family responsibilities and planning events or activities that include families and colleagues.

Hospitals within AdventHealth have sponsored a variety of initiatives designed to foster communication and build relationships, from picnics to art shows, physician concerts, health screenings, and prayer breakfasts. One of the more successful and enduring initiatives that has gained wide acceptance in AdventHealth hospitals is known as "Finding Meaning in Medicine." A small group activity, organized and hosted by physicians for the participation and benefit of physicians, Meaning in Medicine was created by Dr. Rachel Naomi Remen, Clinical Professor of Family and Community Medicine at UCSF. It consists of facilitated discussion of chosen topics around what Dr. Remen refers to as "the heart of medicine." Often in association with a meal in a relaxed setting, physicians are afforded an opportunity to share their own experiences and stories on a selected theme. Participating physicians, with rare exception, find Meaning in Medicine to be a rich and fulfilling collegial experience. More information is available at www.theheartofmedicine.org.

At AdventHealth, we've been pursuing our physician wellbeing initiative for over a decade now. An annual, company-wide, physician engagement survey has been implemented, and several questions have recently been added to directly address issues of physician alignment and relationship with the hospital. We are exploring ways to include nurses, administrators, and other staff in this effort. Areas of opportunity include strengthening physician orientation, enculturation, leadership training, and values-oriented physician recognition.

There is growing interest in physician wellbeing around the country and, more particularly, within faith-based hospitals and systems. Beginning in 2010, Dr. Malcolm Herring of St. Vincent's Hospital in Indianapolis, Dr. Dianne McCallister of Centura Health, Brian Yanofchick, then Director of Mission Integration for Catholic Health Association, and Dr. Ted Hamilton, representing AdventHealth, began meeting together to create a vision for a collaborative effort to address physician wellbeing. Today, the Coalition for Physician Wellbeing, a 501(c)(6) type association, is comprised of some 100 individuals, representing over 60 institutions, including several large Catholic hospitals and systems, along with AdventHealth, and Loma Linda University, among others. We are committed to working together to help physicians experience greater life satisfaction and professional fulfillment.

The Coalition sponsors hour-long, monthly, teleconference/webinars covering a broad array of topics pertinent to understanding physician wellbeing. Topics include depression and burnout, physician alignment and engagement, spiritual formation, and values development. Presentations are archived for retrieval as desired. The annual Coalition meeting offers educational, networking, and planning opportunities. Coalition leaders and members are available to interested organizations for consulting and coaching. The ultimate goal is to assist physicians in achieving balanced lives, purposeful practices, and meaningful relationships. For more information about the Coalition, visit our website at https://www.forphysicianwellbeing.org.

Sister Nancy Hoffman, former senior Vice President for Spiritual Ministries at Centura Health, offers wise counsel in undertaking this work: "Start small." We believe that the fundamental mission of faith-based hospitals provides both a spiritual mandate and a cultural advantage for pursuing this work. We engage this effort with the intent of extending the healing ministry of Jesus Christ to physicians and, through them, to our patients and staff.

Reference

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Chapter 13
Forming a Physician Culture of Mission and Wellbeing

Michael W. Doyle

The indescribable satisfaction that comes with healing patients and affecting other people's lives is undoubtedly one of the most fulfilling aspects of being a physician. Yet, the quality of this fulfillment is frequently dependent upon a physician's experience of service in a healthcare environment that understands purpose and meaning as part of a life of wellbeing. At a time when a growing number of physicians are experiencing burnout and frustration with the demands of today's healthcare environment, some faith-based healthcare organizations have resolved to renew a sense of purpose in the healing profession. These healthcare organizations are accomplishing this goal by joining with physicians to explore the meaning of mission and wellbeing within the physician culture. This chapter will focus on the efforts of Mercy healthcare to form physicians within a mission and wellbeing culture through a variety of initiatives, activities, and experiences. The focus of these efforts is the integration of mission and a culture of wellbeing in recruitment, within daily encounters of care, and through various professional and personal transitions within the healthcare environment. Mercy's desired outcome for physicians is that they find renewed meaning in their work as part of a balanced, larger sense of wellbeing.

It Begins with the Right Fit

In order to develop and sustain a physician culture of mission and wellbeing, the selection of physicians who align well with this culture is a strategic priority. One of the significant goals of Mercy's physician candidate interview process is the selection of doctors who find meaning in a mission culture that has its foundation within

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a heritage of faith. While the heritage of Mercy is rooted within a Catholic and Christian faith tradition, physicians of diverse faith and spiritual life experiences are welcome to serve within the Mercy healthcare ministry. Mercy's religious heritage provides a framework for physicians to see their work in healthcare as a ministry within their own particular formation and traditions. The desired outcome of the interview process is the identification of physicians who are a natural "fit" for our mission and ministry culture, distinguishing them from those who reveal limited interest in the Mercy culture or are driven by purely financial objectives in practicing medicine.

Serving within a faith-based healthcare organization requires an awareness and respect for the influence of religious heritage within the organizational culture and the way in which the attendant mission and values are lived out in daily encounters with patients. For Mercy, the recruitment and evaluation process for physician candidates includes criteria that assess the qualities, attributes, and competencies needed to be a fit within our faith-based culture. Some of the key areas for review and assessment include: excellence and professionalism; service; the meaning of ministry and of being spiritually grounded, ethical sensitivity; justice and right relationships; care for the less fortunate; and the meaning of common good. Questions to explore these qualities include:

Excellence/Professionalism

- What led to your decision to become a physician?
- What gives you a sense of personal and professional meaning?

Service

- How have you practiced compassionate care with patients? Describe an experience in which you expressed empathy and compassion with a patient.
- How have you responded to difficult situations with patients or co-workers? Describe an experience which was challenging for you and describe your response.

Ministry/Spiritually Grounded/Ethical Sensitivity

- Mercy is not just a healthcare organization; it is a healthcare ministry. How does this understanding connect with your beliefs about healthcare and being a physician?
- Holistic care, especially the spiritual needs of patients, along with ethical sensitivities, is foundational to the practice of care within Mercy. How would you integrate this understanding of care within your practice?

Justice and Right Relationships

- Describe your patient relationship expectations.
- What kind of work environment is important to you, especially in collaboration with your colleagues and clinical care teams?

Care for the Less Fortunate/Common Good

- How does care for people who are financially challenged shape or impact your practice of care? Why is that important to you?

- What has been your approach to caring for Medicaid patients and the uninsured? What are your beliefs about access to health services for all people, especially those living within the service areas of your healthcare organization?[1].

With the help of these questions, the interview process reveals candidates who are a natural fit, those who have strong indicators for developing a fit, and those who are a non-fit. When physician candidates are confirmed to be a Mercy fit, a recommendation is made to offer the person a position.

Once a new physician is hired, orientation begins with an introduction to the Mercy culture of care. A valuable resource for new doctors is Mercy's Physician Handbook,[2] which offers background on the Mercy culture and highlights the influence of heritage, mission, and values upon patient care. The handbook is divided into two sections, covering both Mercy's understanding of ministry and physician and leader expectations. It calls for creating a transformative experience of care for patients which requires a commitment from physicians to excel in compassion for the wellbeing of each patient and co-worker. All orientation formation calls for an awareness of and appreciation for Mercy's mission statement:

> ***As the Sisters of Mercy before us,***
> ***we bring to life the healing ministry of Jesus***
> ***through our compassionate care and exceptional service.***

In keeping with the mission, the Mercy values of Dignity, Excellence, Justice, Service, and Stewardship support the ministry culture of care. The mission preserves and carries forward the purpose that has been present since the initial founding of the Sisters of Mercy over 185 years ago. The values support the mission. The mission and values guide how decisions are made. They are not abstract notions; they are core, immutable, and defining to the Mercy healthcare ministry and will be just as important in the future as they have been in the past.

Formation at the Heart of the Physician Experience

An integral part of forming a Mercy physician is the array of formation experiences offered from the moment a doctor joins Mercy through the doctor's continuum of service within the healthcare ministry. In formation, physicians are invited to discover the meaning of mission and ministry within their professional and personal lives. Experiences are offered in several forms and settings that align with a physician's entry into Mercy, into their practice or specialty, and through their ministry

[1] *Physician Hire for Mercy Fit/Questions and Screens*. The Physician Hire for Mercy Fit Questions and Screens resource is intended to be an interview guide for evaluating the Mercy Fit qualities and competencies of physician candidates.

[2] *Mercy Physician Handbook.* The Physician Handbook is divided into two sections*:* Part I, Who we are, how we are structured, and how we make decisions, and Part 2, What we expect from you as a physician and leader; what you should expect from Mercy.

and community engagements and leadership roles. The purpose of formation is to educate doctors about Mercy's faith-based heritage, mission, and values, with the intention of connecting them to a deep sense of meaning within their practice of medicine and culture of care.

Formation experiences include orientation formation (described above) and:

- New leader formation
- Clinic formation
- Clinic board formation
- Mercy Clinic leadership formation
- Personal formation
- Physician leadership mentoring formation[3]

In particular, clinic formation and physician-led formation offer excellent examples of Mercy's strategic efforts to engage the over 2,100 integrated physicians who provide care in more than 750 Mercy Clinic practices and who serve in various leadership roles and specialties. Here is a closer look at both:

Clinic Formation

Physicians serving in selected clinic practices helped develop the initial clinic formation content and ongoing approaches currently used today. Their input provided valuable insights into the vocation of the healing profession as well as the distinctive contributions of diverse cultural and faith experiences to Mercy's efforts to offer compassionate care and excellent service. Desired outcomes for these formation activities for physicians include:

- Deeper understanding of the call and commitment to the healing profession
- Deeper awareness of serving in a faith-based healing ministry
- Exploration of the personal meaning of our Mercy heritage, mission, and values
- Result showing a positive impact on patient care and co-worker work life

The foundational Mercy Clinic formation experience invites physicians and their team of providers and staff to gather for regular reflections and conversations on topics related to Mercy mission and ministry culture, and their personal experiences of providing care. These gatherings take place in the morning or over lunch, with the intention of offering each participant a sense of renewed purpose and meaning. Topics include:

"The Healing Profession" – The call and commitment to the healing profession.
"The Healing Ministry" – To participate in a faith-based healing ministry.

[3] *Physician Formation.* Physicians are offered various formation experiences that invite them to discover the meaning of the healing profession and the mission and ministry of Mercy.

"The Meaning of Mercy" – The mission to offer compassionate care and exceptional service.
"Living the Mercy Spirit/Right Relationship" – The commitment to positively influence work life and patient care.
"Spiritual Care" – A hallmark of Mercy culture.[4]

Once the clinic practices have completed the foundational formation experience, the teams of physicians, providers, and staff are encouraged to engage in various activities of their choosing that will continue to offer meaning and to help support a mission and ministry culture within their practice of health services. Some activities include:

- Formation within staff meetings (monthly/weekly)
- Formation within huddles (weekly)
- Retreat/group (quarterly/yearly)
- Community outreach/service activities (quarterly/yearly)

The physicians and staff who participate in this formation experience are offered the opportunity to share their feedback and impressions through an annual survey. Their input helps assess the effectiveness of the formation experiences toward the desired outcome of providing a meaningful impact and influence on participants' personal and professional lives. Common responses have included:

"Formation helps to connect me to my ministry and my calling to the healing arts."
"Formation allows me to connect the work we do in our clinic to the mission and values of Mercy."
"Formation reminds me of my spiritual mission as a healthcare provider."
"Formation has helped me refocus on why I entered medicine."[5]

Physician-Led Formation

As more physicians became involved in formation over the past few years and experienced a positive outcome within their personal and professional lives, a number of physician leaders proposed an initiative that would combine formation learning with physician wellbeing. Their efforts resulted in a formation experience that was led *by* physicians *for* physicians and focused on developing a mission and ministry culture within their lives with a special emphasis on wellbeing. Physicians were especially instrumental in creating the content around wellbeing, which has become

[4] *Mercy Clinic Formation.* The purpose of formation is to offer an ongoing process of learning and exploration that contributes to the development of our knowledge, abiding convictions and behaviors regarding our healing profession, faith-based ministry, and Mercy heritage, mission, values, and charism. Formation draws upon the contribution of our diverse cultural and faith experience as we learn together the meaning of Mercy.

[5] *Mercy Clinic Formation Annual Assessment.* The reflections of formation participants were taken from their responses to this survey question: Describe what has been the greatest benefit to you personally.

a valued discussion and reflection topic. Some of the general themes have included the healing profession, ethics, the meaning of Mercy as a healthcare ministry, and culture of care. The specific topic of wellbeing has been a popular focus of the sessions.

These physician-led formation experiences have been very well received and indicate the special kind of meaning that this type of gathering can have for physicians. Comments by two of the physician participants offer insight into the personal nature of the experience:

> "Formation helps center us on a regular basis. It is easy to get caught up in the hustle and stress of everything that is going on and when we take time for formation it brings us back to where we first came from and helps us remember why we do what we do, and what our greater purpose is in our roles here at Mercy."

> "When I recall that I am participating in the healing ministry of Jesus, it changes my attitude, shapes my heart, and shifts my view of myself and my patient."[6]

Forming a Culture of Wellbeing

Mercy formation initiatives help physicians recognize the value in taking time to explore the meaning of the healing profession and in serving within a faith-based mission culture. The reality of burnout among physicians and caregivers has made physicians realize that attention to wellbeing is a valuable use of time. As a result of the positive outcomes of formation and the desire to enhance physician wellbeing, Mercy has been actively engaged in fostering a physician culture of wellness and ongoing formation. Through a partnership between physician and mission leadership, a number of creative programs and resources have been developed to help Mercy doctors find meaning in mission and ministry and focus on living a life of wellbeing. From various wellness events to internal preventive and urgent care services, Mercy has focused on care for the caregiver and meaning for service within a healthcare ministry. The following key initiatives are examples of wellbeing efforts.

Mercy Clinic East Community Wellness and Formation Committee

The Mercy Clinic East Community Wellness and Formation Committee provides support to the Mercy Clinic East Community (St. Louis area) with a focus on physician wellbeing initiatives for clinic boards, physicians, and practice locations. A few of the key events sponsored by the committee are described here.

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[6] *Physician-Led Formation Assessment.* The reflections of physician participants who responded to this survey question: Describe the personal and professional value of this learning experience.

Presentation by Dr. Dike Drummond
A special presentation for physicians and spouses was given by Dike Drummond, M.D., a family medicine physician and national expert on physician burnout. Two dates were made available so participants could choose a time and meeting setting (breakfast, lunch, or dinner) to attend the event. CME units were offered, and every physician/AP that attended received a free copy of Dr. Drummond's book, "Stop Physician Burnout: What to Do When Working Harder Isn't Working."

Presentation by Dr. Jill Kruse
Dr. Jill Kruse, who serves as the Avera Health Medical Director for the LIGHT (Live, Improve, Grow, Heal and Treat) program, offered reflections on her personal journey through burnout to wellness. Two days were set aside for physicians, their spouses, and other care providers to participate in this event.

Presentation by Dr. Nick Ogle
Dr. Nick Ogle, director of mental/behavioral health services at Mercy Hospital Northwest Arkansas, is an expert on human relationships and their impact on everyday functioning. He presented information about Rapha, Mercy's new physician wellbeing initiative. Rapha, a Hebrew word meaning to restore or heal, is Mercy's plan to prevent physician burnout in the workplace and promote physician wellbeing (more on Rapha later).

Mercy Clinic Fort Smith Mission Integration Committee

This group plans events for physicians with the goal of enhancing wellbeing for all caregivers. Featured events have included:

An Evening of Reflection with Dr. Farr Curlin
Dr. Curlin, a hospice and palliative care physician from Duke University, holds joint appointments in the School of Medicine, including its Trent Center for Bioethics, Humanities and History of Medicine, and in Duke Divinity School, including its Initiative on Theology, Medicine and Culture. He has a special interest in developing a physician culture that embraces holistic care. Dr. Curlin offered a reflection on the vocation of the healer and highlighted the importance of physician wellness. The event was well received by the many providers who attended.

"Fullness of Life" for Co-workers and Providers
This event was for Mercy providers and co-workers to explore meaning in medicine. The focus was on finding ways to be inspired, learning how to encourage others, and discovering deeper meaning in day-to-day work.[7]

New Initiatives

A number of physician and mission leaders from various Mercy communities have been meeting regularly to share ideas for Mercy's physician wellbeing initiatives. The group recognizes the value of creating a culture of wellness and ongoing

[7] *Physician Wellbeing and Formation Initiatives.* Descriptions of the various ministry-wide initiatives and efforts related to wellbeing and formation taken place throughout Mercy.

formation through physician and mission partnerships. To that desired goal, the group has invited other physician and mission leaders to join this partnership to support and sustain this culture. Some of the resources offered by the physician/mission group include:

The Rapha Program at Mercy
"Rapha" in Hebrew can be translated to mean to heal, healer, or physician. This innovative initiative was developed by Nick T. Ogle, Ph.D., LPC., to create an internal support system for Mercy providers and their families. It is directed to professionals such as doctors, nurses, and other healthcare professionals who have high levels of burnout, depression, relational distress, drug and alcohol abuse, and suicide. Rapha was created to offer an internal ministry to help Mercy providers and co-workers flourish professionally and personally. The program contains a maintenance and crisis component, allowing for both preventive and urgent care.

Physician Mentor Program
This is an onboarding program for new physicians that utilizes members of the Physician Leadership Council who are paired with new physicians and meet one-on-one with them each month. These gatherings explore the personal and professional meaning of serving as a Mercy physician and are respectful of time and adjusted to accommodate family and patient needs. Goals and expectations are mutually established by the physicians, along with times and locations for the meetings.

Physician Wellbeing Resource Toolkit
Physician leaders and mission leaders are working together to coordinate various resources (internal and external initiatives, articles, speakers, forums, etc.) that focus on physician wellbeing to be shared throughout Mercy.[8]

Forming a Culture of Healthy Wellbeing

The partnership formed between physician and mission leaders at Mercy to create a culture of wellness has led to engaging experiences for physicians and caregivers throughout the Mercy ministry. Physicians have recognized the importance of self-care as a way of living a life of wellbeing, and their participation in ongoing formation has given them a deeper sense of purpose and meaning as part of a faith-based healthcare ministry. These wellbeing initiatives have truly made a difference within the Mercy culture of care.

Mercy remains committed to deepening a physician culture of mission and wellbeing. Our work is based on a recognition of the common understanding among healthcare professionals regarding the core influence of holistic health upon the healing process and the value of this belief for both patient and provider. The journey of learning over the past few years has led Mercy to a path of discovery that

[8] *New Physician Wellbeing and Formation Initiatives.* Descriptions of current initiatives and highlighted by *The Rapha Program at Mercy* intended to support and care for doctors, nurses, and various other healthcare professionals.

reaffirms the value of taking time to reflect on the vocation of the healing profession and the meaning of serving in a faith-based mission culture.

Michael W. Doyle is former Vice President, Mission, Mercy Clinic, the ministry-wide integrated physician network and practices of Mercy. He provides strategic and operational leadership in developing and evaluating organizational efforts to integrate the Mercy mission into the Mercy Clinic culture of care. Michael served as a presenter at the 2011 Catholic Health Association Assembly on the topic, *Formation in the Physician Practice – A New Model of Care*, and at the July 2012 CHA Webinar on *Physician Wellbeing and Engagement – Supporting a Call to Care*. He also participated as a presenter at the November 2013 CHA Physician Leader Forum on the topic, *Integrating Mission into Physician Practices*, and the October 2016 CHA Physician Leader Forum on the topic, *Finding Meaning in Mission and Ministry – Living a Life of Wellbeing*. Mike co-authored the article entitled, *Formation in the Physician Practice: New Model Renews the Call to Heal*, for the September/October 2011 edition of *Health Progress* and authored the article entitled, *Integrating Mission into Physician Practices*, for the May/June 2014 edition of *Health Progress*. He currently serves as a member of the CHA Physician Advisory Committee.

Michael holds a Bachelor of Arts degree in philosophy/theology from St. Francis De Sales College and a Master of Divinity from St. Francis School of Pastoral Ministry in Milwaukee, Wisconsin.

Headquartered in St. Louis, Mercy is the fifth largest Catholic health system in the United States.

Chapter 14
Provider's Mission Fit and Alignment

DeAnna Marie Santana-Cebollero

"The good physician treats the disease; the great physician treats the patient who has the disease."

—William Osler

Many healthcare organizations face challenges in hiring, retaining, and onboarding providers who fit within their culture and mission. Considering the investment in recruitment, start-up, and lost revenue, physician turnover costs are estimated at an average of $1 million per physician (Schutte 2012). Unfortunately, 54% of physicians leave their group within the first 5 years (Schutte 2012). Turnover occurs for a variety of reasons, including discrepancy in physician expectations and nonalignment to the organization's culture, mission, or standards. How do we as an organization support our providers and ensure that they are satisfied and aligned with the organization's mission? Why is this so important for an organization? How do you find providers who are aligned to the foundation of your organization, your mission, and culture?

The challenge is not just on the organizational side. Physicians and advanced practice providers (APPs) deal with multiple stressors as they start a new position within an organization. In the midst of all their responsibilities, how do we help them align and integrate with the mission of their new organization? How do we also help them with the challenge of maintaining their wellbeing within the realities of a 60+ -hour workweek? This chapter aims to answer some of these questions by exploring what we have learned in our work at AdventHealth through Partnering with Healers for Wholeness. Our program was designed to hire, onboard, integrate, support, and engage our new physicians and APPs to our culture and mission so that in turn, they can extend our mission to their colleagues, staff, and patients.

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Responding to the Challenge

Many providers seek out opportunities to work with an organization because their personal mission and goals are aligned with those of that organization. At the same time, when organizations spend time and money recruiting, onboarding, and supporting a new provider, they want to know that the provider will have long-term viability in the organization. At AdventHealth, our mission, "*Extending the healing ministry of Christ,"* is the foundation of all that we do. Our goal is to recruit and retain mission-aligned providers.

We find that assessing a provider's *"fit"* is the best way to ensure that the provider's goals and mission are aligned with the organization's. Therefore, the provider's understanding of the mission and culture of the organization is vital. Even more importantly, administrators' understanding of the mission is critically important as administrators need to articulately describe the mission and culture during the initial interviewing process. We start by asking administrators questions like these:

- *What does your mission mean?*
- *Why is this important to the organization?*
- *What is the present perception of the mission?*
- *How do you want your mission to be perceived?*
- *Does our organization truly live out this mission?*
- *Do we support those who do align with our mission?*

Leaders who participate in the recruitment and selection of providers are the guardians of the organization's mission. They are the first ones to model what "*Extending the healing ministry of Christ"* can look like: extending love and compassion to our patients, to our staff, and to our colleagues. During the initial recruitment and selection process, it is important to fully describe the mission and culture of the organization and what it means. Providers can then determine if their own mission is aligned with that of the organization. It is much better to find out that a provider is not a good fit before employment begins.

The Clinical Mission Integration (CMI) department at AdventHealth has created a streamlined matrix centered on provider wellbeing and engagement. The focus of this department is to ensure providers are cared for in all aspects of health so that they can in turn provide their patients with high-quality whole-person care. The CMI department was developed to (1) provide mission support in the outpatient practices and for providers; (2) equip and support providers to practice whole-person care; (3) increase provider wellbeing and engagement; and (4) help providers seamlessly integrate into the organization and its mission. Essentially, CMI brings mission to each employed provider, their practice, and their staff, thus equipping them to *"Extend the Healing Ministry of Christ"* and supporting them as they provide whole-person care to our patients.

The CMI matrix centers on four basic priorities: (1) best practices to select a mission-fit provider; (2) developing a robust mission-centric orientation; (3) onboarding and integrating providers successfully; (4) assigning a mentor to each provider to serve as a resource and to increase the provider's wellbeing, engagement, and collegiality.

Selection

The selection process is critical. Hiring a non-missionally aligned provider is costly to the organization in terms of both finances and dissatisfaction. Recruiting providers who are aligned to the mission of the organization is vital to ensure success, satisfaction, and, ultimately, retention.

AdventHealth is developing a *"Mission-Fit Screening"* tool and behavioral interviewing process to help leaders identify providers who are aligned and fit within our organization. This tool will be sent to the provider for completion prior to their interview. The results will provide an additional resource for leaders to identify the best-fit candidate for the opportunity available. The results will also help the leaders focus on specific topics to gain a clearer sense of potential alignment and the candidate's ability to thrive in this culture and mission.

Onboarding and Orientation

Providers are finding it difficult to navigate through new hire orientations that may not have direct application for them, finding themselves not knowing who to turn to for support or resources and in some cases, being unaware of where to show up on their first day of employment. Many facilities that have orientation programs send providers to a general new employee orientation, sit down one-on-one with new providers, or do not provide an orientation at all. AdventHealth is developing a standardized orientation process for all newly employed providers. This provider-only orientation demonstrates mission integration throughout the entire process. A unique part of our orientation is its foundation in a program called Creation Life. Creation Life is a faith-based, whole-person health philosophy based on eight principles: Choice, Rest, Environment, Activity, Trust, Interpersonal Relationships, Outlook, and Nutrition.

Each department that presents in the orientation must demonstrate mission integration in their presentations. They must also include the purpose—the "why"—to connect their presentations to the provider and mission while also tying their presentations to a letter and principle from Creation Life. All presenters focus their presentations to information that is only pertinent to the providers.

Mission Integration Plan

By the time a provider starts employment, their focus is on "practicing." At AdventHealth we have developed a mission integration plan (MIP), a customized plan for newly employed outpatient providers. The MIP ensures that vital meetings and touch points with key stakeholders are conducted early on in employment. It assists physicians to fully integrate the mission, organization, and their practice, while also fostering engagement with their leaders, team, staff, and colleagues. The

MIP is outlined for 3 years, laying out a “road map to success” and shaping the provider’s expectations about the support they will receive from the organization. On the flip side, it also allows the provider to understand what is expected of them as an employed provider of the organization.

