REFLECTION

Physician Burnout: Resilience Training is Only Part of the Solution

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ABSTRACT

Physicians and physician trainees are among the highest-risk groups for burnout and suicide, and those in primary care are among the hardest hit. Many health systems have turned to resilience training as a solution, but there is an ongoing debate about whether that is the right approach. This article distinguishes between unavoidable occupational suffering (inherent in the physician's role) and avoidable occupational suffering (systems failures that can be prevented). Resilience training may be helpful in addressing unavoidable suffering, but it is the wrong treatment for the organizational pathologies that lead to avoidable suffering—and may even compound the harm doctors experience. To address avoidable suffering, health systems would be better served by engaging doctors in the co-design of work systems that promote better mental health outcomes.

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INTRODUCTION

Physicians and trainees are among the highest-risk groups for burnout and suicide,[1,2] and those in primary care are among the hardest hit.[3-5] In addition to the obvious harm this causes doctors, medical students, and their families, physician burnout can also lead to negative impacts on patients, staff, and health care organizations.[4] Recognizing this, health systems around the world have promoted resilience training as a way to help physicians cope with the emotional demands of their work.

Resilience is defined as "stress coping ability" and "…the personal qualities that enable one to thrive in the face of adversity."[6,p.76] Training to strengthen these qualities is intended to help physicians avoid or recover from the affective, physical, and cognitive exhaustion and disengagement from work that constitute burnout.[7]

Given the inherently stressful nature of clinical work, it makes sense that improving individual resilience might help, but is it really the best answer? Recently, this approach has been called into question by those who say that poor working conditions and unreasonable expectations are to blame for physician burnout and suicide, not a lack of grit on the part of those who are harmed.[8,9] The "con of individual resilience," they argue, "is part of the problem."[9]

As usual in such debates, the truth is probably to be found somewhere in between these 2 positions. So when does resilience training make sense, and when is it just a sham treatment that leaves the underlying pathology untreated?

Picking the Right Tool for the Job: Avoidable vs Unavoidable Suffering

Effective risk reduction interventions require a good match between the target of the intervention and the underlying causes and contributing factors that give rise to that risk.[10] Resilience training is a viable solution if,

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and only if, the underlying problems include a lack of individual resilience.

By borrowing a framework from the literature on patient suffering, we can readily assess the appropriateness of resilience training as a treatment/prophylaxis for the occupational suffering of physicians. Specifically, we need to differentiate between unavoidable suffering and avoidable suffering.[11,12]

For patients, unavoidable suffering is an irreducible consequence of their condition or treatment, and avoidable suffering is the result of faulty care systems.[11,12] So, for instance, reduced mobility during recovery from a major heart surgery would be the cause of unavoidable suffering, while unmanaged pain during the recovery—or receiving the wrong surgery in the first place—would be causes of avoidable suffering.

The same categories can be used to assess occupational suffering in health care. Certain sources of psychological stress are an inherent part of a physician's job: not every patient can be healed; life or death decisions will need to be made without enough information; some patients/families will assume that any adverse outcome is the result of a lapse in care, etc. These are sources of unavoidable suffering, and because they cannot be prevented, the goal of health care organizations should be to minimize the harm they cause. Of course, they should ensure that there is no excess likelihood of such events, but they should also focus on mitigating the effects on doctors when they inevitably do occur. Resilience training makes perfect sense as part of a response to unavoidable suffering.

But other sources of suffering clearly are avoidable, such as overwork and understaffing, a hostile work environment, unsafe working conditions, and failure to provide the resources doctors need to provide safe care. For avoidable suffering, which by definition can be eliminated, the primary goal should be prevention, and interventions should focus on systems improvement, not on individual resilience. And, while the best current evidence is limited, what we know about interventions to reduce burnout suggests that approaches targeting organizational improvements are more effective than those that focus on physicians themselves.[13]

Resilience training does nothing to solve the underlying causes of avoidable suffering, and may even cause harm: First, by giving the illusion of a simple solution, it may preempt the hard work required to address systems failures. And second, it may send the message to affected doctors that they are the problem, that they need to do better at "absorbing negative conditions,"[8] and that failure to "tough it out" is a sign of weakness.[2] This is an unethical abdication of duty on the part of health care managers.

