

Burnout, resilience and moral injury: How the wicked problems of health care defy solutions, yet require innovative strategies in the modern era

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Accepted May 21, 2019

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DOI: 10.1503/cjs.002819

SUMMARY

Physician burnout is an increasingly concerning issue that affects patient care, costs and the sustainability of our health care system. Burnout is not solely related to personal resilience; it is important to recognize the major role of the institution of health care in creating this wicked problem. Only this way can we fully understand the shared responsibility required to develop local strategies to tilt the fulcrum in our favour.

Is burnout a diagnosis or a symptom? Burnout is a syndrome characterized by a loss of interest in one's work, a sense of hopelessness, depersonalization and exhaustion.¹ A 2018 Canadian Medical Association survey of 2547 physicians found that 30% showed signs of burnout, and 8% had suicidal ideation in the last 12 months. These results were significantly worse among medical residents. Is this a diagnosis that requires further assessment, treatment and study? Or is this a symptom of something else? Burnout historically has not been a popular topic of discussion among physicians. Among surgeons at our institution who completed the Mayo Clinic Physician Well-Being Index in 2018, 86% stated they had felt burned out from work, and 81% stated that their work was hardening them emotionally.

As physicians, we pride ourselves on having developed tremendous resilience after years of preparation in residency and fine tuning in medical practice. We are highly trained through study and apprenticeship to deal with the emotional and physical challenges of a modern medical practice. Yet, why is the suicide rate for physicians in the US 40 per 100 000 — 3 times that of the general population? Burnout suggests that we have failed to develop the skills and abilities that we pride ourselves on and have honed over decades. Could the phenomenon of burnout simply be a symptom of something far more insidious?

In their book, *Patients Come Second*, Spiegelman and Barrett write, "... the motivation to work in health care is a series of sacred encounters. They come from trying to describe a deeper connection with people, trying to make a difference not only to our patients, but also in how people treat one another."² So modern health care creates tremendous expectations and has lofty goals, but then introduces tremendous barriers in front of the women and men expected to attain those goals. What sort of disconnect does this produce?

A day on call and in the operating room can feel like a war zone at times. "Moral injury,"³ a term initially used to describe how military personnel respond to war, describes the response that we have when we fail to prevent, or simply watch, things that go against our sense of morality and identity. Is this something that happens in our modern health care system? A Rand Corporation survey on physician burnout found that the primary stressor affecting physicians was their inability to provide accessible,

quality health care.¹ Without controls over system funding and administration, we are expected to be the financial gatekeeper to universal health care by rationing and rationalizing patient access. Poorly designed electronic medical records, increasing paperwork, medicolegal jeopardy, administration demands, regulatory college requirements, the desire to improve patient experience scores, quality scores, and our own personal needs all create a schism between our “intense drive or need” to meet the patients’ best interests and the reality of modern health care. This creates a deeply emotional and exhausting psychological wound. No amount of yoga, mindfulness, physical activity, or pharmaceuticals can heal this wound. In addition, personal solutions, such as drastically reducing working hours, can have detrimental systemic effects.

WICKED PROBLEMS

A concept first used by Professor Horst Rittel, a design theorist in the 1960s, a “wicked problem” has no easy, reproducible, or attainable solution. A simple problem would be something like getting directions to a destination. A complex problem, such as performing a coronary bypass, can be addressed in a reproducible fashion with quality once the correct team, technology and processes are in place. A solution to a wicked problem, such as how to govern a nation, address pollution, or solve the issues of health care, however, has no single, reproducible solution or end point; results in little agreement; and is unique. Often, the problem itself cannot be defined.

Could our health care system itself be the wicked problem? When one looks at the state of surgeons now, one sees an intense competition for few staff positions; wait times for resources, such as operating room time or diagnostic imaging; high workloads due to institutional disincentives to hire; poor engagement; litigation; burgeoning administrative demands; and harassment — all barriers preventing effective patient care. Most of us find meaning through our work, but what happens when that very work and workplace become toxic? All the resilience in the world will not help because burnout is predominantly an organizational issue, not a personal one.⁴

STRATEGIES

There are no solutions to wicked problems, only better or worse strategies. We must pursue a collaborative approach in which all stakeholders have the opportunity to participate and are actively involved in the creation of strategies, not solutions. Front-line physicians need to have input and the authority to make decisions and drive solutions from the bottom up. We want to deliver efficient, quality care and to be appreci-

ated for that by patients, colleagues and the institution. The Mayo Clinic has produced a seminal article that clearly delineates an organizational approach to recognize and address this vital issue in 9 clear steps.⁴ Key organizational approaches include effective leadership, targeted interventions, promotion of flexibility in work–life integration and provision of resources to enhance resilience. One insight they describe is the 20% rule: spending at least 20% of your time on what you find most meaningful can substantially reduce the risk of burnout. Another key insight is that individual offerings to promote self care should not be the primary focus of the institution, as that can lead to skepticism about the ultimate motivations.

