Tina Shah, MD, MPH, on how health leaders can start reducing physician burnout now

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, Tina Shah, MD, MPH, a principal of TNT Health Enterprises joins AMA Chief Experience Officer Todd Unger to discuss the importance of reducing physician burnout, including the top five actions health care leaders can take now to support their teams.

Speaker

- Tina Shah, MD, MPH, principal, TNT Health Enterprises

Transcript

Unger: Hello. This is the American Medical Association's Moving Medicine video and podcast. Today we're talking about the importance of reducing physician burnout, including the top five actions that health care leaders can take now to support their teams.

I'm joined today by Dr. Tina Shah, principal of TNT Health Enterprises in Jersey City, New Jersey, who's worked closely with the AMA and other leading experts on addressing burnout. She'll be sharing her perspective as a critical care physician and a policy expert. I'm Todd Unger, AMA's chief experience officer in Chicago.
Dr. Shah, thanks so much for joining us today. As you know, the AMA has introduced a recovery plan for America’s physicians and reducing physician burnout is a very, very important pillar of that plan. We’re going to start with a conversation about your thoughts on the needs for a recovery plan for physicians right now. Why do we need that?

**Dr. Shah:** Todd, thank you for having me. It is mission critical if we want to keep everyone in America healthy that we actually implement this recovery plan, particularly for physicians but, really, if we think even more broadly, anyone that works in health care. Think of it this way. If we don’t have workers that are well enough, how are they going to be able to take care of us when we are sick, when we might need to see our doctor, we might need to go to the hospital?

And to be honest, let us lay out the stage. Before the pandemic, 50% of physicians were burned out. So we know the pandemic has not only added new challenges but has really stretched our limits of what we can do, especially as we’ve had more and more limited resources.

The rates of burnout remain critically high. And as we’re going into this, more than two years into the pandemic, we really just have such a little reserve that we need to really think strategically and think about systems as we try and tackle all the drivers of burnout.

**Unger:** Well, let’s talk a little bit more about that. I wish there were an easy fix for burnout but there isn’t. And AMA and other leaders like you have long emphasized something you talked about, which is a systemic approach versus an individual approach. Tell us a little bit about why that’s so important and what do health leaders need to help make that kind of paradigm shift quickly?

**Dr. Shah:** It's really critical that we think about treating burnout with the right treatments. And if you go to how we get burnt out, burnout is literally an occupational condition. That means it is a workplace that is making us sick, not us ourselves.

And to just kind of push this point a little bit more, physicians, when compared to education-matched peers, are some of the most resilient people we have in this country. Our resiliency factor is so high. So it's not about giving us more resiliency tools, although that can be helpful. This is really about diagnosing and then applying a treatment that is appropriate.

In this case, our workplaces are so toxic with clunky EHRs, with poor workflows, with not enough resources to just take care of the patient in front of us. So we must focus on addressing these system problems so that we can address burnout and work at the top of our game.

**Unger:** Well, to help meet that particular need, you, along with a team of experts, including the AMA, you’ve got an action plan that can be initiated within three months. Tell us more about that plan. And where do you begin?
**Dr. Shah:** So I love that you brought this up. The plan is called the Well-Being Five or, in more long form, the 2022 Health Care Workforce Rescue Plan. And this is five evidence-based tactics that health systems can take with the current amount of resources and the current environment. We know everyone is under a financial strain. But these five tactics actually can be implemented in three months and actually work.

And I'll start by telling you a few of them. The first one is these are non-normal times, so adjust expectations. This makes me think of a cardiologist friend of mine who said, "I am seeing more and more sick patients because they've been waiting to come in because of COVID. And now that they're here, I'm trying my hardest. But it takes more time to see them.

But at the same time, I'm being told, well, I have to see a patient on time, and they can't wait more than 15 minutes in a waiting room. So how do we set our doctors up to succeed?" They want to make sure the patients have good experience and they want to make sure the patients get the best possible care. We need to adjust the expectations so that they can just do the best they can given where we are today.

And the second one that I can give—and this is my favorite—it's getting rid of stupid stuff. And this is a title from a New England Journal of Medicine paper from a health system in Hawaii who asked this very deceptively simple question to all of their clinicians.

And this is really, hey, there are a ton of low-value things that we are asked to document into the electronic medical record or things that we're asked to do day to day that just don't make sense. Can we get rid of this stupid stuff and focus then on what our patients need so that they can get better and we can do it in the fastest way possible? So these are two examples of the five of things that we can do today that we know work.

