ECOLOGICAL PERSPECTIVES FOR PROMOTING MENTAL HEALTH AMONG CLINICIANS

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Introductions

Can you imagine trying to use a shovel to reverse the incoming tide? Exhausted and overwhelmed, the self-preserving thing to do is to run away. That's what we see now in modern medicine in the United States (US); doctors and nurses fleeing the field.

It is our premise that "burnout" and its resulting consequences will not diminish until our nation grapples directly with the consequences that, in the U.S., medical care is dominated by a corporate business mentality—in both for-profit and not-for-profit organizations—which has created deeply embedded structural elements that seem to defy change.[1] In essence, clinicians alone cannot overcome institutional and societal policies and practices solely based on dealing with the unrelenting demands from the business of medicine—high service demands with the illusion of all-hours availability afforded by advances in information technology, RVU expectations, and inefficient workflows. Workplace leadership, culture, and practice compensation models are correlated to burnout.[2]

Strategies for coping with stress have been classified into primary control coping (reducing or removing stressful situations) and secondary control coping (individuals adjusting themselves and working with situations as they are).[3] To effectively alter what we see as the "culture of burnout" that has been developing during recent decades, it will be essential to focus heavily on the former. The Dr. Lorna Breen Health Care Provider Protection Act (H.R.1667 — 117th Congress [2021-2022]) was recently signed into law.[4] It offers broad latitude for creative solutions. Thus, it is timely to define where we see the need for greatest changes.

The Workplace Change Collaborative[5] is one result of this funding. Its mission is to capture best evidence-based practices, lessons learned, tools and resources related to reducing burnout and promoting wellness. Many ameliorative interventions already have sought to enhance individuals' resilience by fostering mindfulness or gratitude journaling—ways to palliate the ever-incoming tide of work place stress. Others have focused on the reasons they went into medicine, nursing, and related "helping professions," and have sought to reinforce spiritual reasons for their work. However, no amount of individual endeavor will suffice without a complementary "organizational mindfulness" that prioritizes better operations and supportive workplace cultures.

The confluence of uncoordinated, unharmonized, ever-increasing expectations far beyond what is needed for the direct patient care has created a massive amount of "non-value added" stress atop fiscally driven metrics (RUVs, caseload expectations, revenue monitoring) that are tied to the evaluation of clinicians' performance. Healthcare systems, accrediting agencies, patient safety efforts, insurers, and state agencies have layered numerous processes and mandatory education requirements upon clinicians. Collectively, such initiatives have yet to show

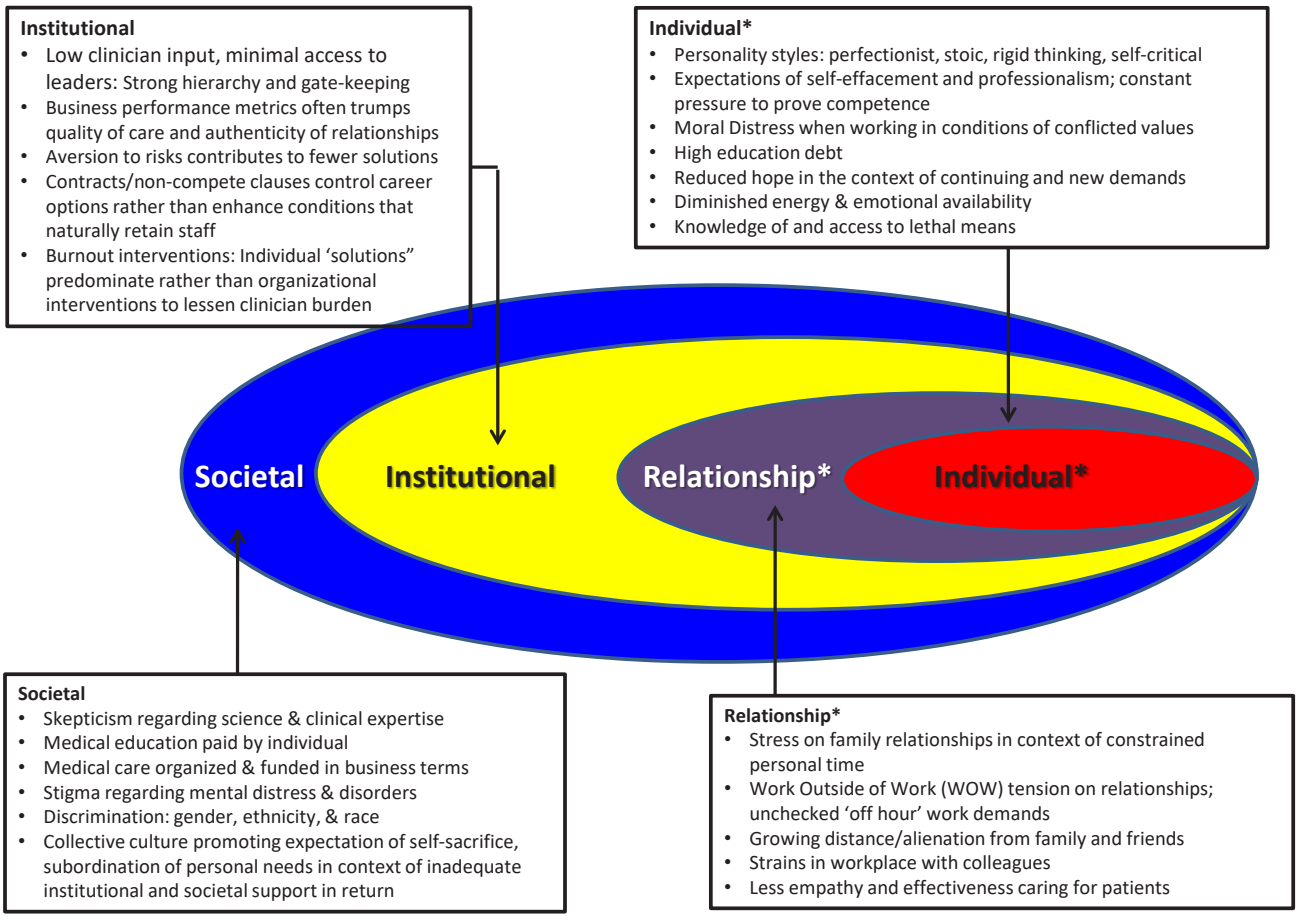
sufficient evidence of improved patient safety or quality outcomes to justify negative quality of life (personal, family and relationship) and financial impacts on clinicians.[1] Together with poorly designed electronic medical record systems, these factors have radically reduced the efficiency of providing excellent patient care and forced clinicians individually to solve institutional "productivity" problems by completing medical records during evenings, weekends or early morning hours. No wonder a recent study looking at the COVID-19 impact in U.S. Healthcare workers showed that one in five physicians and two in five nurses plan to leave their practice all together in the next two years.[6]

