Mark Greenawald, MD, on intentional connections among colleagues

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Featured topic and speakers

In today's COVID-19 Update, a discussion with Mark Greenawald, MD, professor and vice chair of family and community medicine at Carilion Clinic and Virginia Tech Carilion School of Medicine, about how the pandemic has exacerbated physicians' feelings of disconnection and isolation, and how intentional connection among physician colleagues may help.

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Speaker

Mark Greenawald, MD, professor and vice chair, family and community medicine, Virginia Tech Carilion School of Medicine

Transcript

Unger: Hello, this is the American Medical Association's COVID-19 Update. Today, we're talking with Dr. Mark Greenawald, professor and vice chair of family and community medicine at Carilion Clinic and Virginia Tech Carilion School of Medicine in Roanoke, Virginia, about the importance of creating intentional connection among physician colleagues in the wake of the pandemic. I'm Todd Unger, AMA's chief experience officer in Chicago.
Well, Dr. Greenawald, I'm going to put this issue of disconnection and isolation in the bucket of things that were bad before the pandemic, and then got worse. Is that kind of a correct characterization?

**Dr. Greenawald:** Todd, you're right on target. The data showed that certainly physicians were struggling, care teams were struggling well before the pandemic and all the pandemic has done is exacerbated and added onto what already existed.

**Unger:** I don't think a lot of people think necessarily physicians and health care teams as being isolated. Can you talk a little bit first about what goes into that and why is there that problem?

**Dr. Greenawald:** There's a culture within both our selection as physicians in particular and also our training to be really ruggedly independent and in many ways to armor up. Not just around our patients, but also around each other. A lot of posturing can go on professionally, and so that becomes part of the culture. So when physicians then find themselves in need of help, when care teams find themselves in need of help, often they're not quite sure where to turn or even how to turn to get that help.

**Unger:** I imagine the impact of that kind of isolation and feeling of disconnection is not good, not positive.

**Dr. Greenawald:** No, it's not for any human being. We are relational connection creatures, and so in health care in particular, knowing the issues that we deal with and really the emotional challenges, as well as the physical challenges of what we go through every day in our work, it's essential that really no one cares alone when it comes to this important work that we do.

**Unger:** So tell me, now we've had a year under our belts with just unimaginable stress and isolation broad-scale, but particularly physicians being hard hit by this. What's been the impact of COVID on this problem?

**Dr. Greenawald:** Well, the impact is that it took what was already a bad problem and really made it worse. A lot of physicians, I think, are feeling more isolated than ever and in some ways because physically and socially, we've been asked to isolate. We've distanced ourselves in ways that we never would have before, and even when we're together, we're disguised in many ways and covered up. I think that that has gone over into our ability to connect with each other. A lot of our connection has been now electronic, and so we miss some really important cues when it comes to just connection when we lack that ability to physically be present with each other.

We've also then had this whole phenomenon that I think has been exacerbated by COVID of something called moral injury or moral distress. This idea that we are violating some of our very principles in the context of caring for patients and just trying to navigate through the pandemic. Which I think existed also before the pandemic, but has just been brought into the spotlight during this time.
that we've traveled over the last year.

**Unger:** Is that just basically an issue, I mean, not basically an issue, but an issue of how overwhelmed health care worker have been, physicians particular, when you think about at the height of the pandemic and the inability to kind of respond to that level of death and injury?

**Dr. Greenawald:** Yeah, that whole sense of helplessness, the sense of, in some cases, depending on the geography of the physician, hopelessness. That feeling that I want to help these people, and either I can't, because we don't know what to do, or I don't have any equipment to be able to do it or the resources or the staffing. So, there's been so many complicated problems and challenges that have come about because of COVID in particular.

**Unger:** You interestingly were working on this problem before the pandemic and you had started a pilot, a peer-to-peer support program back in 2019 to address these issues. Can you tell us the thinking behind the program and how it works?