The MIP helps imprint mission during the identified meetings and touch points through the commitment we make to partnering with the provider and through the provider’s connection with their physician enterprise group.

Mission Mentoring Program

New providers often state that they feel isolated and alone in their practice when first beginning their employment. Many providers we have spoken with felt as though they were lost within their practice, with no physician collegiality and no one with whom to discuss ideas. The mission mentoring program has been developed as a response to those concerns.

Based on the feedback we received, a 3-year mentoring plan was created to equip our providers with a mission-aligned mentor who will walk them through the culture and the nuances of employment with our organization. The mentor program is designed to help the provider expedite their assimilation to the organization. This is vital for professional development, retention, and provider engagement, affecting both the mentor and the mentee. The mentor meetings are also listed on the MIP to affirm the importance of their completion. The implementation of the Mission Mentoring Program has helped increase providers’ satisfaction with their new organization, increased their understanding of the mission and culture of their new organization, and served to develop and train the mentee to become a future mentor.

Serving as a mentor is also beneficial as it entrusts the mentor with leadership responsibilities, improves interpersonal skills, helps increase job satisfaction, and can help the mentor establish a new referral stream or become a resource for consults.

Wellbeing and Support Programs

With physician burn out on the rise, organizations need to be more cognizant of this pressing concern. Providers need an outlet to deal with their daily struggles. Having a safe place to talk about similar experiences is essential to helping providers heal. So many providers feel that they are the only ones experiencing the feelings that lead to burn out or dealing with demanding issues, when in fact many other providers experience the exact same feelings and issues.

The informal wellbeing and support discussions we hold are led by physicians who share their experiences of practice. By being a part of the discussion, providers

realize they are not alone, helping them cope with struggles, and at times providing closure. This program has shown to increase a provider's wellbeing and strengthen provider relationships. AdventHealth supports many relational initiatives, including a *"Finding Meaning in Medicine"* program at each facility, ensuring that this resource is available to all employed providers.

Conclusion

The CMI department has worked to develop standardized programs for new providers entering the AdventHealth system. These programs include the mission-fit screening tool, mission onboarding and orientation, mission integration plans, mission mentoring, and *"Finding Meaning in Medicine."* Through these best practices, our providers are (1) connected to resources; (2) equipped to navigate through the systems' mission and culture; (3) imprinted with and integrated into our mission throughout the onboarding process; and (4) provided a road map to success.

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Chapter 15
New Physician Assimilation: The Role of Mentoring

Malcolm B. Herring and Rachel Forbes Kaufman

> *"For without friends no one would choose to live, though he had all other goods; even rich men and those in possession of office and of dominating power are thought to need friends most of all; for what is the use of such prosperity without the opportunity of beneficence…. "*
> —Aristotle (384–322 BC), Nichomachean Ethics, VIII, 1155a.

Introduction

Physicians find it difficult to take time for themselves, highlighted by the fact that half of all physicians do not have a physician themselves. A "lack of time" is a common response when asked why physicians do not participate in programming designed to support their wellbeing. Another response is that they are skeptical of wellbeing programming that all-too-often has been poorly designed, or even manipulative, rather than supportive of their needs.

A surgeon who was mentored as a new physician expressed his surprise that he was able to make room in his busy schedule to participate. "This mentoring experience has added a degree of 'forced calmness' to a busy and hectic workday. Making time in my day to sit with a colleague and reflect on the practice of medicine may not be an easy accomplishment for some (or many), but I have surprised myself in seeing how easy it has become for me." When physicians view a program as filling an authentic need, the outcomes can be transformative, for them and for the health systems in which they serve.

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New Physician Assimilation

Physician assimilation methods have far-reaching consequences for our physicians, our hospitals, and our clinics. Physicians commonly spend 40 years or more in a practice. Given that longevity in a culture, it is amazing how few hospitals have a new physician assimilation program to get them started. In faith-based institutions, the need for assimilation is especially great since most physicians come from secular learning environments.

Assimilation has two goals. The first and overriding goal is to sustain the hospital mission. A critical subsidiary goal is to sustain the practicing physician. Optimum assimilation is an integrated process that includes orientation and mentoring. Initially, an approach to assimilation built around the needs of a freshly trained physician seemed to make most sense, but many physicians new to the staff have been in practice for a long time in another setting. Whether new or long-practicing, both classes of physician have similar assimilation needs. They need to understand the mission of the hospital and they need an opportunity to share their own personal purpose. Responding to those two needs aids physicians in envisioning a confluence of their personal goals and the mission of the institution. Gathering a small group of physicians to talk with one another about their professional goals and about what energizes them in the practice of medicine is a highly effective method of assimilation. Rich conversations emerge. New physicians frequently make referral contacts in the orientation session.

The institutional story is also a vital piece of assimilation. I like to begin the mission story with the first hospitals in the third century. In those days, the hospital was the backroom of the bishop's home. From there I cover key elements in the development of the local mission. Medical practice is highly complex. A myriad of information needs to be transmitted to the new physician during onboarding. I recommend giving these detailed instructions and facts on a handout, CD, memory stick, or via a hospital-physician portal, because the volume of orientation material simply overwhelms. Keep in mind the preciousness of the time that you have with new physicians gathered together. Focus that time on what is most important: personal formation and relationship building.

Should this kind of assimilation be mandatory for all new physicians? Remember the reason for assimilation is to sustain the organizational mission and sustain the practicing physician. Simply ask the questions: "Should it be mandatory to sustain the hospital mission? Should it be mandatory to sustain the physicians?"

Mentoring

The remainder of this chapter focuses on the second goal of assimilation: sustaining the physician. Transmitting our passion for the missional nature of our work to new physicians, while also helping to protect them from burnout, presents huge

challenges. Research data (Shanafelt 2012; Privitera 2015) shows startling levels of burnout among physicians, marked by emotional, physical, and spiritual exhaustion. Practice administrators would be wise to pay attention to this data and to develop responses before the problem becomes more devastating. Some of the risk factors for physician burnout include a growing practice isolation, the demands of the electronic medical record, sleep deprivation, and loss of physician autonomy. Roy Blount Jr. sardonically hinted at this reality when he quipped, "Doctors and lawyers must go to school for years and years, often with little sleep and with great sacrifice to their first wives."

How can this growing crisis be addressed from an organizational level? Educational programs help, but many of the issues facing physicians are best handled in a mentoring relationship (Fig. 15.1). Mentoring has been around since ancient times. Aristotle held that a "virtuous friend" offered the most efficacious way for humans to grow and experience a good life, which he termed *Eudaimonia,* or "human flourishing." A virtuous friend should both support us, and at times, challenge us to thoughtfully consider our actions and motives. Aristotle asserted that this grist, or the grinding off of the hard exterior with a virtuous friend, was the best way for humankind to grow and experience human flourishing.

The mentorship model has long been at the heart of physician training, a method that intends to impart clinical acumen and professional development. Typical physician training methods though are not based on the equality and mutuality espoused by Aristotle, rarely does clinical mentoring lead to "human flourishing." Conversely, the Life Centered Mentoring™ physician-to-physician model is founded on the belief that physicians have mutual experiences and needs. These experiences and needs, when shared in a thoughtful way, can enhance and encourage physician well-being and engagement, and help avert the development of medical staff burnout.

Physicians constantly absorb myriad experiences and emotions, which they must set-aside to provide care for their patients. These set-aside emotions do not simply go away; they are packed down, often just below the surface of consciousness, where they accumulate. These unacknowledged and unresolved emotions can have devastating effects on the physician's relationships with family, patients, colleagues, and health systems. As a result, physician burnout is a persistent and growing challenge throughout the United States.

Unfortunately, the physician community is currently ill-equipped to heal themselves. Physicians who want to help colleagues during times of pain and loss frequently lack the skill set to be effective. Listening is important, and good clinicians are trained to listen. They are trained to extract key information, analyze and match that information to known syndromes, and prepare a treatment plan. While these are critical listening skills for the practicing physician, they are not the necessary skill set for an effective life-mentor. A successful physician life-mentor offers colleagues a safe, unhurried, nonjudgmental environment where together, through the lenses of shared experiences and values and the joint articulation of what it means to be a healer, they can nurture a relationship that fosters mutual growth, and even human flourishing.

Issues affecting wellbeing and Where they are addressed	Orientation	Mentoring	Administrative Assistance
Bring talent to work	●	●	
Humanity brought to deep call	●	●	
Personal “me” time	●	●	
Rewards - social	●	●	
Role clarity	●	●	●
Values match	●	●	●
View medicine as calling	●	●	
Adaptability		●	
Autonomy or control loss		●	
Church attendance		●	
Covenants not contracts		●	●
Depersonalization		●	●
Faith importance		●	
Influence decisions		●	●
Isolation		●	●
Mutual support		●	●
Resources allocated fairly		●	●
Service - timely delivery		●	
Work load		●	
Call schedules			●
Environment at work			●
Rewards - financial			●

Fig. 15.1 Assimilation components

Physicians are most influenced by other physicians. Physicians are therefore the most effective mentors. Moreover, private, one-on-one conversations are a highly effective setting for influence on behaviors and attitudes. We recommend that physicians start with six mentoring sessions of 60 minutes each. Each session focuses on a strategy to create margin in a key area of life (Swenson 2004) and encourages

self-discovery. The first session is dedicated to getting acquainted more deeply. The second looks at life balance. The third session explores relationships and emotional margin. The fourth is dedicated to physical self-care. A fifth session is about finances. Financial and marital stability are essential to stability in the workplace. Though it might seem odd to include finances in physician mentoring, marriages break up over financial issues so financial health is critical to physician wellbeing. The sixth and final mentoring session examines *ho*w we work and *why* we work. It is also time to debrief the whole Life Centered Mentoring experience. Method is important. In each session, participants review the objectives of the session, explore some pertinent scripture or wisdom literature, and plan for their next meeting. They may choose to pray if they wish their mentoring to include a spiritual dimension. While this approach to mentoring can be useful for any care provider, it is most effective for new physicians as it helps them establish positive behavioral patterns at the beginning of their careers.

The recruitment and training of strong mentors from the medical staff are vital to a successful program. Mentors need to be physicians of good character who are well regarded by the medical and nursing staffs. They need to be spiritually mature, because a mentoring relationship is a contract that can mature into a covenant: a three-way agreement between two people and their creator. Recruiting red flags include a high rate of malpractice, drug and alcohol problems, and medical staff officeholders. It is fair to ask what holding a medical staff office has in common with the other red flag indicators. The answer is, "not much." The concern is that medical staff bring with them a disproportionate power that can introduce imbalance into the mentoring relationship. This upsets the mutuality and equality described by Aristotle. New mentors need training. We recommend training new mentors in a 4-hour program called Doc2Doc that helps them develop necessary reflective listening skills.

Life Centered Mentoring™

Life Centered Mentoring includes three vital components: (1) hardwiring mentoring into medical staff onboarding process, (2) mentor training for physicians using Doc2Doc, and (3) equipping a physician champion—through specialized pastoral skill training and a year-long practicum—to serve as the mentoring supervisor for the pool of trained mentors. A physician-mentor supervises the entire program. The supervisor's role is to renew and sustain the mentor pool and to infuse spirituality. The mentor supervisor and the six, structured, one-hour sessions form the heart of Life Centered Mentoring™ (Herring 2012, 2016).

The history of this program is important. Despite decades of effort, the clear majority of physician wellness and engagement programming failed to substantively impact the root causes and the escalating consequences of physician burnout. For that reason, it seemed logical to adapt a successful model from outside of health care. As we looked for resources, we recognized that an effective physician-mentor

training program would have to address the mentoring skill set most physicians do not have: new ways of listening, and competency in techniques to facilitate and sustain the benefits of self-awareness activities and reflective learning. For guidance in these skills, we turned to a Benedictine monastery in southern Indiana to learn about a long-standing program they had successfully developed for a different type of healer: ministers caring for their colleagues.

Saint Meinrad Seminary and School of Theology in St. Meinrad, Indiana, offers a 15-month training program that leads to a Certification in Reflective Practices. Reflective practice is a specialized service that has long been used in the helping professions—with chaplains and pastors, marriage and family counselors, psychologists, psychotherapists, and social workers—offering tools to effectively unpack, grapple with, and learn from the myriad experiences that arise in Christian ministry. Like physicians, those in ministry must often set aside their emotional experiences to "take care of business." As with physicians, ministers who fail to unpack their emotional experiences in a meaningful way find themselves facing professional burnout and reduced effectiveness. The challenges are strikingly similar. The reflective practice model that has been helpful to ministers has proven to be suitable and adaptable for the physician community.

The guiding principle of reflective practice is the desire for mutually purposeful lifelong learning, a type of evocative collegiality envisioned by Aristotle. A Certified Reflective Practices practitioner is trained to provide a safe space for a professional caregiver to explore, question, and make use of the work-life experiences they encounter—both the realized life experiences and those which may be hidden just below the level of consciousness—believing that *all* the experiences inform their ability to grow and flourish.

The Certificate in Reflective Practices Program at Saint Meinrad combines classroom instruction with a yearlong supervised practicum, providing skill development unlike anything most physicians will have experienced. The 15-month program consists of two, 1-week seminars, set 12 months apart, with a supervised yearlong practicum scheduled between the two seminars. The classroom work covers the theoretical framework and necessary skills for reflective practice; the yearlong practicum allows the reflective practices candidate ample opportunity to increase confidence with their new skills. Both authors participated in this program in 2013–2014 and we found that the extended practicum was very important. While motivated individuals can certainly learn the principles and theories of mentoring from books and lectures, it is the grist of the supervised, yearlong practicum that provides physicians the best chance of sustaining their own wellbeing and becoming effective, transformative mentors for their colleagues.

The integration of the Reflective Practices Certification Program into a structured form of the Doc2Doc mentoring program provides the proactive, preventative benefits of virtuous friendships, and creates a physician assimilation program like no other. During the certification process, all physician-mentor-supervisors also receive training in the Doc2Doc program. Once they complete their certification, the physician-mentor-supervisor is equipped to begin training other physicians within their organizations to become physician-mentors. However, certification should be

viewed as a developmental launching point, not as an end goal. Ongoing, systematic support must be hard-wired into the mentorship program. A key tenet of reflective practice is that all mentor-practitioners, at every level, themselves sit monthly with a reflective practices mentor. This measure is crucial for the wellbeing of the medical practitioners and the sustainability of programming.

We have discovered that in many institutions, mentoring carries the stigma of a medical staff intervention intended for physicians who misbehave. We recommend two preventative steps in this regard. First, present colleague-mentoring to the staff as a preventative approach for medical staff burnout rather than a corrective intervention. Second, make mentoring an inexorable part of the physician assimilation process. If every new physician is assigned a trained colleague-mentor during the first 6 months of service, they will start their relationship with the institution with life practices to protect against burnout, including a valuable relationship with a trustworthy colleague to whom they can turn when the need arises.

The Life Centered Mentoring™ model is generating enthusiastic response from physicians and administrators who have struggled to find ways to address the escalating consequences of physician burnout. After one health system found the Life Centered Mentoring™ program to be beneficial within the physician community, they decided to pursue a second phase of mentor training, this time for their nurse practitioners. That system has seen the need for and the value of proactive mentoring within their provider network. They have supported a nurse practitioner through the certification process, and are planning for an eventual cadre of trained mentor-colleagues for their entire network of medical practitioners.

Agnes Kovacs, Director of Continuing Formation at Saint Meinrad Seminary and School of Theology and one of the instructors in the Reflective Practices Certification Program, reports that skills gained through the certification program have the potential to transform every relationship in an individual practitioner's life. Jennifer Stanley, M.D., the Physician Formation Lead for St. Vincent/Ascension Health in Indiana, attests to the holistic impact of the Saint Meinrad training. Dr. Stanley received her certification in 2016 and now supervises the Life Centered Mentoring™ Program, a pastoral approach to physician-to-physician mentoring, within her health system. In reflecting upon her experiences through the Saint Meinrad program, Dr. Stanley describes the "human flourishing" Aristotle envisioned from "virtuous friendships."

> I expected I would learn new ideas and theories about how to serve my colleagues, but I didn't realize how much I would grow through the process myself. The Reflective Practices training has given me the opportunity to learn new ways to sit with my colleagues and help them appropriately unpack, reflect upon and learn from our shared experiences. Interestingly, I am now not only a better colleague-mentor, I am also a better physician, a better wife and mother. My new skills have helped me re-engage with the reason I went into medicine, and in ways I did not expect. I have to say, I've found my joy again!

The Life Centered Mentoring™ model offers a holistic approach for improving the wellbeing in our health systems. By stepping outside our industry to look for possible resources, we discovered an effective strategy that can help physician wellness and engagement programming to finally take root in our health systems. When

we complemented the business model of physician mentoring with the reflective practices model, we discovered that physicians can re-engage with their sense of calling, find new energy for their work, find fulfillment for their life, and become powerful agents for positive change in their practices, hospitals, homes, and communities. That is *Eudaimonia*.

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Chapter 16
Shining a LIGHT to Wellbeing

Mary A. Wolf

I vividly remember attending my first Coalition for Physician Wellbeing Conference a few years ago in the most beautiful place I had ever been—Ponte Vedra, Florida. I had traveled from my home state of South Dakota, where I worked as the director of the LIGHT program and the Employee Assistance Program (EAP) for Avera Health, based in Sioux Falls. With more than 1,100 employed physicians, nurse practitioners, and physician assistants, we had observed that providers were not reaching out for help until they reached the far end of the continuum of wellbeing, becoming depressed, burned out, addicted, or displaying disruptive behaviors. We wanted to create a preventive, proactive program that allowed providers to ask for help sooner. So I found myself in Florida for this conference that would change the course of my own life and career, and that of our providers.

A conference speaker talked about building an airplane while also flying the plane and I immediately thought that has been my experience building the LIGHT program, Avera's provider wellbeing program. At that time, there were no compasses, guides, maps, blueprints, research studies, or instruction manuals. I felt like a pilot out on top of the plane tweaking each part, experimenting to see what works, while flying in the dark. And to make matters worse, I'm afraid of heights!

The creation of LIGHT began with what we know best at Avera: mission and strategy. We built a vision of a continuum of wellbeing with five driving strategies. Four years into the build, we are writing our own guide.

Through multiple avenues, we mapped out a plan to bring awareness, resources, and healing to our providers. We began with enhancing relationships with loved ones and colleagues. We then focused on the entire provider journey—from residency to retirement. We developed coaching programs to deal with individual issues, as well as overall tactics to combat what we see as a central issue that confronts virtually

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all providers at some point along their journey—burnout. As we look out across the horizon, we realize we haven't reached our destination, and so we continue to try new ways to develop a holistic program.

Beginning with Mission

Mission is core to who we are at Avera, whether that is our mission to patients and their families, to employees, or to physicians. As a Catholic healthcare system sponsored by the Benedictine and Presentation Sisters, Avera Health is a health ministry rooted in the Christian gospel. Our mission is to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values.

Throughout Christian scripture, light symbolizes God, faith, truth, and holiness, so LIGHT (Learn, Innovate, Grow, Heal, Thrive) became an ideal acronym for our ministry to physicians, nurse practitioners, and physician assistants (collectively referred to as providers throughout this chapter).

The challenges facing clinicians in practice today are unprecedented. Government regulation, electronic medical records, rapidly advancing medical trends, employer expectations, and the age of consumerism are just a few realities that form a backdrop to burnout. Early in the development of LIGHT, our focus was on education about burnout. This was important to set the stage, but we soon realized that a much deeper dialog was needed. Our team redirected our focus to improving overall wellbeing. Successful engagement required more than just talking about the problem.

Building LIGHT

Our five driving strategies were developed through conversations with our providers. We wanted to create ways to support and encourage our providers using key tactics to carry out these strategies including retreats, social events, onboarding sessions, educational events, workshops, online resources, and executive and peer coaching. The five strategies are outlined below.

- LEARN: Striving for program awareness through website, LIGHT lunches, CME's and blogs
- INNOVATE: Working toward solutions through research and pilot programs
- GROW: Promoting system and government change through advocacy
- HEAL: Offering confidential coaching, resources, referrals and Schwartz Rounds
- THRIVE: Providing strategies to achieve overall wellbeing including retreats, socials and retirement workshops

The *support of senior leadership* has been integral to LIGHT's success. Before LIGHT was even created, Avera Medical Group Chief Medical Officer, Dr. Tad Jacobs, formed a steering committee to design the wellbeing program without duplicating what was already offered through EAP. Avera EAP had a strong reputation and high utilization, but not among our providers. We needed to offer something different, a more proactive approach without the stigma of mental health services and without having to report contact on their license renewal. After a year of monthly committee meetings, LIGHT was formed and budgeted. The current *LIGHT steering committee* is comprised of physicians, a mission leader, physician spouses, a physician assistant, a chief medical officer, nurse practitioners, a clinic manager, and representatives from marketing. As a champion and advocate for LIGHT, Dr. Jacobs is a well-respected physician administrator who talks the languages of both physician and administrator.

Having a *LIGHT medical director* has been an important part of the success of the program. The dyad leadership adds credibility and offers a broader perspective when presenting to providers and leaders on the need for a culture of wellbeing.

Our *website* (https://www.avera.org/light) is the closest thing we have to a manual. Providers can navigate through short videos on EMR strategies, meditations, burnout prevention tips, and self-care options. The site also features assessments, resources, contact information, and upcoming events. We will be adding blog posts and Facebook groups.

Ongoing *communication* is critical, yet communication is challenging as only about 45% of providers read their email. Dr. Jacobs sends out all communications about LIGHT to increase the chances of readership. He also emails the Avera Medical Group UPDATE newsletter. We highlight LIGHT in every issue.

Enhancing Relationships

In developing LIGHT programs, we first focused on enhancing relationships. We looked at ways to shine light on our providers' relationships with their spouses/significant others and relationships with colleagues. Avera Medical Group's Vice President of Mission, Steve Tappe and I coordinated a *mini couples retreat.* The 4-hour event provided all participants with an individual DiSC® assessment of their styles along with a comparison of styles with their spouses. Next, we invited a physician and her spouse to lead a session on the pros and cons of a medical marriage. This session brought participants validation of frustrations, support, connection, and joys with all of the commonalities of their lives. Couples bonded not only with each other, but also with other couples in similar circumstances. Lastly, Steve and I led an activity based on "The Five Love Languages" by Gary Chapman. Couples received this book as a gift. They assessed their preferred love languages and shared

with each other. We challenged participants to show affection on an ongoing basis in their spouse's love language.

From this retreat three spouses volunteered to serve on our LIGHT steering committee as well as our *spouse engagement group*, which plans social gatherings for providers and their spouses, significant others, and families. As I talk with our providers, I hear they desire more time with colleagues on a social basis. Busy practices often make for lonely, siloed providers. In marketing our events, we also make them friendly for single providers. We want everyone to feel welcome.

Next we mapped out a plan for *No Agenda Socials*, offering attendees a time to talk with colleagues, enjoy food and beverages, and decompress from the day. There truly is no agenda. We talk about LIGHT for a minute and let them connect.

Following the Entire Journey

LIGHT supports providers from residency to retirement.

When physicians join Avera, it begins with *onboarding*. LIGHT presents an evening portion of the physician onboarding event, and spouses and significant others are welcome to attend. Our LIGHT medical director or a physician from our LIGHT steering committee gives an overview of his or her own personal story of burnout, work/life prioritizing, and faith. As the program director, I talk about the purpose for the program, upcoming events, why people utilize executive coaching, and the resources available to providers. Through onboarding, we want to send a message that LIGHT was created to help providers keep balance for themselves, their families, and their teams. We want them to feel cared about in a healthcare world that cares about numbers. We want to help them focus on the joy and rewards of healing others.

We also provide *LIGHT lunches* at which our medical director and I give a short presentation on LIGHT and discuss common stressors. This is also an opportunity to learn what our providers need to sustain a meaningful career over their lifetimes. The lunches provide a way to build trust before calling for assistance. Those who voluntarily seek out coaching have most often met me at a lunch or through onboarding, or received encouragement from an administrator or colleague. Getting out and meeting our providers to build trust has been a key strategy in encouraging providers to reach out for support.

LIGHT offers a *retirement series* that specifically challenges providers to think about the emotional aspects of retirement, not just the financial. Goals include finding meaning when they are no longer seeing patients, developing an identity outside of their career, and re-establishing relationships now that couples and families have more time together. Spouses and significant others can also attend the series. One physician said, "The three-session retreat provided time dedicated to processing my upcoming retirement with my spouse. Included in the retreat were many helpful suggestions. One suggestion I have already implemented involved expanding my social circles. Another valuable concept was to think about 'mattering,' and in what ways I will matter after I have retired."

I worked with Dr. Karen Garnaas, Avera neurologist and chief of staff, to develop a *Women in Medicine 2-day retreat* focusing on spiritual renewal and rejuvenation. The speakers encouraged women to care for themselves, connect with other women, and further develop their faith practices. We gave them gift bags with books, a journal, and dark chocolate. Feedback was excellent, with requests to offer it on an annual basis.

Coaching

As a licensed professional counselor for over 20 years, I could see a new strategy was needed to extend assistance to our busy, smart professionals who have a don't-ask-for-help mentality. *Executive coaching* became that strategy. I was already using my certifications in life and spirituality coaching, but added executive coaching to specifically assist with leadership, communication, strategic planning, personal branding, and collaboration. Coaching has become a favorite part of this adventure since the momentum of progress is quick and solution focused. Providers tend to be highly driven to succeed in whatever they commit to, so once they enter the coaching process they are diligent in completing homework and progressing. Common themes I have noticed in providers seeking coaching include:

- Reducing burnout and overwhelm
- Juggling work and home responsibilities
- Achieving timeliness and accuracy with EMR documentation
- Prioritizing time based on values
- Strengthening leadership skills
- Navigating change
- Preparing for retirement
- Communicating with colleagues, leaders and staff

Referrals for coaching come from CEOs, CMOs, administrators, clinic managers, previous coaching clients, primary care physicians, self-referral, or spouses. As more professionals sought coaching, I returned for training to become certified to train our providers as coaches. Since then, I have trained nine physicians, two nurse practitioners, and a physician assistant to fulfill the role of *peer strategy coaches*. Providers often want to talk with their peers about issues and appreciate that fellow providers have been there. I think it also makes asking for help a bit easier.

