Speaker 1:

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Kirsten Steffner, MD (guest host):

On behalf of the Society of Critical Care Anesthesiologists and Women in Critical Care, I'd like to welcome you to our podcast miniseries. This Stanford Medcast miniseries is dedicated to women in critical care medicine, but it's really for all physicians and working professionals out there who may be listening. I'm Dr. Kirsten Steffner, a critical care physician and cardiac anesthesiologist at Stanford University.

Amanda Schilling, DO (guest host):

I'm Amanda Kore Schilling, I'm an intensivist and anesthesiologist who practices critical care medicine at Tucson Medical Center in Arizona.

Kirsten Steffner, MD (guest host):

Our ultimate goal is to provide professional development content that puts a new lens on how we define success and quote, "Having it all." Today we speak with Dr. Jina Sinskey and Dr. Rebecca Margolis about physician wellbeing and burnout.

Amanda Schilling, DO (guest host):

Through these dynamic conversations, we hope to support and nourish the multiple roles that we play in our day-to-day lives. Dr. Jina Sinskey is an associate professor of anesthesia at UCSF specializing in pediatric anesthesia. She's an inaugural associate chair of wellbeing for the Department of Anesthesia at UCSF and serves as vice chair of the American Society of Anesthesiologists Committee on Physician Well-Being. She completed her internship and residency at UCSF and her pediatric anesthesiology fellowship at Boston's Children's Hospital.

Her approach to clinical wellbeing leverages her experience in management, consulting, and quality improvement where she applies concepts of change, management, human-centered design, continuous process improvement, and implementation science to create systems approaches to reduce burnout and foster wellbeing.

Dr. Rebecca Margolis practices pediatric anesthesiology at Children's Hospital, Los Angeles, and presently serves as an associate professor of clinical anesthesia and as the inaugural director of wellbeing in the Department of Anesthesiology Critical Care Medicine. She serves as the founder and co-chair of the Society of Pediatric Anesthesia's Committee for Physician Wellbeing.

Dr. Margolis received her undergraduate degree from New York University, her medical degree from the Philadelphia College of Osteopathic Medicine, and completed her anesthesia residency at Virginia Commonwealth University. Thank you for being here.

Jina Sinskey, MD (guest speaker):

It's great to be here.

Rebecca Margolis, DO (guest speaker):

My pleasure.

Kirsten Steffner, MD (guest host):

Jina and Rebecca wrote an amazing article called The Wicked Problem of Physician Well-Being. It's this really incredible summary of physician wellbeing and burnout describing the historical context and pointing to the available evidence of how these problems have been approached and how we should probably think about these issues moving forward. And first of all, I just wanted to thank you for such a rigorous take on these important topics.

The issues of wellbeing and burnout pretty quickly elicit eye rolls from a lot of people because the conversations can very quickly devolve into just venting and personal anecdotes. Your article is a nice, refreshing, systematic take on these issues, and I really appreciated that. I wanted to start by asking what inspired you both to write about physician wellbeing and also how did you decide to take these issues on as core parts of your careers?

Rebecca Margolis, DO (guest speaker):

This fell into my lap as a problem that I was completely unaware of. I was at CHLA where I practiced anesthesia. We have nine different training programs. And I was the designated mother hen of the training programs. My official title was the residency director, but really I just cared for and coordinated the education for 150 trainees a year. And I got a call at five in the morning one day, and it was a resident calling me saying, "We've been called back to our home institution. We have to be there this morning. None of us are going to be there to start first case starts." And in that phone call, she didn't know, but I knew what that meeting must be about.

And sure enough, there was a resident who was found dead in his home. We know in anesthesia, we know in medicine physicians have a higher rate of suicide and substance use disorder than most other career choices. And physicians actually have a 200 times increased rate of suicide compared to the general population. And it's started me down this, I need to know more about this because I had never experienced any of this or any of these thoughts and how do I now support all of the residents and how do I disseminate this information in a caring, compassionate, thoughtful way to all of these residents who are going to be massively affected by this? And I felt so unprepared to do this, frankly.

