Central Line
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(SOUNDBITE OF MUSIC)

VOICEOVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

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DR. ADAM STRIKER (HOST):

Welcome to Central Line. I'm Adam Striker, your editor and host. Today I'm joined by Dr. Amy Vinson, Chair of ASA's Committee on Physician Well-Being, and Dr. Florence LeCraw, Chair of the Working Group on Systems and Policy for the Committee. Welcome to the show.

DR. AMY VINSON:

Thank you. Happy to be here.

DR. FLORENCE LeCRAW:

Yes, me too.

DR. STRIKER:

Well, this is such an important topic, and a timely one, and it's going to be difficult to cover all facets in a conversation such as this. But do you both mind giving us a quick overview of how you came to get involved in physician well-being and what drives your passion for it?

DR. VINSON:

I can start with that. My name's Amy Vinson. I am originally a pediatrician. And then I wandered into the world of anesthesia after my pediatric training to, at the time, I thought, complement my skill set as a NICU doc before I fell in love with anesthesia and pursue that solely. And what happened was interesting. In, in my first year of anesthesia, I noticed there was a very, very different way that anesthesiologists responded to and handled themselves and were affected by adverse events.

When I was a pediatrician, we would have bad things happen and they happened as a team and we all handle them together. And there wasn't a terrible amount of, of internal strife. It was sad, but you, you kind of supported one another through it. When I got to anesthesia, though, I was struck by how isolating the job can be. And, you know, we're, we like to believe that we have control over everything and we plan for A, B, C, D, E and F contingencies in all of our planning. So when things go bad, we can often take this outsized level of responsibility for it and really beat ourselves up and, and really have quite a bit of internal strife about it. And so when I transitioned to anesthesia, I get very, very interested in peer support and supporting people through adverse events.

One thing led to another. I ended up presenting a research study at a Component Society Meeting and then got invited to get involved with the ASA Task Force on Physician Wellness at the time. And one thing led to another after that. And I ended up being Chair of the ASA Committee on Physician Well-Being. But I think, you know, we have a unique job and a, and a unique personality type as anesthesiologists that really sets us up to have quite a human toll from what it is, what we do.

DR. STRIKER:

Thanks very much, Dr. Vincent. And that's the aspect I want to touch on throughout the conversation, the anesthesiology aspect. But before we get there, Dr. LeCraw, do you mind sharing your experience?

DR. LeCRAW:

Sure. I was a practicing anesthesiologist for over thirty-five years. Due to the dramatic increase and morbid obesity in Georgia and the increase in outpatient surgery procedures, I experienced much more stress in the latter part of my career than in the early days. So when I was not working, I practiced mindfulness and cognitive behavior therapy to reduce my stress levels as experts recommended. I exercised more and developed better sleep habits. It helped, but I had to return back

to my stressful work environment and I'd get stressed all over again. I felt like the proverbial canary in the toxic mine, so I decided that I wanted to repair the toxic mine.

As a health economist by the MD route, I heard about a medical liability program that helps patients, their families and the physicians and nurses when an unexpected adverse outcome occurs to the patients. Now, the essence of the program is a physician tells the truth about what happens to the patient and apologizes if there's a medical error. But it's a program that can require hard work by the hospital to implement.

Erlanger Hospital in Chattanooga, Tennessee, implemented the program in 2009. Erlanger's Chief Legal Officer told me that it decreased litigation, defense costs, and time to resolve a case. But he told me the most important effect of the new program was it lowered the stress, the patients, the physicians, experienced when an unexpected bad outcome happened.

Now that, that resonated with me. So I was part of the research team to see if he was correct. Our investigation found evidence that he was spot on. But now a program that decreases the stress of physician may experience when their patient suffers about the outcome is one thing we can do to fix the toxic mine but there are other issues we need to change, like electronic health records, bullying by colleagues, racism, just to name a few. So Dr. Vincent asked me to be part of her great team whose goal is to fix the entire mine. And I said, absolutely. What do you want me to do, Dr. Vincent?

DR. STRIKER:

Well, that's wonderful. To, just get started, let's start by letting our listeners know a little bit of background on the Committee on Physician Well-Being and your work. And Dr. Vincent, why don't you go ahead and, and take that.

DR. VINSON:

Yeah, thank you. Yeah. And I'm really excited to share how the ASA has organized its efforts to support the membership as pertains to their well-being through resources and networking of like-minded individuals and all that has gone on for years in the ASA.

When I first became involved with the wellbeing community, if you will, of ASA, it was when there was a group underneath the Committee on Occupational Health that

was looking at sort of the emotional spiritual wellbeing, if you will, being part of occupational health.