**Dr. Greenawald:** Absolutely. The program is called PeerRxMed™ and it was a program that I had actually been thinking about for a long time, and just for whatever reason was not able to bring all the pieces together, but in 2019, we did a pilot just to see what kind of response we would get from physicians around this idea of proactive peer-to-peer connection. There's a lot of peer support programs right now that are what I would consider more reactive. Once a physician needs help or reaches out for help, then help arrives in the context of either peer support or other support.

This is a way to say, let's try to prevent the problems from happening in the first place. How do we provide people support so that both as they travel the challenges of health care, they can do that with a professional colleague with them? But also then when they need help, they've already established rapport with someone, and so they don't need to necessarily reach out to someone who they don't know, they can be more vulnerable with somebody who they've already established that relationship with and that connection with. That was the vision behind PeerRxMed to start.

**Unger:** What was the kind of time commitment that's involved in something like that?

**Dr. Greenawald:** Yeah, physicians and others are always concerned about what will this take to do? I designed it to be very simple. It essentially is every week for as little as 90 seconds, just to connect with your buddy. Which is what I call your PeerRxMed buddy, or your PeerRxMed colleague or partner, just to connect with them for as little as 90 seconds to say, "How are you doing? What can I do to be helpful? What can I do to encourage you? What can I do to support you?"
What I find, of course, is that once those connections start to be made, you want to do much more than 90 seconds with this person, because this person becomes an essential part of your week, and in many ways, part of your, not just survival strategy, but thriving strategy as you work your way through your week.

**Unger:** So let me ask you, did you take your own medicine in this regard and experiment with the program yourself?

**Dr. Greenawald:** Oh, absolutely. Some would say I'm overdosing. I actually have three PeerRxMed partners. I have a partner here locally, somebody who I work with and sees me working every day, somebody who I got to know through my work and wellbeing who's in another city and then the third person, who's one of our community physicians here, just to get a sense of what they're going through in those different contexts in their different workplaces.

**Dr. Greenawald:** So, what I've learned from that is that for me personally having this person as someone who's accompanying me on the journey has just been a lifesaver, that I find many times things that I wouldn't have talked about, things I would have stuffed, that instead I realized I'm going to get a chance to talk to my PeerRx partner this week and I'm going to go ahead and share this with them. In many cases, I can't wait to share this with them.

What I've also found, of course, is the other side, which is they call me on things. When I share with them something I'm going through and they say, "How are you doing?" And I say, "I'm doing fine." They say, "No, wait a minute. No, you can't just be doing fine with that, let's talk about that a little bit more." Again, things that historically I would've just buried and they would've come up in other ways are now things that I find myself addressing regularly.

My wife is a physician and sometimes I found myself taking those things home, and what I've done now is to say I don't want to take those things that are going to burden her. That's not what I want to talk about at the end of the day, that's not going to be uplifting for our relationship. So, it's also provided me an opportunity to make sure I'm not trying to bring things home that need to be addressed in other places.

**Unger:** What was the biggest surprise during your participation in the program?
Dr. Greenawald: Few surprises. My biggest surprise for me personally has just been how comfortable it's been to open up to colleagues and develop rapport in a way that I hadn't before, including some things that have bubbled up that I'd actually forgotten about. What I've been encouraged by from others, even physicians who have historically felt that they were connected, is they've shared with me how much they appreciate the nudge that they get every week, because otherwise they would have known this was something they wanted to do, but they often would have neglected or forgotten about it in the busyness of our week.

So what they do, the way the program works is every Monday they get an email that I call the buddy check nudge, that essentially says time for buddy check. Here's some information or something to think about, here's two or three trigger questions when you check-in, just in case that you want some things to talk about. Then I have a blog post that I do that provides some additional information for people who want to go deeper. But that's not necessary, it's really a matter of the nudge, and then the check-in by phone, by text, by email. There are lots of different ways that the buddies do it. Many do just by chat and they do it multiple times a day, just to say, "Buddy check, how are you doing today?"

So, it's been fun to watch the creativity of people once they begun the process. The other piece, of course, is that many have stuck with the process now over almost two years. So that idea of the longevity of this, it's not something that you do for a while and say, "I'm sick of being supported," it's something that people have appreciated and continue to appreciate as they go along.

