

Tait Shanafelt, MD, on addressing physician burnout

AMA's Moving Medicine video series amplifies physician voices and highlights developments and achievements throughout medicine.

Featured topic and speakers

In today's episode of Moving Medicine, AMA Chief Experience Officer Todd Unger discusses steps organizations can take to combat burnout and prioritize physician wellness with Tait Shanafelt, MD, Jeanie & Stewart Ritchie professor of medicine and chief wellness officer at Stanford Medicine.

Virtual registration closes Oct. 6 for this year's American Conference on Physician Health (ACPH), a scientific conference sponsored jointly by the AMA, Mayo Clinic and Stanford University, taking place Oct. 7-9.

Speaker

- Tait Shanafelt, MD, chief wellness officer, Stanford Medicine

Transcript

Unger: Hello, this is the American Medical Association's Moving Medicine video and podcast. Today we're talking with Dr. Tait Shanafelt, Jeanie and Stewart Ritchie professor of medicine and healthcare chief wellness officer at Stanford Medicine in Stanford, California about steps that organizations can take to combat burnout and prioritize physician wellness. I'm Todd Unger, AMA's chief experience officer in Chicago.

Dr. Shanafelt, thanks so much for being here today. Question, did you ever think 20 years ago that you would be the country's first chief wellness officer?

Dr. Shanafelt: Absolutely not. It has been a very interesting journey, the way an interest that developed as a resident snowballed a bit, one thing led to another, developed as a research interest in parallel with my leukemia research and clinical work, and ultimately led to sort of a shift in the emphasis of my career and definitely was not something that I anticipated or saw coming.

Unger: I love this story because your interest in burnout began 20 years ago, when you were a senior resident at the University of Washington and you saw something happening there to your interns and it was really kind of before there was even a name for it. Can you give us a few more details about that experience and how did it lead you to groundbreaking research that you did and where you are today?

Dr. Shanafelt: Yeah. As you said, I was a senior resident and supervising the interns on the team and just watching their exhaustion, their reaction to another admission, the comments they would make about patients or how they were approaching the work day that you just recognize was completely incongruent with the altruistic values of the profession. And also, I knew incongruent with what these individuals stood for and all that they had sacrificed and dedicated to pursuing this career.

And had a wonderful mentor at the time, Anthony Bach, and we were starting on a research rotation and I said I wanted to study the experience of internship. And being an incredible mentor, Tony asked many questions about, "What are you observing and why do you care?" And I said, "It's affecting the patients and the care we provide." And Tony said, "I think you're talking about burnout." And it had been studied a lot outside of medicine, quite limited, especially in United States, in medicine.

So we did that first small study and it really was a lightning rod. It got a lot of lay press coverage. It was in the news. It was driving a lot of conversation because we found this dose-response relationship with resident distress and suboptimal patient care and really the first study to show that. And I remember just having this question. It was an unfunded study led by a resident that was catalyzing this national conversation. And it was also something we'd kind of known about for quite a while, in the sense of 'House of God' and those types of things. Why was this catalyzing the conversation? And it was because we studied it in a methodologically rigorous and scientific way to have an evidence base around it on how this was affecting quality of care. And I think that was really the observation that led me to say, "We need more data, we need more science, we need more evidence if we're going to really move this field." And that was really the first step.

Unger: Do you think people were kind of shocked by, I don't know, for lack of better words, the conditions under which this burnout was occurring?

Dr. Shanafelt: Yeah. In some ways, I don't know that any residents were shocked or probably any physicians who trained residents, we always had a front row seat but this was just the way we did it.

And so in that sense, I think there was this rites of passage mindset of, "I went through it. It was formative. You should go through it too." And I think it was when we started to say, "That might be a really closed way of looking at things." And if it was only about us, maybe you could justify it in some places, I think that could be debated. But when it's affecting patients and quality, you can't have that closed belief. We need to think about a better process.

Unger: Well, fast forward 20 years and due to a lot of your work and work that the AMA has been doing in this space, obviously the awareness of this issue, and much more widespread than when you first started looking at residents, but looking at all physicians and health care teams and the overall system, a lot of attention being paid to this. Are we making progress on this? And are the scenarios that you looked at 20 years ago still happening in hospitals today?