It went by many names over the years. It, it existed for, or over a decade with some incredible leaders over the years. It was a task force. It was a, a working group. It was an advisory group. But what its important function was, was to create this kind of grassroots, very large group of people interested in the wellbeing of clinicians, interested in the wellbeing of physicians, from a million different angles. There were people interested in nutrition and mindfulness and meditation and yoga in health economy, in organizational policy level things. As you can imagine, the meetings were very difficult to run at the time because there's just so much enthusiasm and passion for, for lots of different topics. It was very exciting. And what grew out of that, as more attention was focused on wellbeing, and as really the data started to pour in about how a clinician's wellbeing impacts the quality of care, and how it impacts career longevity, and how it impacts health. As that data started rolling in and it became eminently clear that we had to address this, it wasn't just something that was nice to do, something that we really, truly needed to do in healthcare. It gave the impetus to actually create a standing Committee on Physician Wellbeing.

There was a transition period. Some additional data came out that was in the lay press saying that anesthesiologists had very high rates of suicide. It's unclear if that's a valid data or not, but there certainly is a problem we all know about. And there was an ad hoc Committee on Suicide Prevention. As I said, it became clear that there needed to be a standing Committee on Physician Wellbeing. And, and so that was formed two years ago.

There were many people instrumental in that happening. I, I remain grateful to all of them for, for having the vision to put that in place. Now, once that was put in place, we had the issue of, well, we have this hundred plus group of passionate, engaged, talented people with expertise in a wide range of wellness. They can't all be on a standing committee. But I didn't want to lose the engagement and that expertise of that larger group. And we also have a lot of work to do. There's a lot of aspects of wellbeing. And so immediately we organized the Committee into four working groups. And, and it's my expectation as Committee Chair that each person on the committee be involved with at least one of the working groups.

That's really where the rubber hits the road for us as a group and where we can actually affect change. So, each of those working groups is chaired by a member of the committee, but anyone can join the working groups. And if you're listening to this and you want to get involved with them, send me an email and I'm happy to hear from you. I'm happy to get to engaged with any of them. We can use all the help we can get.

But the four working groups are the first one from, from the high level is going to be Systems and Policy. And that's where we're looking at culture change. That's where we're looking at organizational structure at, at the macro level. And that's where Dr. LeCraw and I have always been heavily engaged. And I've asked Dr. LeCraw to, to continue to lead that group, actually.

The next one is going to be Education and Endeavors. And what does that mean? It's kind of a funny name, but what it is, is those individual interventions that improve our, our own wellbeing and also those curricular and lecture type and skills building things that help us be as resilient as possible, that help us be our best most healthy selves, while still acknowledging that that's just a piece of the pie, that we still have that system and policy work to do. So that's a really robust group of people working on, on that.

And then we have a working group on Clinician Mental Health and Suicide Prevention doing a lot of good work, trying to destigmatize seeking mental health care and, and all that goes along with that from the questions we ask from licensure and credentialing applications to potentially even creating a database of suicides so that we can identify the risk factors and prevent these things from happening again.

And the last group is the ASA Outreach Group, and that's the group that's re, revamped the website. If you haven't seen the wellness resource website lately, take a look. That's the group that, that organizes the booth, that organizes the social media strategy and anything else where we're trying to, to get those resources to the membership in a functional way that's helpful.

DR. STRIKER:

That sounds like incredible work and a dynamic committee, so wonderful ways to get involved. Dr. Vinson, why don't you give us the picture on a large scale? How did we get to where we are as physicians, where we're struggling so much as, as a profession when it comes to well-being? You know, we always think of ourselves as highly resilient, but as best you can, maybe give us a broad overview of what factors are behind all this.

DR. VINSON:

It's, it's a great question. I mean, the fact of the matter is, we are highly resilient. That's actually been demonstrated data as early as, as last summer. Even in those data sets, there are highly resilient people who are highly burned out as well. So it's not entirely protective. You know, it's, it's kind of like that, that canary in the coal

mine example, that was outlined really beautifully in opinion piece by Thomas Schwenk in 2018, where, you know, he said that the physician is the proverbial canary in the coal mine. While, you know, it may be compassionate to care for the canary, it's futile until there's more fresh air in the mine.

You know, it's interesting when you think about that. When, when did we start thinking about physician well-being? Well, I've got quotes from leaders and pioneers in medical education from 1900 telling people to, you know, develop interests outside of medicine and that physicians are most often derelict in his duty to himself and things like that. And so it's nothing new that we're thinking about here.

The idea of burnout came about in the mid 70's, looking at occupational stressors. And Christina Maslach and her colleagues in the early 80's developed a, a metric where we could study it and quantify it. And, and to be clear, you know, burnout is for me, it's a surrogate marker of unwellness. Burnout is an occupational phenomenon. And it's very tightly related to how supported you feel in your work life.