There may be some small role for resilience training as a response to avoidable suffering if it is used as—and clearly communicated as—a stopgap measure to reduce harm while systems-focused improvements are put in place. But doing so without seeming to blame individual physicians for lack of grit would require a great deal of managerial deftness. A more potent and less fraught way to raise morale in such cases may be to engage doctors in the co-design of systemic improvements, allowing them to help diagnose and treat the organizational pathologies that are causing them harm.

Barriers

The routine working conditions for physicians and trainees would be considered unsafe, unprofessional, and even illegal in other safety-critical industries. But long tradition has made this appear acceptable to the medical community, and a whole host of rationalizations (economic, educational, etc) have been put forward by both doctors and administrators to suggest that they are actually necessary.[14] The truth, however, is that these working conditions can only be seen as acceptable and necessary if the health and well-being of doctors (and the safety implications for their patients) are not a priority.

Why has the need for systemic solutions has been largely ignored in practice? As any good academic will tell you, more research is needed. But one key root cause is clear; both health care administrators and doctors themselves operate within a culture that pretends physicians are mythic beings who are, or at least should be, supernaturally resilient,[2] infallible, and omnipotent.[15]

The cultural expectation is that "…'good doctors' do not complain, do not show pain, do not shirk work, and, above all, do not ever show signs or symptoms of mental illness, especially depression."[16,p.5] Those who seek help risk being seen as weak, and not up to the job.[2] And the stigma of failing to live up to this impossible image becomes yet another source of stress, "… setting the stage for an individual's downward spiral of suffering in silence and perpetuating the hidden curriculum that has historically promoted 'toughing it out' and foregoing help."[16,p.1]

This cultural dynamic is not limited to informal peer pressure. It is also codified in widespread regulatory requirements for mandatory reporting of mental health diagnoses among physicians—which can lead to loss of licensure.[1,9] It is a small step from failing to acknowledge one's own suffering to failing to acknowledge the problems that cause that suffering. And it is very hard to solve a problem that no one will admit to.

In terms of administrators, the prioritization of physician well-being (or lack thereof) probably starts

at the top. Clinical experience is rare among hospital board members, and board members often lack confidence in their ability to affect improvement in clinically focused outcomes like quality of care. This lack of confidence in clinical affairs may be part of the reason why many boards focus more on financial governance and meeting external targets than on issues like quality and safety.[17,18] Given the presence of a separate medical staff governance system, this "hands off" approach is likely to be even more pronounced when it comes to physician well-being. And this outlook naturally trickles down to nonclinical administrators at all levels, because it defines what they are accountable for.

A very different cultural barrier is ingrained in the practice of health care safety and quality improvement: a preoccupation with training as the solution to almost any problem. This is by no means in line with the literature in the field, but is an almost universal feature of current practice.[19]

Training and other administrative controls (eg, signs, alerts, policies) offload responsibility for systemic problems onto the shoulders of frontline workers. Not only is this unfair and unsustainable, but it is also likely to be ineffective[19] and sometimes counterproductive.[19-21] In recent years, a number of tools have been developed to help health care teams design stronger improvement interventions,[10,22-27] but practice has been slow to change. As a result, administrators who do try to take action on physician burnout may fixate on resilience training without ever considering more effective, systems-oriented solutions.

Solutions

In the longer term, it is vitally important to build an evidence base for improved practice in the prevention and mitigation of occupational suffering in health care, and to work toward building a culture that acknowledges the essential humanity of physicians. But what can health care organizations do right now?

Burnout among physicians (and other health care workers) is the result of both avoidable and unavoidable suffering. It cannot be fixed through individual resilience training alone. Instead, health care organizations should treat burnout like the key quality and safety issue it is. Solving basic problems like workflow and communication deficiencies may significantly improve physician well-being,[28,29] and the use of scribes to support EHR documentation is a particularly promising practice.[29,30]

Health care organizations should ensure that their governance and management systems maximize the participation of clinical staff in setting priorities and solving problems. They should also develop and track indicators of physician burnout (eg, the Maslach Burnout Inventory[13] or the Oldenburg Burnout Inventory[7]) and important stressors that may lead to burnout, such as excessive work hours[14]; use of second victim support services[31-33]; the clerical burden imposed by EHR systems and workflow design[29,34-36]; the number, and signal-to-noise ratio, of EHR alerts[36,37]; psychological safety survey results[38]; teamwork quality[39]; etc.