So I ended up down this literature rabbit hole, and if I'm going to care for all these people, I have to understand these problems. And it started at the suicidality substance use disorder level, and then really expanded for me to realize, "Oh, this is a systems issue. We have a problem as a healthcare community. This is a threat to patient safety, this is a threat to quality of care." So I went to the American Conference on Physician Health in 2016, which is a phenomenal conference on physician wellbeing. Vivek Murthy was one of the keynote speakers, and Abraham Verghese was there.

And it was a pivotal moment in my career where I just was like, "This is what I want to do. I've never wanted to do research before in my life and I want to do this." And it just lit a spark. And I haven't looked back ever since.

Kirsten Steffner, MD (guest host):

Unfortunately, most if not all of us probably know someone, have had a colleague that struggled with substance use disorder, mental health issues, suicidality. But I think it's incredible that when you were faced with this in your career, you decided to tackle these issues head on rather than shy away from them. So I think that's amazing. And Jina, how about you?

Jina Sinskey, MD (guest speaker):

Speaking of personal experience, as a fellow, I actually had found out that I had been named in a malpractice suit from residency, and that really made it incredibly difficult during my training. And it was involving a pediatric patient and I was doing pediatric anesthesia fellowship, so every day I was going into the operating room to take care of a pediatric patient. I was reliving this trauma. I had a lot of self-doubt, guilt, anxiety, a lot of the emotions that now I realize is very normal as part of the second victim phenomenon, but at the time it led to a lot more self-doubt because I was wondering if I wasn't cut out for medicine and cut out to be an anesthesiologist and if this was the right career path for me. And I honestly almost quit at that point.

And I had a grand rounds during my fellowship on the topic of the second victim, and this was about two months in. And it really just opened my eyes to, "Wow, there's a whole science around this and what I'm feeling is really not just me." And I realized that I had never really received that training before. And so when I went back to UCSF, that's where I did my residency, when I went back as a faculty member, I became involved in the anesthesia education day or our wellbeing curriculum, became the associate director of residency wellbeing.

And while I was doing that work, what really stood out to me was that, as much as I worked on resident wellbeing, if the faculty weren't well and if the work environment was poor, it didn't make a difference. I could say everything I wanted to at the anesthesia education day, we could talk about these things, have these deep conversations, but when they went back into the operating room and things were not supportive of their wellbeing, it almost made them more aware of their unwell-being. And I'm wondering if that's why there's so many of these eye rolls. As we learn so much more about wellbeing, why aren't we supporting people in the way that we know we should support them? And I think that's where we're getting this increased cynicism.

So really my work came from wanting to support my residents and then wanting to support my colleagues, and also the faculty who had trained me. And so I do this work because I really want to be able to bring scientific evidence to create policies and bring resources in to be able to support my colleagues and my trainees.

Kirsten Steffner, MD (guest host):

It's so true that the residents, when they're being given resources about physician wellbeing, we forget that they're paying attention and they're looking to the attendings at their work life balance. And if what they see doesn't match, what they're being told, they're going to start to question the authenticity behind these wellbeing curriculums. In your article, you described the problem of physician wellbeing and burnout as a quote, "Wicked problem." Can you explain the historical background of that phrase and why you chose to use it in this context for this article?

Jina Sinskey, MD (guest speaker):

Yes, with a wicked problem, that phrase really comes from urban planning and societal and cultural issues. I contrast it with tame problems. A tame problem is something like an arithmetic problem where there's a definite answer when you've hit the answer and you just move on and you don't think about it again. A wicked problem is really when the more you try to solve this problem, it's like an onion. The more it unfolds and there's all these deeper layers, and if anything, a more difficult problem to solve, you get to the core of the issue. And in doing so, I think one thing that's really affected my work in wellbeing is that every time you make an attempt to solve this problem, it's not without consequences.