Through coaching, we have been able to retain two providers, one physician, and one CRNA who likely would have otherwise left our system. Our physician turnover rate is already very low at 3–4%. A participating physician commented, "I had the opportunity to work with a physician coach specifically for physician burnout and needing to make an extremely important decision that I was not able to make under the circumstances. The coach was perceptive enough to ask the appropriate questions and give the guidance in such a manner that I was able to make this deci-

sion after just three sessions of coaching and doing the assigned homework. The homework was geared toward facilitating my decision-making process and it was very helpful. The coach was very supportive and helped me consider the various solutions without bias and without judgment."

Preventing Burnout

In the second year of our program we partnered with the *American Medical Association* as a pilot site for their Mini Z burnout survey. The survey data showed us that we were at national average for burnout, while our satisfaction rates were higher than average. The professionals at AMA are strategizing with us to not only look at self-care aspects to prevent burnout, but also achieve clinic efficiencies and develop practice management tools. This will be where we focus our time and resources in the year ahead.

Avera's Vice President of Ethics, Mary Hill, and I implemented the *Schwartz Center for Compassionate Healthcare Schwartz Rounds*. These rounds provide a facilitated process, focusing on the social and emotional aspect of being a healthcare provider. As the Schwartz Center's website states: "When caregivers are compassionate, patients do better and caregivers rediscover their passion for healing. We are leading the movement to make compassionate care a national priority."

Schwartz Center's programs help:

- Support and engage staff
- Build stronger teams
- Increase caregiver satisfaction and resilience
- Improve authentic communication
- Create a culture of compassion

LIGHT offers *comprehensive assessments* and resources for those who are experiencing serious burnout. Avera is home to a trusted Employee Assistance Program (EAP) that can help with mental health and substance use disorders. I see providers to help determine level of care.

Over the last 4 years, we have developed a good relationship with *Acumen Institute* in Lawrence, Kansas. They provide comprehensive, four-day evaluations for professionals who are experiencing burnout, mental health challenges, addiction, ethical or boundary violations, cognitive impairment, or disruptive/distressed behaviors. Acumen offers assessment summary, recommendations, and follow-up care strategies. I was fortunate to do a fellowship with Acumen as we were starting the LIGHT program. Also, we have contracted with Vanderbilt University for comprehensive assessments.

Dr. Jacobs and Avera's Human Resources department created the Avera Medical Group *Distressed Physician and APP Guidelines* to outline steps in helping professionals when their struggles manifest into work problems. Avera shows great compassion to providers who are struggling with these difficult issues while also

holding them accountable. Avera makes every effort to offer the resources for treatment and healing. After the physician pays for the assessment, he or she is reimbursed. This allows physicians to see that Avera is invested in them.

LIGHT has allowed us to *shift culture*, making it more acceptable to ask for help. We are building a culture that cares for our patients while taking great care of our colleagues and ourselves. Through this shift, we are redefining quality not only in our patient satisfaction, but also in our physician and provider satisfaction. To help with the culture change across our 400-mile footprint, we have recruited *LIGHT champions* in each Avera region to promote LIGHT activities and advocate for wellbeing locally.

Watching the Horizon

We still have many strategies we hope to implement:

- Develop a mentoring program
- Continue to build our force of peer strategy coaches
- Prove our progress through metrics to show return on investment
- Complete projects to enhance efficiencies, processes, and workflow

While challenging, LIGHT has offered a scenic and rewarding ride. A lesson we've learned is that we need a strategic plan to help with pacing; otherwise, every project becomes the immediate priority. Also, I needed this pacing as my role was limited to quarter time the first year, and half time the last 2 years. In 2018, my role became full time.

We were honored to be recognized with the Coalition for Physician Wellbeing Medicus Integra Award, as well as Catholic Healthcare Association (CHA) Achievement Citation Award. CHA created a video that highlights our program (https://www.youtube.com/watch?v=RPdSP_ew9a4).

The LIGHT program exists to help our providers in balancing necessary parts of their jobs, along with promoting the reasons they actually went into medicine in the beginning. In the healthcare world everything has become about measurement. For providers, numbers and measurement are essential in diagnosing and treating patients. Hospital and clinic leadership analyzes numbers to maximize productivity and care. Yet we try to remember the famous quote by Mother Teresa to return us to what is important—mission and strategy: "Never worry about the numbers. Help one person at a time and always start with the person nearest you."

Chapter 17
Collegiality and Physician Well-Being

Doug Wysockey-Johnson

> *I cannot but believe that David's aloneness, his addiction, was worse for being in the medical profession—and not just because of ease of access, or stress, or long hours, but because of the way our profession fosters loneliness.*
>
> – (Verghese 2011, p. 341)

Introduction

I recently asked a group of experienced doctors what they might say if they had a chance to address a graduating medical school class. What words of advice would they offer? There were a number of different comments, some comical ("Go into dermatology! Concierge practice!"), but after a while, a definite theme began to emerge: "Learn to lean on others"; "medicine is a team sport"; "call others in sooner"; "don't do it alone"; etc. This group of experienced physicians offer the deep insight that relationships and collegiality are critical if one is to survive and thrive in the practice of medicine.

In this chapter, I will build on this understanding by exploring how to use something as basic as collegiality to help lessen, or even prevent, the effects of physician burnout. We all know that larger forces work to create the current environment where half of practicing physicians report at least one symptom of burnout. There are no easy answers (Medscape Lifestyle Report 2017: Race and Ethnicity, Bias and Burnout 2017). I am increasingly convinced though that collegiality is one of the most effective (and low-cost) tools to increase physician well-being within the many pressures at play.

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Why Is Medicine a Lonely Profession?

The loneliness and isolation of physicians emerge within the larger context of our society. Many researchers identify a weakening sense of community within our culture. One of the first to name this concern was sociologist Robert Putnam, who in his seminal work *Bowling Alone* warns that our stock of social capital—the very fabric of our connections with one other—has plummeted, impoverishing our society and our lives.

Putnam draws on a variety of evidence, including nearly 500,000 interviews over the last quarter century, to show that we sign fewer petitions, belong to fewer organizations with regular meetings, are not as familiar with our neighbors, spend fewer hours gathering with friends, and socialize less with our families. We're even bowling alone; more Americans are bowling than ever before, but they are not bowling in leagues. Putnam shows how changes in work, family structure, age, suburban life, television, computers, women's roles, and other factors have contributed to these declines (Putnam 2000). Given this decrease in "social capital," I suspect that it is not just physicians who report a loss of collegiality. Workers in most professions would likely report a similar experience.

It needs to be said that the lack of collegiality among physicians is also a natural consequence of "positive" factors. Younger physicians are seeking a more balanced life, and they want to be active participants in their families' lives. They not only *want* but also *expect* to be at their kids' soccer games. This creates a number of professional challenges, but an expectation of better work/home balance is ultimately a positive movement.

While there are indeed larger cultural forces at play along with positive reasons for the lessening of collegiality, there are distinctive dynamics within the practice of medicine that exacerbate the lack of community within medical staffs. These factors are well known to physicians and to those who seek care for them: long hours that crowd out time for relationships, training that has (until recently) emphasized a lone-ranger mentality, increased demands around electronic health records and productivity metrics, and a form of perfectionism that makes it difficult to say to another doctor "I need help." For all these reasons and more, medicine is increasingly a lonely profession.

Research Catching up with Our Experience

Both intuitively and experientially we know that strong relationships and collegiality make a difference in our resiliency. Anyone who has gone through a work challenge and experienced the support of others (or not) knows that help from colleagues matters. Fortunately, there is an increasing body of research backing up these intuitions.

In a recent study led by Colin West, researchers looked at the impact of physician participation in facilitated small groups. The curriculum in the groups focused on mindfulness, reflection, and shared experiences, all of which enhance collegiality.

The research team found that "… rates of depersonalization, emotional exhaustion, and overall burnout decreased substantially…" (West et al. 2014).

Google is an organization that loves metrics and numbers almost as much as hospitals do. For years they have been asking questions like: "What makes a team successful?" "What are the characteristics of best performing groups?" **"**Are the best teams made up of top individual performers?" "Of people with similar interests?" "Of people motivated by the same rewards?" Through an initiative called Project Aristotle, Google studied many of their organization's teams. They were initially unable to discern a pattern in response to their questions. As they persisted, the company discovered that group norms mattered most, with norms meaning the unwritten rules that govern how we behave with one another. Google then turned its attention to the question of which norms matter the most. They found that the highest-performing groups were ones where (1) everyone got a chance to talk and participate, and (2) there was a high-level social sensitivity, meaning people were skilled at intuiting how others were feeling.

Clearly, factors like well-defined goals and dependability make a difference for group performance, but Google found that the most important element in group performance was psychological safety. As with medical staffs, this can be tricky at Google—a company filled with engineers, people who don't particularly love talking about feelings in the first place. In response, they have been working on ways to create the kind of environment where employees can tell and hear stories from each other and where vulnerability is encouraged, not discouraged (Duhigg 2016).

These are just a couple of examples of research demonstrating the importance of collegiality. This research might best be summed up in words from the past Medical Staff President of Castle Rock Adventist Hospital, Dr. JD Guilland:

> *One of the important categories of "relationship" that has been squeezed out of our day is the one with our physician colleagues and associates. I remember the day when we actually had/took the time to sit and have lunch with our teams, now we just grab something and head back to the computer. Without the relational equity we build into our culture, accomplishing the monumental task of patient care is virtually impossible. We cannot and will not take care of patients any better than we take care of each other.* (Memo to Medical Staff of Castle Rock Adventist Hospital, 11/13/13)

Encouraging collegiality in a profession that fosters loneliness and with physicians who are busy and stretched thin is not easy. Despite the challenges, it is not impossible. Healthcare systems are developing strategies for how to be more intentional about building collegiality and relationship within the medical staff. These strategies include methods to model, meet, equip, and eat.

Model

Most likely there are physicians on every medical staff who value collegiality and make it a priority. Whenever possible, leadership should shine a light on the physicians who are already modeling collegiality. Whether through formal structures like a "Physician of the Year" award or informal shout-outs in the monthly newsletter,

the goal is to leverage the physicians who are valuing collegiality. Invite them to speak; give them a pulpit; share with others the way they go about their work.

A second opportunity to model collegiality involves moving beyond the local medical staff. More and more, physicians write about the importance of relationship in books, blogs, and journal articles. One example from a recent *New England Journal of Medicine* article by Dr. Adam Hill provides an example:

> *The fourth lesson is about vulnerability. Seeing other people's Facebook-perfect lives, we react by hiding away our truest selves. We forget that setbacks can breed creativity, innovation, discovery, and resilience and that vulnerability opens us up to personal growth. Being honest with myself about my own vulnerability has helped me develop self-compassion and understanding. And revealing my vulnerability to trusted colleagues, friends, and family members has unlocked their compassion, understanding, and human connection*. (Hill 2017, p. 1103)

Physician reflection on the importance of collegiality is on the rise. *When Breath Becomes Air* by Paul Kalanithi and *Do No Harm* by Henry Marsh are two recent examples of memoirs that speak to a more relational style. Another place to look for content is the "In My Opinion" section of every issue of the *Journal of the American Medical Association*. Often those pieces highlight some aspect of collegiality.

A third way to model collegiality is to employ some form of mentoring program. By their very nature, mentoring programs are relational. They provide an easy opportunity to increase collegiality, particularly for those physicians who are early in their career. There are abundant examples of great mentoring out there. In his book *The Physician Champion: Agent for a Compassionate Culture*, Dr. Herring writes, "[m]entoring sustains and reinforces behaviors. It develops like no other tool…..Conversations are tailored precisely to the protégé's needs. Because mutual care develops and is expressed, mentoring fosters a hospital culture of mutual care and compassion" (Herring 2010, p. 141).

Meet

There is no way to build collegiality and relationships without meeting. Social media connections and other online strategies can help, but relationships are built and strengthened through face-to-face interactions. These interactions can come in a number of different shapes and sizes, each with its own opportunity to build collegiality.

Short Meetings Here I am referring to the brief opening that some use at the start of other meetings (e.g., business or medical executive committee meetings). Even in a compact 5 minutes, there is an opportunity to build collegiality. Rather than just reading an article or poem for the whole time, it is helpful to spend one of the minutes giving content and leave the other 4 minutes for conversation in dyads. Most people spend more time on content than on forming a good question, but it is questions that lead to better collegiality. Good questions invite good conversations, and even short conversations plant the seeds for further relationships.

Medium-Length Meetings Here I am referring to meetings of approximately 30–60 minutes where the primary agenda is physician well-being. In Lumunos's physician colleague program (physicians.lumunos.org), these meetings happen a few times a month at a variety of times. As with the shorter meetings, the goal is always doctors talking to each other. Provide a short amount of content around a topic relevant to the participants, and then facilitate the conversations. If it is a larger group, the conversation needs to be guided so that each person is invited to participate in a way appropriate to them.

Long Meetings In this category I am thinking primarily of retreats of various lengths. These might include anything from a half-day retreat to a weeklong ski trip. Long meetings provide a huge collegiality boost. Getting off site, eating meals together, and having free time for group or individual activities all make a significant impact on collegiality. While these opportunities cost money and time, the benefit usually lasts throughout the year.

Equip

I have had more than one physician say to me that their medical training required them to put their social and relational development on hold. Even if that is not entirely true anymore, the reality is that all of us need encouragement now and then around our relationships.

Without turning collegiality efforts into group therapy, it is possible to address topics like, "How to approach a colleague who is showing signs of burnout," or "Ideas for expressing appreciation to other physicians." At Lumunos, our weekly physician colleague emails occasionally focus on other relationships in life, including family and friends. The equipping takes the form of encouragement, and of reminders of the importance of tending relationships. Sometimes we even include "conversation tips for those who have been married a long time." These things may seem obvious, but the truth is that all of us need equipping when it comes to deepening relationships and moving beyond the surface.

Eat

Most hospitals have physician lounges. Some function more like a 7–11, with doctors racing to grab a quick snack before heading back to their desks. Others are beehives of activity, with tables filled with physicians talking, laughing, and supporting one another. Hospital leadership has the opportunity to be thoughtful in creating physician lounges as spaces that encourage collegiality. Creative elements include everything from the food served to the art on the walls. One size does not fit all. The key is being thoughtful and soliciting input from physicians.

Conclusion

A committed physician should not be confined to a lonely profession. There are elements of shared understanding that go with being a doctor. The rigorous training and intensity of experience naturally invite community, but forces within society at large and within the practice of medicine have made it increasingly difficult for physicians to support one another. For that reason, healthcare systems will need to be purposeful about creating space and opportunities for doctors to build collegiality.

Many years ago a wise elder used the image of a rope to talk about the importance of relationships. He said that while one strand can be easily torn, "A threefold cord is not quickly broken" (Ecclesiastes 4:1 New Revised Standard Version). Let's work to strengthen and encourage our physicians by weaving them together with one another. In that way, they will continue to offer a life rope to the patients they seek to serve.

Doug Wysockey-Johnson is the Executive Director of Lumunos, an organization that has been a leader in physician well-being for 10 years (physicians.lumunos.org).

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Chapter 18
Counseling, Coaching, and Consulting

Kathleen C. Gibney

The secret of change is to focus all your energy, not on fighting the old, but on building the new.

– Socrates

In this chapter I seek to illustrate the transformative power of counseling, coaching, and consultation in physicians' lives, as told from the perspective of a psychologist who works alongside them in their hospitals and practices. I suggest that these three approaches—counseling, coaching, and consultation—can prevent, identify, and treat burnout, foster resilience, and build trust. To protect the confidentiality of the physicians involved, all names and identifying details have been changed.

Counseling

As Dr. France sat across from me, the enormity of what had unfolded began to sink in. In a matter of minutes, his stoic expression gave way to trembling hands and a steady stream of tears running past a tightly clenched jaw. At the urging of a colleague, Dr. France made the appointment with me to, "…*report the incident before someone else did, so that at least it would be accurately explained*." As he recounted the story of losing his temper in the operating room, his emotions swung like a pendulum from sadness and confusion, to anger and frustration, then finally settling on worry and fear. "*My 25-year career is in jeopardy because of the lack of attention and professionalism exhibited by my OR team*." As he surrendered to his emotions, I noticed his breathing slow down. He sunk down into his chair. He talked at length about his frustration and sense of helplessness, feeling himself at the mercy of a situation that felt out of control, made worse by a team he believed he could not

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trust. By the time he finished recounting the details of his experience, the room felt calm and quiet. I let the silence linger for a moment. "*Dr. France, what else might be important for me to know?*", I asked. He looked up from his hands to catch my glance, then let out a quiet sigh. He was now ready to tell the rest of his story.

Six years prior, Dr. France was sued for the first time in his career after a bad surgical outcome, one that did not involve a medical error. The suit resulted in a 4-year protracted process that, against Dr. France's wishes, was settled by the hospital. Driven by the fear of another lawsuit, Dr. France made the personal decision to stop providing that specific surgery. "*I sold the practice to the hospital*," he said with a wince, "*My baby. I thought being employed would provide more time with family and less administrative responsibilities*."

The new arrangement with the hospital required that surgeries be performed in a new OR and with a different, younger team. Sadness washed over Dr. France as he talked about having to stop working with his old team after 20 years together. He described the pain of trying to deal with family illnesses and deaths while transitioning to this foreign new world of work. "*No one knows this story except for you. I do not want to be viewed as weak or unable to manage my own decisions*." As I reflected what I heard back to Dr. France and put his experience in the context of his loss and grief, a small smile appeared. "*I guess I have had a lot on my plate*," he said, followed by a thoughtful pause. "*But it doesn't justify being so disrespectful of the team, does it?*"

This is what I love about my job. In creating a safe space where people can tell their unfiltered stories, I witness them finding their way to an understanding of where they need to go next. Over the next several sessions, Dr. France and I came up with a multifaceted plan that acknowledged the losses and changes that were occurring, while at the same time supporting Dr. France in developing self-care strategies, improved communication skills, and setting more realistic expectations that were no longer grounded in fear. The OR team graciously accepted an apology that had been well-scripted and practiced in our meetings. They agreed that there was work to be done to build a stronger unit. Administration acknowledged the many improvements made by Dr. France, and pledged their commitment to help address some of the self-care challenges physicians frequently face.

According to Dr. France, the greatest outcome of our 4 months of work together was an emerging awareness of his personal responsibility and power to choose his actions in any given situation while acknowledging the need to share some of his limitations with others at work and in personal relationships. "*It was hurtful for me to hold onto what was, and to long for it once again. I have learned that I have the power to live more fully, and I have a new awareness that I cannot be alone on this journey*." His statement was an important affirmation of the power of the counseling relationship. When bounded by safety and trust, the counseling relationship can help people improve their sense of well-being, alleviate feelings of distress, and resolve crises while also maintaining awareness of the person's developmental stage, the strengths of the person, the environmental influences at play, and the places for applied advocacy.

Physicians are taught to figure things out, to fix problems, to suppress emotion, and to avoid mistakes. "*Be more than human – be perfect!*" Perhaps what we really have come to expect from our doctors is that they be *less than human*. Perhaps our expectations demand that physicians wall off emotion, keep their stories to themselves, and walk with their patients through the most intimate of situations without deeply connecting with them. Should any of us then be surprised when some physicians present like robots without feeling? In many ways, that is what they have been trained to do. Rather than pushing them to embrace their humanity and to use their emotions to connect with their patients and colleagues through the hard work that is medicine, doctors have been trained to disconnect, both inwardly and outwardly, in the name of "helping others." No wonder then, that 400 physicians commit suicide each year and over 50% report at least one of the symptoms of burnout that include exhaustion, cynicism, or lack of meaning in their work.

Through counseling with our physicians, I have come to admire their courage and persistence in excellence, while honoring the pain that comes with an unanticipated outcome or their inability to care for patients the way they used to. The healthcare system is broken in many places. While solutions to improve that system are explored, we can implement individual counseling to assist physicians in carrying the burdens of their profession. I know it is not enough.

Coaching

"*Hey Kathy, over here*." I turned to see who was calling me as I walked through the physician lounge with my lunch in hand. "*We have a situation that could use your expertise*," said Dr. Thorpe as he waved me over to his table of lunching physicians. This was music to my ears. After spending so much time in our physician lounges trying to forge relationships with the physicians, I was beginning to feel more like a salesperson making cold calls. Now, at last, here was a group of physicians sitting together and asking me to join the discussion about their concerns for their young teenage children's use of technology. We had a spirited debate about role modeling, technology-free times (dinner) and zones (bedrooms), and the impact of technology on the developing brain. The time together ended with some suggesting they would try the ideas we had generated. I promised to bring some literature to substantiate the ideas we discussed.

The very next week, we were back at it, but this time we were supplied with interesting reading material on the topic. From here, the interest only grew, and I was soon facilitating a parenting workshop for physicians called "*Social Media & Gaming Addiction in Children & Teens*." To my delight, the workshop was well attended and received.

Another day, at a different hospital, I was walking through a unit when I heard: "*Dr. Gibney, do you have a few minutes to talk?*" I am used to our physicians calling me Kathy, so I guessed it might be a resident. I was right. We moved to a quiet area of the unit and focused on the resident's report that one of the attending physicians,

as he stated, "*has it in for me*." We examined whether there was any evidence to support his impression, what communication patterns might be reinforcing that belief if in fact it were true, and what changes the resident could make to feel less judged, less anxious, and more confident in the presence of this leader. We role-played options and made a simple plan for how, when, and where to try out the ideas. A few months later, I saw the resident again at a small group training I was conducting for their residency program. Things had already improved! "*I know I can manage my reactions and not personalize comments, and actually use the feedback to improve*," he said with a smile. "*I no longer believe the attending is out to get me. He just thinks a good doctor is developed by being criticized. A lot!*"

On a different day, at yet another hospital, I was approached by a new physician for suggestions on how her presentation to leadership would be best received. We brainstormed hopes for the encounter, how to manage the time, and the most effective way to present the idea. When I saw her again a few weeks later, she said, "*My presentation was received with respectful interest. I am not sure anything will change, but I think they may be considering my idea, so we shall see how it goes*."

Three different situations. Each an example of informal coaching where one person actively guides another through a process, leading to performance enhancement through affirmation and practice of what they already do well, while also building new skills. Physicians don't ask for help easily, and when they do, they like practical advice from a person they believe has some credibility. The approach of being present in their social and professional space lends itself to building credibility and to collaborative coaching that minimizes judgment and maximizes relational connection. After about 6 years of informal physician encounters in the hospital hallways, I'm noticing a growing willingness among physicians to ask for help—from me, *and* from each other. It is something I celebrate every time I am invited to participate.

Consulting

Dr. English called to set up one of our individual consultation services called, "Intentional Rounding." Her latest HCAHP score report found a significant deficit in patient satisfaction. "*The truth is I am just not good at connecting*," she said in a matter-of-fact tone. "*Do you think there are ways that I might be able to learn how to better connect?*" We set up a time for me to shadow her for an entire day, taking notes on my observations and asking questions about processes. This resulted in a compilation report on findings, strengths, and recommendations, as well as an implementation plan.

During our time together, it became clear to me that Dr. English connected well with patients through excellent eye contact, showing interest in their story, and sharing the review of their file, which was always completed before entering the room. What Dr. English did not know was how to close the encounter, outline the next steps, or communicate orders with nursing effectively. This resulted in nursing

calls several times during the day to confirm orders and relay patients' concerns. The patients were anxious and uncertain about what was to be done next, when discharge would occur, or if there were any special plans required to return home safely. In addition, Dr. English had not taken advantage of the IT team's ability to create "power notes," so she was spending a lot of extra time with time-consuming and outdated documentation methods. Efficiency suffered. Exhaustion took over as the day became protracted due to the need for repetitive tasks, extra phone calls, and refocusing of attention. In her state of exhaustion, I also noticed that she seemed unaware of resiliency strategies that might help revive her energy and her spirit: mindfulness breathing, refocusing, eating well, drinking sufficient water, or connecting with peers.

As she read my report after shadowing, Dr. English was surprised that I characterized her ability to connect with patients as a strength. She was enthused to implement some of our new ideas, and even shared my report with her colleagues, asking nurses to assist her by requesting clarification when things were not clear or complete. Dr. English asked that the team help her by using the phrase, "*stop, order, confirm*."

Weeks later, when we met for a follow-up appointment, Dr. English was eager to share her successes. She was feeling less stressed and was getting home a bit earlier. It will be interesting to see if there is a change on her future HCAHP scores, but even if there isn't, Dr. English feels like the consultation was, "*an undertaking worth doing*." I couldn't agree more.

We receive requests for department-wide consultations as well. These have included team interventions to address unique department needs such as communication barriers, low morale, team burnout, and unprofessional behaviors. In one case, a department manager asked for assistance in understanding negative communication among team members, overall lack of team support for one another, and decreased patient satisfaction with the program. Through the consultation we identified a deficit in specific interviewing strategies as well as hesitancy to share information due to a perceived lack of confidence and trust between leadership and the team. Two skill-building meetings were held to address the deficit. In addition, I led several team meetings that required each member of the team to present a challenging case before leadership and peers with the goal of developing new strategies and building trust.

Over time, we held eight meetings during which new and confident presentation styles were noted along with increased risk-taking in the presentation of more complex cases and positive collaboration among team members. In the final consultation meeting, we summarized the expanded use of newly acquired interview skills systematically and effectively across the team, improved team dynamics in seeking each other out for support and case conceptualization, a better sense of leadership support, and a decrease in patient withdrawal from the program due to dissatisfaction with team communications.

Consultation affords physicians the opportunity to receive expert advice from an objective person with the goal of improving personal and professional performance, evaluating and streamlining processes, and expanding team effectiveness.