While "zero occupational suffering" and even "zero burnout" are probably unachievable goals, health care administrators and physician leaders can use data sources like these to identify outbreaks of burnout and–better still–detect emerging risks before they cause harm. But identifying problems solves nothing by itself. Health care organizations also need to leverage the best available tools to design effective and sustainable treatments for the underlying organizational pathologies they uncover.[10,22-27]

Hospitals, and increasingly, other health care organizations, already have systems improvement infrastructure in place to help investigate and address causes of adverse outcomes[11]; we simply have to make sure we are using those resources to protect clinicians as well as patients.

And yes, resilience training—as well as peer support and stigma-free mental health treatment—should be offered in parallel with these systems-focused efforts,[1,2,8] because some occupational suffering is truly unavoidable. But offering these interventions instead of serious, systemic improvement simply adds insult to injury. Resilience training is not our only hammer, and not every problem that leads to physician burnout is a nail.

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References

1. Gunter TD. Physician death by suicide: Problems seeking stakeholder solutions. *Arch Depress Anxiety*. 2016;2(1):20-25.
2. Baker K, Sen S. Healing medicine's future: prioritizing physician trainee mental health. *AMA J Ethics*. 2016;18(6):604-613. http://journalofethics.ama-assn.org/2016/06/medu1-1606.html.
3. Halliday L, Walker A, Vig S, Hines J, Brecknell J. Grit and burnout in UK doctors: a cross-sectional study across specialties and stages of training. *Postgrad Med J*. 2017;93(1101):389-394.
4. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med*. 2014;12(6):573-576.
5. Lee FJ, Stewart M, Brown JB. Stress, burnout, and strategies for reducing them: what's the situation among Canadian family physicians? *Can Fam Physician*. 2008;54(2):234-5-5.
6. Connor KM, Davidson JRT. Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-RISC). *Depress Anxiety*. 2003;18(2):76-82.