**Unger:** Where can we find the rest of the five?

**Dr. Shah:** Oh, I love these questions you're asking. So I'm happy to share. We have this up on a website. It's under the ALL IN for Healthcare website. And the remainder three are the following. Number three—get radical to shore up staffing.

We know that we just don't have enough doctors and this was an issue even before the pandemic. Something that AMA has brought up time and time again is they work with policymakers and health systems. But what can we actually do today? Well, let's go from man-to-man defense and let's get into zone defense.

What would it look like if we took a doctor and, instead of just making her do all of the tasks, as we kind of were pre-pandemic, what if we re-envisioned a team? How could a doctor better work with other members of the team, with other care team members in different specialties? And so we can
really take one physician and multiply her to be three physicians.

Or, for example, bringing in folks that typically don't have direct patient care to help offload us. So this is really where we think about who's retiring and what kind of work can they do, maybe in a shorter shift length? How could they support more junior doctors or more junior nurses because we work so closely with our nursing teams?

There's just so many different innovations that happened for me. As an ICU doctor, we saw the whole different way that we could practice medicine in the ICU, where we had one doctor working with two nurse practitioners or two other physicians from different specialties. And all of a sudden, we were able to double or triple the number of patients we could take care of.

And then, if you really think about it, since we're pushing well-being in a very deliberate way, this really requires having a point person. So number four on the list is designate a well-being executive. This could be a chief well-being officer and we've seen that in some organizations. Or this could really just be the person that's still in the COVID command center or is leading operations. The key point is has operational abilities to make those decisions who can then be the point person as we push out these systems interventions.

**Uunger:** Well, you mentioned something in there that is specific to medicine but also I think we're dealing with broadly here in a post-pandemic world, which is staffing shortages. So if there was already a problem before, we're now facing some additional complications. They're putting additional stress on health care workers who are, of course, left to shoulder even more work than they had before. What kind of actions can leaders take immediately to address an issue like this?

**Dr. Shah:** So I think it comes down to asking your teams what they need. And one word that comes to me is this word autonomy. Imagine if we gave physicians, nurses and other care team members the autonomy to choose when they want to work. It's not that we don't want to work, right? We are so tied to our patients. But the thing is we're only human. And so we have other demands outside of work.

And when I think about myself as a doctor in the ICU, I can't do my job without the nurses. And so one of the things we've seen in the pandemic is when you give the nursing teams the ability to self-schedule their shifts—they can choose which day they're taking off—they're more engaged at work. They're more present. Same with other support-type staff roles.

And on the physician side, this is about getting creative. How can we actually build a hybrid day so that we're not just forced to be in the office, seeing patients? We can marry up telemedicine with office space visits to accommodate not just patients' needs but to accommodate our own as moms and dads and caretakers of others.
This is where I think the secret sauce is. There's so much we can do with technology. And this is about asking our people what they need and then trying to design for that, whether that's incorporating more virtual care in or just giving autonomy back to us, the physicians and others that we get to work with.

**Unger:** You used that word "radical" earlier. Is that what we're talking about here? It's funny to think some of the things you're talking about are considered radical. But is there more to that or not?

**Dr. Shah:** There sure is. And I think the silver lining of COVID is that we've gotten to experiment. And the experiments have gone really well. So to give you an example—again, I'm going to talk about my world, day to day, in critical care—we would really have the traditional model of one doctor in the ICU, one nurse taking care of two patients. And again, I like to go back—I'm a basketball fan. Todd, so I have to say we were really practicing man-to-man defense.

Now, imagine if you had zone. Imagine if you had one doctor working with the same set of nurses. But instead we covered, as a team, the patients. You can actually see more. In fact, as we're dealing with the Great Resignation and as we're dealing with more travel nurses helping us when we're in the field or people that are a little bit more green—and we know that there are a lot of folks that have been experienced that are leaving, both in the physician side of the house but also for nursing—we need better supports for newer folks that are maybe a little more less experienced.

And this is where we really want to get radical. Imagine if you had a virtual senior position who was just kind of there, sitting at home but wanting to, after being retired, actually help. Maybe they could port in—and this really happens in the ICU but can happen elsewhere—and be that backup for doctors or residents. Maybe you could have a senior nurse also be that backup when you need a second check for administering a medicine or giving blood or literally just to be that backup so that a more junior person, a clinician that's in the field, has an extra set of eyes or someone to bounce ideas off of.