In 2012, it really came into sharp focus because (sic) and his colleagues at Mayo Clinic published the first major large study of burnout physicians and it got everyone's attention. Everybody started studying. And for the next, for the next five years or so, you saw lots and lots of publications about individual interventions to prevent burnout, you know, from meditation and mindfulness, to yoga, to sleeping more, all sorts of things, to, to the point, and they're all good things to do. They're all healthy, good things to do. But it's, it's not going to fix the problem. And it almost became a joke that, you know, there's another mandatory wellness session where they're going to tell you to yoga your way out of burnout. And it almost became offensive, if not definitely offensive, to people that that was the solution being proffered.

It wasn't until 2017, 2018 that we really saw a shift to focus on culture and systems. That's when you saw all these major national organizations coalescing together and coming up with collaborative endeavors to address the physician well-being crisis and the burnout crisis from a systems and policy level, and looking at solutions coming from on high. That's when you saw things like the National Academy of Medicine's Well-Being Collaborative publish their four hundred page missive on preventing burnout in clinicians from a systems based standpoint. And we know that culture impacts burnout. It is key to focus on workplace culture. But how do we improve culture to create these more supportive environments and address long standing issues? I mean, think about the culture of medicine. You know, we're, we take the Hippocratic Oath, we put our little white coat on. We say we're going to put the patient first, but nobody ever tells us how to set limits on that and how to care for

ourselves and to know when you have to take a step back and care for yourself a little.

We almost create this game of performative self-sacrifice, you know, of, of competitive self-abasement in medicine, you know, that, that whole idea of staying strong work after you've done something that you probably never should have been asked to do in the first place, like working, you know, forty hours straight, or, or whatever it is we're, we're applauding. I mean, and it, and it's interesting, it's essential to address these things, issues like burnout, substance use disorder, disengagement. They all have side effects. They all have downstream effects, poor efficiency at work, poor patient outcomes, poor patient satisfaction. There's financial cost. There's, there's issues to retention and, and even early retirement, decreasing work hours. And, and that's all just on top of the, you know, overall well-being and happiness of physicians, which is also reasonable to desire in our workforce.

You know, COVID has thrown a few curveballs our way and, and we can get into that a little bit later. But we have to address these issues of well-being from a systems based approach, not an individual based approach, because it's emanating from a systems based problem. The question shouldn't be how do we fix the docs, but how do we fix the system? So that's, that's the work of this, of our Committee in general. And that's definitely my, my work personally.

DR. STRIKER:

Well, that certainly seems to be a shift as of late and then, I mean, within recent years is, is about fixing the system. And I, I certainly know a lot of physicians who over the years have now moved on from the idea that, well, it's just me and I have to figure out ways for myself to be better so I can navigate this incredible obstacle course that is the profession. So it's great that that will be the focus is, is fixing the system. But while we're on the subject of burnout, just really quick, do you mind outlining what are some factors or signs that all of us should be looking for when it comes to burnout? What is that specifically mean when you talk about burnout?

DR. VINSON:

Yeah, so, I mean, that's, that's a really good question. And, and, and the thing about burnout is, burnout is an occupational phenomenon. Burnout is easy to quantify. We have well validated metrics. And, and as members of the medical community, we like data. We like data that's particularly quantitative data. And, and studying well-being is difficult because so much of it is qualitative. So we have used burnout as a surrogate marker for a lot of aspects of unwellness.

Burnout really falls into three major domains, the way most people use the term. And that's really, as Christina Maslach and her colleagues in the early 80's created the Maslach burnout inventory really breaking into three major domains. And those domains are emotional exhaustion, meaning you've just given out all your emotional energy to your patients or to your job, and you haven't been able to replenish that. And you've just got nothing left to give. It's got aspects of it relating to things like depression, but it's still different.

Then you have the second domain, which is the depersonalization, or some people call it cynicism. And, and it's just a way to distance yourself from what you're doing because it all just becomes too much. And for me, this is my big early warning sign is, is with cynicism. I realize that I'm just starting to become burned out when I start making more sarcastic jokes, right, and other people around me may not realize that anything's wrong at all because I'm making jokes and we're all having fun and laughing. Right? But for me, when I start getting a little sarcastic, that's when I realized that I'm starting to get a little burnt out and need to be a bit more intentional about my own self care and, and rejuvenation.

And then the third is a low sense of personal accomplishment, that sense that you're not making a difference, or you're not appreciated for what you're giving. Interestingly enough, I've, I've seen this actually go up quite a bit during COVID and in a couple of data sets. So that'll be something to keep an eye on, but traditionally, that has not been a major domain of issue in physicians.