7. Demerouti E, Bakker AB, Vardakou I. The convergent validity of two burnout instruments: a multitrait-multimethod analysis. *Eur J Psychol Assess*. 2003;19(1):12-23.
8. Oliver D. David Oliver: When "resilience" becomes a dirty word. *BMJ*. 2017;358:j3604.
9. Aubusson K. "She was eaten alive": Chloe Abbott's sister Micaela's message for the next generation of doctors. *Sydney Morning Herald*. http://www.smh.com.au/national/health/she-was-eaten-alive-dr-chloe-abbotts-sister-micaelas-message-for-the-next-generation-of-doctors-20170704-gx4jt3.html. Published Jul 5, 2017.
10. Card AJ, Ward JR, Clarkson PJ. Rebalancing risk management—part 1: the Process for Active Risk Control (PARC). *J Healthc Risk Manag*. 2014;34(2):21-30.
11. Card AJ, Klein VR. A new frontier in healthcare risk management: working to reduce avoidable patient suffering. *J Healthc Risk Manag*. 2016;35(3):31-37.
12. Mylod D, Lee TH. A framework for reducing suffering in health care. *HBR Blog Netw*. 2013:1-7. http://blogs.hbr.org/2013/11/a-framework-for-reducing-suffering-in-health-care/.
13. Panagioti M, Panagopoulou E, Bower P, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. *JAMA Intern Med*. 2017;177(2):195-205.
14. Greig P, Snow R. Fatigue and risk: are train drivers safer than doctors? *BMJ*. 2017;359:j5107. http://www.bmj.com/content/359/bmj.j5107.full.
15. Mandel ED. *The Mythic Image of the American Physician* [dissertation]. Madison, NJ:Caspersen School of Graduate Studies of Drew University: 2007.
16. Moutier C, Norcross W, Jong P, et al. The suicide prevention and depression awareness program at the University of California, San Diego School of Medicine. *Acad Med*. 2012;87(3):320-326.
17. Jha A, Epstein A. Hospital governance and the quality of care. *Health Aff (Millwood)*. 2010;29(1):182-187.
18. Jones L, Pomeroy L, Robert G, Burnett S, Anderson JE, Fulop NJ. How do hospital boards govern for quality improvement? A mixed methods study of 15 organisations in England. *BMJ Qual Saf*. 2017:978-986.
19. Card AJ, Ward J, Clarkson PJ. Successful risk assessment may not always lead to successful risk control: a systematic literature review of risk control after root cause analysis. *J Healthc Risk Manag*. 2012;31(3):6-12.
20. Mills PD, Neily J, Kinney LM, Bagian J, Weeks WB. Effective interventions and implementation strategies to reduce adverse drug events in the Veterans Affairs (VA) system. *Qual Saf Health Care*. 2008;17(1):37-46.
21. Mills PD, Neily J, Luan D, Stalhandske E, Weeks WB. Using aggregate root cause analysis to reduce falls. *Jt Comm J Qual Patient Saf*. 2005;31(1):21-31.
22. Vacher A, D'Hollander A, El Mhamdi S, et al. Effectiveness of a tool for structuring action plan after analysis of adverse event. *Proc Hum Factors Ergon Soc Annu Meet*. 2011;55(1):1631-1634.
23. Pham JC, Kim GR, Natterman JP, et al. ReCASTing the RCA: an improved model for performing root cause analyses. *Am J Med Qual*. 2010;25(3):186-191.
24. Card AJ, Simsekler MCE, Clark M, Ward JR, Clarkson PJ. Use of the Generating Options for Active Risk Control (GO-ARC) technique can lead to more robust risk control options. *Int J Risk Saf Med*. 2014;26(4):199-211.
25. Card AJ. The Active Risk Control (ARC) toolkit: a new approach to designing risk control interventions. *J Healthc Risk Manag*. 2014;33(4):5-14.
26. Card AJ, Ward JR, Clarkson PJ. Generating options for active risk control (GO-ARC): introducing a novel technique. *J Healthc Qual*. 2014;36(5):32-41.
27. Card AJ, Ward JR, Clarkson PJ. Rebalancing risk management—part 2: the Active Risk Control (ARC) Toolkit. *J Healthc Risk Manag*. 2015;34(3):4-17.
28. Linzer M, Poplau S, Grossman E, et al. A cluster randomized trial of interventions to improve work conditions and clinician burnout in primary care: results from the healthy work place (HWP) study. *J Gen Intern Med*. 2015;30(8):1105-1111.
29. Sinsky CA, Willard-Grace R, Schutzbank AM, Sinsky TA, Margolius D, Bodenheimer T. In search of joy in practice: a report of 23 high-functioning primary care practices. *Ann Fam Med*. 2013;11(3):272-278.
30. Gidwani R, Nguyen C, Kofoed A, et al. Impact of scribes on physician satisfaction, patient satisfaction, and charting efficiency: a randomized controlled trial. *Ann Fam Med*. 2017;15(5):427-433.
31. White AA, Brock DM, McCotter PI, et al. Risk managers' descriptions of programs to support second victims after adverse events. *J Healthc Risk Manag*. 2015;34(4):30-40.
32. Scott SD, McCoig MM. Care at the point of impact: Insights into the second-victim experience. *J Healthc Risk Manag*. 2016;35(4):6-13.
33. Trent M, Waldo K, Wehbe-Janek H, Williams D, Hegefeld W, Havens L. Impact of health care adversity on providers: Lessons learned from a staff support program. *J Healthc Risk Manag*. 2016;36(2):27-34.
34. Shanafelt TD, Dyrbye LN, Sinsky C, et al. Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clin Proc*. 2016;91(7):836-848.
35. Tai-Seale M, Olson CW, Li J, et al. Electronic health record logs indicate that physicians split time evenly between seeing patients and desktop medicine. *Health Aff (Millwood)*. 2017;36(4):655-662.
36. Friedberg MW, Chen PG, Van Busum KR, et al. *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy*. Santa Monica, CA: Rand Corporation; 2013.
37. Wachter R. *The Digital Doctor*. New York, NY: McGraw-Hill Education; 2015.
38. Edmondson A. Psychological safety and learning behavior in work teams. *Adm Sci Q*. 1999;44(2):350-383.
39. Valentine MA, Nembhard IM, Edmondson AC. Measuring teamwork in health care settings: a review of survey instruments. *Med Care*. 2015;53(4):e16-e30.