Dr. Shanafelt: Yeah, good question. We've unequivocally made tremendous amounts of progress and I think it's sometimes difficult to appreciate that because there's still so much more to do. But as you said, the awareness of the issue is broad. And although there had been limited awareness in residents, there really was almost none in the broader practicing physician community, no awareness really to discussion about that. That probably really entered the profession or the conversation of the profession a decade ago but now it's the conversation of the population. The general population is aware of this. We're talking about this more on a societal level.

Beyond the awareness, we have an extensive number of intervention studies that have shown that interventions at both individual levels, but more importantly, system levels do work. So there was also this nihilistic view that, "Yeah, complicated issue, important, but nothing we can do." And now we know that's not an accurate belief. We have groups like the AMA, like the National Academy of Medicine, who have really prioritized this as a critical threat to the health care delivery system and I think added some gravitas to the importance of the issue. And then I think we have vanguard organizations like Stanford and others that have said, "We believe that this is critical to us achieving the mission of our organization and we are going to prioritize it, invest in it, establish leadership and really try to drive change."

And so we've come a long way. And I think it's really that last bit of both a broader number of organizations and a deeper commitment at the organizational level to driving holistic system level change in the practice environment is really our next frontier.

Unger: One of the first things I learned when I came to the AMA from one of your frequent collaborators, Dr. Christine Sinsky, was when people first kind of started thinking about burnout, initially a lot of the emphasis was on promoting, I'll call it individual level resilience for physicians. How is the thinking evolved from there in terms of what individual level resilience, the role that that plays?

Dr. Shanafelt: Right, and an individual level resilience is important and those interventions are important, they're just not the root of the problem. And we need to not be trying to teach or train

physicians and other health care workers to be better able to tolerate a broken practice environment. We need to actually fix the practice environment. So we won't resilience our way out of this. We often say this is an 80/20 problem, maybe 20% of it is impacted by choices we can make, things we can do as individuals but the other 80% is that practice environment. And so that's where we really need much more evidence and data. Those two things are complimentary but we have to get really at the core issues that are the majority of the problem.

Unger: Yesterday on an unrelated topic but I was talking with Warner Thomas and Dr. Robert Hart at Ochsner about recovering from a Hurricane Ida, and one of the things they really spoke to was, I'll call it organizational resilience.

Dr. Shanafelt: Yes.

Unger: And I think that kind of gets to what you and Dr. Sinsky have been looking at, which is that these problems are rooted in systems. Can you talk about how did you get there and what are the types of interventions at that level that are making the biggest difference?

Dr. Shanafelt: Yeah, that's a great question. And I think that the first thing I would say is that once we prioritize this as an organization, we then do have to have a mindset of going and listening and asking our own people and teams what we should be focusing on locally and prioritizing because I think one mistake is to say, "Gosh, here's something that worked at another institution. Let's just bring it here and implement it." And the risk to that is that you wind up with just sort of a hodgepodge collection of things designed and implemented elsewhere that may or may not address the most pressing need or opportunity within your organization.

And so that's why I think we need to begin with that system thinking and thinking about assessing current state greatest needs and opportunities at your organization. And then as you identify those, go out and say, "Ah, here's an area we want to improve, inbox management. Now let's go learn what organizations that have moved the needle in that space have done." So rather than starting with just what worked out and bring it, really kind of identify the local need and then go learn from others, which may give you a solution, or sometimes you have to invent it on your own.

Unger: Anything in your examination of these kinds of system level changes that has surprised you in terms of the magnitude of impact? I mean, you just mentioned something, inbox management, that if I were to ask people 10 years ago, "Make your list of things that are causing burnout," maybe or maybe not that it would have appeared on the list but is there anything that you've been surprised by that's had a huge impact here?

Dr. Shanafelt: That's a great question. And that one, as you said, it was an issue a decade ago but even in the last four years, we know there's been logarithmic growth, especially pre-pandemic but exacerbated by the pandemic. I guess I would say that some of the ingredients that I think are most

foundational to organizational change is the mindset that leadership behavior is one of the most critical ingredients in any organization. And so rather than viewing practice redesign or changing organizational culture or promoting wellness as something that the CWO or some team off to the side is going to do for the organization, is to really view it that the leadership of every one of our leaders, particularly those closest to the commissions doing the work, are the longest lever we have.