It's very clearly an occupational phenomenon. In our data set that was published in Anesthesiology this year with Dr. Afonso, we found that the question, how supported do you feel in your work life, carried an odds ratio of ten with being fully burned out. It's very clearly related to how supported your work life is. And then obviously that begs the question what makes people feel supported. And, and that's, that's where future work has to focus.

(SOUNDBITE OF MUSIC)

VOICEOVER:

DR. STRIKER:

Well, you stressed earlier that this is about culture, not about individuals. You also mentioned earlier about COVID-19 and how that's exacerbated some of our wellbeing concerns in healthcare. Dr. LeCraw, how should institutions be reacting? How do we go about changing that culture to promote well-being?

DR. LeCRAW:

Well, I'm, the ASA's Committee of Well-being's recommendations for how a health care system, what they can do to implement, to improve the well-being of all their health care workers is there, it's evidence based and the opinions from experts on the field of burnout. And it is on our websites and our recommendations are similar to the AMA and the National Academy of Medicine's recommendations, how to improve well-being.

So the first thing is the hospital must establish a system so their staff can report any concerns or problems they're facing. There must be no fear of reprisal. People will not report a colleague who is bullying someone, or committing an error, or making a racist remark, if they face negative consequences for speaking up. But the problem is the hospital leaders cannot affect a change if they do not know there's an issue. Then, once they receive the complaint, the hospital needs to form different teams to investigate the various complaints, whether it's a personnel issue or an electronic health record.

Now, due to my research in medical liability, patient safety and burnout, I have been trained to deal with personnel issues. But do not put me on the team that deals with the HR complaints. You know, I just I will not be able to help solve those problems. Then after the team that is set up to look at the problem, investigate this, they report to the hospital leadership, their findings, then the leaders determine what should they do about the complaint and they have an action plan. Then the hospital must implement a two-way channel of communication between the front line workers and themselves so that after the complaint has been investigated and an action plan is determined, the hospital then communicates with their front line workers what they plan to do to improve the situations.

People will stop reporting problems if they believe the hospital just ignores their concerns. So they have to hear, people have to hear from their hospital group, yes, we've heard you, this is what we're going to do. You know, and then once the program is implemented, the leaders have to get feedback from their staff to determine if the, if the action plan was effective. If not, why? Does the plan need to

be revised or should they try something different? It's a constant communication back and forth between the two groups.

So that's, that's the basics of what it is. They, it's an honest, transparent communication. And let's see what we can do to figure out if there's a problem. If so, what, what we can do about it.

DR. STRIKER:

And what should personnel or clinicians do if their administration is not receptive, or if they're receptive, this is probably more likely, they're receptive but action items don't really ever manifest?

DR. LeCRAW:

They give up, they quit, they quit reporting. And then ultimately what happens is the hospitals that do, do make those problems and help and support their staff as Dr. Vinson said, they move to those hospitals. People talk. People talk about if they have a great working system, that hospital versus another. If you're in a working environment where your leadership is not treating you well, not responding to problems, and you hear of other physicians or nurses that their hospital leaders are, are trying to help them and support them, you leave. You leave and go to the, the good guys. And then the, that hospital is short and it gets worse and worse. You just, there's consequences if you don't take care of your staff, but you've got to listen to them and try to determine the problems. And if there's nothing you can do or say, turns out it was a miscommunication, you tell them and explain or say, well, this is the problem. We don't have enough PPEs right now. This is how we're, you know, we, we can't get more. Like this is, you know, what happened in the first months of the pandemic. And, you know, this is what we've got, y'all. Let's, let's see what we can do to, you know, share whatever. It's, it's, it's hard, though,

DR. VINSON:

I think Dr. LeCraw brings up a really good point about that open and honest communication, especially when you have to communicate bad news. You know, there's, there's ways to communicate things that, that will land terribly and there's ways to communicate things that will build a team together and, and share a struggle together. And, you know, going back to the PPE thing, we all saw examples around the country of different communication styles. And one of the, the biggest things that will turn bright, intelligent, savvy clinicians off the most, is when they feel like they're being gas lit, you know? And so I, I think that honesty is critical in communication, especially when it's bad stuff.

DR. STRIKER:

Well, as long as we're, we're on this topic, let's discuss money. Dr. LeCraw, you're a health care economist in addition to being an anesthesiologist. And you certainly know that these kinds of systems changes cost money or can be costly. And, why don't you, if you don't mind, talk a little bit about the costs, why they're worth it, and how do groups figure out return on investment on all this?