And I'm not saying that you shouldn't try to solve the problem, but you have to be very thoughtful in the way you're solving these problems because leaves these traces. And for example, if you ask people to tell you what they think is going on and how you can improve their wellbeing, and you don't actually address that issue because you've tried to come solve this problem, but you didn't really do it in the way where they either were able to understand what you were trying to do or trying to feel that you were invested and trying to help them. I think you leave these traces where people start to get really resentful and resistant, and they're like, "Why are you wasting my time asking for my opinion when you're not going to really take it into account or you're going to do something that's completely opposite of what I just told you?"

So I think that's where we decided that wellbeing really is a wicked problem. And in some ways the word wellbeing has been weaponized, which I think is why a lot of people have such a visceral reaction almost against it. And so that's why we decided to title this piece The Wicked Problem of Physician Well-Being.

Kirsten Steffner, MD (guest host):

And I think what makes this problem so hard to tackle is lack of definitions or lack of a consistent use of these phrases, wellbeing and burnout. What definition for burnout have you guys landed on?

Rebecca Margolis, DO (guest speaker):

It's made up of depersonalization.

Jina Sinskey, MD (guest speaker):

Emotional exhaustion and reduced personal efficacy.

Rebecca Margolis, DO (guest speaker):

Yeah, reduced personal efficacy, meaning I'm not practicing to the best of my ability, I'm not getting that professional fulfillment. And depersonalization, meaning my patients, they're not humans anymore to me. And we've lost that personal connection where we drive a lot of meaning actually. There's no question that what protects from burnout is meaningful clinical care. It is one of the best things that can protect about burnout is everything else that detracts from it. When we go talk about wellness and burnout, we make a very clear distinction that the individual component is a small component. It's an important component.

It is very important that you have good self-care strategies and you sleep and you eat and you exercise, all these things. But we as a medical community have a systematic problem. And when we are there to talk to you about wellbeing, it is not because you have a problem, it is because you have to survive the infrastructure that is cracking. And Jina and I joke that we are not the ice cream and pizza party people, so don't call us for that. We are the structural, institutional, policy people who need to attack the problem from multiple angles.

Kirsten Steffner, MD (guest host):

In your article, you mapped out a really useful timeline of how this discussion surrounding physician wellness and burnout really started to get attention in the lay press and how that dialogue has played out and evolved over time. Can you go into that a little bit more for our listeners?

Rebecca Margolis, DO (guest speaker):

It's been an interesting course of how this has gone from a personal problem that we didn't talk about to actually a public health crisis. Physician burnout is a direct threat to the care of our patients. And the way that we got there was really, physicians always had an undercurrent of being derelict in their care to themselves. The Hippocratic Oath was not for us, we were not taking care of ourselves, and there was always unwellness and suicidality in medicine.

And then in 2012, Shanafelt and colleagues published really the first large scale study of burnout in the US physician population. And it got lay press attention that more than half of US physicians were at high risk for burnout. And this was the first time this was really publicized, that this was a threat to patients, and that our physicians were unwell. But that's where things steered in the wrong direction a little bit with we have to take care of the physicians and the public scrutiny with mounting, and administrators understandably were looking for solutions.

And this is where these quick-fix solutions came in and this sort of idea that the physicians are broken and we have to fix them. And then there was a flurry of papers over the next decade really, primarily focusing on these individual interventions to improve wellbeing from meditation and mindfulness, sleep, nutrition, physical fitness, all the things that Jina and I are aware of but try to steer frankly away from. But then in 2018 at the ACGME, the National Academy of Medicine, really highlighted the importance of a systems-based approach and really rigorous institutional policies and national policies need to be changed so that physicians can take care of themselves.

Jina Sinskey, MD (guest speaker):

The National Academy of Medicine, the 2019 report that came out, that really emphasized the importance of a systematic and systems-based approach. They had six goals and I think the two major ones that I feel are so important are creating positive work environments and creating positive learning environments. And I think that was just a great support in terms of everyone else who is really doing this work in terms of showing this is really supported by the National Academy of Medicine, and they've created some great resources on their website, whether it's toolkits and just speaking points, to be able to do this. And I think it's really shifted the discourse.