And those are the individuals who set the tenor and tone for their teams, establish why we do the work, what our priorities are, what we care about, identifies the local things that are barriers to making it easy to deliver the care patients need and then enable and power their teams to change those things. And I think that that's one just critical ingredient is having that mindset, that this is every leader's job and they will be the most critical to drive change.

And then I think the second thing is, again, just that notion of having a conversation in every local unit about, "If we could fix one thing under local control in the next three months, what would we change?" And yes, someday we want AI-based listening to our visit that will key up the note and every order that needs to be done and we'll walk out and it'll all have been done magically or we want a new EHR, we want the system to build a new building for us so we have more space. Those things may come with time but they won't benefit you tomorrow or next week. And there are so many things that can be changed in the local and practice environment and the way workflows, teamwork, other elements, to make it a better work environment in the near term. And I think it's getting those things launched that also helps make people feel change is possible, "We've done one thing, let's do the next," and it builds momentum.

Unger: I love that, that focus on kind of low-hanging fruit, high-impact stuff that you can change right now, very localized. Just for our viewers out there, if you want to find out more about some of those system-level changes, our STEPS Forward modules on the AMA site, a lot of insight there.

Dr. Shanafelt, one of the things that you've been a big advocate for is, well, more chief wellness officers, not just you out there. Is this something that's just for a big health care system or is it something that a smaller practice can do?

Dr. Shanafelt: That's a great question. I think I'll begin with the initial premise that setting a goal as an organization does not actually lead to results. What leads to results is prioritizing an issue, establishing leadership, structure and process to drive the change we need to achieve the goal. And I'm of the mind that if you're an organization that has 500 or more physicians involved in the group or the organization, you unequivocally should have a chief wellness officer.

Below that threshold in smaller organizations, there may be a variety of ways to think about designating the leader or leadership team and structure to drive the change. So you need to establish the leadership and the structure and the process but you might need a little different format to it to meet the needs of a practice of 30 physicians. And so I think that's how I think about it. And in a good

notion, I think there are now somewhere around 40 to 50 chief wellness officers at major health care centers across the country that are checking all the boxes of truly a senior level leader reporting at the top of the organization with a substantive amount of their time dedicated to leading this work. And so that is crescendoing and I think that trend is going to continue.

Unger: I think one of the things that I've seen certainly from the team at AMA is this, how do you make the case for why this is so important? Why do you need a senior level team member? What's the payoff for doing this kind of work? When you think about folks out there that are prioritizing this or trying to build the case, are there any key message points or tools that have really seemed to make a difference in terms of making this happen?

Dr. Shanafelt: That's a great question and it's one that's been quite dynamic because certainly the pandemic has brought this to the forefront for every organization. They see their people doing heroic things day after day, after day, becoming exhausted and burning out, sadly many, leaving the organization, hard to replace those people.

Unger: And very costly, I have to add.

Dr. Shanafelt: And costly.

Unger: Yeah.

Dr. Shanafelt: Yeah, very costly. So I think that right now, there's almost this, everybody's focused on the acute dimension of this. And although the attention is good, they also then are having an acute mindset of how we respond to it and putting things in place. "We're going to give you food and beverages and give you a little respite and peer support and some mental health resources to deal with an acute need." And again, necessary, all important, need to be doing those things but they don't get at those system things that predated the pandemic.

And so I think how do we make sure organizations are tending to that and committing to that long term? And that piece, we've often said there's a regulatory case if you have residents, ACG, I mean clear recommendations are in play for academic medical centers, double AMC guidelines, joint commission is leaning into this topic and probing it in their site visits. So there's a regulatory element, a business element, as you said, cost of turnover, productivity, malpractice claims, patient satisfaction, so economic argument. There's the tragic argument when a physician commits suicide, and sadly, that is too common. And then there's really just the moral/ethical case that we would like to believe that our organizations say that one of the things that's a core value is taking care of their people so that they can do this work for humanity and for the public we care for.

And so I always find that which one of those arguments is what your organization will be motivated by is quite heterogeneous. And so you need to be familiar with all of those arguments, but be able to

discern in the conversations with your own leaders, which one of these is sort of our priorities now? Which one of these things are already one of the top three strategy priorities for your health care system? And if that's a quality argument, then you should be making that business case around there's a quality dimension to this. If cost reduction is on that list, you hammer on that economic element. If there's something about, "We were just cited for our training program and we're on probation," you might leverage that.