DR. LeCRAW:

Ok, to see the benefits of our recommendations to the health care systems staff and their patients. You're right, the medical facility needs to spend money. There are frequently large upfront cost associated with these broad system change that improve the well-being of physicians and nurses. I would say implementing a salaried position for a chief wellness officer who can oversee the changes needed is usually the health care systems largest expense. But, you know, many hospitals are hurting financially, especially since the pandemic. They cannot afford to lose more money. So we need to help them understand that implementing the Well-being's recommendations will improve their bottom line.

For instance, studies have found an increase in turnover rate for physicians and nurses who experience burnout. One study published in JAMA found the cost to replace a physician ranged from half a million to a million dollars. Now, with the turnover, the very high turnover rate we've been seeing among nurses, the cumulative cost of nursing turnover for a hospital could be even higher than the cost of physician turnover. So that's one big expense if you have a high burnout rate.

Another cost of burnout is that healthcare professionals that have symptoms of burnout report they have a higher incidence of medical error. And medical error is not just a patient safety issue. Medical error results in increased health spending to treat the resultant injury. This results in higher health care costs for everyone, not just the patient who may have to pay more out of pocket costs, but you and me, by higher health insurance premiums in our states and what the federal government may have to pay.

So our teams talking to the different hospitals need to explain to the hospital why that not only will they show a profit if they spend this upfront cost, but that will also improve care. It's a win-win. But you've got to show 'em the numbers. You know, that's that is very important for the hospitals that are suffering right now financially.

Now, last thing. To sustain this program can be very challenging, especially when there's a change in senior hospital leadership. The healthcare system needs to measure the impact of their investment, just like any business would do. Like how much does it cost to replace the loss of this personnel now? What is the incidence of burnout? Has there been a decrease in medical error due to the improved well-being of their staff? The bottom line is that if the health care system does not measure the health outcome and economic impact from these changes, it is unlikely the program will be sustainable. So it's, it's a numbers thing. You have to really look at the numbers, as Dr. Vinson mentioned.

DR. STRIKER:

Ok, so that certainly makes sense. I would even imagine most administrators would agree with that and say, yeah, absolutely, that's a costly expense to lose our personnel. We want to make sure we don't. But taken in a vacuum, I think that all sounds good. But now, when you get down to the nitty-gritty, and let's say you have a well-being office or an ad, administrative department that deals with clinician well-being and they do surveys and go around and ask, and even if they get specific responses, it might be something like, you know, ever since they implemented this electronic record, you know, it's just been awful. The support isn't there or maybe it's extra regulations that the hospital's administering, or mandating, or extra policy implementation or all these little tidbits that make the work just not only not enjoyable, but difficult to do. And I'm, I'm just generalizing here. I don't have any, I'm not talking to anybody specific, but if that's the case, what is the incentive then to get some of those things taken care of?

And I guess what I'm asking is that I always. My impression has been in the past that that's all. If you can, you can do little things that aren't a big deal. The administration will be on board. But if you start talking about big systems changes like that, you know, they're going to figure out ways to, to get around that. And is that something that you guys have seen or heard about? Am I wrong? And B, is that something that's feasible? A lot of times it's just really difficult to address the big ticket items that that, that lead to, or that contribute to this?

DR. VINSON:

Adam, you're hit the nail on the head right here. I mean, there's big ticket items and there are smaller ticket items. And you can go to, to Muhammad Ali to, to, and I'm going to paraphrase here because I'm going the quote wrong. But he basically says it's not the mountain that's going to keep you, it's not the size of the mountain is going to keep you from climbing the mountain, but it's the pebble in your shoe, right? And, and it's not a unique analogy I'm making here, right? A lot of, of groups take

this approach to the pebble in your shoe being the thing that, that just sent you over the edge and makes you feel unsupported in a workplace.

And so, there's a lot of initiatives out there of people looking at, there was a study, I think, out of Hawaii where they were asking about what's the stupid stuff? What's the stuff that bothers you, right, and then getting engagement from people to fix those little things. And oftentimes it's not a huge financial burden to address those little things. But when you survey people, because you, you, you touched on a couple of points there when you were asking that question. When you survey people and you ask them about their well-being and, and, and all you're sending is a burnout inventory with nothing else, it's very disingenuous. And it's not going to be helpful. It's going to be is, you know, just one mark in a time of where you're sitting with no actionable interventions to make. You need to ask people what bothers them, what makes them feel supported, what makes **them** feel unsupported, what do they think we can fix right now?