Kirsten Steffner, MD (guest host):

With this shift towards focusing on culture change and systematic initiatives to change the environment that we're working in, are there any standout examples of successful initiatives that have been implemented to promote at the systems level a culture of wellbeing?

Rebecca Margolis, DO (guest speaker):

There's been this underculture in medicine for years that if you need to see a therapist or you have mental health concerns, it really was underground. Many of my colleagues have paid cash for these services to keep it out because they're concerned about licensing issues and state licensing. And understandably, there has been a push over the last many years for the state medical boards to give parity for mental health concerns to physical health concerns. Questions have changed from, "Have you ever in your whole darn life being a therapist or taken medication?" To, "Are you currently impaired?" And I think that is an example of successful grassroots organization.

I remember in 2016 at the American Conference on Physician Health, seeing a poster on the number of states that have changed, and now I think almost all except maybe two have changed to giving parity.So the other thing that I've seen as a positive change is designated wellbeing lead. Jina and I are good examples of people who are empowered with some degree of administrative time, some degree of

budget to make these changes. Chief wellness officer is now a term. That was not something that was here 10 years ago.

Just the fact that you're starting to see those come into the C-suite to participate in decisions, to have a voice in those decisions, staffing, recruitment, retention, these are all wellbeing-related issues and we can help with the sustainability of our healthcare system. And that recognition is beginning, and I think that's a huge change.

Kirsten Steffner, MD (guest host):

The point that you made about your roles as advocates, the time that you're spending on physician wellbeing is now being acknowledged as something that is a formal role that needs time and compensation and acknowledgement. It's not just a hobby. That in and of itself is a huge step. When you mentioned in your article that part of the solution to physician burnout would include acknowledging physician time as a finite resource, that really hit home for me.

The thing that shocked me the most when I became an attending was the sense that I didn't have control over my time. And that lack of control of how I spent my days really contributed to burnout in my personal situation. And so I definitely agree that addressing our time as a finite resource and being appropriately compensated if we're being asked to give more of our time, that is definitely part of the solution. Additionally, I think we need to be given the option to say no without negative consequences.

Rebecca Margolis, DO (guest speaker):

Yeah, I say that you have to say no to protect your... Yes, because the amount of nonclinical burden is really significant and you want to take on things to help your practice, to help your patients, to help medicine, but it really does start to burn when that is on your own time, you've lost complete control of your schedule, and you feel like you're donating it. And then you're down this path of, "How long till I can retire?" And that is really where things go wrong. The recognition that we are a finite resource, we're very hard to make, we're very expensive to make, and how can you set up a healthcare system where your time as a physician or a nurse practitioner or any member of the medical team is used as efficiently as possible?

Jina and I both concentrate a lot of our efforts on creating in these environments where you feel like you're practicing to the top of your ability and you have a good support system underneath. Are there lots of cracks in the system? 100%, I recognize that. We've had 20% of our workforce leave Great Resignation since the beginning of COVID. And as critical care physicians, as anesthesiologists who are the captains of the ship, I'm sure we're spending lots of our time doing things that I'm mixing medications the pharmacy should be mixing. Just very raw tasks that frankly you don't have to go to medical school to do. And part of our job as wellbeing leaders is shining a light on those holes, and there's a business case for all of these problems being fixed by non-physician leaders.

Jina Sinskey, MD (guest speaker):

What you're describing to me reminds me of the areas of work-life model that Christina Maslach and Leiter have brought out. They're both organizational psychologists and they talk about these six areas where you have poor job first and fit, and that's predictive of burnout. And two of those that came to mind were the areas of control. So for example, like not having autonomy, not having scheduling predictability or flexibility. And the other is really values, where you're trying to find that meaning-making in your work and feeling that you're really doing the job that you came here to do and trained to do.