Now, before the pandemic, we rarely did this. We only saw this kind of thing with virtual care, especially in our hospitals used in areas where it may have been harder to attract doctors and nurses—for example, using tele-ICU. But why can't we do this all the time, every day? This is for population health goals. This is for saving that patient in front of us. And this, for sure, is addressing burnout. Because we finally get the resources to meet the job demands we have every day.

**Unger:** Well, those that know me understand I get into trouble when I talk about sports analogies. But I did play basketball in junior high. And so I know what you're talking about at least there. And those are some radical but really common-sense kinds of ways that we can approach a problem that really has been made worse by the pandemic.

The final action item in the plan really pushes organizations to go beyond what we would consider standard employee assistance programs. What's going beyond look like?
**Dr. Shah:** This is, I think, one of the most critical of the five for what we know will work. And I think it's this. When we think about what happened in the pandemic, the first was, ok, we know our employees are distressed. We know doctors are distressed. Let's make sure we have an Employee Assistance Program, an EAP, set up. Because they may need some mental health help.

And the truth is we do need that. But that, like the typical pattern of dealing with burnout, it's missing the boat if we focus on this individual targeted support alone. And the truth is, we are working so hard. And we believe in serving our patients, sometimes at our own expense. And we may not even be able to access the EAP or make that phone call because we are working so hard.

So here's examples of what we can do beyond EAP to support our mental health, which is related to burnout but doesn't exactly treat burnout and also treat burnout. Here are examples. Number one—peer support groups. I am more apt to go talk to my colleague versus call a mental health provider. We know this. There's just stigma in medicine.

So give us the funds and the time to be able to talk to our peers. I want my boss to tell me, "Hey, I've had a tough day, too. Let's sit and chat. Help me defuse this and make it normal. I need space." In fact, Mayo Clinic ran this study where they actually paid doctors to go have dinner with each other. I mean, we all love to eat, so this worked out.

But at the end of dinner, there would be a question on physicianhood. And that simple ask actually is a proven tactic to address burnout. So what can you do? And I'm not talking pizza parties. I'm talking help us where we are. Help us find time for peer support.

There are even evidence-based peer support groups that can be put in place to train up peer coaches in a matter of hours. And they really can help us when we're in the field. So this is another example. This is about meeting people where they are and not just saying you have a mental health problem, here's a phone number.

**Unger:** What I really love about your plan is that it takes some very specific and tactical strategies that organizations can do right now. When you look longer term, though, at strategies for addressing physician burnout, what other types of things, then, do you begin to consider?

**Dr. Shah:** Well, as you said in the beginning of our talk, burnout requires a multipronged intervention approach. We really can't go one by one. And so while we have this five-point plan, there have been many leaders thinking about what needs to be done long-term. And I'm happy to say—and I recently served as senior advisor for the U.S. Surgeon General. And the nation's top doctor, Dr. Vivek Murthy, has made this a national priority with the release of a Surgeon General's Advisory on Health Worker Burnout. And this came out in May.
So this is actually the first time in history we have a roadmap or a blueprint, coming from the federal government that says, health systems, this is what we need to do, short term and long term. Policymakers at the federal government, at the state government, and at the local level, here’s what we can do. The tech industry, here’s what we can do. And insurance plans, here’s what we can do. And there are several other categories, as well.

So it really is going to take us following this plan. And I really urge everyone to take a look at it. Because it is a starting point that we finally have on paper, not only planting the flag by, literally, this advisory existing for the country but calling on all of the key stakeholders—beyond doctors, beyond the AMA, beyond health systems—to say this is our problem and we need to solve it together. And Todd, the best thing about this is it tells us that this is not just a health care crisis, this is a public crisis. And we’re calling on the general public to help us solve all of these system issues that have led to burnout.

**Unger:** And that is exactly why the AMA's goal in launching our Recovery Plan for America's Physicians, it needs meaningful change. We look forward to working with you and other health care leaders to make this happen. Thank you so much for the work you’re doing in this field. It's really, really needed.

That wraps up today's episode. Dr. Shah, we appreciate all your perspective. We'll be back soon with another Moving Medicine video and podcast. In the meantime, you can check out all of our videos and podcasts at ama-assn.org/podcasts. Thanks for joining us today and please take care.

**Dr. Shah:** Thank you.

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