You know, I ask my department twice a year at least, you know, what can we fix right now? What can we, what do we need to fix that's going to take more time? Do you want to be involved in helping fix this? And there's a million different ways you can approach that. But, but at the end of the day, you have to fix those little things that bother people. You have to find out what those little things are that bother people. And really importantly, and, and one of those things that I think people get wrong a lot is when you send out a survey and you ask them about their well-being and you ask them to take time out of their busy day to answer a survey, you better do something about it. You better really be looking at the answers to that and pouring over it and figuring out what themes am I seeing here? What's the tenor of the culture here? What's bothering people? What's keeping people from being engaged? What's, what's keeping people from feeling supported in this place when all they really want to do is come in and do a really good job with their decades of training that they have under their belt, that they've devoted their lives to? And how can I get all this nonsense out of their way so they can do the job that they wanted to work hard at doing? Right?

And so you better do something with the results of that survey. And the interesting thing is, if you do a survey and you ask people to tell you what's bothering them and what we can fix, and then you actually report back to them and say, hey, this is what I heard. This is what I surmised from this data that you gave me, that you spent your time to give me. And this is what I'm going to do about it. Guess what? The next time you send a survey out to them and you tell them, hey, as a reminder, last time this is what we did with the results, more people are going to answer and more people are going to leave responses. And that's a positive sign, that's a sign of engagement. That is not a sign of hopelessness and helplessness. That is a sign of creating a

shared vision for a better culture. And that is what you're going for. But you have to, you have to fulfill your end of the bargain and actually listen to what they're saying and do something about it.

DR. STRIKER:

Well, that's a great point, because it's certainly probably even contributes more when you see another survey or another meeting or another, you know, hey, session. But, but if nothing's happening with it, it's, it's, it's worse. It's like why, I'm already burnt out. I got to go to another meeting about burnout and nothing happens, but.

DR. LeCRAW:

Right. And let, let me say Dr. Striker, the, the, the thing is for the leadership to do to investigate it and communicate it, it takes money. It takes time. You can't just get people to do it on their volunteer time or go, you know, or work one hundred hours because you're put, you're asking administration to do a lot more work. And so you're going to really have to support them and pay for people to do all this extra work. So and, and that's part of the problem is that they get the data and they can't measure it. They can't, you know, they can't look at the survey. In fact, the AMA has a very free ability, if you want to do they have a survey that they can give you and they'll analyze it, make sure there's no reprisal because they make sure you can't discover who reported. So, and that's very cost effective. But there's still things that are time consuming for the administration. So you have to get back to, is it worth it for them to spend this time?

And the classic example I give for that, Cleveland Clinic is one of the first institutions to really work on physician burnout. Someone who was **a** health care consultant in that area consulted for a lot of the hospitals in the surrounding area, health care system. And they were complaining because all their nurses were leaving and going to Cleveland Clinic. Why? Because they, they were told it was great, because the, the Cleveland Clinic supported them. They were doing some wonderful things. And the con, business consultant said they just didn't seem to get they're going to have to change the culture and could no longer continue this top down, you gotta do what I say. You've got to get a system of listening and then trying to, and communicating with them.

So it, you know, and those hospitals were really, really hurting, nursing especially. I mean, and so there are consequences if they ignore the complaints and the concerns that their staff have. There's financial consequences. And in addition, the patients in particular are, suffer greatly from it. So the hospital can't just, they need help. They need the money. They need the resources to get things going. And then

see the bottom line is they're not losing money, but it's going to be better for everyone.

DR. STRIKER:

So in, in your experience, do you feel that the, the organizations that are not able to do this effectively, is it simply resource limitation or is it that the administrators don't seem to understand or get it? Or is it that they just neglect it?

DR. LeCRAW:

It's both, it's all three, it's really both. I mean, some, some people this is how they've done it. It has been very successful. The 20th century medicine, we're going to keep it up. But the thing is, environments have changed and they have not adapted to the new environment of the twenty first health care system. Others, they don't have the resources. I mean, they are, you know, we have had so many hospitals, I'm in, I'm in Georgia. We did not expand Medicaid. We are losing hospitals. They're, they're closing. Other states are also losing hospitals. They just do not have the resources. So it's a real problem. But that is why we are here. And we work with the AMA. We're working with the National Academy of Medicine to give people and hospital leaderships and others, grassroots support to maybe effect these changes in the most cost effective way they can. But it's, it's a challenge to, we're in the twenty first century medicine. It's a challenge.

DR. STRIKER:

Without a doubt. I mean, it's incredibly important, but incredibly complex and, and difficult as well. Well, let's talk, if you guys don't mind, just briefly about anesthesiology specifically. Oftentimes in the lay press or on social media I see factors relating to burnout, a lot of them deal with specialties, factors, I should say, that anesthesiologists don't typically have to deal with on a daily basis. If you had to list a few factors specific to anesthesia, or high on the list that affects anesthesiologists when it comes to burnout, what would you say those are?