So I think familiar with the portfolio of arguments, but then use the one that's going to get you traction. And sometimes, even in one organization, you might be having a different one of those elements you're featuring when you're talking with the COO, the CFO, the CMO, a chair, a dean, a practice leader.

Unger: Dr. Shanafelt, any other piece of advice? I mean, that is great advice that you just laid out there, for those that are just beginning their journeys as chief wellness officers?

Dr. Shanafelt: I think the one other thing I would say that I see hold back a lot of organizations that do believe this matters, they're going to prioritize it, they're going to jump in, is the common mistaking a framework or a collection of tactics for a strategy. And we touched on this a little bit earlier but it's so easy to say, "We're going to start a peer support program, we're going to create community dinner groups, we're going to prioritize a team to address inbox management and we'll be on our way." And as we talked about, those are all good things, but if you take that approach, I think there's a very high probability you will not move the needle over the next six to 12 months.

And so to begin by saying, "Look, there's many things, there's quite a universe of things that we could do, but we can't do them all." We need to acknowledge that the needs of different specialists and different disciplines are distinct. So there are some shared things, teamwork, leadership, values, alignment but then beyond that, a neurosurgeon, emergency medicine and a radiologist are very different. They have different work. Same thing for nursing, social work, pharmacy. We need to respect those differences.

And so as we sort of assess that current state of the organization, look at all the things we could do but then say, "Which ones are we going to prioritize? For our organization, we're going to focus in these two or three areas." And then, what specific tactics will advance those three or four things, recognizing those other things we will get to later but we're really going to go hard at these. And to commit to it in a substantive way and then move those things and have your metrics and move those things. I think that is really critical. And it's so easy to just say, "Give me the menu of evidence-based tactics that have worked elsewhere and then we're going to try to do all those things." And that, I think, is the wrong way to start.

Unger: Do you recommend, in terms of just to kind of get the lay of the land and understand where you are in this process, is that benchmark-level setting measurement process of understanding where

your organization, your physicians and health care teams stand on the issue of burnout, is that a place you recommend people start?

Dr. Shanafelt: It's really important, Todd. It's a great point because I think that there's a temptation, and I hear it frequently, "Why do we need to do a local assessment at our medical center? I just saw the latest publication from the AMA or for Medscape. I know it's an issue, let's just do." And that is a mistake and for many reasons. One, you do need to know where we are. How do we fit into that context with benchmark? Are we the same as everyone else? Are we doing better, are we doing worse? What sort of things that are the drivers are most opportune in our environment, which a good assessment will help you do. You need that also to be able to track progress.

But I often tell another story too that when I arrived at Stanford in 2017, we had just completed the 2017 national study that we do in collaboration with the AMA, do every three years over the last decade and Stanford had also just completed an internal assessment. And it was just so revealing that the lowest risk, one of the lowest risk specialties in our national slice of all specialties was this department with the single highest rate of burnout at Stanford. And a group that we would have said, "Sure, there's some things we need to do for all but then there's areas where the house is on fire and we've got to deploy to that unit with additional attention, energy and resources as an organization." We would have never gone there. We would have said, "That group is most favored nation status." But at Stanford, they were the single most acute area.

And so again, we would have been completely ineffective if we wouldn't have started with that step you said of assessment and benchmarking. And then we can, again, use that data to craft a broad plan, as well as a targeted plan for high opportunity areas.

Unger: Well, Dr. Shanafelt, I can't tell you how much we appreciate you being here today and sharing your perspective. I love stories like this where kind of happenstance puts you in a position to do groundbreaking work and changes the direction, the course of your life and just so much understanding over the past 20 years as a result and so much impact. So thank you for all that work.

That's it for today's episode. You can hear more from Dr. Shanafelt at this year's American Conference on Physician Health, a scientific conference sponsored jointly by the AMA, Mayo Clinic and Stanford University, taking place October 7-9. Virtual registration closes tomorrow so go fast to physician-wellbeing-conference.org. Click on the link in this video description also to register now. The AMA will also be hosting a webinar with Dr. Shanafelt on October 21. Email stepsforward@ama-assn.org to register.

We'll be back with another Moving Medicine episode soon. Never miss an episode of this and get a chance to hear from those that are making such a difference in medicine by subscribing on AMA's YouTube channel or Apple, Spotify or wherever you listen to your podcasts, ama-assn.org/podcasts. Thanks for joining us, please take care.

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