Ecological Model to show Contributory Factors and Additive Impact

We take an ecological approach to considering the factors that potentially have adverse impacts on individual clinicians. (See Figure 1, below.) Efforts to effectively enhance clinician mental health and reduce burnout must work together at all levels, rather than being viewed solely as a personal responsibility. We have ample evidence of the adverse consequences of being trapped within current health care environments. Individuals alone never will escape the effects of institutional and societal forces—unless they flee.

"Burnout" covers a broad range of dysfunction, including clinically significant depressive conditions, emotional detachment and numbness, irritability, disruptive behavior, and difficulties in personal lives. Neuroanatomic studies of severely affected individuals reveal changes in prefrontal cortex, hippocampus, basal ganglia and amygdalae.[7] Anatomical changes are partially reversible if the high stress is removed. Alterations in function may influence medical decision-making, memory, fine motor control, and reactions to stress. Suicide is the most dreaded outcome. The feeling that one's life is hopelessly out-of-control, or facing perceived threats to one's career, can elevate the risk for suicide among physicians. [8] While suicide risk may seem to arise from clinically evident psychiatric disorders, seemingly healthy, stoic individuals may take their lives with few detectable antecedents or without warning. As noted recently by Jaiswal: "Physician suicide is a very

Fig 1. Ecological model: Current Mental Health, Social Risks for Burnout, Depression & Suicide in Clinicians



*dynamic changes across career trajectory

visible problem in a very broken system. So, it'll be very difficult in isolation to treat it without making any systemic changes, because that's happening right now and it's not working". [9]

Patients and Clinicians Working Together to Improve Healthcare

In the Rochester area, a Patient Clinician Alliance (PCA) Model has been developed but since it needs independent funding to be free of conflict of interest, it has been difficult to find funding locally. However, the idea is currently being spread at the national level. This PCA amplifies the voice of both patients and clinicians collaboratively. Input comes from any and all clinicians and patients in the community and the metrics developed are able to give actionable data to decision-makers at executive levels of the healthcare system while also being transparent to the public. Long term national patient advocates helped spark this idea in our area.[10] (Ecological Broad Stroke levels of Interventions, see Figure 2, below.)

Conclusions

We often try to improve access to mental health while battling the stigma of receiving care and while we must continue to encourage those suffering to get into care. However, much more needs to be done to improve those conditions in healthcare delivery that contribute to negative mental health outcomes in our clinicians as they strive to take care of us. Those who lead and shape the healthcare ecosystem must candidly take stock of their cultures and values, and including day-to-day operational practices in order to drive much-needed systemic change. Only then can we, collectively, build together health systems that truly promote the health of those who seek care and for those who care for them.