Get involved in the management of your institution — a leader without a title is often the most influential one in a group. Learn your local politics and learn how to get things done at your hospital. Instead of working on structures that will change processes and in turn change your local culture, start at the end and address the issues of culture first to get local buy-in. Improvements in workflow, reduction of unnecessary data collection, streamlining electronic medical records, automated order sets, and an acknowledgement of the sacrifices physicians make to provide excellent care can go a long way to improving satisfaction.⁵ The resources provided to caregivers need to be appropriate both contextually and culturally, and are likely more important than a focus on personal resilience.

In Oakville, we have adopted a number of strategies to address this issue. We are hiring 10 new surgeons over 1 year to address issues related to wait times and volume of work. In addition, to address institutional issues of barriers to timely, quality care, we have started an acute care general surgery service (ACS) with 3 additional new surgeons and are in the process of hiring a physician assistant to support them. The ACS allows us to have a surgeon available to do consults on inpatients and emergency department patients as well as dedicated diagnostic imaging slots and ACS operating room time every afternoon to allow patients to be treated and discharged home as soon as possible. In turn, elective surgeons can focus on their practices without being pulled in multiple directions at the same time. We have created separate breast and colorectal diagnostic assessment programs (DAPs). The breast DAP allows patients with breast imaging abnormalities to receive a same-day biopsy, be guided through their care by a dedicated patient navigator, and be seen by a surgeon rapidly and proceed to definitive care. Similarly, our colorectal DAP takes much of the burden away from surgeons by having patients staged in dedicated diagnostic imaging slots, guided by a patient navigator, and ready for surgical or oncological management faster. We have also introduced a new Oakville Virtual Care Program to provide our surgeons

with an innovative and novel way to communicate virtually with patients using the Reacts platform (an integrated, collaborative tool for health care professionals). We believe that this will improve access and reduce barriers to health care.

Our coordinator of staff wellness, Louisa Nedkov, presents on topics of burnout, resilience, compassion fatigue and secondary trauma each month at our Department of Surgery meeting to raise awareness and help change the local culture. In addition, she is assisting us in the development of multiple programs involving guided imagery and peer support to enhance surgeon wellness. Francoise Mathieu, a compassion fatigue specialist from TEND, has presented rounds on the topic of managing compassion fatigue and burnout in health care. We are currently assessing the institutional role in secondary traumatic stress using the Secondary Traumatic Stress Informed Organization Assessment framework (www.uky.edu/CTAC).

In Oakville, our Department of Hospitalist Medicine, led by Dr. Stephen Chin in conjunction with Ms. Nedkov, has started regular Schwartz Rounds — “an interprofessional forum where caregivers have the opportunity to discuss difficult emotional and social issues that arise in caring for patients and families.” We are developing a collaborative model of care between surgeons and hospitalists. We have key local advisors with extensive experience in this field, including Dr. Alex Ginty (physiciansselfcare.com) and Dr. David Posen (davidposen.com). We have also created a peer support network in the Department of Surgery with representatives from each surgical division to provide support and act as resources to our surgeons. We have on our departmental website (www.oakvillesurgery.com/energy.html) key resource papers and strategies that we are currently developing.

In October 2018 our Department of Surgery had dedicated system rounds in the field of team training. Guided by Dr. Robert Johnston of the Canadian Medical Protective Association, caregivers from the entire program attended to teach one another how to work better together. This initiative has led to a number of system changes that are currently being implemented and to a change in tone about how we need to work together.

The “Revised Declaration of Geneva — A Modern-Day Physician’s Pledge” from 2017 says, “I will attend to my own health, well-being, and abilities in order to provide care of the highest standard.”⁶ We need to address some fundamental problems with the health care system if we are to successfully develop and share strategies together.

CONCLUSION

We have created a Sisyphean task for our physicians and then abandoned them and laid the blame at their feet.

Where is the justice in that? Politics is fundamentally about “who gets what,” and if we are committed to improving the organizational and personal issues leading to burnout and moral injury, we need to get involved in politics both locally and nationally to address this as a shared responsibility. We need to reduce institutional barriers, to provide rapid access to resources for our caregivers, understanding the moral distress we feel when we cannot provide timely, quality care. Our institutions need to be more risk tolerant and understand that, while all change is not improvement, there is no improvement without change.

Empathy needs to be demonstrated throughout the entire continuum of health care, from patients to nurses to physicians and administrators. The institution of health care needs to understand that its very survival depends on an existential pivot to focus on the wellness of caregivers. One of my favourite actors, Sonequa Martin-Green said, “Empathy is inconvenient. It hurts you to empathize with someone. We have our own pain. We don’t want to take on other people’s pain. But that’s what’s needed in this world.”⁷ And that will be the key strategy as we roll the boulder up the mountain, together.

Acknowledgements: The author thanks Ms. Louisa Nedkov, coordinator of staff wellness at the Oakville Trafalgar Memorial Hospital. She has patiently taught surgeons the value and virtue of self-care and how it is not as selfish as they may believe.

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Competing interests: None declared.

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