Our use of consultation is also grounded in the belief that culture is changed at the individual, team, and organizational level, and that interventions must be uniquely designed to maximize the creation of healthier work communities.

Conclusion

Burnout is not a result of individual deficits alone, but also of systemic failures within health care. The epidemic of physician burnout requires a diverse set of strategies to provide comprehensive prevention, confident identification, and effective treatment. It requires system strategies, individual strategies, and an acknowledgment that the men and women who are called to medicine report feeling that they are caught in an assault on their personal and professional lives. We inhabit a crucible—a time of severe trial that we hope will create a new environment for healthcare delivery. Counseling, coaching, and consulting are three interventions that may provide promising means to care for our providers. Our physicians' lives, and consequently our patients' lives, depend on it.

Part V

What About the Spiritual Dimension?

In this section of the book, we explore the ways in which resilience can be fostered for physicians. Brene Brown, PhD, in *The Gifts of Imperfection*, her book exploring research into resilience, states that "without exception, spirituality – the belief in connection, a power greater than self, and interconnections grounded in love and compassion – emerged as a component of resilience" (Brown 2010, p 64).

Because resilience is a huge factor in wellbeing, it is important to explore the role of spirituality as an aspect of the physician's life. Many physicians express their spirituality through their religion of choice, while others express their spirituality in quiet, in nature, and through service. However a physician chooses to exercise spirtuality, it is a vital part of life that is often overlooked in the exploration of wellbeing in physicians.

We hope, through this section of the book, to open a wider discussion and encourage research into the ways we can support one another in the spirituality inherent in each of us as physicians, and in each patient as well, in order to restore this important aspect of practice into the conscious choices we make as we structure healthcare systems and processes.

Physicians deal with the heart-wrenching realities of illness, pain, and death on a daily basis. We owe it to one another, and to our patients, to delve deeply into this fundamental source of strength.

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Chapter 19
Physicians and Spirituality

Kathleen Perno and Harold G. Koenig

The greatest mistake in the treatment of diseases is that there are physicians for the body and the soul, although the two cannot be separated.

– Plato

Introduction

Case Study

Picking up the schedule for the day, Dr. Jonas notices with a sigh that Mrs. Smith is slotted for a 10:00 am appointment. This will be her third visit to the practice in 6 weeks with the same vague complaints. He had already run a battery of routine diagnostic blood work and imaging and did the appropriate workups for her symptoms, searching for everything from autoimmune disorders to vitamin deficiencies, ruling out any of the obvious diagnoses, but they yielded no explanation for her concerns.

After seeing several patients for reasons ranging from the flu to annual physical exams, Dr. Jonas greets Mrs. Smith in the examination room, and the physical assessment begins as it has on previous visits.

"How are you doing? What seems to be the problem today, Mrs. Smith?"

"I just don't feel well," responds Mrs. Smith with tears in her eyes. "I have no energy, I can't sleep, and I have no appetite."

As Mrs. Smith begins to ramble about this year being the 40th wedding anniversary and how much she misses her husband, Dr. Jonas is aware that she is lonely,

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isolated, and grieving, yet he feels helpless and ill equipped to handle her grief. If he encourages her to share in more detail, he is worried that he will keep the other patients waiting, which would impact his productivity. Should he run additional tests, or could there be a deeper spiritual issue which may be driving her symptoms? He is concerned that if he doesn't address her deeper spiritual needs she will keep coming back with the same symptoms. He is aware that spirituality can impact health, but he feels inadequate to address these issues.

Physicians are aware that tending to the body is not enough because, as Plato said long ago, the body and soul cannot be separated. Busy physicians need capacities beyond awareness. They need training and support to respond to the whole person in order provide patients the full range of care required. A spiritual care team (SCT) led by the physician can work together to provide the structure and support physicians need to acknowledge spirituality as an aspect of health and healing.

Spirituality

Physical symptoms reveal the needs and suffering of a patient's body; emotions are windows into the spirit. Yet, as Plato articulated, the two cannot be separated. In order to treat the whole person, attention must be given to both the body and the spirit. A head may ache when the actual cause is grief. After customary physical examinations have been conducted, physicians face the additional challenge of understanding underlying factors that impact the psyche. These patient needs usher physicians into the realm of spirituality.

"Spirituality is an ideal term to use in clinical settings where talking to and engaging with patients is the goal. Patients should be allowed to define what spirituality means to them, and clinicians should address it in that way" (Koenig 2013). This presents a core problem, say spiritual care experts: "primary providers seldom address the spiritual needs of medical patients or engage in health-related spiritual activities with them—especially in outpatient settings, where there is increasingly little time to even do a standard medical evaluation" (Curlin et al. 2006).

The idea of providing spiritual care for patients can be very intimidating. Medical school generally does not prepare doctors to provide this form of care, in spite of the fact that three-fourths of patients would welcome a spiritual dialogue with their doctor. As a result, most doctors feel ill equipped to engage in conversations about spirituality. In a recent study on integrating spirituality into clinical practice, fewer than 10% of providers had any training on how to address these unique issues with patients, although the vast majority (greater than 90%) were willing to undergo such training (Koenig et al. 2017a).

Mrs. Smith's well-being might improve with spiritual care, and her story is not an isolated case. Many patients dealing with general medical illness, chronic pain, diabetes, cancer, cardiovascular diseases, end-of-life issues, and overall stress report spiritual support as helpful in dealing with these issues (Koenig 2012). Providing spiritual care includes acknowledging a patient's unique spiritual needs within the context of whole-

person medical care, discovering the manner in which the patient wishes to be cared for, and providing the care with competence, kindness, and compassion.

Between February 2015 and August 2016, AdventHealth conducted a research study to examine the attitudes and practices of physicians concerning identifying and addressing the healthcare-related spiritual needs of patients. A total of 520 participants completed a baseline questionnaire, 436 completed the 1-month follow up, and 432 completed the third and final survey at 12 months. We discovered that a significant proportion of AdventHealth providers and staff favor engaging in spiritual practices with patients, but training is needed to engage appropriately and sensitively in these activities (Koenig et al. 2017b). In addition, responses in the Adventist study demonstrate the value of a spiritual care team approach to providing spiritual care. If Dr. Jonas were to incorporate whole-person care, he could benefit from this team approach, which would enable him to have the support and structure he needs to respond to the intertwined physical and spiritual needs of his patient.

The Spiritual Care Team

A spiritual care team (SCT) can be drawn from currently employed staff. The team consists of the physician, a spiritual care coordinator, and a spiritual care provider (pastor/chaplain/spiritual caregiver of choice). The purpose of the SCT is to assist the physician in ensuring all patients receive whole-person medical care.

The physician As leader of the spiritual care team, the physician plays a distinct role, with specific requirements and responsibilities:

- express a willingness to discuss spiritual concerns related to medical illness with patient/family;
- conduct spiritual assessment (three questions—see below);
- document responses in the electronic medical record (EMR);
- alert spiritual care coordinator if spiritual needs are identified;
- follow up to ensure that spiritual needs are met.

Spiritual care coordinator Another vital member of the team is the spiritual care coordinator who helps transition the patient from the physician to the spiritual care provider, thus allowing the doctor to move on to the next patient. The spiritual care coordinator is the spiritual nurturer for the practice and supports the physician in providing spiritual care by offering additional resources for patients who reveal further spiritual support needs in addition to what the physician provides. These additional resources might include prayer, comfort, and referral to community support groups. The spiritual care coordinator also

- obtains information from the physician's spiritual assessment;
- coordinates the addressing of spiritual needs;
- prepares the patient for spiritual care referral, if needed;
- provides ongoing spiritual support to other healthcare team members.

Spiritual care provider The spiritual care provider is a professional, such as a pastor or chaplain, who is equipped to address the spiritual needs of patients, as requested.

The Spiritual Assessment

While there are many approaches to conducting spiritual assessments, the following three questions, when asked by physicians, have proven effective in identifying the patient's spiritual needs:

- Do you have a religious or spiritual support system to help you in times of need?
- Do you have any religious beliefs that might influence your medical decisions?
- Do you have any other spiritual concerns that you would like someone to address?

Although conducting an assessment may sound intimidating to an already burdened physician, the evaluation itself may take only a few minutes with the use of these leading questions. Sometimes the patient will respond with brief answers (yes or no). The physician may then choose to encourage the patient to unburden their deeper concerns. This can assist the physician in making an accurate diagnosis, thus addressing both the body and the spirit.

A spiritual assessment may not be indicated for every patient. Five patient types benefit the most from these assessments:

- Patients with serious, life-threatening conditions.
- Patients with chronic, disabling medical illnesses.
- Patients with depression or significant anxiety.
- Patients being admitted to a hospital or nursing home.
- Patients being seen for a well-patient exam.

A common concern of physicians is the challenge of providing spiritual care if they themselves are not spiritual or religious. A spiritual assessment to identify spiritual needs is similar to an assessment on any other body system. As with other assessments, a physician does not need to possess all the answers to the issues presented. He/she can refer the patient to someone who is able to respond. For example, a family practice physician may be treating a patient who is complaining of chest pain, shortness of breath, and dizziness. Although a cardiac workup may be indicated, the physician does not need to be a cardiologist, but instead needs to refer the patient to a cardiologist. In the same way, if a patient presents with spiritual needs such as anger, guilt, or grief, the physician does not need to be a spiritual expert. Both doctor and patient benefit by simply identifying the need and referring the patient to a spiritual care provider.

Another valid concern about entering into a dialogue with a patient about spiritual needs is the risk of initiating a topic that takes too much time to adequately cover, thus opening Pandora's box. Establishing a spiritual care team for the practice alleviates this concern by providing physicians with the needed support to turn

discussions with the patient over to someone else while the provider moves on to the next exam room.

Physician Responses

There is a growing body of evidence that supports the value of integrating spirituality in patient care and documents its positive impact on patient outcomes. An added bonus of this approach is the positive effect on physicians themselves. At the conclusion of the AHS-Duke study, the physicians were asked to share how participation in the study impacted them. The following responses are drawn from the respondents' own words:

- This made me aware of the need and has helped develop me as a physician.
- This completes the overall impact of medicine for me as a physician.
- This helped me get back to whole-patient care.
- My practice now has more meaning, as I am aware of addressing spiritual needs.
- It has helped to enforce in me the physician I strive to be.
- It has allowed and reminded me to strive for excellence.
- I appreciated being part of the study. I have learned to pray with my patients.
- This brought me a higher level of comfort with spiritual care.
- This helped me to be more of the physician I want to be.
- It has given me a way to have meaning in my everyday practice of patient care.
- It added a new piece to the practice that I had thought would not be a part. I was surprised at the positive response of the patients.
- It has given me a process that has enabled me to embrace the spiritual needs of my patients. I find I am becoming more of the physician I am called to be.

Although Dr. Jonas lacked formal training in how to address spiritual care with Mrs. Smith, if he had a support system he could proceed with confidence in proactively meeting the needs of the whole person, thus enabling patients like Mrs. Smith to receive the spiritual help for which their physical symptoms cried out.

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Chapter 20
Physician Well-being from the Perspective of Judaism, Islam, Hinduism, and Buddhism

Harold G. Koenig

Introduction

The problem is an acute one. A survey a few years ago by the Physicians' Foundation found that half of US physicians reported being pessimistic about the medical profession, one-third indicated feeling overworked and extended beyond their capacity to perform, and almost half said they were planning to either retire or do whatever it takes to reduce patient load to decrease their stress (Norbeck 2014). If anything, the situation has gotten worse with increasing documentation and time spent dealing with computerized medical record platforms, increasing knowledge required to avoid litigation, increasing complexity of patient medical problems, increasing need to haggle with insurance companies to get paid (or pay for patient prescriptions), and the list goes on. With potential limits on spending and growing numbers of patients with chronic illness due to the aging of the population, our healthcare system may soon be on life support, and it is physicians who will most likely need ventilator assistance. No one can deny that well-being within our hallowed and sacred profession is heading for an all-time low.

As emphasized in this book throughout, many factors influence the well-being of physicians. One factor now being increasingly recognized as important is religious involvement. There is a large and growing research literature showing that religiosity is related to better mental health in both community and professional populations, and the latter includes physicians (Koenig 2018). Although most of this research emerges from studying English-speaking Christian populations, there is also considerable research now coming from non-Western countries that also demonstrates within a wide range of faith traditions there exists a relationship between

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religious involvement and mental, social, and behavioral health (Koenig 2017a, b, c; Koenig and Al Shohaib 2014, 2017). While there is limited research specifically on religiosity and physician well-being in Judaism, Islam, Hinduism, and Buddhism, much of the research from general population studies is likely applicable to physicians as well. In this chapter, I will (1) examine research on religious involvement by physicians from non-Christian faith traditions, (2) review the evidence that such involvement is related to mental health and well-being, and (3) discuss applications, based on this research and common sense, with the goal of enhancing the well-being of physicians from Jewish, Muslim, Hindu, and Buddhist faith traditions.

Physician Religious Involvement

In the Bible, priests were also the physicians responsible for the "diagnosis" of diseases (Leviticus 13:1–59) and it was God who healed (Exodus 15:26). This overlap continued up through establishment of the original 13 colonies in the United States, where the professions of medicine and religion became blended together (Watson 1991). In order to support themselves and their families once denominational support from their bases in Europe was lost, clergy often sought medical training before they came to New World. Indeed, it was only natural for those who were healing the soul to also provide healing for the body. Studies of the US physicians today indicate that as a group, religious involvement is not all that different from the general population, although this may depend on specialty and on religious affiliation. In national surveys of physicians in the United States (composed of 52–64% Christian, 11–14% Jewish, 3–7% Muslim, 5–8% Hindu, and 0–1% Buddhist), a significant percentage indicates that they believe in God (three-quarters), religion is very important in their lives (34–44%), they attend religious services at least twice monthly (30–53%), they engage in daily private religious/spiritual practices (35%), they self-identify as both religious and spiritual (52%), and they consider medicine to be "a calling" (40%) (Daaleman and Frey 1999; Frank et al. 1999; Curlin et al. 2005; Yoon et al. 2015). Family physicians and pediatricians tend to be the most religious, whereas psychiatrists and radiologists tend to be the least, although the distance between them is not that great either.

How do these figures in predominantly Christian samples compare to religious involvement by members of non-Christian faith traditions both in and outside the United States? Much of the available research from outside the United States comes from physicians in training, as there have been only a few studies of religious behaviors in practicing physicians.

Judaism In a survey of 181 Jewish physicians compared to 849 religiously affiliated non-Jewish physicians in the United States, Stern et al. (2011) reported that intrinsic religiosity (15% vs. 45% high), attendance at religious services (14% vs. 59% twice/month or more), and belief in God (59% vs. 87%) were all significantly lower among Jewish physicians. These findings are relatively consistent with a

survey of 443 Jewish physicians (half born in Eastern Europe) working at hospitals in Israel, which found that 70% indicated that they were "completely nonreligious," 21% said they were "traditional," 7% "religious," and 2% "very religious" (Wenger and Carmel 2004). Religious physicians in that study tended to be older, had more children, and were less likely born in Eastern Europe or have immigrated in the past decade to Israel. This probably reflects both the influence of the Holocaust and the communist restrictions on religion in Eastern Europe before the fall of the Iron Curtain.

Islam In a survey of a random sample of 255 members of the Islamic Medical Association of North America (91% Sunni Muslim), Padela et al. (2016) reported that 89% indicated that religion was very important (or "the most important") in the physician's life, 26% attended religious services several times a week or daily (77% doing so more than once/month), 85% "strictly" kept the Ramadan fast, and 32% read the Qur'an daily outside of prayer (64% at least 2–3 times/month). Interestingly, 24% also indicated that they sometimes or often experienced religious discrimination at their workplace (76% reporting they rarely or never did so); 47% said their religious identity placed them under greater scrutiny at work; and 50% admitted they struggled to find time for prayer at work. Note further that 8% left a job due to discrimination in the workplace and 9% said that patients had refused care because of their religious identity. Nevertheless, 66% also said that their religious identity positively influenced their relationship with colleagues.

Religiosity among Muslim physicians outside of the United States is even greater. For example, in a study of 92 physicians (58% Muslim, 18% Hindu, 13% Buddhist) at the International Islamic University of Malaysia, Yousuf et al. (2010) reported that 97% believed in God, 97% in the existence of life after death, and 99% that religion/spirituality has a positive influence on health. Over half of physicians (58%) indicated that they enquired about/discussed patients' religious/spiritual life, 52% said that patients liked to discuss religion/spirituality, and 67% reported that doing so strengthens the doctor-patient relationship. In a study of 427 busy medical students at a university in Tehran, Iran, Hafizi et al. (2013) reported that 51% engaged in private religious activities (prayer, meditation, or Qur'an study) on a daily basis and 60% indicated they "definitely" experienced the presence of God in their lives, although only 25% said they had the time to attend mosque or religious meetings a few times per month or more. Religiosity and religious activity were the same in both male and female students, in contrast to that usually found in Christian physicians, where women are more religious than men.

Hinduism In one of the few studies examining the religiosity of Hindu physicians in the United States, Ramalingam et al. (2015) surveyed 99 physicians identified from Hindu Physician International and Hindu American Foundation. Most (96%) were born in India and were international medical graduates (98%). Although the focus of this study was on end-of-life care beliefs, physician religiosity was also

examined. Intrinsic religiosity was assessed with two statements: "I try hard to carry my religious beliefs over into all my other dealings in life" and "My whole approach to life is based on my religion." Intrinsic religiosity was categorized as low if physicians disagreed with both statements, moderate if they disagreed with one statement but not the other, and high if they agreed with both statements. Results indicated that only 6% indicated high, 7% indicated moderate, and 87% indicated low. This study suggests that Hindu physicians in the United States are not very religious. However, this is only one study and the response rate was only 34%.

Outside of the United States, Hindu physicians appear to be considerably more religious. Lucchetti et al. (2016) compared the religious beliefs/practices of physicians in India (n = 295, 69% Hindu), Indonesia (n = 122, 85% Muslim), and Brazil (n = 194, 95% Christian). Physicians in Indonesia (Muslim) were more likely to say that religion was very/moderately important to them (92%) compared to those in India (72%) or Brazil (69%). Likewise, 98% of Indonesian physicians indicated that they "look to God for strength, support and guidance" compared to 82% of those in India and 80% of those in Brazil. Thus, Muslim physicians were again more religious than either Hindu or Christian physicians (who were quite similar). All three groups of physicians, though, were very or moderately religious in contrast to the study of Hindu physicians in the United States.

Buddhism To this author's knowledge, no studies have examined the religious beliefs/practices of Buddhist physicians in the United States. However, Malloy and colleagues (2014) examined the religiosity of 1255 physicians from Canada (n = 168, primarily Christian), China (n = 350, 38% Confucian; 49% none), Ireland (n = 142, 80% Catholics), India (n = 124, 69% Hindus), Japan (n = 152, 34% Buddhist; 55% none), and Thailand (n = 319, 96% Buddhists), allowing for comparisons. Intrinsic religiosity was assessed with Jessor's Religiosity Measure, which "assesses religious orientation of the individual without identifying that orientation with an external religious network or social structure." Results indicated that, on average, physicians from India (20.5), Thailand (19.3), and Ireland (17.9) reported significantly higher rates of religiosity than physicians from Japan (14.7) and China (12.6); Canadian physicians (15.0) scored midway between those two groups; and all groups scored higher than Chinese physicians. No other studies of Buddhist physicians could be found.

In summary, Muslim physicians—regardless of where they are surveyed—tend to be the most religious, including more religious than Christian physicians. Based on very limited information, Jewish and Buddhist physicians tend to be the least religious, whereas information on Hindu physician religiosity appears to be inconsistent. To some extent, the relationship between religiosity and physician well-being will depend on the particular religion and how important religion is for physicians in that religion. Thus, one might expect religiosity to be strongly related to the well-being in Muslim physicians, whereas it might not be so strongly related to the well-being in Jewish or Buddhist physicians (unless they come from Thailand).

Religiosity and Well-Being

General factors known to be related to physician well-being are workload, degree of autonomy, having meaning and purpose, support from colleagues, and healthy work-life balance (West et al. 2014). Predictors of well-being in the general population include adequate financial resources, support from family and friends, and good physical health (Diener 2009). I would add religious involvement to that list. Non-Christian physicians in the United States face additional challenges that Christian American-born physicians are generally protected from. Often viewed as foreigners, non-Christian physicians must often deal with exclusion, subtle biases, and discrimination in the workplace that likely affect their well-being. Difficulties that many have with the English language can make communication more difficult; simply having an "accent" may affect how colleagues and co-workers view and treat them. Add to these stresses the fact that their religious beliefs are different from and may conflict with the majority religion of the culture, which may be threatening to colleagues and staff.

Research conducted in the United States among predominantly Christian physicians, residents, and medical students finds that greater religious/spiritual involvement is related to higher physician well-being (Ayele et al. 1999), fewer malpractice suits and maladaptive behaviors (Salmoirago-Blotcher et al. 2016), less depression (Yi et al. 2006; Pillay et al. 2016), greater sense of purpose and meaning in their work (Yoon et al. 2015, 2017), better attitudes toward patients (Pawlikowski et al. 2012), better self-reported health (Yi et al. 2007), and less burnout (Holland and Neimeyer 2005; Wachholtz and Rogoff 2013; Yoon et al. 2017). What about research on religion/spirituality and well-being in physicians who are affiliated with religious faiths other than Christian?

Judaism Research on the relationship between religiosity and mental health in Jewish physicians is very limited. After an exhaustive literature review, this author could find only one study in physicians and one study in nurses, both conducted in Israel. Weiniger et al. (2006) examined predictors of PTSD among 102 Israeli hospital surgeons exposed to victims of terror and 110 control physicians. Religiosity (religious vs. secular, OR = 0.9, 95% CI 0.4–1.9) and religious coping (OR = 1.30, 95% 0.91–1.88) did not protect against PTSD in that study. Examining spirituality and job satisfaction among 120 female Jewish Israeli hospital nurses, Lazar (2010) found that religiousness (self-rated religiosity) was unrelated to job satisfaction, as were all nine dimensions assessed using an 85-item measure of spirituality. The only exception was "Idealism" and "Transcendent." Idealism (e.g., "I believe the human spirit is powerful and will win in the end") not surprisingly predicted greater job satisfaction. Transcendent (e.g., "I have had transcendent, spiritual experiences which seem almost impossible to put into words"), on the other hand, predicted significantly lower job satisfaction. Thus, there is little evidence among Jewish health professionals that religiosity/spirituality makes much of a difference in their mental health or job satisfaction.

However, in a comprehensive review of quantitative studies examining religiosity and well-being in general Jewish populations, 12 studies were identified; of those, 8 (57%, all conducted among Jews living in Israel) found a positive relationship between religiosity and well-being, and four reported no association (all conducted among Jews living in the United States or Canada) (Koenig 2017a).

Islam The findings above contrast to those reported in studies examining religiosity and mental health in Muslim physicians. Padela et al. (2016) surveyed 255 Muslim physicians in the United States, finding that those who strictly kept the Ramadan fast (an indicator of greater religiosity) were 70% less likely (OR = 0.3, 95% CI 0.1–0.8) to feel they had been passed over for professional advancement due to their religious identity (an indicator of job dissatisfaction). In a study of 429 medical students (all Shia Muslims) at the Tehran University of Medical Sciences (Iran), Hafizi et al. (2013) found that greater religiosity (religious attendance, private prayer, intrinsic religiosity) was associated with fewer borderline personality traits, particularly symptoms of (1) extreme ups and downs in important relationships ($p = 0.01$); (2) an unstable sense of self ($p = 0.004$); (3) sudden changes in goals, career plans, etc. ($p = 0.004$); (4) suicidal thoughts/actions ($p = 0.009$); (5) wide mood changes ($p = 0.003$); (6) feeling empty inside ($p < 0.001$); (7) and easily being angered ($p = 0.002$). Other studies have reported less depression, lower anxiety, and better academic performance among Muslim medical trainees who are more religious (Vasegh and Mohammadi 2007; Tavabi and Iran-Pour 2011). Thus, these studies indicate that greater religiosity is almost uniformly associated with better mental health in Muslim physicians and trainees. Similarly, a comprehensive review of religiosity and well-being in Muslim populations found that of the 20 quantitative studies identified, all 20 (100%) found that higher religiosity was related to significantly greater well-being (Koenig and Al Shohaib 2017).

Hinduism An exhaustive review of the literature identified only two studies in Hindu health professions, one examining predictors of psychological well-being in general (but not religiosity) and one examining religiosity and burnout in medical students. In the first study of 200 paramedical professionals in India, older age, work autonomy, intra-professional relationships, and extent of employee participation in hospital decision-making predicted greater well-being and higher job satisfaction (Agarwal and Sharma 2011). In the second study of 100 Hindu medical students (where 64% scored above the threshold on burnout), greater religiosity measured by the Duke Religion Index (Koenig et al. 1997) was associated with significantly lower levels of student burnout ($p < 0.001$) (Chiddarwar and Singh 2016). While no study has yet examined the benefits of yoga in physicians, this Hindu practice has been suggested as a way to relieve stress and anxiety in medical students (Fares and Fares 2016).

In a comprehensive review of quantitative research examining religiosity and mental health in Hindu populations more generally, the author identified 33 studies that examined this relationship. Of those, 70% found better mental health among Hindus who were more religious or receiving religious interventions, 12% reported

worse mental health, 18% reported no association or mixed results (Koenig 2017b). Based on this review of Hindus more generally, one may conclude that Hindus often use their religious beliefs to cope with stress, often explain mental illness in religious terms, and often seek religious treatments for mental conditions. Furthermore, greater religiosity is usually related to better mental health, well-being, and ability to cope with stress, and this is also probably true for Hindu physicians.