DR. VINSON:

From, from my experience, I, you know, when you're looking at the different specialties and the sources of burnout, burnout is the result of, of relentless stress or frustration that you don't recover from in between. I think for a lot of the specialties out there, a lot of the sources of their burnout stem from frustration, repeated, repeated, repeated frustration. I think for anesthesia, we often encounter more real, true physiologic stress and, and, frankly, fear in our day-to-day work. I mean, there,

there are some scary things that happen. Add to that that we are, are quite isolated in our practice. We're literally behind a drape by ourselves for a lot of our job. And to lose that point of comparison to colleagues, you know, all we hear in the break room is either false self deprecation or aggrandizement and not a lot in between and not a lot of realness there. I mean, not always, but, you know, I think if you understand what I'm saying. And add to that, our personality types are, you know, a little OCD, a little, a little anxious, a little controlling, a little all those things, you know, I think our spouses will tell us that as well. And, and, and so we feel like we can control everything. And we try to and we try to plan for every possible outcome, there's, there's, that, that game you play with residents where you walk in and you're like, so what are you going to do if you stick the Trocar through the aorta? You know, like hee hee, you know, can you come up with this plan? And that's, that's literally what you're thinking about during the day, is what if the Trocar goes through the aorta? What am I going to do? And, and I think all that combined, the isolation, the, the planning, the controlling, leads to taking an outsized ownership of the outcomes, especially when it's bad. And, and I think we carry that. That's, that's been my observation. And, and add to that that, that, that even when things go well, it's a very stressful job, moment to moment, oftentimes. On top of the usual work stressors of production, pressure and threat of medical malpractice and all the other things that are inherently stressful in medicine. I think those things are particularly stressful in anesthesia.

DR. STRIKER:

Certainly, I, I don't think it can be underestimated the fact that many of us are and, you know, have adrenaline rushes throughout the day doing this job. And then you, whenever you do go home, it's just, you crash and, and it's that constant fluctuation I have to think, takes its toll. And that leads me to another question, which is, is simply just getting enough time off of a, a part of the solution?

DR. LeCRAW:

No, no, I, I mean, because, I mean, yes, it helps to take breaks, but then you go, you're going back into the quote unquote toxic mine. I mean, you just going to get sick again and we've got to fix the mine. And, you know, one of the things to fix that, and this is where I was involved in my research is that this medical liability program I mentioned it's called CANDOR for Communication and Optimal Resolution Program. Part of it is they have a program called Care for the Caregiver to help those physicians and nurses whose patients have, you know, died or been seriously injured, you know, either through no fault of their own or maybe they did commit a medical error. It's tragic. So treating them and helping them get through that, those,

these things take some, you have to train people how to help those patients who've had that trouble.

These are all things that we can do. We have to support our health care workers, you know, and not just physicians, nurses, but our pharmacists, our techs. You know, we are a team and we must take care of each other. So burnout experts say 20% of the burnout is related to the individual factors, but 80% of burnout is related to the culture, the system, the work environment where the health care person works. So that's why my, I'm going for the most bang for the buck and working on the actual culture, because that's where I think we can make the most impact. Amy, what are your thoughts?

DR. VINSON:

You know, when you start talking about does time off help? Yeah, time off does help to a point, right? Like we should all take a certain amount of downtime to rejuvenate. And frankly, most of us do that quite poorly, right? You still answer work e-mails when you're on vacation and oh, by the way, we're still emailing you when you're on vacation. And so there's, there's even systems, things there that impact, like if you can actually take time off and actually be off. But, but it comes to a broader question is what, what Florence's initial response was when she said no, you know, my initial thought was sure, time off. Well, you know, how long can you hold your breath when you go back in? Right? Are we just setting up a work culture and, and, and a relationship with work where you hold your breath and you dive in and you deal and you deal and you deal and you deal until you can't take it anymore and then you surface for air. Right? That's no way to work. That's no way to sustain a career.

DR. STRIKER:

Yeah.

DR. VINSON:

You know, I, I, I am a believer that when you start seeing those signs of burnout in yourself, when you start seeing the cynicism and the exhaustion and feeling like you're not making a difference and you start seeing those early warning signs for you, you should probably try to plan some time off and look forward to that and, and, and focus on that a little bit. But that can't be the overall strategy for a fulfilling career. That that's a, a way to, to, to fix a problem in the interim while you try to strike a good balance. Yeah, I, I, I am a proponent of time off. It's important to, to rejuvenate and refill yourself with that, that essence of who you are as a person so that you can be that person to your patients and to your family and to yourself. But

we can't just hold our breath and go in until we have to surface as a way to live day to day.

DR. STRIKER:

Yeah, necessary, but not sufficient.