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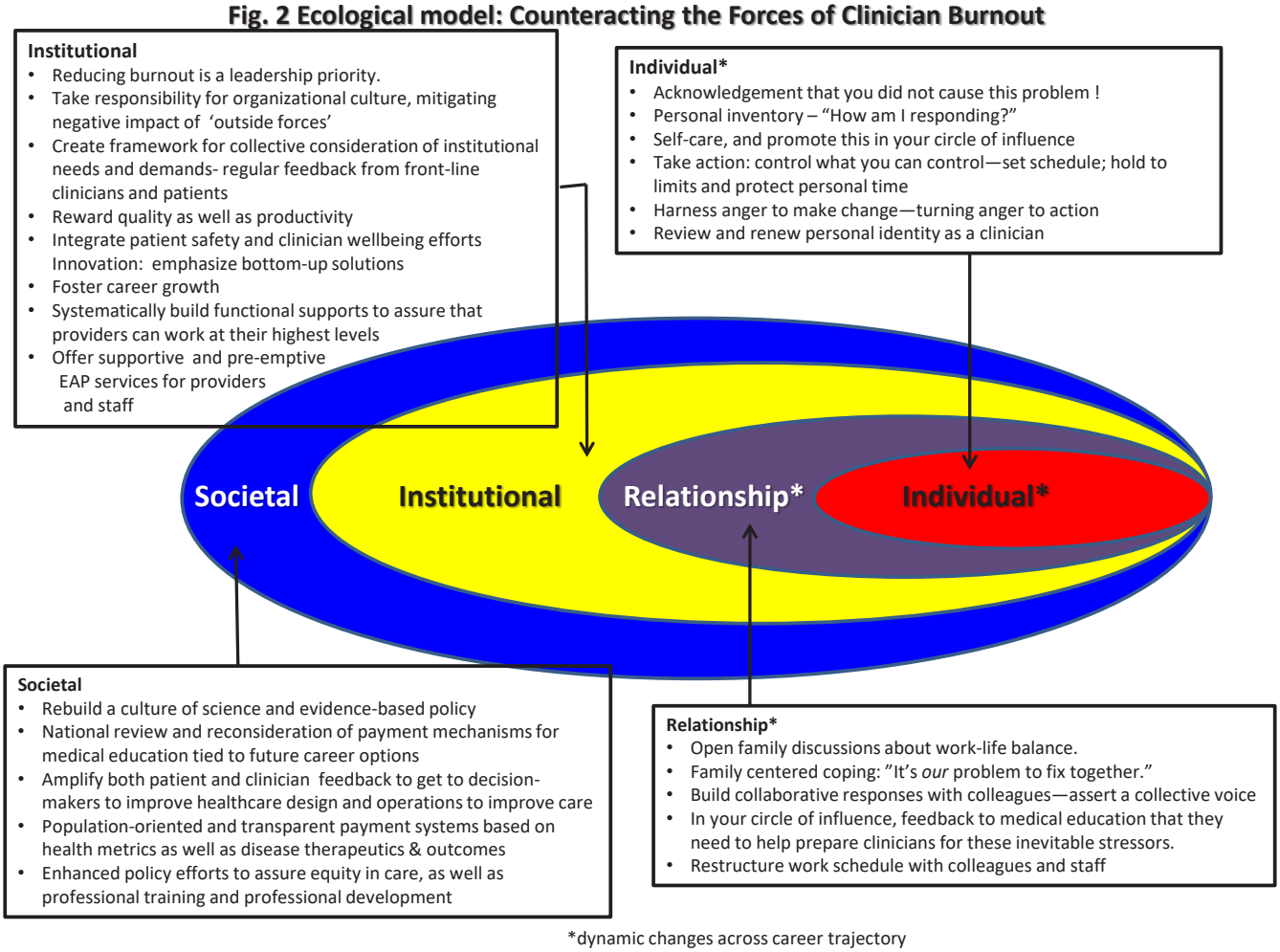
Fig. 2 Ecological model: Counteracting the Forces of Clinician Burnout



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Supplemental Reading to support Figure 2 interventions.

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Dr. Caine joined the faculty of the University of Rochester Medical Center in 1978, and led the Department of Psychiatry from 1993-2017. He founded with colleagues the UR Center for the Study and Prevention of Suicide (CSPS) in 1998, was one of three co-Directors through 2021, and now is a member of its Senior Faculty. In addition to continuing to teach and mentor, Dr. Caine serves on the Board of Scientific Counselors for CDC's National Center for Injury Prevention and Control. He is also a Reviewer for NIOSH, Total Worker Health Burnout curriculum.