Buddhism Based on this author's review of the literature, no systematic studies have yet examined the relationship between religiosity/spirituality and well-being in Buddhist physicians. However, a core Buddhist practice, mindfulness meditation—based on the seventh step of the Buddhist Eightfold Path—is a key component of physician programs designed to reduce burnout and increase physician well-being. These programs, now tested in at least one single group experimental study (Krasner et al. 2009) and a randomized clinical trial (West et al. 2014), both indicate success in meeting these goals. Furthermore, in a comprehensive review of the quantitative research examining religiosity and mental health in Buddhist populations more generally found that 46% of 39 studies reported that greater religiosity among Buddhists was associated with better mental health, 10% reported worse mental health, and the remainder (44%) reported no association or mixed findings (Koenig 2017c). Thus, when Buddhists commit to and follow the core Buddhist principles outlined in the Eightfold Path, they usually experience better mental health and greater well-being. Research is needed to determine whether this is also true for Buddhist physicians practicing in the United States.

Clinical Applications

What then can we take away from the research on physician religiosity and its relationship to well-being in Jewish, Muslim, Hindu, and Buddhist physicians, medical trainees, and general community populations?

Jewish physicians Although Jewish physicians in the United States tend to be less religious than other physicians and there is little evidence that religiosity is related to greater well-being or less burnout in Jewish physicians, bear in mind that every person is unique and generalities do not apply to individuals. On the one hand, for religious Jews (particularly those toward the conservative or orthodox end of the spectrum), religious beliefs and practices will likely be very important to their well-being and will help to counteract burnout, as found in the majority of general population studies. Reading the Torah, participating in services at the Synagogue, and observing the various Jewish Holy Days, rituals, and ceremonies (particularly within family and Jewish community settings) can provide emotional resilience in the face of work pressures and demands. On the other hand, for Jewish physicians who are secular, religious beliefs and practices may not provide much comfort, and religious settings may even increase distress, as demonstrated for other nonreligious groups (Ysseldyk et al. 2016). However, participating in Jewish holidays and feasts

(as cultural practices) and engaging in community activities at reform, reconstructionist, or secular humanist synagogues may be important for maintaining personal and family emotional health.

Muslim physicians Muslims are among the most religious of physicians and religiosity is related to better mental health in an overwhelming majority of research studies in Muslims. Thus, there is solid evidence that religious involvement will be important for many Muslim physicians in maintaining psychological well-being and preventing burnout. Muslim practices include fasting during Ramadan, saying the five obligatory prayers daily, going on pilgrimage to Mecca, wearing a *hijab* (for women), and reading, reciting, or listening to the Qur'an being recited. All will contribute to the mental health and well-being of most Muslim physicians. Providing the opportunity to practice their faith, then, will be essential for healthcare systems that wish to support physician well-being. This includes providing time and a private space to engage in prayer, making *halal* food available (prepared without alcohol, without pork meat products, and meat that is butchered in a special way), as well as allowing for time off to go on pilgrimage or attend services at the local mosque. Honoring and respecting the Muslim physician's faith tradition is the best way to enhance their well-being and counteract stress, particularly given the biases and discrimination pressures that Muslims now face in the United States.

Hindu physicians Research also shows that religious beliefs and practices are important to many Hindu physicians, and is likely to affect their mental health and workplace performance. Hindu practices such as yoga and meditation have been shown in randomized clinical trials to relieve stress and increase well-being in general populations (Koenig 2017b). They are likely to have the same effect in Hindu physicians. Religion among Hindus is often described as "a way of life" that is integrated into all activities, relationships, goals, and drives, including how Hindu physicians treat patients and colleagues. Besides meditating and engaging in yoga, religious practices that are important to many Hindus include worshiping, praying, reading the Bhagavad Gita, Upanishads, and other sacred Hindu scriptures, conducting rituals and making offerings at Hindu temples in the community or at shrines in their homes, and going on pilgrimages. Just as accommodations must be made for Muslim physicians to show respect for their faith, so also should relevant opportunities be provided to Hindu physicians so that they can engage in religious rituals of their choice. Respecting and honoring the religious and cultural practices of Hindu physicians will invariably convey acceptance and inclusion, helping to reduce stress and enhance emotional well-being.

Buddhist physicians Although to the author's knowledge there is no systematic research that documents the benefits of spiritual practices to the mental health and well-being of Buddhist physicians, much can be learned from the relationship between religiosity and well-being in Buddhist populations more generally (which in nearly half of studies is positive). The Eightfold Path (the core of Buddhism) involves right understanding (everything is subject to change and nothing is

permanent), right intention (stop clinging to pleasure, wealth, power and fame, and avoid hatred, all violence or cruelty), right action (no cheating, stealing, or gaining possessions by dishonest means, but rather showing respect for others and their possessions), right speech (no lying, gossiping, slander, or crude talk, but rather speaking softly, gently, affectionately), right livelihood (avoiding any occupation that involves harm to others or contributes to their suffering), right effort (making effort to change unwholesome states in life and increase or adopt wholesome states), right mindfulness (constantly paying attention to whatever is happening in the present moment), and right concentration (unifying the mind so as to bring conscious attention to a single point through meditation). Based on common sense and theoretical grounds alone, following the Eightfold Path (whose principles are included in many other world religions as well) should be a prescription for good mental health, less burnout, and greater psychological well-being (Koenig 2017c). Buddhist physicians who follow this Path will no doubt achieve the peace that it promises.

Conclusions

In addition to the usual intense workplace pressures that all physicians face, Jewish, Muslim, Hindu, and Buddhist physicians in the United States are likely to experience many additional stressors from subtle discrimination and acts of bias that Christian physicians do not have to face. This places these physicians at greater risk for emotional distress, burnout, and reduced productivity. Healthcare systems and medical providers in those systems need to be aware of the religiosity of physicians from these various faith traditions and understand the relationship between religious involvement, mental health, and well-being. Acknowledging, accepting, honoring, and showing respect for the unique religious beliefs (or lack of belief) of these physicians, as well as providing accommodations for them to practice their faith, are ways to reduce burnout and increase the well-being and productivity of medical staff. For Christian providers, it's also central to loving your neighbor as yourself.

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Chapter 21
Spirituality and Physician Well-Being in Multi-faith Contexts

Doug Wysockey-Johnson

> *The spiritual meaning of health care will outlast all mergers, all managed care organizations, all Medicare and Medicaid cutbacks, all bogus accusations of fraud and abuse, all malpractice suits, all direct to consumer advertising for drugs, and all manner of profiteering at the expense of patients. If spirituality is real, it is real for times of trial as well as times of triumph.*
>
> —Sulmasy (2006, p. 22)

Introduction

There were 14 of us in a circle, 13 physicians and myself. The question for the evening was "Where or how have you experienced grace in your practice of medicine?" Grace is usually thought of as a religious word, often defined as "unmerited favor." It was helpful to have that definition on the table, but I also wanted to expand it. So I quoted from this article in the *Journal of the American Medical Association*:

> *Grace is at work in medicine as well, and I frequently discuss this with colleagues. When I am most stretched—questioning how I can ever clear my desk or provide the care I ought to—I am boosted by kind words from a patient, a stimulating consultation from another physician, or my student's naked pleasure in learning. Our challenge is to receive these gifts. Not to shrug them off, but to loll about in them and let them fill our lungs. Our work abounds with funny, poignant, and life-affirming moments. We must allow them their say.* (Stillman 2012, p. 156)

One by one the physicians told stories of how they had experienced grace in medicine. Many talked of times they had made mistakes and expected punishment.

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Instead, they received grace: A card of gratitude rather than a lawsuit, a word of appreciation rather than an angry online review. The conversation was profound, sacred even. It was not religious, but it was very spiritual. We left that evening a little more resilient, because we had touched not only some of the core issues of medicine, but also what it means to be human.

Defining Spirituality

In 2005, the Joint Commission began its definition of spirituality with these words: (Spirituality) is a "complex and multidimensional part of the human experience—our inner belief system" (Joint Commission on Accrediting on Health Organizations 2005).

Complex and multidimensional is right. It is a challenge to define spirituality, but Christina Puchalski summarizes the key points this way:

- *Essence*: the core of one's being
- *Meaning*: that gives us a sense of purpose in life
- *Transcendence*: an awareness of something greater than oneself
- *Relationship*: connection to self, others, God
- *Values*: beliefs, morals, standards that guide one in life
- *Rituals*: spiritual practices
- *Wholeness*: a movement away from fragmentation, and toward integration (Puchalski and Ferrell 2010, p. 191)

No one definition captures it all. However defined, we can say with confidence that spirituality matters. It matters because purpose, relationship, and values are critical to us as human beings. And it matters because practicing medicine is hard and spirituality helps. Dictionary.com defines resilience as the ability to recover from being "bent, compressed, or stretched." That accurately describes how many physicians feel today. Spirituality can be a key component in helping physicians recover after being bent, compressed, and stretched by modern-day healthcare.

Challenges and Guidelines

It is not surprising that spirituality has often been avoided when doing physician well-being work. There are dangers and challenges:

1. *Spirituality does not lend itself to measurement or metrics*: The world of healthcare is nothing if not evidence-based today. This is mostly a good thing, taking advantage of data and metrics that provide good patient care. Spirituality is dif-

ficult to define, let alone measure. Most of the physician's day is taken by that which can be measured. Spirituality can seem "soft, wishy washy, and a little too 'kum bah ya' for some."
2. *Wariness of the Dominant Religion:* Many physicians work in faith-based health systems. Most of those in the United States are Christian. Even if you are a physician in a "secular" healthcare system, Christianity is still the dominant religion in the United States today. Some physicians fear being proselytized, or subtly invited into spiritual practices or beliefs that are not their own.
3. *Articulating the Ineffable:* Spirituality is deeply personal, and, for many of us, hard to articulate. It is at our core and important, but that doesn't make it easy to talk about. Spirituality is not a part of our everyday vernacular. In the words of the poet John O'Donohue, "What is nearest to the heart is often farthest from the word" (O'Donohue 2008, xiv). It is not easy for doctors or anyone to put words to that which is mysterious.

In the past, there have been two primary approaches around spirituality with physicians. One is to take a religious approach, like that used by the Christian Medical and Dental Society (https://cmda.org) or the Muslim Doctors Association (https://www.muslimdoctors.org). There are Hindu, Jewish, and Buddhist medical organizations as well. The opposite approach is to treat it as a third rail of the human experience and leave it out altogether: we are mind and body, but not spirit; if spirit and soul exist at all, they exist only as an element of our brain function.

I advocate a third way, one that affirms the centrality of spirituality as a core part of the human experience, and one that can be engaged in inclusive and nonsectarian ways.

How

Lumunos (Physicians.Lumunos.org) is a 90-year-old faith-based nonprofit that for the past 10 years has been supporting the physician vocation. We are equally comfortable doing this work in "secular" and sacred settings, and consider both to be a part of our mission. Over the past years, we have developed a few guiding principles in our approach to physician well-being. We apply these principles to the various aspects of our physician well-being program, including group meetings, weekly content, and one-on-one coaching.

1. *Keep It at the Center*: If indeed spirituality has to do with elements like values, hope, calling, reflection, relationship, and resilience, then it is the heart of our approach to physician well-being. Other people are better equipped to address aspects of physician well-being like business practices and improving the electronic health record. Spirituality is our contribution to the physician well-being

conversation. We don't shy away from engaging doctors as spiritual beings. *Example*: In our weekly content, we will use words like hope, grace, and forgiveness, and connect them to the physician experience. We might ask a question like, "What is the role of forgiveness in the practice of medicine? When have you experienced it?"

2. *Define It Broadly*: Everyone is spiritual. In our written content or when we set up a conversation, we draw examples from a wide range of belief systems, including no belief system at all. We incorporate concepts like gratitude, sense of calling, and forgiveness.
   Example: December is a busy month for many physicians as patients are using up their health savings accounts. At the same time, some physicians are also engaged in the religious aspect of the holiday and some aren't. In talking about that, we frame it broadly, saying "Some of you are also busy with Hanukah, Christmas, or Kwanzaa. Others of you don't follow a particular religion, but still feel the holiday pressure."
3. *Use Relatable Examples*: Like all of us, physicians tend to respond best when they hear something from their peers. Someone who has been through similar training, someone who has experienced some of the same ups and downs. The good news is that there are more and more examples of reputable journals, quality research, and thoughtful books dealing with spirituality. We do a lot of quoting from physicians. Nothing is better than when a well-known academic institution puts out something on spirituality.
   Example: Our past Surgeon General Vivek Murthy speaks often about loneliness and the importance of connection. (Vivek 2017), Paul Kalanithi (When Breath Becomes Air); Rachel Remen (Kitchen Table Wisdom); Danielle Ofri (What Doctors Feel); and many others increasingly write on human and spiritual topics.
4. *Create Safe Space for Conversation*: Because we often feel inarticulate about these topics, it is critical to create safe space for people to find their words. We use basic group guidelines and expert facilitation to create the kind of environment where people feel more comfortable talking about things that are personal. Nothing shuts down a good conversation like a person who proselytizes or condescends. This is more important than anything: when there is a high level of trust in the room, people will be more authentic. With authenticity comes cohesiveness and collegiality.
   Example: One of our guidelines is "no fixing or solving each other's problems." This is a challenge for physicians who spend their day doing exactly that.
5. *Ask Questions That Evoke a Story:* Spirituality is personal. Our role is to evoke these stories and thoughts so people can hear themselves and each other. In our written content and group conversations, we ask questions that enable people to reflect or tell a story.
   Example: What renews your spirit? What spiritual practices help you set down your work? Here, as throughout, we would give broad examples of spiritual practices. This might include prayer and synagogue attendance, but also mindfulness, gardening, or walking.

Example of What It Looks Like

The following is an example of an approach to spirituality from one of our weekly email reflections. Take note of these elements: (a) the reference to numerous religions, (b) a quote affirming spirituality from a scientist, (c) mention of research, and (d) a question inviting their reflection.

Dear Colleagues

The week of Passover and Easter feels like a good time to turn our attention to spiritual matters. Through our previous conversations with colleagues, I know that for many of you there is no conflict between the science you rely on to practice medicine and your spiritual practice.

Dr. Francis S. Collins is a physician and the geneticist behind the Human Genome Project. He is also the Director of the National Institutes of Health. In an interview with National Geographic, he says:

> *I find it oddly anachronistic that in today's culture there seems to be a widespread presumption that scientific and spiritual views are incompatible. Science and faith can actually be mutually enriching and complementary once their proper domains are understood and respected…. At the most fundamental level, it's a miracle that there's a universe at all. It's a miracle that it has order, fine-tuning that allows the possibility of complexity, and laws that follow precise mathematical formulas. Contemplating this, an open-minded observer is almost forced to conclude that there must be a "mind" behind all this. To me, that qualifies as a miracle, a profound truth that lies outside of scientific explanation.* (Collins 2015)

Brain research is also helping to bridge the gap between science and spirit. Dr. Andrew Newberg, a neuroscientist at the University of Pennsylvania, has been scanning the brains of spiritual people for more than a decade. He has found that people who meditate—from Franciscan nuns to Tibetan Buddhists—go dark in the parietal lobe: the area of the brain that is related to sensory information and helps us form our sense of self. The effect is a heightened sense of oneness with others.

> *When people lose their sense of self, feel a sense of oneness, a blurring of the boundary between self and other, we have found decreases in activity in that area [the parietal lobe].* (Hagerty 2009)

Newberg found this same result whether he imaged the brains of Buddhists meditating, Roman Catholics praying, or Sikhs chanting. "There is no Christian, there is no Jewish, there is no Muslim, it's just all one," Newberg says (Hagerty 2009). Of course, there are important differences among the various religions and spiritual practices. In this day of faith-driven conflict though, it is good to know that we have more in common than we think.[1]

[1] For more on brain research and spirituality, see http://www.andrewnewberg.com/research/

Questions for Reflection and Conversation Is there any conflict between science and spirituality in your own life? How do they conflict or complement each other in your experience?

Conclusion

Christianity does differ from Islam. Prayer isn't always the same as mindfulness. There is a time and place for dialogue and discussion about our different approaches to spirituality. In general though, physician well-being gatherings are neither the time nor the place for those discussions. Instead, our hope is to welcome and invite more spiritual conversation among physicians with an emphasis on what we have in common and what works for doctors. Above all, we want to encourage each physician to engage her or his own spirituality as a way to be more resilient. It is the renewable resource that is available to every doctor.

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Chapter 22
Mindful Living: Harnessing the Power of the Moment

Kathleen C. Gibney

"A person paying attention with purpose to the present without prejudice or judgment."

— The definition of mindfulness,
Adapted from John Kabat-Zinn

Dr. Lopez sat across from me in my office gasping for air, crying and repeating: "*I can't do this, I can't do this, I just can't do this anymore.*" Filled with compassion, I wondered what had created the profound sense of helplessness and exhaustion I was witnessing in this young man. After what seemed like a long while, he said, "*I just don't know what to do. That is why I called you, Kathy. My friends told me I really had to*." At that I responded, "*Tell me what you can about what is going on for you. Help me understand what it is like to be you in this very moment.*" He proceeded to tell me that he had finished his fellowship only 3 years before and that his life was not at all what he had expected it to be.

And then he outlined for me a typical day in his life. "*I get up before anyone stirs in my house and I am at the hospital before 6 am. I rush through my day never feeling like I am making a difference for the patients or my colleagues and then I return home at 7 or 8 o'clock at night.*" He took a deep, shaking breath and continued. "*When I get home, my wife has saved dinner for me. We have 2 small children who she would already have ready for bed. They have had dinner and are all bathed and just waiting for me to come home. When I walk in, I literally fall onto the couch in front of the TV and the kids just climb all over me. Most nights I don't even know what is on the TV or what the kids are talking about. My wife then takes them and reads to them and puts them to bed. I don't do anything to help her or really say much to the kids. Sometimes I eat, and sometimes I just go to bed and get up and do the same thing the next day.*" He paused and brought his tearful gaze to meet mine: *"I just can't do it anymore!"*

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He and I spoke for a while longer about the details of his work and his desire to feel like he had a life – that he made a difference. That he was a good person, a good husband, a good father. As our time together neared to a close, he was calmer, without the emotional charge that had started our meeting. I asked him if he would be willing to meet again in 3 days' time. He quickly agreed. Then I asked if he would do one thing for me that very evening. "*When you get home tonight I would like you to take a shower*." He looked at me quite perplexed, then finally nodded in agreement and said that he could do that.

Two days later, a day prior to our planned meeting, I received a call from him asking if he could see me sooner. We agreed to meet at noon that day. As soon as he entered my office and sat in the very same chair, it was clear that a different man was present. He started straight away: "*I couldn't wait to see you until tomorrow as we planned because I had to tell you what happened the other night.* He explained, "*When I got home that night after our meeting, I did what you had asked. I took a shower immediately. I put on shorts and a T-shirt and I came out to the family room where the kids were playing. I felt a little better. I asked our 6-year-old daughter if she would like to go for a walk with me. She asked if she could take her new flashlight in case it got dark, and we ventured out together as she held her flashlight proudly. We walked around our block. She told me a little about her day and we came back home."*

He continued, *"Then I saw our 4-year-old son looking up at me as if to say… how come I didn't go? And so, I said to him, 'come on buddy, let's go in the yard and pick up some sticks.' He asked for his sister's flashlight, which she gladly shared, and we went out and picked up sticks and stones. We were out there 5 minutes at the most. We piled his collection at the door and came back in the house. That was about it, Kathy. I helped put them to bed, and I felt a little better."* He paused for a moment, and I sensed he had something else to tell me. *"But that is not what I want to tell you,"* he said. *"I want to tell you what happened when I came home last night."*

He took a deep breath and continued. "*As I opened the side door and entered the house, my 6-year-old daughter came running toward me saying: 'Daddy! Daddy! Daddy will you be the Daddy you were last night?'"* He started to cry softly and my eyes filled with my own tears. "*Kathy, you have to help me be that Daddy. I don't know how."*

We sat quietly with one another and then I said to him, "*The beautiful thing about this story today is that you do indeed know how to be that Daddy. You were that Daddy. And your children felt it*!" We talked about the fact that what he and the children had experienced was being present in the moment. I talked about the importance of transitions in our lives, and how they give us an opportunity to shift our hearts and minds to the tasks at hand. He decided that he wanted to work together to learn to be more present, to understand more about transitions, and to live mindfully. Dr. Lopez has been my hero! He decided in that moment that he would work as hard at being present as he had worked to become a doctor. A year later, he has found energy for his family, he notices beauty in places he hadn't before, and he finds meaning in his work. Who would believe taking a shower could be so powerful?

Of course, the shower is a metaphor for changing from one thing to another, for cleansing ourselves from one role and preparing us for the next. In my role as the Director of the Center for Physician Wellbeing at AdventHealth Hospitals, I teach about transitions and the importance of physicians being able to "hang up their white coats" and move into their varied roles and relationships with their loved ones. Some have found driving home in a silent car a good modality to shift their minds and hearts. Others like talking to their spouse as soon as they get home. Changing out of their scrubs into street clothes does the trick for still others. It is the intentionality and the awareness that we are moving from one important part of our lives to another that is crucial. It is learning that our thoughts, feelings, and behaviors are attached to the roles we perform, and that intentional actions help us shift from one part of our lives into the next with purpose and direction.

Mindfulness Principles

The longer I work with physicians, the more I am convinced that the most effective prevention and antidote to burnout is living in the present moment – at least until we can make systemic changes in healthcare overall. Translating that into "physician speak" and not being accused of "selling fluff" has been the greatest challenge of my career. We borrow from neuroscience and psychophysiology to explain what is meant by mindful living. Three primary principles guide our conceptualizations and interventions: (a) peak performance strategies, (b) mindfulness meditation, and (c) learning to live in the present. We use the acronym SEE ACT when summarizing peak performance, which indicates strategies of:

- Setting goals
- Using imagery
- Executing routines or rituals
- Activating relaxation or energy
- Controlling attention/awareness
- Thinking positively

Research from Harvard (Vago and Sildersweig 2012) and the US military, (Jha et al. 2015) regarding Mindfulness Meditations Training have established that the practice of focusing one's breathing and attention in specific ways has significant physical and emotional benefits. Positive psychology has found correlations with health and happiness when people focus on the present (Killingsworth et al. 2010).

When a physician shows interest in the topic, perhaps from our workshop opportunities, CME programs, counseling, coaching, or consulting services, we present mindfulness as a way of living based on what we know about these three research areas. We use a child's drawing as an illustration of what we mean. The drawing portrays an adult holding the hand of a child with cartoon narrative clouds above each of their heads. The contents of those clouds indicate the stark difference in their minds at that point. The adult cloud is filled with computers, phones, money,

papers, and stuff! The child's cloud holds the simple flower on the ground between them. We then ask, "*Is your mind FULL or is it mindful – filled with the present moment – filled with the beauty and mystery around you*?" We follow by asking them which thought cloud brings more focus, more peace, and more energy.

None of us really have the power to add minutes to the day for a physician. I have instead worked on teaching them how to use moments within a day to care for themselves, their patients, and their loved ones by keeping things as consistent and simple as possible. For example, many of our physicians don't have time to do a full meditation, but everyone is able to commit a moment throughout the day to slow down and breathe.

The "doorknob exercise" is an example of an uncomplicated way for our physicians to slow down just enough to recharge. The idea is that before a physician enters a patient's room and their hand touches the doorknob, we ask them to intentionally hesitate. We ask them to take a deep breath in through the nose, and think, "*Hello moment*." As the breath is exhaled through their mouth, we ask them to think, "*I am here*." The physical trigger of the door, the exercise of engaging mind and body, and the shift of focus are all helpful to let the last patient go for the moment and to prepare to be available to the next patient. Our physicians report using this technique; they note they have more energy throughout the day.

Some of my greatest curmudgeons have agreed to placate me and have found treasures in their day when they accept the challenge of hunting for positives in the moment. Some have needed extra directions, such as the physician who passed a beautiful tree every day, twice. Yet, he never noticed it until I mentioned it. That very night after I brought it to his attention during the session, he and his wife were on a dinner date. As they passed by the spot, he pointed out the beautifully blooming tree to his wife. She became animated and said: "*Are you dying? You are bringing me to dinner to tell me, aren't you?*" He laughed out loud as he told me. "I really am pretty negative, aren't I?" He truly is a curmudgeon. Yet, he is learning that simple awareness does make a difference.

Technology robs us of our time, energy, and connectedness. If we don't notice, it soon holds us hostage to an addiction. Physicians working with mindfulness are agreeing to put down their phones for at least 15 minutes a day and are starting to practice "no technology times and/or places" with their families. They are finding, sharing, and using helpful applications on their phones to improve time management, teach breathing exercises, help reframe negative self-talk, and keep track of diet and exercise. There is a significant difference between playing games all the time to "relax," versus using scientific methods that have been correlated with healing mind, body, and spirit.

A final story comes from a motivational speaker I heard in a training years ago. The story has stayed with me and has influenced my desire to live in the present as much as possible, while also spreading the word about how being present may be the most important thing we can do for ourselves and for each person we meet along our life journeys. This motivational speaker was driving to work 1 day, running a little late, when he pulled up behind a car at a stop sign. The car in front did not move and he could see the driver making lots of motions in the front seat. He started

to get frustrated and began honking the horn and complaining, but the car in front did not move. He got out of his car and as started yelling while approaching the car in front. A woman stepped out and cried, "*Help me*!" as she yanked open the back door. In the back seat, he saw a young child in a car seat choking. He immediately reached in and managed to get the child out and dislodge an item that was stuck in the child's throat. The child started to cry. As he handed the child to the woman he was overcome with emotion. The message the speaker delivered to the audience that day was this: "*Never forget that there may be a baby in the back seat.*"

That story has guided my life. I don't remember the man, but I remember his story. I use his words to remind myself that I do not know the stories of other people unless they honor me with sharing them, but I do know that we all have a story. I want to help our physicians tell their stories as they live them because I know the value in sharing them. I also want to help them live in the moment so that they can *experience* their lives, and not just push through.

I would like to ask a few simple questions to my physician clients for discussion and reflection: Are you living your life in the past, filled with regret? Or staying where you cannot change anything? Are you living in the future, filled with anxiety about what might be and where you may never be? Or are you living in the present where you can feel everything, change anything, and be special to another? How are you living your life?