Amanda Schilling, DO (guest host):

We actually, in our group of ICU physicians and nurse practitioners, used your latest article as part of our journal club and we have a bunch of nurse practitioners, and they really felt what Rebecca and Jina were saying earlier, that if physicians did their role, then nurse practitioners felt more valued in doing their roles. And when physicians were getting piled on and doing everything, it took away from the value that the nurse practitioners felt in doing their jobs. And what you just said really resonates with just job satisfaction going from the ground up, and that helping overall with feelings of wellness and combating burnout from an ICU setting.

Kirsten Steffner, MD (guest host):

There's this amazing book called The No Club: Putting a Stop to Women's Dead-End Work, and it was written by behavioral economists and professors of organizational behavior, and they talk about this concept of non-promotable tasks. So a lot of these things that we do for our work life to keep the engine running, to keep people happy, but you don't get compensated for it, you're expending a lot of energy and resources on something that doesn't move your career forward. And their book talks about how women are expected to do these tasks more so than men, and we have a harder time saying no when asked to do these tasks, and I'm sure that this is contributing to burnout. Is there data showing that women specifically suffer from burnout?

Rebecca Margolis, DO (guest speaker):

There is a recent article that came out in anesthesiology about what you're calling, they described as the good citizen tax on women. And over the course of time, women make about a million dollars less than men in anesthesiology because of these unpaid, uncompensated administrative tasks. Being the scheduler in the OR, or the same thing in the ICU. All these things need to be done, but mostly they're being filled by women. So yes, there is a disparity.

Amanda Schilling, DO (guest host):

I think this is a perfect segue into us standing up for ourselves from a professional standpoint, us learning how to say no, us prioritizing what is important in our lives, our personal and professional lives. And I don't want to take away from the concept that burnout and wellness are all very much a higher level and administrative thing, but let's say we're talking to a woman in critical care medicine, an anesthesiologist who's working in the OR seven on seven off, maybe new in a practice or don't have that ability to get administrative changes, and they're feeling the burnout right now. What advice would you give for them?

Rebecca Margolis, DO (guest speaker):

First of all, I would like to acknowledge it's extremely hard, but this artificial choice between you can have a successful professional life and a fulfilling personal life is a narrative that sometimes we perpetuate and we have to be aware of it. You can have both, and that is these personal boundaries that have not been taught to us. So I'm not saying that it's anybody's failure for not having them, I had to find them over the last decade of being an attending. And being extremely clear about what are my goals and actually the intentionality around goal setting and boundaries, I really can't overstate.

And I think when you get to the end of your day and you haven't thought about how it's going to go and where things are going to go, you feel a little bit out of control and your day can happen to you. It seems like crazy, but I literally block out, "Okay, prep for this for 1:00 to 2:30," and that's when I'm going to do

that. And if I have a lecture in six weeks, I look at my calendar two months ahead of time and say, "Okay, I'm going to need 20 hours to put this together. Where am I going to find that? Where am I going to cobble it together?"

Jina has a saying about this. It repeats in my head, which I'm going to let her say, but you don't always have to do everything to an A+, and you have to decide what is okay.

Amanda Schilling, DO (guest host):

Jina, how do you set your boundaries and keep professional and personal boundaries, but also be able to climb the ladder from a professional standpoint and reach your professional goals?

Jina Sinskey, MD (guest speaker):

Yeah. So this goes back to what Rebecca was saying about the phrase that I always say, which is the 80/20 rule. So I just aim for 80% and depending on how things are going, if things are really rough, like COVID, then I go down to 60. So right now I'm at 60 and it's okay. No one complains to me like, "Oh, your slide doesn't look perfect." It's okay giving yourself that permission. We are our harshest critics, and so giving yourself that permission to be like, "It's okay if not all the font looks exactly the same, that's okay as long as you get the stuff out there."

I also really try to make things count twice. So whatever I do, it's either whether I, like I do something and I write about it or I do something and I speak about it, or I make the same slides and I use them for different purposes. I always want to make sure that you're not wasting your energy on something that's only going to count once, so I think that's really important.

