Resident Physician Wellness Postpandemic

How Does Healing Occur?

Burnout, an ever-present risk in medicine, is defined as a pathological syndrome in which emotional depletion and maladaptive detachment develop in response to prolonged occupational stress. Since March of 2020, physicians and health care teams have witnessed extraordinary COVID-19-related morbidity and mortality, struggled with the awareness of compelling health inequity in conjunction with increased advocacy for social justice, and provided substantial care in an environment with uncertain occupational and personal risk.

Those especially affected include resident physicians, for whom relevant stressors may further disrupt training and create an uncertain future in which to launch careers. This profile of stress during the COVID-19 pandemic meets the requirements for burnout and makes the resident physician vulnerable to burnout and the attendant consequences. The future course of SARS-CoV-2 infection remains uncertain, but now is the time for much-needed recalibration and hopeful reinvigoration. Illness, exhaustion, despair, sadness, and hopelessness experienced during the early waves of the pandemic create longer-term risks to the health and wellness of resident physicians and may influence an entire career of clinical practice. It is important to recognize these risks, understand lessons learned, and provide restorative support where needed.

The study of resident physician occupational stress before the pandemic evolved dynamically with the 2003 discussions of limiting resident work hours and ensuing policies. Ludmerer et al2 described “work compression,” whereby limitations on work hours, presumed to promote wellness, unintentionally worsened resident satisfaction. Higher patient volumes and more clinically complex cases with fewer hours in the work day led to increased workload demands on work pace and less time dedicated to education and eventual mastery. Fang et al3 noted that baseline levels of depressive symptoms among interns were significantly higher in 2019 as compared with 2007. While limitations to work hours were much overdue, these findings of depression and work compression argue for a revisit of resident physician education and introduction of new measures to limit emotional depletion and resultant stress.

In general, conversations regarding physician wellness have centered on activities targeting mindfulness. These initiatives include a number of non-evidence-based programs: the provision of wellness spaces; funded dinners or snack breaks; and even “lavender” codes, which provide an on-call therapist who provides massage, music, or spiritual support such as meditation and prayer.7 However, there is no objective evidence demonstrating efficacy of these interventions in improving resident physician wellness.8 Requiring an already overworked resident physician to allocate precious free time outside of work for more scheduled activities is arguably a decidedly counterproductive approach. A reconstructed approach to address resident wellness requires more than meditation and snacks. The underlying causes, not just the manifestations, must be addressed with structural change.

The continuously high rate of emotional exhaustion and occupational stress among resident physicians, exacerbated by the pandemic, suggests a recalculant root cause. In part, it may be based in the acculturation of physicians. Medical students, with long
discharge planning, and longitudinal care) have been incorporated into all general medicine rotations, not just the Aliki team. The program now includes quarterly community meetings, a curriculum of patient-centered care on intensive care unit (ICU) rotations, and an interprofessional collaborative practice model with the School of Nursing. The program has had positive effects on resident physicians; residents felt greater pride and more fulfillment in their work.

What are the next steps? A good beginning is to allow more space, at the start of training, to accommodate wellness by changing the vernacular used to induct physicians in training. This means challenging the seemingly established criteria of what it means to be a good physician. Work-life balance, considered a presumed antidote for occupational stress, is elusive and perhaps even nonattainable in a quantitative sense, but retaining and enhancing valuable life moments should be obligatory. The stress of a physician’s life, especially in the setting of crisis, can only be countenanced by a time for personal recharge, a network of support, and healthy experiences outside of medicine.

It is time for a new recognition of the resident physician role, one that emphasizes active and deep learning. Work hour limitations are important, but how are those hours spent? How can resident physicians invest time wisely rather than just plentifully to learn medicine? Johns Hopkins Bayview Medical Center established the Aliki Initiative in 2009, consisting of a resident rotation that reduces the number of patients for which a resident team provides care. Instead, it emphasizes the longitudinal care of these patients, with special attention to socioeconomic barriers and personalized medicine, even beyond hospitalization. Patient satisfaction (as measured by Press Ganey scores) more than doubled for those cared for by the Aliki team, and as of 2018, the tenets of the program (ie, lower number of admissions per team, patient-centered discharge planning, and longitudinal care) have been incorporated into all general medicine rotations, not just the Aliki team. The program now includes quarterly community meetings, a curriculum of patient-centered care on intensive care unit (ICU) rotations, and an interprofessional collaborative practice model with the School of Nursing. The program has had positive effects on resident physicians; residents felt greater pride and more fulfillment in their work.

Changing the focus from the individual resident physician to the team is another educational opportunity. Rather than setting aside time outside of work for individual wellness activities, a deeper immersion of both wellness and belongingness in the daily workflow with an emphasis on team management may be helpful. For example, following difficult resuscitations in an ICU, gathering the ICU team in a quiet space to debrief, emulate, and support each other through difficult feelings may help reaffirm the strength within teams. Early identification of stress and stressors, reduction of time spent needlessly on administrative tasks, and incorporation of time for wellness and togetherness may foster the idea of physician wellness as a group responsibility.

Gibson has depicted in a painting the shared struggles of health care workers during the COVID-19 pandemic and the painful loss of colleagues and coworkers under stress. It is difficult to articulate a greater good arising during the pandemic, but important lessons did emerge. The collective effort to engage in a different and more human connection with patients and each other, place an emphasis on deep and longitudinal learning, and value time outside of work represents steps in the right direction. If put into practice, this is how healing occurs with initiatives focused on humanness and belongingness leading to a more powerful collective resilience for unknown challenges still to come.

ARTICLE INFORMATION
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REFERENCES