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Chapter 23
A Philosophical Rationale for a Bio-Psycho-Social-Spiritual Approach to Wellbeing

Richard J. Bogue

> *"Machines can make us forget the hands and minds behind their creation, they can make us forget ourselves."*
> —SJ Reiser, 1984, p. 7

Being Human

Most of the time, we human beings recognize the difference between the human care giver and the mechanisms and procedures she or he uses in service of health and healing. Sometimes though, we become accustomed to mechanizing, proceduralizing, or depersonalizing our interactions with others. When that happens, we can lose ourselves, our responsibility, and our goals. We can lose the desire to make a positive difference for others, a desire that lies behind the mechanisms and procedures so essential to our craft, whether we be a scientist, physician, or nurse. This kind of disengagement represents a threat to the wellbeing of those we serve and those with whom we work. It also poses a threat to our own selves. By contrast, an appreciation of others and of ourselves as whole persons—as bio-psycho-social-spiritual beings—builds a foundation supporting the wellbeing of others, and of our own selves.

This chapter explores what it means to be a human and how best to care of ourselves and of others as human beings. We have gained significant information about *how human interaction is what makes us human* from well-documented cases of feral children who survived with no human interaction after infancy. In *The Lancet: Neurology*, McCrone (2003) provides a powerful illustration of the essential importance of relationships to human beings.

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In the 1920s, in the Bengal jungle, Reverend Joseph Singh explored near the village of his mission, investigating tales of evil spirits. In his search, he discovered two girls, approximately 3 and 5 years old, living in a wolf's lair. Based on Singh's extensive notes, McCrone wrote:

> Their hair was matted. They scampered on all fours. There was no trace of humanness in the way they acted or thought. They tore off clothes and only ate raw meat. They never smiled or showed interest in human company. The sole emotion that crossed their faces was fear. They did not even seem able to hear human voices. Yet their senses were wolfsharp. Singh said they could see in the dark and smell a lump of meat across a 3 acre yard. (p. 132)

Singh did his best to train and educate the girls. He was puzzled that they seemed so inhuman, with no speech, warmth for others, or self-regard.

> It had seemed like the perfect "experiment." Children reared by animals and then brought back into civilisation. If the human mind was innate, then [these] girls should have been found like [the fictional characters] Mowgli and Tarzan—speaking, intelligent, mentally complete. But if the human mind was really…transformed by language and socialisation, then the girls would grow human only after their return to the fold. (p. 132)

Neither happened. The younger girl sickened and died. The older girl eventually became somewhat house-trained, but never learned to speak. Throughout her life, her mind remained on the level of an animal with no evident spark of insight or self-awareness.

This and other authentic cases of feral children demonstrate that interaction with other humans, apparently quite early in life, is essential for the shaping of a *human* mind as well as for developing that mind further. Without that interaction, the genetic human becomes a biomechanical replica of a human who is unable to *be* human. Although under less extreme circumstances, we in the medical field need to remember that to be truly human we need to ensure that our machines, mechanisms, and procedures do not disengage us from the human relationships necessary for us to serve others and to be well in ourselves.

I and Thou Relationships

In short, *being* human requires participation in human relationships. To the extent that we focus only on mechanisms or procedures, we lose sight of the persons operating the mechanisms and performing the procedures, as well as for the persons for whom those care tools are wielded. *WE humans* fade from view.

Martin Buber, the existentialist philosopher, explored this notion using the phrase ***I-It*** to summarize a utilitarian relationship in contrast to an "authentic" life formed through the practice of *I-Thou* relationships (Buber 1958). As Buber explained, when we experience another person as an "It," we see only the mechanical aspects of that person— his or her utility to ourselves alone. An essential meaning of who the other person is does not form in our minds. Because we fail to experience the other person as a whole *person*, our own experience of the relationships in which we

engage becomes mechanical, procedural, and inhuman. That is, this failure to understand the fullness of other persons also reduces our own meaning because all around us become mere objects. We become empty.

By contrast, when we experience others as "I and Thou," we understand others as persons first, without qualification or objectification. As we gain authentic understanding in our relationships with other people, our own understandings about ourselves are amplified. That is, by living in I-Thou relationships, we also gain richer meaning in ourselves: "She wasn't just a leiomyosarcoma; I cared for her throughout her fight, met her children, saw her brushing her hair, talked with her about her career as a teacher."

In brief, humans derive self-identity, meaning, and understanding *in relation to others*. These "others" are not only other individuals or social groupings, but also oneself as other. When we engage in reflection, self-doubt, or deliberate decision making we engage the self as other. The physical world and the transcendent or God are also others to be engaged. In a nutshell, we are beings with authentic meaning only when we are in meaningful relationships with others. Eric Fromm concludes *The Art of Loving* as follows: "To have faith in the possibility of love as a social, and not only exceptional-individual, phenomenon, is a rational faith based on the insight into the very nature of man" (1956, p. 133). American philosopher John Dewey ends his 1934 essay on *A Common Faith* more amply: "The things we most prize are not of ourselves. They exist by grace of the doings and sufferings of the continuous human community in which we are a link" (p. 87).

I and Thou in the Practice of Medicine

Using Buber's I-Thou conception, Felicia Cohn observes that understanding humans as being *in relation to self, others, society, and the transcendent* is beneficial in the practice of medicine (2001). Figure 23.1 illustrates that when physicians practice I-Thou relationships in their patient care, the process is therapeutic for both the patient and physician, whereas I-It relationships are merely medical, mechanical, and incomplete. Cohn highlights the importance of our understanding of I and Thou relationships in medicine by suggesting three conceptual shifts to help deepen meaning and therapeutic value for both the patient and caregiver. (1) Shift beyond "patient-centered" to "person-centered." (2) Focus on everyday matters of patient care as much as on crisis situations. (3) Frame medical practice

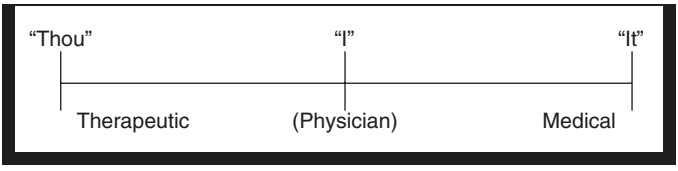

Fig. 23.1 I-Thou versus I-It Relationships in medical care. (Adapted from (Cohn, p. 175))

and education in terms of relationship in the moment as it can best be understood, rather than frame them by abstraction or maxim (pp. 177–8).

The American Medical Ethicist, Daniel P. Sulmasy, MD, PhD, follows this same philosophical tradition when he calls for a bio-psycho-social-spiritual approach to medical care and health (2006). He emphasizes that the biological, psychological, social, and spiritual are distinct dimensions of one person. No dimension of self can be separated from the others; each affects the others. And the person's history and illness affects each distinct aspect of the person (p. 123). In brief, Sulmasy proposes "…that human persons are intrinsically spiritual…*based on a notion of the human person as a being in relationship* (italics added)" (p. 128).

From a more direct "healthcare system" perspective, recent discussions of "the Quadruple Aim" also suggest the significance of meaning through relationships in the context of medical practice (Bodenheimer and Sinsky 2014; Merya et al. 2017; Sikka et al. 2015; West 2016). The Quadruple Aims for improving health care are: (1) reducing costs, (2) improving care quality, (3) improving population health *and, also, to achieve these aims,* (4) improving the wellbeing of caregivers. To meet all the four aims, it is necessary for those receiving the care and those giving the care to engage in a care process well beyond the mechanical or procedural aspects of a specific medical interaction. Each specific medical interaction is, or is intended to be, considered in relation to costs, patient safety and quality, population health, *and* caregiver wellbeing. The fourth aim of the Quadruple Aim explicitly recognizes that caregivers are persons in relationship with the persons who are their patients, and that caregivers themselves, as persons, are affected by their interactions with their patients. The fourth aim is, therefore, a natural—or existential—extension of the first three aims (Levkovich 2016).

Authentic Engagement and Wellbeing

Sulmasy provides a more detailed view of the I-Thou relationship in a medical context. Figure 23.2 illustrates that our experience as humans includes relationships with self and others across bio-psycho-social-spiritual aspects/dimensions/domains of experience. Take a moment to appreciate, in Fig. 23.2, the complex of relationships that an authentic medical encounter brings to the experience.

These interlocking domains of relationship are what I propose as a definition of *authentic engagement*. Authentic engagement is an *I-Thou* relationship that recognizes self and others as fully human, bio-psycho-social-spiritual beings. By contrast, to the extent that we think of and act toward others as cogs in our own machines—whether as parts of departments, profit centers, or procedural steps—we miss the point of engagement and initiate actions that may make us forget the central meaning of others and of ourselves as human beings.

A review of physician satisfaction surveys provides a practical and familiar glimpse into the significance of these relational distinctions. In remarks, prefatory to describing the development of the Physician Wellbeing Self-Assessment Tool

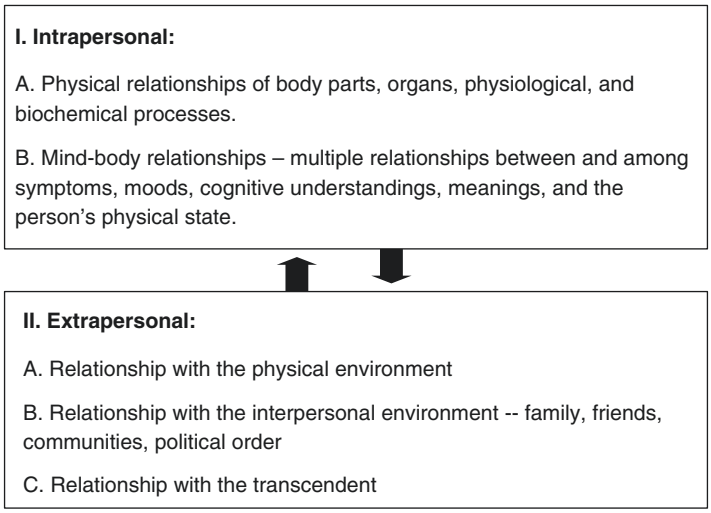

Fig. 23.2 The many relationships implicit in medical encounters. (Adapted from (Sulmasy, p. 126))

(PWSAT),[1] through an extensive review of the literature on physician satisfaction, Bogue, Fisak, and Lukman (2011) identified three types of "physician satisfaction" surveys: (1) Those focused on the *organization* and limited only to the physician's life *at work*, the most common type; (2) those focused on *physicians* and limited only to their life *at work*, which are also quite common; and rarely (3) *those focused on physicians as whole persons, with personal lives that extend beyond the boundaries of work*. The first two types reflect the interests of health systems, hospitals, and medical groups. Such one-sided and incomplete views of physicians are too frequently labeled as engagement. *Inquiries that do not engage others in a mutually reciprocal relationship as a whole person cannot contribute to authentic engagement*. Depersonalization may add to the stressors of work and add to stressors when seeking satisfying relationships with family and friends, increasing one's risk of burnout and everything that burnout may generate. Once authentic engagement is in place, however, the potential for satisfying reciprocity and mutual effort toward shared goals and progress is amplified.

Empathy as a Bridge

Empathy is the bridge that connects I and Thou. That same bridge of empathy connects engagement with wellbeing. Wellbeing requires three things: (1) *authentic engagement* (in short, empathy for self and for others as whole persons); (2) *mindfulness* (attention and reflection) about how to act on this engagement to

[1] PWSAT and its derivative versions, © 2010 AdventHealth System/Sunbelt d/b/a Florida Hospital.

promote wellbeing for self and for others; and (3) adopting *attitudes and practices* that promote wellbeing for self and others. Authentic engagement does not replace medical tests and procedures. Authentic engagement becomes the *impulse for* and a *result of* adopting practices that promote wellbeing of the whole person. Thus, with authentic engagement, mindfulness, and practice, one can become increasingly good at manifesting and promoting wellbeing for one's patients…and for oneself.

Through intentional focus on authentic relationships, the leadership of a health system and the system's health care professionals can move toward a more relational view of medicine and more authentic engagements between and among physicians, other care professionals, patients, and people outside one's work life. Simple practices to strengthen these three requirements for wellbeing can give you ideas to help your system start moving in the right directions. The chapters in this book offer a number of ways to get started or move further. For example, Chap. 2, Research on Physician Burnout and Wellbeing: A Solution-Oriented Perspective, reviews key research issues and identifies numerous additional resources outside this book. In the meantime, consider the following ideas drawn from my research and steps others have taken:

1. Engage physician and nursing *leadership* to demonstrate authentic relationships by visibly seeking suggestions and enabling selected approaches to increase empathy for patients and for each other. As a starting place, promote brief discussions on how to invest an I-Thou sensibility into existing activities such as huddles, rounds, and health system events. Make increasing empathy for patients and each other a key performance indicator, a metric-based goal in annual planning and budgeting for every department. Encourage leaders at all levels to show empathy for others, and model empathy for self on a regular basis.
2. Stimulate *mindfulness* to promote wellbeing. For example, can the system offer the following: Periodic self-assessments of a whole person wellbeing? Self-assessments for burnout risk? Quick notes, webinars, seminars, or retreats exploring wellbeing? Does your system provide confidential counseling for staff?
3. Assist in the adoption of *specific practices to improve wellbeing*. There are numerous possibilities. I'll offer just a few. (1) Ensure there are appropriate spaces for exercise, rest, and prayer. (2) Create an atmosphere of collegiality and mutual support. (3) Incorporate healthier menu options. (4) Conduct stress and wellbeing debriefings every 2 weeks to review and decompress from problems faced by a work team. (5) Figure out how to enable as much self-scheduling as possible. (6) Set an expectation early that you want to work with maturing staff to keep them on the team in ways both the system and they will find valuable.

Burnout is a syndrome resulting from the persistent accumulation of unresolved stressors. Not surprisingly, the means of avoiding burnout are to avert or better manage stressors. *Wellbeing may be defined as mindfulness and the active adoption of attitudes and practices that each person chooses to use to avert or mitigate the stressors she or he experiences in work and outside work*. The authentic engagement of "I-Thou" relationships with one another and with self, as whole persons,

underlies this mindful journey to wellbeing. Put another way, caring for yourself and others more fully as whole persons—bio-psycho-social-spiritual beings—can help you and others better identify and adopt the stress-averting practices and attitudes that work for each person. The benefits of recognizing self and other as complete human beings can serve everyone involved: patient, caregiver, team, family, and all those who depend on and support them, at work and outside of work.

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Chapter 24
"Remember Who You Are" – The Journey Home: A Perspective on Integrity Through the Writings of Parker J. Palmer

Thomas J. Butler

"Our deepest calling is to grow into our authentic selfhood."
—Parker J. Palmer

Listening to Bill recount his life story provided me a true moment in time. His desire to invite me into the process of capturing that story became for me an experience of a lifetime. Bill, an accomplished architect, a defensive tackle for Notre Dame back in the day, and a man of deep faith, possessed all the ingredients to create an inspiring narrative. One story line from Bill continues to inspire me: a remembrance he had of himself as a high school kid. Bill's football team had earned the opportunity to play a championship game in New Orleans. Bill's father, an accomplished architect as well, chaperoned the team. "Here we were," Bill said, "all of us young teenagers in New Orleans wanting a night out on the town." Granting permission to take on the sights and sounds of the infamous "French Quarter," Bill's father gently took him aside and said, "you can go and have a good time—but remember who you are." That experience stayed with Bill the rest of his life. It has stayed with me as well.

In this essay, I reflect with Parker Palmer on integrity as our journey home – a journey toward "true-self." My intent is to invite us into the work of an educator and author who courageously took the path of the "road less traveled," and sought to share the map he forged for himself with other fellow sojourners seeking to find their own way home to true-self. This reflection is an invitation to rediscover and remember who we are.

I share these words as a conversational essay specifically aimed at physicians and healthcare providers whose daily life involves sharing the truth with others about their own wellbeing. I hope this reflective piece will lead all of us to check the pulse of our wellbeing. This essay focuses on three things:

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- Exploring integrity through the lens of Parker J. Palmer's life and writing
- Contextualizing integrity within our work/life experience (story)
- Inviting questions that will allow for a deeper self-appropriation of what integrity means personally, professionally, and organizationally

My intent here is a conversational essay, not an academic treatise of an author's works. Deep exploration of this topic would require a lifetime opus. I seek here to offer the reader (you) just enough research to awaken what emerges within your own heart in the hope that it will influence your thoughts and behaviors as you traverse this path toward integrity and "hidden wholeness."

Parker Palmer's relationship with his father bears particular note. Max Palmer, a successful businessman, shared with his young son his fundamental philosophy (spirituality) of work/life:

> Now, Park, you have visited our office building and warehouse and seen all that would be considered tangible assets. But there's going to be another item on our list that isn't physical and tangible. The name of that other item is "good will," – the reputation you have for doing your work with integrity, coming through on your promises, and treating people decently. And good will is going to have a larger dollar amount than all the tangible assets in this company. (Intrator 2005, p. p. xxviii)

This explicit example from Parker's story partially accounts for Parker's developing awareness of integrity. That awareness emerged within his relational experience with his father and would eventually become the motivating force that guided his life and work. Integrity does not come easily; it must eventually become one's own value and choice. Parker, like all of us, continually struggled between the forces in life that pulled at the fabric of his own identity. Wondering, "should I be this or that?" Become a minister? A professor? Get the Ph.D.? Do community organizing? Parker's discernment was grounded in this innate search for what was true within him, and how that truth would find an expression in his life's work.

The Bookshelf Phenomena

In exploring the life of Parker Palmer, it is essential to first consider another great spiritual writer, *Thomas Merton*. In speaking to the Congress in September, 2015, Pope Francis mentioned the names of four Americans who impacted the spirit of the United States: Abraham Lincoln, Dorothy Day, Thomas Merton, and Martin Luther King, Jr. Like millions of other people, Parker resonated with Merton, a great spiritual writer. This is illustrative of an interesting piece of history that I call *the bookshelf phenomena*.

In February 1937, a young Tom Merton paused in front of the window at Scribner's bookstore in downtown Manhattan. This young undergrad from Columbia University had known for quite some time his desire to be a writer. His interest in philosophy was equally as strong as his skill in writing. There in the window at Scribner's was this new book proudly on display: "The Spirit of Medieval

Philosophy" by Etienne Gilson (Gilson 1936). Merton was drawn to the title and purchased the book with the few bucks he had in his pocket. He spent the night reading and came to the unmistakable conclusion that there was a convincing and coherent explanation for the existence of God that truly captivated his own soul. Prior to this reading, young Merton had no belief in any transcendent being and keenly felt an emptiness growing in his heart. Gilson's book changed Thomas Merton. Four years later, he entered a Trappist Monastery in Kentucky where he wrote his own spiritual autobiography, a book that captivated readers emerging from the devastation of World War II. Today, *The Seven Storey Mountain* by Merton continues to be a best seller (Merton 1948).

In the spring of 1970, a discerning Parker Palmer visited a used bookstore on Dupont Circle in Washington, DC in search of *The Magic Mountain* by Thomas Mann (Mann 1996). In the place on the shelf where Mann's tome was supposed to be, he found another instead: *The Seven Storey Mountain* by Thomas Merton (Merton 1948). Parker figured it was close enough and spent the entire night reading it. Merton's book made a major impact on Parker, just as Gilson's had on Merton. It was a foundational element for Palmer, influencing his own search for integrity and for how to give expression to truth in the world he encountered. The title of one of Parker's books – *Hidden Wholeness* – is taken directly from Thomas Merton's writing (Palmer 2004):

> There is in all visible things and invisible fecundity, a dimmed light, a meek namelessness, a hidden wholeness. This mysterious Unity and Integrity is Wisdom, the mother of all, Natura naturans. (Merton 1978)

My own encounter with Parker Palmer occurred years ago when I took a new job and was moving into an office provided for me by the university president. Remaining on the bookshelf were a few books owned by the previous occupant. This one book caught my eye: *Let Your Life Speak* by Parker J. Palmer (Palmer 2004). I spent the night reading it. It changed me, giving me a cogent and convincing sense of the significance of integrity and nurturing the courage to live out of that integrity as the basis for my life journey. I had read *The Seven Storey Mountain* (Merton 1948) when I was 18 years old, but it took discovering Parker Palmer to reawaken in me the seeds of Merton's writing. Parker's powerful use of Merton's book created a universal appreciation for spirituality as the essence of the human experience, offered in a language in which I could feel at home and included.

Parker's commitment to encouraging people to live out of this transparent relationship of soul (true-self) and role in professional life forms the foundation of *The Center for Courage & Renewal* (www.couragerenewal.org). Through the center, over 300 individuals around the world have been trained as facilitators, creating *Circles of Trust* ® retreat experiences across a variety of professions and organizations.

Parker's impact on the medical community continues to grow and expand as more and more medical providers seek refuge from the storm of their complex work environments. I offer two examples of Parker's alliance with the world of healthcare:

- David Leach, MD, former executive director of the Accreditation Council for Graduate Medical Education and Paul Batalden, MD, formerly of the Center for the Evaluative Clinical Sciences at Dartmouth Medical School, address Palmer's notion of integrity in their essay, "The Inner and Outer Life of Medicine: Honoring Values, Relationships and the Human Element in Physicians' Lives" (Bataldan and Leach 2005). They suggest that the integrity evident in the image of the undivided life is critical to the role of physicians: necessary not just to survive, but to find joy and meaning in their work. After hearing Parker speak, Dr. Leach asked his board to establish a Parker J. Palmer Courage to Teach Award for outstanding residency program directors to be given annually to a director who exemplifies the message of Parker Palmer: living and promoting an undivided life of integrity within the profession. The award continues to this day.
- A second example is Henry Emmons, MD, who provides a holistic psychiatric practice in the Twin Cities of Minnesota. Inspired by Parker Palmer, he founded the *"Inner Life of Healers"* program at the University of Minnesota's Center for Spirituality and Healing (https://www.csh.umn.edu). Dr. Emmons's work has touched the lives of hundreds of practitioners seeking to renew their spirit and to find resources to sustain them in their calling.

Each of these initiatives is rooted in Parker's primary objective: to invite people to rediscover their own truth, personal identity, and integrity, and to find the courage to act on that truth and live wholeheartedly.

Consider Palmer's notion of integrity as illustrated in the example of the Mobius strip. Take a simple strip of paper and connect the two ends, then twist the strip into a kind of Fig. 24.1 as illustrated below).

In this illustration one cannot tell the inside from the outside, or where it either begins or ends. They are perfectly interwoven. For Parker, this is what integrity means: a seamless, transparent connection between one's inner life (true-self) and one's engagement with the world. Parker loves to speak of the "soul-role" connection, meaning that who I am finds its fullest expression in what I do. Jokingly, Parker refers to the Mobius strip as his "Quaker Power Point" (Parker is a Quaker).

Both Merton and Palmer eloquently articulate the necessity of the inward journey and recognize the courage it takes to reorient oneself again and again to this way of being in the world. If pursuing the undivided life is essential, imagine the consequences of living a divided life instead. Palmer notes:

Fig. 24.1 Mobius strip

> …dividedness is a personal pathology, but it soon becomes a problem for other people. It is a problem for students whose teachers 'phone it in' while taking cover behind their podiums and their power. It is a problem for patients whose doctors practice medical indifference, hiding behind a self-protective scientific façade. It is a problem for employees whose supervisors have personnel handbooks where their hearts should be. It is a problem for citizens whose political leaders speak with 'forked tongue.' (Palmer 2004, pp. 6–9)

Integrity: A Journey Home

It's easy to get lost. Most people can readily point to their all-time favorite story of "getting lost": "Then the GPS told me to turn left and suddenly I was in this cow pasture in the middle of the night." As amusing as this may sound, there is a more sobering side to this metaphor, revealing a deep sadness. The story of getting lost is the story of persons who listened to voices other than their own, made decisions on motivations driven by impulse, expediency, or thin and fragile rationales that could not stand the heat of the day. This form of getting lost creates a divided life and a longing for home.

This notion of integrity for physicians and providers (and all who work within the healthcare community) will certainly find resonance with other professions, but my desire here is to be of service to our particular profession – health and healing.

Two iconic films immediately come to mind when I reflect on this notion of integrity as true-self and the metaphor of home coming. Who can forget the last scene of Citizen Kane: the mystery surrounding the word *Rosebud*; the sled being thrown into the fire at the film's end, Rosebud written across the boards. Then of course, there is Dorothy Gale trying to find her way home to Kansas and the characters she meets on that wonderful yellow brick road to Oz. What is your "Rosebud?" Are you on the "Yellow Brick Road?" The journey home and the path of integrity always begin and end within us.

A great question that usually gets asked somewhere along the line is, "why did you become a doctor / nurse." For some, this is an easy answer because they have never stopped checking in with themselves on this question. For others, it is more challenging because their "why" was not addressed adequately. It began as a vague notion or was influenced by other circumstances disconnected from one's true-self. It is here where the great divide begins and can continue to grow unless there comes a pause in its progression.

Parker Palmer's writing suggests some succinct possibilities for providers and healthcare professionals to consider along the path to integrity:

- Find the time to pause and hear your own voice (True-Self)
- The path of freedom is through the threshold of vulnerability (failure teaches)
- No one makes this journey alone (holding solitude and community in tandem)
- Find the courage to live out of true-self (let your life speak)
- In the hurt and anger of life, ask: "is my heart broken in pieces or is it broken open?" (compassion as pain transformed)

- Explore how your patients and their families perceive you. What can you learn from them as to your quality of presence? Do we "hear" each other into speech?
- Invite four or five other people to meet with you to discuss this article.

These three questions might be a good place to begin the discussion:

- What are your innate birthright gifts – what is becoming of them (you) as you do the work you do?
- What does your own "Mobius strip" look like? What is the level of transparency between your inner life and your professional life?
- How have you transformed your own pain into compassion?