And then the other thing is really just building community. And I have a group of collaborators like Rebecca, who if I'm not able to do something, I'm going through something, I need to do something, I take care of something at home, she's able to step in. And when that happens with Rebecca, I can do it. And so you're able to have someone who's constantly moving the ball forward for whether it's a project or a committee. And I think that's how really we can help all of us go forward. When I was a sub-I, one of the attendings said that there can be no systole without diastole. So oftentimes diastole is when your LV is getting perfused. Without that, you're just not going to be able to go forward.

And so a lot of times I'll just tell people like, "I need some diastole, and I'm saying it's okay because it's going to make you more effective when that systole comes." Give yourself that permission and that grace. In medicine, we train people to just give up everything for medicine. And that is not healthy. And I think that's why there was this undercurrent of burnout even before COVID. Now it's just reaching this fever pitch where people are having to choose between, "Can I do this career or can I not?"

And as Rebecca says, it is an artificial choice. You can make your job sustainable, and if the culture of medicine's not ready for that, I think about my sphere of influence, what's under my control, what's under my influence? And within the things that I can control and influence, I really try to make it so I'm doing the things I enjoy.

Kirsten Steffner, MD (guest host):

I really love that. And I think only recently in the last few years have I learned to define success by how much fun I'm having. I wish I had adopted this earlier. It's not something that is talked about when we're in training where there's such a culture of self-sacrifice that you feel like it's almost a badge of honor to be miserable. But now I think moving forward, it really makes such a difference to measure success by how much joy it brings me in the activity.

Amanda Schilling, DO (guest host):

What advice would you give to a physician starting off in their careers who have defined career goals, personal goals, and professional goals?

Rebecca Margolis, DO (guest speaker):

Well, finding a great mentor is one of the most important things, but the ability to see that your career is over the course of 30 years. If we can find sustainability, you're going to be doing this into your 60s. Culture of fatigue that we perpetuate in medicine, and I know I've done it, is so toxic. And if we can normalize that it's okay not to be busy all the time, and I don't want to be busy all the time, and that's where the joy in this diastole, it would be transformative in medicine.

Kirsten Steffner, MD (guest host):

I'm so grateful for the time we've been able to spend together. I just wanted to add one last thing because I think the last few points that you made were so important. Back to that other idea of having a team of people around you who can keep the ball moving forward so that you can step back every once in a while. That is definitely a key component to building a long-term career that's satisfying and fulfilling and doesn't burn you out. But there is this letting go of ego that also needs to happen.

When we're in training and investing, and donating our 20s to medicine, part of our defense mechanism is to build ego that kind of justifies what we're doing. We are not single-handedly going to save everyone. Me as a single individual physician, I cannot save everyone, and I need to rely on a team, whether it's my division, my mentors, my sponsors, just my friends, the people that I know that I can vent to. And I think just letting go of this sense that, "I can do it all and that I have to do it all," that is this relearning that we need to develop to be able to thrive over the long term.

Rebecca Margolis, DO (guest speaker):

This idea that we are humans wired for connection, but we often work in silos is so important. And what you're doing through society work, through committee work, can be so fulfilling because yes, the work is important, but actually the fact that I'm doing it with five other amazing physicians from other places is half the joy that I get out of it. The data shows that women actually lead better together, and it's no surprise that I lead the site for pediatric anesthesia committee on wellbeing with somebody else.

I ask to co-lead it even though they've never done that before because sometimes I need to back up and we are extremely good at jumping in when the other person needs it. So if you can find somebody else in the work that you're interested in, that you can work with and confide in, it really is the beauty of academics sometimes and where you can derive a ton of joy.

Amanda Schilling, DO (guest host):

I really thank you and appreciate the insight and knowledge that you are giving to women in critical care.

Kirsten Steffner, MD (guest host):

You are shutting light on issues that are so important and so relevant to all of us, so thank you for all the work that you're doing, and thank you for spending time with us on our podcast.

Speaker 1:

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