DR. LeCRAW:

Yeah, well, I'll tell you, there's some real encouraging news. It's not all depressing. I mean, we have some health care systems who are doing it and they're showing effect. One of our wonderful colleagues that we work with, Kenneth Sapire, is at MD Anderson. And they started this process several years ago. And he said it has made a dramatic improvement in their feelings of well-being in their health care system. And as I mentioned, Cleveland Clinic, Hopkins has been doing stuff, Yale, I mean, and other smaller hospitals. So, and we're starting now to see it enough that we're beginning to look and research to see what the quantitative numbers are so we can do it. We're doing it. There are places that are doing it. We just want to increase the number and, and more health care systems implement it as, and show the numbers really do work. And that's where the research comes in. As an economist is we want to show what the data of these places are. But we're, we're, I'm excited about what they're doing so far.

DR. VINSON:

I think a lot of places are doing some really innovative stuff right now, and, and I think that's a good segue into talking about COVID and, and, and what impact COVID has had on well-being. I, I don't think COVID introduced anything profoundly different to the burnout landscape, if you will. I think, you know, there were certain stressors that many of us had never experienced before, like the, the stress of realizing that how you behave at work could potentially put your family at physical risk. That was new. I'd never experienced that before. And there were certainly stressors that were, you know, profoundly accentuated by the experience that many had this year. But what I think it did, most importantly, was it's shown a bright light on the cracks in our systems and, and what leads to unwellness, what makes people feel unsupported. At the same time, it laid bare the humanity of what we do and the toll that it can take on us personally in a way that was undeniable and that, that many people felt for the first time that it was acceptable to talk about just because of how profound it was. And so I think we're at this moment where we can see the cracks in the system. People are willing to talk about the human toll of what we do. This is the moment and a lot of things changed. A lot of things got turned upside down last year. And now we're in this moment where we're wading back into, quote

unquote, normal. And I think we have to ask ourselves is, do we want to go back to just how it was before or do we want to take this moment to rebuild into something better and to address those cracks in the system instead of just paving over them again? Do we want to address the issues in our culture of medicine that were set up for a demographic that's no longer the predominant demographic in medicine anymore, right? Do we want to make this culture of medicine be something that can be supportive and affirming to all the richness of people in, in health care in a way that we know from the data is going to impact the quality of care we provide, career longevity, retention, patient satisfaction, patient safety, and, oh, and our happiness? I think we do, and, and I think there's a lot of, of appetite for that right now. And yeah, it can be costly, but not doing something is also costly and, and not everything costs money. I mean, things like onsite counseling and enhanced administrative support costs money. That's true. It does. But there's a strong return on investment there. Improving communication, developing leadership with better empathy skills and retribution-free systems. They aren't necessarily so much about the financial investment as much as they're about motivation of leadership. You don't need a fancy program. Sometimes a group of highly invested people at the top who are ready to make a change in culture can make a massive change. So, you know, hopefully all this new attention to problems that have existed for a long time lead to both big and small changes that ultimately improve the culture of medicine into something that, you know, we want our kids to go into one day and that we're hopeful about.

DR. STRIKER:

Absolutely. Well, before I let you go, can you both tell us about any helpful resources the Committee has created and put together for any of our members or anyone to use or that they can take back to their own institutions or use for themselves or anything at all?

DR. VINSON:

Yeah, I can answer that. So Dr. LeCraw and, and, and several others have created a one pager on creating a culture of support that goes over a lot of these things. It was edited and, and approved by the Committee and is up on the website as committee work product right now. It is a really, really good document and a good one page synopsis that you can bring it to your leadership. And it's been done in a number of, of health care systems already. We have a lot of resources that you can find at the ASA HQ website. If you go to the website and then you go to the tab at the top, it says it, it says Advocating For You. On the first column, at the bottom it says Well-being. And that will link to a number of resources for the institution, for the individual,

for the department. We curate them and, and we continually review what's up there. And so I, I would encourage you to visit that for, for resources on a number of levels.

Feel free to email me as well. If you have any questions, concerns, want to get in touch. We are happy to answer your questions. You can find my information on the ASA HQ website as well.

DR. STRIKER:

Well, thank you both for such an insightful and important conversation. I hope that our listeners find this valuable. This is such an important topic and it's a timely one and it's relevant to all of us. And so I, I can't thank you both enough for really sharing your expertise and your insights on it. Hopefully we continue to make improvements and strides throughout the health care community.

DR. LeCRAW:

Thank you.

DR. VINSON:

Thank you, Adam.

DR. STRIKER:

Well, this is Adam Striker signing off on another episode of ASA's Central Line. Please tune in again next time. Thank you again for joining. Take care.

(SOUNDBITE OF MUSIC)

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