Summary

For many, life has a way of providing us with a "wake-up call." It may be that gnawing, gut-wrenching feeling asking us, "why did I ever become a doctor in the first place?" Perhaps it is the feeling of emotional numbness after hearing for the first time the news of a serious illness. Parker endured three bouts of clinical depression as he probed the deeper questions of his own life and what it meant to live wholeheartedly. The journey to true-self (integrity) is a journey that cannot be taken alone. It is a journey that requires both solitude and community. The road is not one of competition, but of collaboration. For physicians and practitioners, the silo of science alone will not lead to the discovery of meaning and wholeness. Rather, it is at the intersection of art and science – mystery and medicine – that one discovers one's hidden wholeness.

I conclude this essay with a preface Merton wrote for the Japanese edition of The Seven Storey Mountain. It contains his second thoughts about the book almost 20 years after he wrote it. I believe this note encapsulates what Parker strives for and what I hope this essay allows for in you:

> Perhaps if I were to attempt this book today, it would be written differently. Who knows? But it was written when I was still quite young, and that is the way it remains. The story no longer belongs to me…Therefore, most honorable reader, it is not as an author I would speak to you, not as a storyteller, not as a philosopher, not as a friend only. I seek to speak to you, in some way, as your own self. Who can tell what this may mean? I myself do not know, but if you listen, things will be said that are not in this book. And this will be due not to me but to the ONE who lives and speaks in both. (Merton 1998, xvii-xviii)

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Part VI

How Do Particular Aspects of Life Affect Physician Wellbeing?

As leaders, we look for solutions that will create change across the organization—the "magic bullet" to cultural shifts. We think in multiples and statistics. However, cultural change statistics, like all statistics, only apply to groups. In the individual, it's either 100% or 0%; it works or it does not. Therefore, we have to look to the individuals to find the motivations, concerns, desires, and needs that are unmet. In so doing, we hear the heartbeat of the organization. We may find that we have collective needs, or we may find we need to do something to help individuals hear themselves. Or, we may find that all of that is true.

In any case, in this section we share personal views and practices of physician wellbeing and struggles of physicians with working toward wellbeing. Our hope is that this will help those who are not physicians peer inside the hearts and minds of physicians, and encourage physicians themselves to learn to listen to their own deepest needs.

In the end, it is in stories that we hear truth ring most clearly.

Chapter 25
Living 24/6 in a 24/7 World

Matthew Sleeth

As a third-year medical student, I learned an important lesson about what happens when things go missing. We were starting our clinical rotations, and six of us stood around an illuminated X-ray screen, ready for our first lesson in radiology. While we stared at the front and side views of the chest X-ray, a radiologist asked us if we saw anything amiss.

> We were quiet.
> "Well, if you don't see anything wrong, does anyone care to comment on what's right?"
> Still more quiet.
> "Okay, let's start with the basics. Who can tell me the gender of the patient?"

And so he began teaching us the fundamentals of reading an X-ray. *It* was a *she*, 20–40 years of age. The diaphragms were normal; the heart was not enlarged. No infections could be seen in the lungs. We couldn't see any tumors. After half an hour of tutelage, we were really getting the hang of radiology.

> Then, our professor began with some less obvious questions.
> "Has she ever had chest trauma?"
> Vacant stares.
> "Does she have a partially collapsed lung?"
> Whoops, forgot to look for that.

We went round and round until we'd looked at every structure multiple times. Finally, the X-ray held no secrets. An hour's worth of looking had confirmed what our textbooks said was the hardest kind of X-ray to be certain of: a normal one.

Then our mentor said, "This film was read by the doctor in charge of the emergency department last night, and the radiology resident on call last night,

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and the one this morning—and they agreed with you. But I called the patient to tell her I think she has cancer."

We went back to looking again, but no matter how hard we tried we couldn't spot anything on the film that didn't belong.

Finally, he asked, "Where is the left clavicle?"
Where was the left clavicle?
It had been eaten away by cancer.
The take-home point? Something that's missing is hard to see.

What's missing from our lives today is a rhythm that has been established for thousands upon thousands of years, a rhythm of stopping all commerce and work 1 day out of seven. What's missing is a day of rest when we make time to renew our relationships with family, friends, and God.

Doctors are well known for their work ethic. We devote a decade of life to medical school and residency with draconian hours, and then many of us work 50–80 hours per week until retirement. Little wonder, then, that 70% of polled physicians say they don't have as much time for their personal life as they think they should.

But you don't have to go to medical school to feel like your life is out of control. We drink coffee and drive cars. We drive cars and talk on the phone. We talk on the phone and shop on the Internet…and fix dinner…and watch the news.

In the last 20 years, work is up 15% and leisure is down 30%. Yet, those statistics don't even account for multitasking.

Despite speed dialing, fast food, and electronic medical records, most of us are busier than ever. "There aren't enough hours in the day" is a common complaint.

If there is one thing I've learned in my over 60 years of life, it is this: one more time-saving device is not really going to give us more time.

A day of rest is something that was faithfully passed along, generation upon generation—until now. It's like the radiologist's lesson. It is now hard for us to see something that's not there.

Just a few decades ago, almost everything in society stopped 1 day a week. Businesses closed at night and on Saturdays or Sundays. Not any more. Now we go 24/7. And in the change to a 24/7 world, something—like the clavicle in the X-ray—has gone missing.

What went missing wasn't the average Monday. It was Sabbath. Sabbath was the day when businesses closed and people got dressed up and went to church. Those without particular religious convictions simply took the day off. Jews marked Saturday as a holy day and Adventists did likewise. Others observed Sunday. Irrespective of their faith or day of observance, society was given, and even guaranteed, a day of rest each week. No more.

Subtracting that day of rest each week has had a profound effect on our lives. How could it not? One day a week adds up. Fifty-two days a year times an average life is equal to more than 11 years. Take away 11 years of anything in someone's life—work, education, or rest— and the entire character of one's existence is altered.

The definition of insanity is doing the same thing over and over and expecting a different result. If there is going to be any hope of advancing physician wellbeing,

we must first admit that something is wrong. Something is missing. If it seems like there aren't enough hours in the day, instead of working harder, smarter, or longer, we might follow the Creator's example in Christian scripture and simply stop 1 day out of seven.

Why We Need 24/6

In the Book of Genesis in Jewish and Christian scripture, we learn that God spoke the universe into existence. For six beautiful, heavenly days, God went about creating something out of nothing. And on the seventh day, God created nothing out of something. God created stopping. On the seventh day, God threw it in park, kicked back, and relaxed.

Later in the Hebrew Scriptures, God gave the Hebrew people the Ten Commandments. Most people know them: love God above anything else, don't worship idols, and don't take the Lord's name in vain. Honor your parents. Don't kill, commit adultery, steal, lie, or covet.

The fourth commandment is the one we often seem to forget. Perhaps that's why it's the longest and begins with the word "remember." *Remember the Sabbath day, to keep it holy. Six days you shall labor, and do all your work, but the seventh day is a Sabbath to the Lord your God. On it you shall not do any work, you, or your son, or your daughter, your male servant, or your female servant, or your livestock, or the sojourner who is within your gates. For in 6 days the Lord made heaven and earth, the sea, and all that is in them, and rested on the seventh day. Therefore the Lord blessed the Sabbath day and made it holy* (Exodus 20:8–11, English Standard Version).

When we look at the Ten Commandments as a whole, we see that the first three are about our relationship with God. The last six have to do with our dealings with each other. The fourth commandment acts as a bridge between God and humanity.

The Sabbath commandment embraces the wealthy, and the poor, the citizen, and the illegal immigrant. It pertains to minimum-wage workers and to students. It covers animals. The Fourth Commandment applies equally to men, women, and children. It is made to protect those who believe in God and those who don't. It is followed by humanity, and it is observed by God's own self.

After God gave the Commandments to Moses, centuries went by. During this time, God sent prophets to get the Hebrew people back on course, but they kept getting caught up in more and more bureaucratic rules and regulations. They had good judges and bad judges and good kings and bad kings; they were exiled for decades and returned home.

And then one Sabbath morning, Jesus stood up in his childhood church and read from the book of Isaiah: "The spirit of the Lord is upon me, for he has anointed me to proclaim that the captives will be released, that the blind will see, that the oppressed will be set free, and that the acceptable year of the Lord is here!"

What does Jesus mean by "the acceptable year of the Lord?"

The acceptable year of the Lord means the Jubilee Year. Every week the Hebrew people had a Stop Day, and every 7 years they had a sabbatical year. The sabbatical year in ancient times had special provisions to let the fields go unharvested, which allowed the poor to glean and the wildlife to regroup.

But every half a century, a special year called the Jubilee Year was supposed to occur. If it were a Jubilee Year and you were a slave, you were set free. If you owed money, you got loan forgiveness. If your farm had been foreclosed, you got it back. The Jubilee Year was a holy reset button on life.

When Jesus read this passage about the Jubilee Year—the mother of all Sabbaths—everyone got quiet. Then Jesus said, "Today you have seen this scripture come true." Jesus was saying something radically new: that *he* is the Sabbath. He is the Jubilee Year.

Jesus declared himself Lord of the Sabbath. He said: "You are not meant to save the Sabbath. It—*I*—am meant to save you."

You see, at the time Jesus started his ministry, the Sabbath had turned into something it wasn't meant to be. People had added so many derivative laws and amendments to the Fourth Commandment that it wasn't a celebration anymore. It had turned into work.

Jesus didn't come to abolish God's laws, especially the Ten Commandments. Rather, he came to point like a compass toward the *intent* of the laws, and the intent of the Sabbath is the exact opposite of rules and regulations. It is said that Jesus came to keep us from being condemned by laws we couldn't keep, and that is true, but Jesus also said he didn't come to take away one jot or tittle of the law. So, when the commandment says don't kill, Jesus doesn't say it's all right to murder. Instead, he says don't even be angry with someone.

The *intent* of Sabbath is holy rest. The Bible says that rest is holy. God rests. God is holy. Therefore, rest is holy. In Christian tradition, Sabbath keeping is not a condition of getting into heaven, but it does happen to be the condition heaven is in if you get there.

Everyone needs rest—even physicians. We need rest from our labors, rest from our worries, rest from compassion fatigue, and especially rest from playing god. You and I were designed to get away once a week from the speed of change, from our jobs, from information overload, and from our own sense of self-importance.

Now, more than ever, Jesus calls out to us in this 24/7 world and says, "Let me teach you, because I am humble and gentle at heart, and you will find rest for your souls. For my yoke is easy to bear, and the burden I give you is light."

Jesus is the Lord of the Sabbath. He came to give us rest.

How We Do 24/6

We live more than twice as long as our country's founding mothers and fathers. On average, we have twenty to thirty times more income. We have so much food that we are in far more danger of eating ourselves to death than of going hungry.

In good times, we begin to think that all we have results from our own cleverness and ingenuity. No one ever found the Lord on the day they won the lottery. Faith is more likely to blossom on the day we lost our job. In my experience, Sabbath encourages thankfulness without the wake-up call of illness, loss, or ruin. It allows me to see miracles. Sabbath reminds me that I don't need more wonders; I need a greater sense of wonderment.

When we go 24/7, God gets taken out of the equation. We begin thinking that the world can't run without us. Certainly the hospital can't.

We need the Sabbath for the perspective it gives us. We have more than we think if we think we have too little, and we have less than we think if we believe we have it all.

God punctuates our lives not only to give us rest, but to help us live in relationship with God. That's why we pray, go to church, and read the Bible on the Sabbath.

In order to grow, relationships require time. There is no rushing intimacy. If we feel like we don't know the Lord well enough, maybe it's because we simply haven't spent enough time with God.

In the 24/7 world, we "pencil in" friends on the calendar, but our good intentions frequently fail to materialize. We have the best of intentions, but intentions don't build relationships.

I have found that honoring the Sabbath every week not only changes my relationship with God, it changes everything else in my life for the better. In a world that always dangles faster cars, connections, and solutions in front of us, it's important to be reminded that God designed us to spend 1 day a week at the speed of stop. God loves us as a human being, not a human doing.

"*But, "*you might say, *"I don't have enough time now. How can I possibly get everything done if I rest one day a week?"*

This is what I've learned: keeping the Sabbath allows me to get more done, not less. Jesus did more in 3 years than most of us get done in a lifetime. Jesus also knew how to stop. He stole away to spend time doing nothing but being with God. He kept the Sabbath every week of his life. He had his priorities straight.

As a doctor, I watched patients walk out of the ER while having a heart attack because they were worried about losing a business deal. I've seen wealthy physicians leave sick children with the nanny while they went off to earn more. For the most part, people in our culture do not need more. They need to recognize how much they have. The Sabbath is a reality check. It says you have enough. Try to get more and your manna will turn to maggots.

After practicing the Sabbath for more than a decade, I don't know how I could survive without a weekly day of rest. For me, Sabbath has become the highlight of the week, what all the other days spring from and build up toward. My busy workweek is balanced by a rest day. It renews and restores my soul.

The Sabbath balances the *active* part of my life with the *holy* part. Jesus needed both to be fully human, and so do we.

Chapter 26
The Physician Family

Scott Brady and Pamela Brady

Scott

Pamela and I have been married 24 years. I'm a physician and Pamela is a meteorologist. We became a family when we said "I Do." Since then we've been blessed with 4 daughters – Abigail Grace, Lydia Grace, Sarah Grace, and Hannah Grace. We gave them all the same middle name – "Grace" – because we were and are still overwhelmed by the Grace of God who has given us these little girls to join our family.

Our perspective is from the standpoint of being followers of Jesus Christ. We are Christians; therefore, we have a Biblical worldview and operating paradigm when it comes to living life. We have seen that the family can be one of the clearest tastes of heaven we experience here on earth.

We consider ourselves a "normal" family – if there is such a thing. We are six sinners living together in the same house, figuring out every day how to live life and love each other. Like most families, we've been through a myriad of ups and downs. Our family has experienced chronic pain, anxiety, cancer scares, infertility, premature births, losing a parent, major surgeries, moving schools, moving churches, moving houses…. We're a normal family. You've probably walked through similar things in your life.

We're also a Physician family. I graduated from med school at Wake Forest University and later became an Internal Medicine physician. I worked in local Emergency Rooms for several years and for the past 23 years I've worked at Florida Hospital in Orlando, Florida. I've had various roles including Urgent Care Physician,

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While writing this article I came across a magazine entitled "Physician Family." The covers of this magazine have artist renderings of what a physician's family is like. There's a picture of an old scale with articles on balancing life: work, home, relationships, finances, and hobbies. Another cover depicts what I can best describe as "Chaos." The general idea: "too much," "too fast," "too little time to do everything," "out of control."

In this article, my wife Pamela and I are going to briefly discuss three aspects of a family: balance and priorities, children and communication, and going through difficult seasons of life. It's our hope that a look into our family will encourage you in yours!

Balance and Priorities

Scott

Balance is often elusive. The idea that we can live life perfectly balanced for an extended period of time is certainly not a reality that I've experienced. Rather, I think of balance in terms of keeping my priorities in order thru every chapter of life. Each chapter presents us with different levels of business and stresses, different challenges, and different blessings. I believe that in each chapter we find "balance" by staying true to our priorities. Our focus should always be on our priorities. The more intentional we are in making priorities for ourselves and our family, the more clear it is when we're out of balance.

In our family we have three priorities: faith in Christ and following Him; family and commitment to one another, and mission (how we love and serve those we are around at work, at school, etc.). When looking for balance, we have to intentionally keep going back to our priorities. Are we keeping our priorities in order? Has priority #3 supplanted priority #1? Have things that are NOT on our priority list overtaken our time, attention, and affection? It's so very easy to allow other "things" to grow and take over our priorities. For me, I find that I often become out of balance because I've neglected my #1 priority. When my personal devotion to Christ and personal worship of Christ gets crowded out by other things (even good things, I quickly get out of balance. When this slips, everything else slips.

> It often happens that when families get their relationship to God straightened out, their relationships with one another begin to straighten out as well. Wayne Mack, Pastor

Pamela

Staying true to my priorities is so much easier said than done. Other commitments and things we feel we "have to do" are constant, and they change all the time. Our kids go to a fantastic school that has 70 billion opportunities for them to get involved in. There's a constant pressure to be doing things – doing *lots* of things – and doing

them to the fullest. In our school they don't just win games or tournaments, they win state championships in multiple sports, from football to volleyball. It's all good stuff, but it's so easy to get consumed with things that aren't, in the long run, important to us as a family.

Saying "Yes" to something is also saying "No" to something else. In general, when we say "Yes" to something outside our family, we are saying "No" to our family and what is most important to us. One example of this is in the arena of volleyball. All of our girls have played volleyball. In the early years, it was manageable in terms of time commitments. As the girls progressed through middle school and high school, the requirement for playing on the JV or Varsity team was that you had to play volleyball 12 months a year. You had to be on a club team that travels hundreds of miles on weekends just to play volleyball against a team from another state. Please don't misunderstand; we're certainly not judging those families that make this choice. There are lots of good lessons learned in the arena of sports! For us though, it quickly became too much of a time commitment to play club volleyball and also keep our priorities in order. We had to have difficult conversations with our kids who saw "everyone else" playing club and getting better and better. As time passed, our girls did play school volleyball in the fall, but their skills didn't keep up with those who played year-round. Many times our girls saw the bench as much as they played. We were laughing the other night that we noticed that when our girls get into high school they make the team because they're very sweet and encouraging. The coach wants them on the team because they are great encouragers and have great attitudes, but there's not a lot of playing time, and soon they don't make the more advanced teams. There's a cost to making family a priority. The fruit I see, and that I am very grateful for, is that they truly love each other, and love and value spending time together as a family.

There are always consequences for keeping or not keeping our priorities. The question to ask is "what's the cost?" because there certainly is a cost. We've had to ask: "What do we want our kids to be solid in when they graduate from school and flutter off into adulthood?" "Do we want them to be professional volleyball players?" "Do we want them to be at a high level in gymnastics?" It is clear for us that we want our kids to love Jesus and love the Gospel. We want our kids to be close to each other as sisters. Four Sisters with close relationships is something to be cherished throughout their entire life. We always tell our girls, "You guys need each other. When you start looking for husbands you need your sister to tell you what she sees in the boy you're dating because you'll be blind! Your sister will be your greatest cheerleader and encourager and friend."

Scott

Again, saying "Yes" to one thing is also saying "No" to another. That reality keeps us coming back to the order of our priorities. What are we saying "Yes" to? What are we saying "No" to? It's so easy to get busy and out of balance with our priorities. When we do, we get stressed out just like everyone else. With me that stress is fairly easy to see. Being overly stressed brings carb cravings and weight gain. I get agitated and grumpy. I don't listen well and my answers can be short. My wife and kids

are the first to see it! I also get busy-minded and find it difficult to be present with the person in front of me. Not too long ago my youngest daughter asked how my day went. Apparently, I didn't reply. She asked again, and I didn't reply. My wife caught my eye and brought to my attention that I hadn't answered her question. In reality, I did see her lips moving and I might have heard her words, but my mind was somewhere else.

Over the years, Pamela has become very skilled at diagnosing me when I'm over-stressed and out of balance. She will pull me aside and say, "honey, you need to go to the mountains." I usually respond, "Really, is it that bad?" She graciously offers to take care of the kids alone for 3–5 days while I go to a little place we have in the Georgia Mountains – alone. The time alone is difficult at first. I'm used to having my kids and my loving wife around! The time is important though, it gives me a chance to journal and pray and think and read and reprioritize. This has been so helpful. In fact, my family likes it when I go away to the mountains by myself because invariably I come back in a better place.

Pamela
Initially, he felt guilty and he wouldn't want to go. He would say, "I don't want to leave you guys." I would tell him, "Honey, I've got this and I can make it a few days without you. You can take time away and be alone to get your soul refreshed – go be with God."

Scott
So I did, and this has become a rhythm of life for our family. I try to get away to the mountains by myself once or twice each year. It has never failed to refresh me and bless my family. When I come home from these trips, I sit our family down and read the things I've written in my journal. I'll read to them the things I've learned; I'll read to them the sins exposed in my heart (and ask their forgiveness for specific sins I've done against them). I'll read to them the encouraging thoughts or Bible verses God gave to me; I'll read about some of the struggles I'm having; I'll read about my priorities going forward. It's a sweet time and it blesses our family.

Children and Communication

> There is no more consistent, pregnant, dynamic forum for instruction about life than the family, because that is exactly what God designed the family to be, a learning community.
> Paul David Trip, Pastor

Pamela
When our first child was a toddler, we were attending a church with a wonderful pastor. The pastor and his wife had older children and they gave us lots of great parenting advice. They talked to us a lot about being "authentic parents" rather than "pretending parents" who put up a façade of being perfect. There are no perfect people and there are no perfect parents!

It's easy to pretend with kids. It's easy to act self-righteous when we're correcting them about their selfishness or lack of love for each other. I'm so convinced that our kids know better! They have the total lowdown on who we are as parents. They live with us! We parents still struggle with sin, with selfishness, and being unloving to others, among a long list of issues. We're not trying to raise a bunch of pretending, perfectly acting kids who say "yes ma'am" and "no ma'am" but are really a bunch of little pharisees who look good on the outside only. When we allow ourselves to be authentic, to put on display our own anxieties and fears and sins, it is a great encouragement to our kids. We're saying to them, "Look, we're not perfect – just like you – but we have a Savior who we can run to who will forgive our sins, and He alone can change our hearts."

When our firstborn was 3, I remember the three of us sitting at the dinner table. Scott was working at an Urgent Care clinic in Lake Buena Vista, Florida at that time. He came home and was sitting at the table and went on to tell a story about his day. He said he'd had a hard day and that he'd sinned against his nurse Gloria by using harsh and angry words with her. He said that his heart was angry and he had to go talk to her and repent and ask her to forgive him. I was looking at him and thinking, "What is he doing?" There is a little three-year-old child at the table in a high chair. She's moving her peas around the plate and not paying him any attention. He wants to model to her an authentic life and I'm thinking it's so sweet, but I don't think she's getting anything because she's not even looking at us. Then, she looks up when he's done telling the story and she says, "Daddy, will you tell me that story again about when you were a big fat sinner?"

Scott
To this day, my kids' favorite stories aren't *Cinderella* or the *Three Little Pigs*. Their favorite stories are the ones we've told about our lives when we've sinned or messed up or been disciplined by our own parents. They can recite all of these stories. Why is that? Because they can relate!

Pamela
I'm even more convinced now, with a 20 year old, that my kids have learned more from my failures in life than from the things I've gotten "right." They learn where real people go when they mess up – that there's a Savior. They learn they can run to the cross and be forgiven. Modeling that truth has been a really big deal in our house.

Our Pastor and his wife also recommended to us that we read a book written by Paul Tripp called *Shepherding your Child's Heart*. We're sure this has been the most influential book in our parenting. The thesis of the book is that parents can too easily see and address the behavior of their kids, but that all behavior is driven by what's deeper in the heart. The Bible says that out of the heart comes all sorts of things that we hear coming out of our mouths. When we address the behavior alone, we're telling our kids that what we're most interested in is their perfect behavior. We're also telling them that perfect behavior is possible, even with a heart that is deeply flawed. We might even settle behavior issues with "tell them you're sorry," "Sorry," "OK,

now don't do that again." Looking behind the behavior to the heart teaches our children that they've not just got a behavior problem, they've got a heart problem! Their anger and harsh words and selfishness comes from a heart that's angry and selfish, and they need to change the heart before there's any authentic behavioral change.

Scott
When our kids were elementary school age they loved playing with dolls called American Girl Dolls. It was not uncommon for one of the girls to take one of her sister's dolls. The conversations that followed focused on trying to get the child who took the doll to understand why she took the doll: "Honey, you know that's your sister's doll. You have your own dolls. Why did you take your sisters doll?" You know the answer: "Because she took mine first," or, "Because I wanted it." I'll then ask, "Yes, but what's in your heart that made you want to take from your sister rather than give to your sister?" It might take a while, but eventually the girls would begin to see that selfishness resides in their hearts and causes their behaviors. When they see that, I will try to share a story about myself and how my heart has selfishness, and that selfishness is a sin that I go to Jesus to forgive and ask Him to change my heart to be more loving and giving.

Pamela
The lessons don't stop at elementary school. It's an everyday thing! My daughters are now between the ages 13 and 20. They pretty much wear the same size clothes, or try to. They borrow my clothes and borrow each other's clothes. We are all interchanging clothes these days – teenage girls and clothes. If you have teenage girls, you know that clothes are a big deal. I was just sitting down the other night with one of my daughters. She has the habit of borrowing from her sister's clothes closet without asking. She was getting ready for church youth group and she walked down the stairs and had on a brand new shirt that one of her sisters had just bought and never worn. It would have been easy to pronounce a bunch of rules: "OK, no more borrowing. Let's just decide not to do it. You have enough clothes of your own." Looking at things from the heart perspective instead led us into a great conversation not just about selfishness, but also about her having fear of what others think of her and envy of the outward beauty of one of her sisters. Jealousy. Selfishness. Fear of man [is this fear of men or fear of others?]. These are issues that are deep. They will come out in a myriad of ways in her life. It was a sweet time to pray with her, and to remind her that she is clothed with the Righteousness of Christ, that she is completely accepted and loved by the King of the universe, and that real beauty comes from the inside not the outside. Rich conversation for sure.