Unger: I mentioned that the structure too is important, because I've participated in buddy systems before where it's kind of more informal or catches catch can, so to speak. But having that structure in there, it's something you look forward to, you're being counted on. I guess that is important.

Dr. Greenawald: It really has been important, yes. The idea of knowing that somebody is going to be checking in, or we're going to be checking in, what I've found many people sharing with me is they not only look forward to it, but they save things to say, "I know I'm going to be seeing my buddy on Friday and I can't wait to make sure that I talk about this particular thing with them." So, processing things in a way that hasn't been done before for many physicians.

Unger: I mean, physician burnout has been a huge problem, that's why the AMA spends a lot of time and energy really looking at the root causes of that, most of which are kind of systems' problems that we work on trying to address. But this issue of peer-to-peer support and correcting, I guess, that sense of isolation, is that a relatively new component of the wellness effort? And how's it kind of fit in with the overall structure of wellness programs?

Dr. Greenawald: So Todd, the whole idea of peer support, of course, is nothing new. Many of the initial peer support programs that have been popularized and written about in the medical literature are what I call reactive peer support programs. Things like a second victim program, where once something happens, then we have a structure in place to reach out to you and say, "Hey, you okay?"
We have this resource for you in case you'd like to talk to somebody."

What's really been lacking though is a more formalized process for connection. In the "old days," I have to be careful about that, but I do have a few gray hairs. In the old days, there was the doctor's lounge. Many of the things that we don't do now happened in the doctor's lounge very organically. In most organizations, those don't exist anymore or do they serve a very different function because many of the attractors to the doctor's lounge was to finish your records and we, of course, can do that from anywhere now.

So in many ways, this picks up the need that has always historically existed, but allows it to be structured in a way that our very fast-paced and unstructured medical lives would just neglect.

**Unger:** So not surprisingly, and I think you referenced this before, a problem that existed before and then an enormous problem now coming out of the pandemic, how do you take a program like this and kind of formalize it and scale it to help address what is a really big challenge now in the aftermath of the pandemic for physicians?

**Dr. Greenawald:** Absolutely. I think that there are many different approaches. Part of the reason I created this program as I did is it's totally scalable, because it's very easy to do. The structure is that I don't assign buddies, people come with their buddy. On the website, there are opportunities for people to understand, "So how do I do that if I don't have somebody who's obvious for me, in terms of a connection?"

Many people have connected with old medical school or residency friends and connected that way, many also connect within their own health systems. So, my hope is over time health systems will adopt this as part of a program for peer support and part of their program for both promoting and enhancing clinician and care team well-being. But this is only a part, Todd. I think that's an important thing for all the listeners to understand is that there's more to addressing this multifactorial, and as you point out, very systemic challenge that we have with clinician and care team distress. So, the combination of all those pieces coming together are really going to be what's going to start putting some kind of progress in what has been a really challenging problem.

**Unger:** Now, I know you've been working with the AMA as part of the STEPS Forward™ webinar series to address physician burnout. You can find out more about that on AMA and at the AMA Ed Hub. If somebody wants to find out more about your program, do you have a site you'd like to refer them to?

**Dr. Greenawald:** Absolutely. So, it's PeerRxMed. P-E-E-R-R-X-M-E-D.org or .com. Either one will get you there. As I said, this is a totally free program and will always be free. I do it because it's for the love of the game and really for the support of my colleagues. We all have stories about why it is that we have passions around the things that we do. I've had many instances over my career where I could have really used a buddy, but ultimately found myself feeling very alone. Sometimes by my own
doing, by pushing people away as they asked for support. So the idea of having that built-in for me became very important, and I think that's going to be part of the key for people as they go forward.

Unger: Well, thank you so much Dr. Greenawald for all the work that you're doing and for putting some action behind taking care of your fellow physicians.

That's it for today’s COVID-19 Update, we'll be back with another segment shortly. In the meantime, for resources on COVID-19, visit ama-assn.org/covid-19. Thanks for joining us, please take care.

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