Difficult Seasons of Life

You don't really know Jesus is all you need until Jesus is all you have. Tim Keller, Pastor

Pamela

For the first four or five years of our marriage we were just rockin' and rollin' along. Scott worked in an Urgent Care Clinic and I worked as a meteorologist for the CBS station in Orlando. Plenty of health. Plenty of money. Plenty of time. Then, we started having kids. We had our first child and two years later were excited to be pregnant with our second. We were 26 weeks pregnant and had both taken off work to go to my Ob/Gyn doctor for an ultrasound to see the gender of the baby. We were so excited and had a whole day of fun planned. We got to the doctor's office and did the sonogram. The doctor was doing it himself, and he said out loud, "Oh No!" He could tell something was wrong. We were in total fear as we left to go to Florida Hospital for a high-level sonogram. I will never forget that day. We were young in our marriage and had not really experienced anything that was significantly hard. Both of us were anxious and crying during the car ride to the hospital. Scott looked at me and said, "Honey, everything is going to be OK." When he said that, he was such a rock and stability for me. I said, "do you think she is OK?" I was trying to take comfort in his words and he replied, "No, I don't mean to say that I think she is going to be healed. I just mean that right now I want us to decide before we know the outcome that we're going to trust that God is good. He only has good planned out for the Bradys, not harm, whether we can see it or not." The diagnosis was not good. A few weeks later our child's heartbeat stopped and the Lord took our little girl to heaven; our first deposit in heaven. The weeks and months after that were very hard and probably led to a period of infertility. Looking back, we see more clearly how God has directed our paths and given us strength. God really is good, even when we don't understand it.

Scott

About the same time that we experienced the death of our child and subsequent infertility, I started developing back pain. The pain lasted a long, long time and became chronic. I saw many brilliant physicians over the next year or two, and they all told me that I had a very bad spine: "The back of a 90 year old man." They said I would be in pain the rest of my life. I was only 40! If you've ever had chronic pain, you know that it takes a toll on every part of your life. You can't think, you can't listen well, you can't sit down and enjoy meals with your wife, and your mind is preoccupied with pain.

I got to the point where I was on several medications, including narcotics, and I was getting two 60cc syringes injected into 20–30 areas on my back every 2 weeks. The narcotics seized to work as well, so I stopped cold turkey (not a good idea!). Finally, I walked into my study and saw a book that a friend had given me called *Healing Back Pain*, by an NYU physician Dr. John Sarno. I read the book and later flew to New York City to spend a few days with Dr. Sarno. He taught me things I'd never learned in med school. He believes that most chronic back pain is caused by stress and repressed strong negative emotions. He recommended that I get a journal and start writing about stresses in life: things that make me frustrated or angry from the past, and present circumstances as well. He recommended that I write about my personality, what it means to be a "perfectionist," and the self-imposed pressure this personality causes. So I did.

I journaled for about 8 hours the first day, and had only written down one page. The next day I was up to five, and the next day I was on page 35! Wow! I had no idea so much stuff was somewhere repressed in my mind, causing muscle tightness and back pain. A couple weeks later I was off all medications and completely out of pain. Amazing, but what about all the "stuff" I had written down in my journal? I remember one day saying to my Pamela, "Honey, I think I'm irritated or angry with just about everyone I've ever met! This is ugly stuff!" The stuff that came out in my journal gave me lots to pray about and lots to repent from, which served to draw me very close to the presence of God. In hindsight, I am thankful for the years of pain. What it produced in my heart and in my relationship to God outweighs the long and difficult road.

In both of these times – the loss of our child and my chronic pain – the difficult seasons were redemptive for our family. Sometimes difficult times can do in us very good things that can't be done without the pain. We don't usually see the redemptive aspects while we're in the middle of the hard season, but it is God's grace that often allows us to see it sometime later.

I also learned that what affects one person in the family affects the entire family. The family is a single unit. If Momma is struggling, everybody feels it. If Daddy is struggling, everyone else in the family is impacted. How important it is to our families to pay more attention to ourselves and our health: mind, body, and spirit.

A Taste of Heaven

Finally, the family can be one of the greatest tastes of heaven we experience while here on earth. In fact, the family is a heavenly concept. In the scriptures we read about a heavenly Father, we learn that we have an elder brother who sacrificed his life for us, we read that we are adopted sons and daughters. We have brothers and sisters. The church is described as being the bride and Christ is the groom; there's a huge wedding feast. There's amazing love, joy, and happiness greater than we've ever experienced elsewhere.

Sounds a lot like Family to me!

> Our Father provides many oases in the journey, but none of them are to be confused with home. C.S. Lewis

We pray that God will bless your family with His abundant love and grace.
Scott & Pamela Brady

Chapter 27
The Physician Mother

Jill Kruse

I am a better surgeon because I am a wife and a mother. And, I am a better wife and mother because I am a surgeon.
– Jamie J. Coleman, MD, Trauma and Critical Care Surgeon.
Blogger@surgeoninkicks

There is a riddle that has been told for many years: A father and his son are in a car accident. The father dies instantly, and the son is taken to the nearest hospital. The doctor comes in and exclaims "I can't operate on this boy."

"Why not?" the nurse asks.

"Because he's my son," the doctor responds.

How is this possible, the riddle asks?

The answer should be obvious: the doctor is the boy's mother. Not too many years ago, it was less obvious—a female physician was a much rarer occurrence than it is today.

According to a 2014 census of physicians done by the Federation of State Medical Boards, there are 916,246 physicians with active, unrestricted licenses in the United States (Young et al. 2014). Of those, 293,564 physicians (32.0%) are females (Young et al. 2014). When that data is broken down further, 30.4% of the female physicians are younger than 40 years old (Young et al. 2014). Thus, it should not be surprising to encounter a female physician who is pregnant and/or has small children. While the number of physician mothers is growing, there are still multiple and unique challenges that physician mothers face when it comes to starting and raising a family. Today women do not, nor should they, need to choose between being a physician and being a mother.

There is no standard of care for how many hours a woman can safely work on-call when pregnant. There is no handbook that tells physician mothers the best way to keep pumping and breastfeeding at work, where it can be hard to even find time

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for lunch. There is no guideline on how to deal with child care emergencies when the physician and spouse are both either working or on-call. There is no medical school lecture on what to do when a sick child needs to be picked up from school or daycare unexpectedly and a fully scheduled clinic is underway. If the physician is a single mother, it can add an increased layer of complexity.

When most any woman sees her positive pregnancy test many different thoughts start racing through her mind. For medical students, residents, and attending physicians this is no different, but the profession of medicine adds a distinctive set of questions and challenges when parenting moves from possibility to reality. For medical students and residents, questions about how this will affect rotations emerge. Are there rotations that can't safely be completed? Can they be rescheduled? Can they be made up? These realities can also affect graduation, particularly if delivery occurs in the middle of the school year.

For residents, the question of when to tell program directors this news and how it will impact their fellow residents looms large, as many of those colleagues will need to carry additional responsibility or burdens when the new mother is out on maternity leave. *JAMA Surgery* published research evaluating career satisfaction in female surgical residents who have given birth during residency. The study found that there were three risk factors associated with professional dissatisfaction (Rangel et al. 2018a): (1) the impact of perception of stigma associated with pregnancy, (2) lack of formal maternity leave policies, and (3) the need to alter fellowship training plans due to difficulties with balancing childbearing within the original choice of subspecialty (Rangel et al. 2018a). This study included a total of 347 women respondents and a reported 452 pregnancies. In the study, 179 (51.6%) agreed with at least one statement of residency or career dissatisfaction (Rangel et al. 2018a).

The issues surrounding pregnancy, delivery, and the postpartum period do not go away after completion of training. For attending physicians, questions arise about how several weeks to 3 months of maternity leave will affect production-based pay or maintaining her practice. She may have anxiety about how this absence may factor into reaching partner status. These concerns are not unfounded according to a study published in *JAMA* regarding maternal discrimination. This study found that of the 5782 respondents, 2070 (35.8%) reported maternal discrimination (Adesoye et al. 2017). "Of those reporting maternal discrimination, 1854 (89.6%) reported discrimination based on pregnancy or maternity leave, and 1002 (48.4%) reported discrimination based on breastfeeding. Of the 4222 respondents who reported either gender or maternal discrimination, 1681 (39.8%) reported both; 2152 (51.0%) reported gender discrimination alone and 389 (9.2%) reported maternal discrimination alone" (Adesoye et al. 2017).

Pregnancy/Delivery

Most often, the pregnant physician will try to minimize her pregnancy and work as normal a schedule as possible, with a few modifications. In a survey of 347 surgical residents, 85.6% (297) worked an unmodified schedule until the delivery

of her child (Rangel et al. 2018b). Of those residents, 63.6% (220) were concerned that their work schedule adversely affected either their health or the health of their unborn child (Rangel et al. 2018b). Surgeons will often pregnancy/delivery compensate by wearing compression stockings to minimize ankle swelling when standing for long surgeries. Interventional cardiologists frequently wear double lead aprons or "Maternity Lead" to further shield the abdomen. These improvisational attempts to keep working are not without risk to the physician or fetus: "The evaluation of staff at two cardiac catheterization units wearing torso shielding with 0.25 mm lead equivalent indicated that the fetal dose limit would be reached after 34 cardiac catheterizations by a cardiologist or 87 procedures by the laboratory nurse" (Shaw et al. 2011). In addition to risks from procedures, exposure to patients with infectious diseases such as varicella, cytomegalovirus (CMV), hepatitis, and rubella is another occupational hazard while pregnant. While contracting one of these diseases from patient contact would be extremely rare, the mere possibility adds another area of concern and consideration when examining patients.

Since only about 5% of babies are born on their due date, it is difficult to schedule patients during the weeks leading up to delivery. The question of whether to stop working early versus working up until labor begins is a much debated and personal decision for all women. For female physicians this is no exception. Knowing the delivery could be several weeks early, should a physician continue to schedule patients and risk having to cancel them versus not scheduling them and risk going late, thereby foregoing any production for that time period? Many women try to "front-load" their call schedules during the first or second trimester so they can cut back on-call responsibilities closer to the due date, thus avoiding the need to find a replacement to cover call on short notice due to early labor.

Maternity Leave

The start of maternity leave does not automatically remove physicians completely from all their professional duties. Many physicians spend maternity leaves studying for boards while the infant naps. Some have taken board tests just days after their child is born. New physician mothers may attend or present at national conferences, finish up paperwork, or manage messages from home through remote login access to the EMR while on maternity leave. The length of maternity leave also varies greatly for physician moms: anywhere from a few days off to three or more months off. Although FMLA requires the employer to allow up to 12 weeks off of work for health-related issues, including pregnancy and delivery, it does not mean it has to be paid time.

Many physician mothers are hesitant to take a full 12 weeks off due to contract obligations, student loan repayment obligations, licensing questions for gaps in employment greater than 30 days, or lack of that much paid time off. Those in private practice may not be able to afford the loss of income while on maternity

leave if they do not have short-term disability insurance or other sources of revenue as they often still have office overhead and payroll staff to consider.

Breastfeeding

The American Academy of Pediatrics reaffirmed their position on breastfeeding in their 2012 Position Paper, "Breastfeeding and the Use of Human Milk" by recommending, "…exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant." (American Academy of Pediatrices 2012). While physicians agree that breastfeeding confers multiple benefits, finding the best time and location for breastfeeding or expressing breast milk while at work can be very challenging. A study of 347 surgical residents showed that while 95.6% (329) felt that breastfeeding was important, 58.1% (200) quit early due to difficulties with poor lactation facilities or stepping away from a surgery to pump breast milk (Rangel et al. 2018b).

While the Affordable Care Act requires employers with greater than 50 employees to provide "reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk," finding and taking that time in unpredictable work environments such as the emergency room, hospital floor, or even a "controlled" office schedule can be challenging (United States Department of Labor, Wage and Hour Division. Break Time for Nursing Mothers). The law goes on to describe the location requirements for pumping or lactation rooms by stating, "[e]mployers are also required to provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk." (United States Department of Labor, Wage and Hour Division. Break Time for Nursing Mothers).

The location of lactation rooms, especially for physicians on a large hospital campus, can be either a help or a hindrance to pumping, depending on the physician's location when it is time to pump. A large university campus may have a lactation room that is physically too far away for the physician to get there in a reasonable amount of time and still be able to pump with minimal clinical duty interruptions. Lactation rooms with refrigerators designated for expressed milk are preferable to coolers with ice packs because they guarantee consistent temperatures, but these are not commonplace. The time pumping or breastfeeding does not have to be lost work time. The availability of a computer with EMR access can make this productive time spent on nonclinical tasks, as women often are using hands-free pumping devices, allowing them to use that time charting, addressing desktop messages, and refilling prescription requests. Other options include bringing infants to the mother to breastfeed during lunch breaks or having a nanny stay with the child in a nonpatient care area of an office, both of which successfully promoted breastfeeding in various practices.

Childcare

Childcare is a major issue for all working families. For physicians with hours outside of the traditional Monday through Friday, 9–5 schedule, finding and keeping safe and reliable child care can be a particularly daunting challenge. Live-in nannies, au-pairs, on-call babysitters, family/friends, and daycare are all options, with each one having its own cost and unique set of pros and cons. Unfortunately, even when childcare coverage plans are made, unexpected situations may arise and those plans can fall through. Dual physician homes may have especially challenging needs for scheduling childcare if there are two call schedules to coordinate.

Babysitters canceling at the last minute, backup child care providers not answering their phones, daycares closing due to power outages, a sick child, or school delays and closures due to weather leave parents scrambling to find a place for their children to stay so the physician can continue working. Unplanned emergencies, urgent requests for a consult, or stopping by the hospital to "quickly check on a patient" often leave older children stuck in physician lounges, waiting at a nurse's station, or staying in a waiting room until one or both parents are free. Single parent physicians have an even greater need for support systems that can help with child care when he/she is called in to the hospital for an unplanned and emergent issue.

These emergent child care issues are often worsened by the transient nature of medical school and residency training, which usually is far away from extended family and friends. With busy work schedules, it is difficult to establish the kind of friendship outside of work where one would feel comfortable calling in the middle of the night to ask someone to stay with the children, while the physician goes to the hospital to address an emergency. Establishing a list of vetted, background-checked babysitters in a common pool available to residents or a practice could be extremely helpful.

Oftentimes, emergent after hours and on-call issues do not allow the physician the luxury of time to call several people and wait for them to arrive at the physician's home or even to drop the children off on the way to the hospital. Hospitals have an opportunity to respond to this reality by providing a safe childcare environment that is available 24 hours a day for these emergencies. In the interest of protecting the hospital from potential Health Insuracne Portability and Accountability Act (HIPAA) violations from a physician's child/children in patient care areas, finding a safe place for children to spend time when parents are involved in emergency care is very important. This not only allow physicians to focus on taking care of the patient; it also ensures that the physician is not distracted by worrying about a child, since the physician knows that the child is safe and cared for as well.

Every parent dreads getting a phone call from school or daycare that tells them that a child is sick and needs to be picked up immediately. For a physician with a stay-at-home spouse, this is less of an issue, but when both parents are working, it is challenging to figure out who will take off of work to care for the child. Many physicians in the clinic setting feel guilty about canceling scheduled patients so they can be home with a sick child. In the hospital setting, there may not be a replacement readily available, so going home is frequently not even be a viable option.

An unspoken more in our society assumes mothers to be the primary caregiver, especially when a child is sick. This adds extra pressure to the female physician as she feels torn between her duty to her patients and her duty to her family. There is also a limit to the number of vacation days nonphysician spouses may take, which may prevent the nonphysician spouse from always being the one to take off of work to care for a sick child. When both parents are physicians or the physician is a single parent, things become much more complicated.

Physician mothers have come up with creative solutions to these issues. Oftentimes physicians in outpatient practices will simply take their sick child with them to work and have the child stay in an unused exam room or the physician's office during the day, so clinic does not need to be canceled. While this is not an ideal situation, it is one that has been replicated countless times with multiple variations from holding the infant in a baby-carrier while rounding or seeing patients, to having nurses stay with the child, or even recruiting unsuspecting drug reps to stay with the children while the physician is in a room with patients. Colleagues who are part-time or have the day off are sometimes available, but often physician parents are hesitant to ask for help as they do not want to impose upon others, especially when a child is sick.

While there are many challenges to navigating a medical career and a family life, the blend of work and life can be a beautiful thing. As the number of female physicians grows, the wealth of advice, experience, and encouragement passed down from physician mentors to students and residents will become richer. We challenge old stereotypes of doctoring as being a "man's profession." Soon the riddle with which I began will no long be considered a riddle. As we move forward, we can shape the culture of medicine as one that does not ask a woman to choose between her career and her family, but supports and encourages her in both.

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Web Resources for Physician Mothers

American medical women's association: www.amwa-doc.org
Mom MD: website www.mommd.com
Mother's in Medicine: www.mothersinmedicine.com
Physician Moms Group: www.physicianmomsgroup.com and Facebook group.
Women MD Resources: www.womenmdresources.com

Chapter 28
The Hurting Physician and Family

Jill Kruse

All it takes is a beautiful fake smile to hide an injured soul and they will never notice how broken you really are.
– Robin Williams (Rudolph 2017)

The general public often thinks that physicians have it all: a wonderful job, wonderful family, and wonderful life. When compared to the average US yearly per capita income of $28,930, the income doctors make looks pretty good to most outsiders (United States Census 2018). With all this presumed wealth, education, power, and prestige, few people can imagine that a physician's life would be anything other than ideal. Unfortunately, this perception is not reality for the many doctors who are struggling with demanding life issues including depression, drug and alcohol abuse, and domestic violence. Behind the façade of a perfect family, many doctors and their families are hurting and suffering in silence.

The advice physicians give out to patients is sometimes difficult for them to follow themselves when the physician or a family member is the one who needs help. Multiple barriers exist for physicians who are hurting or struggling with these issues and need help. Fear of losing respect from colleagues, fear of losing his/her reputation with patients, fear of licensure difficulties, and the sense of isolation these fears cause make it difficult for physicians to reach out, even when help is desperately needed. These issues explain in part why physicians have the highest suicide rate of any profession, with an estimated 400 physicians taking their own lives by suicide each year (Andrew and Brenner 2018). Tragically, suicide is sometimes seen as the only viable option for some physicians who are hurting. Physicians also die at the hands of their partners from domestic violence. In this chapter, we will discuss commonalities and issues unique to physicians who suffer with the issues of mental illness, substance abuse, and domestic violence and will suggest some initial action steps for administrators and physicians.

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Mental Illness

Mental illness still carries a stigma societally. That stigma is further exaggerated for physicians. Many state medical boards include questions such as these: "Have you ever suffered from any physical, psychiatric, or addictive disorder that would impair or require limitations on your functioning as a physician, or that resulted in the inability to practice medicine for more than 30 days?"; "Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last 7 years?" (Polffiet 2008). This form of inquiry from medical boards can become a major deterrent for physicians to reach out for help as there is a fear—unfounded or not—that such an admission might result in loss of licensure, or at the very least loss of privacy regarding a personal health condition.

In striving for privacy, some doctors may attempt to diagnose and treat their depression themselves. Others seek mental health care outside of their towns and pay in cash for these services in an effort to minimize a paper trail. The lifetime prevalence of depression in male physicians is 13% and in female physicians it is 20% (Bright and Krahn 2011). This is not significantly different from that of the general public, in which the lifetime prevalence for depression is 16.6% (Kessler et al. 2005). Mental health issues and depression may even start before a physician begins to practice. Medical students and residents are also suffering from depression and suicidal ideations at alarming rates. In a 2016 JAMA meta-analysis article, 11.1% of medical students had suicidal ideations in the prior year (Rotenstein et al. 2016).

Family members can easily feel overwhelmed and unsure how to help their loved one. Even if the physician is actively suicidal, family members may have a difficult time encouraging or even forcing a physician to get help. Physicians who do not want treatment or do not acknowledge their struggles with mental illness know exactly what to say to a mental health professional to make the family concerns seem like they have been blown out of proportion and to make it appear that the family members are the ones with the issues. Any physician who has given a patient a depression screen with the Patient Health Questioner (PHQ-9) or an anxiety screen with the Generalized Anxiety Disorder Screen (GAD-7) will know exactly the threshold for diagnosis of depression and/or anxiety, and thus can skew their answers in their favor.

Substance Abuse

While many with mental health issues are aware of their problem but are afraid to seek out help, individuals with alcohol and drug abuse issues are often in denial that they have a problem. What may start off as a way to unwind after a hard shift or long hours on-call can quickly spiral out of hand. Colleagues may also be wary to prod into personal issues or confront colleagues with concerns. In a 2010 physician

survey, 33% of physicians with direct personal knowledge did not report a physician colleague who was incompetent to practice medicine (DesRoches et al. 2010). Reasons given for not reporting included "nothing would happen as a result of the report," "fear of retribution," "someone else would take care of the problem," or feelings that they were not prepared to deal with a colleague with these issues (DesRoches et al. 2010).

Often physicians think that these things "don't happen to people like me." As noted in a Mayo Clinic Proceedings article, "approximately 10% to 12% of physicians will develop a substance use disorder during their careers, a rate similar to or exceeding that of the general population" (Berge et al. 2009). Many people are not aware that there are functional alcoholics: people who continue to work and function in a way that belies their dependence on drugs and alcohol until the point where their impairment leads them to make a serious error.

Family members may be at a loss about what to do as exposure of an addiction to a State Medical Board could result in economic ruin for the family if the physician's job is the main or sole source of income. The serious implications of an accusation, which could result in a colleague losing his/her license to practice medicine, often leads to colleagues waiting until the evidence is "beyond a reasonable doubt" (DesRoches et al. 2010). This delay in diagnosis and treatment can lead to serious and tragic consequences not only for the physician, but also for patients and the physician's family members.

There are specialized programs for physicians with substance abuse issues. Often, these are residential facilities that allow a physician a place to work on recovery while surrounded by peers and with no risk of encountering patients who are also seeking help. Getting help voluntarily is far preferable to being mandated by an employer or the State Medical Board. Physicians who want to keep their medical licenses and continue to practice after recovery will likely be required to continue with sobriety monitoring through a Health Professionals Assistance Program (HPAP) that reports back to the State Medical Board. State Medical Boards and State Health Professionals Assistance Programs can provide specifics for each state. Aftercare can also be kept discreet with Caduceus group meetings. These are private meetings that are "doctors only" groups through Alcoholics Anonymous.

Domestic Violence

The justification for reporting impaired physicians to the State Medical Board is patient safety, but what happens when the physician is the one who needs protection? Primary care physicians are taught to look for signs of domestic violence and to screen for domestic violence with patients. As with the other topics of this chapter, intimate partner violence is not something that physicians are immune from experiencing. This is a topic that has not been widely discussed or studied in the physician population, but it needs to be.

A review study of intimate partner violence experienced by physicians found only nine different studies of physicians and medical students. The studies varied widely in their sample sizes and the demographics were mainly women. The percentage of women reporting a history of adult intimate partner violence in these studies ranged from 7% to 24%. While a female physician may be seen as in control of her life at work, those in abusive situations frequently come home to "functional poverty," where all their income is controlled by their partner and they experience few if any options for escape (Couden Hernandez et al. 2016).

Leaving a relationship involving domestic violence may be additionally difficult for physicians who feel hesitant to expose themselves to potential humiliation through public proceedings with law enforcement or court hearings. There is also a bias against highly educated and financially well off women when they reach out for help (Pickus 2010). Many people assume that a woman with a medical degree would be smart enough to avoid getting into an abusive relationship in the first place or would be able to leave (Pickus 2010). There is actually no correlation between education and the ability to leave an abusive relationship (Pickus 2010). Victim blaming is still prevalent in our society. It is common for battered women to feel guilty and to look for ways to excuse their partner's behavior.

The shame that comes with abuse can prevent women from reaching out to others for help. With the demanding schedule of a physician, it is very easy to become socially isolated, which only serves the perpetrator and creates an increased power dynamic. Custody battles and concerns about losing custody of children to a spouse or partner with a more regular work schedule and less demanding hours can also be a deterrent, making abused physicians hesitant to reach out for help (Couden Hernandez et al. 2016; Pickus 2010). Many stay in relationships for the sake of the children and feel that their role is to protect the children from the abuser, something they would not be able to do if custody were shared.

Mental illness, alcohol and drug abuse, and domestic violence are three separate issues, each of which is caused and managed differently. The common thread between them is the reality that the ideal picture of a perfect family projected by the outside world may in fact disguise unimaginable pain, suffering, and sorrow within the private walls of the home. It is crucial that we remember that although the training to become a physician demands almost super-human stamina and endurance, physicians are still human and are prone to all the same ailments that those who seek help from them suffer. The process of becoming a physician can give a person a sense of mastery and accomplishment that makes them feel set apart from patients. The fallacy is the notion that doctors only treat patients and can never become patients themselves or need help from others. Reaching out for help is an important first step for any physician who is hurting, regardless of the cause.

Johann Hari, writer and journalist, has suggested that "The opposite of addiction is not sobriety. The opposite of addiction is connection" (Hari 2015. Physicians work in a high-paced environment where connection with colleagues can be rushed at best and nonexistent at worst. Within that demanding world, connection with another physician or mentor would be an integral part of helping heal a hurting

physician. No one should suffer from depression, addiction, or abuse silently. Physicians need to extend a hand of healing and friendship to colleagues and help us all acknowledge our own weakness and humanity. Embracing each other can be the first steps to making a hurting colleague whole.

Call to Action

For Administrators:

- Have resources available for physicians to discuss these issues in a safe and confidential environment (e.g., Employee Assistance Program or Peer to Peer program).
- Help facilitate mentor-mentee relationships between senior and junior physicians.
- Create occasions outside of work for physicians and their families to interact and help foster community.
- Have someone available on staff who is familiar with processes for treating depression, alcohol, and drug abuse and who knows which resources are most appropriate for physician referral with attention to helping physicians maintain their medical license in good standing whenever possible.
- Have advocates trained to help physician victims of domestic abuse get medical help, counseling, and legal guidance.

For Physicians:

- Look for signs that a colleague might be hurting and reach out to that colleague (have lunch together or ask them to come by for a "curbside consult" so you can talk privately).
- Do not be afraid to tell someone that you are concerned about them.
- Do not be afraid to report someone who is unsafe to practice medicine to the State HPAP program and, if needed, the State Medical Board.
- Help a victim of domestic violence get in contact with those who have the expertise and knowledge to help them safely leave the situation.

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Online Resources

American Foundation for Suicide Prevention at www.afsp.org
Caduceus Meetings blogspot at http://caduceusmeeting.blogspot.com/
National Domestic Violence Hotline at 1-800-799-7233 and http://www.thehotline.org/

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