Wellness in Graduate Medical Education: Is It Time to Pull the Andon Cord?

Meghan M. Walsh, MD, MPH

An *Andon* is a traditional Japanese lantern. Japanese lore recounts tales of fishermen, returning to their villages at night, who would light the Andon aboard their boats to signal the need for help. Originating within Japanese manufacturing and today's continuous improvement lexicon, "pulling the Andon cord" refers to a call for help to say "I can't do my job." It is meant to authorize and empower the individual to immediately stop processes, activate management to investigate and intervene on the problem, and thus allow the individual to function optimally.

As mentioned in the article by Ey et al[1] in this issue of the *Journal of Graduate Medical Education*, prevalence of depression, burnout, and suicidality among medical students and resident trainees continues to outpace the general population, with nearly 50% to 70% of residents exhibiting burnout symptoms and 6% to 12% reporting suicidal ideation. Emotional exhaustion and increased depersonalization are rising among faculty in their first few years of practice as well.[2] We need to shift from building resilience, an attempt to mitigate the effects of a chaotic and depleting clinical environment, toward improving the clinical learning environment for faculty, patients, and trainees alike.

The MEMO (Minimizing Error, Maximizing Outcome) Investigators first described the need for the creation of "healthy workplaces"—the type of environment that can sustain providers and patients—to mitigate burnout in primary care settings.[3] Although the study focused on 119 primary care clinics in 5 regions, the results may be generalizable to the larger graduate medical education environment. The MEMO team identified several themes that were associated with increasing emotional exhaustion in providers: (1) adverse work conditions (eg, work intensity); (2) autonomy and control; and (3) unfavorable culture (eg, trust, alignment of values with leadership, cohesiveness). Although these key triggers were associated with faculty burnout, they also may serve as a starting place for burnout in trainees.

DOI: http://dx.doi.org/10.4300/JGME-D-16-00547.1

Adverse Work Conditions

The enactment of the duty hour limits has reduced hours, but has also contributed to increasing work intensity during work hours. More and more complex patient conditions, with shorter lengths of stay, stringent documentation requirements, and complex electronic health record systems, contribute to high work intensity. The demand for trainees to populate patient data for regulatory requirements or reimbursement rather than for clinical decision making, in tightly controlled shifts or clinic visits, leaves little time for connecting with patients, synthesizing information, and reflection. Cognitive overload and subsequent decision fatigue are likely contributors to burnout and emotional exhaustion.[4] Redesign of workflows that incorporate the entire care team, rather than placing work primarily on the shoulders of the provider, is critical. Emphasizing education over service may also result in a different prioritization and delegation of tasks.

Autonomy and Control

Early research from the social sciences has introduced the "demand control" model of job stress, which has shown convincingly that lack of control leads to high stress and adverse outcomes for workers.[5] In the review article in this issue, Raj[2] notes that a sense of control and autonomy, as well as pursuit and achievement of goals, correlates with greater resident well-being. The adoption of competency-based medical education and entrustable professional activities allows for individualized growth and development. However, the trainee role within the health care system or local clinical environment often lacks control. Institutional metrics, workflows, and standard processes are often prescriptive and rigid. This careful balance between standardization and autonomy must be sensitive to trainees' need to learn and develop. Careful attention to what work should be discontinued, or shifted to other members of the care team, is a good place to start.

To transform the educational environment to focus on wellness, placing more control into the hands of the trainee is critical. Examples include allowing a resident to begin clinic at 7:30 AM

instead of 8:00 AM so he or she can leave earlier to get to a child care provider to pick up his or her child 1 afternoon a week; allowing for breaks in training to accommodate life stressors or other events; and giving trainees some control over the complexity of patients seen and the time necessary to provide good care. Flexibility to transcend the standard clinic template to provide optimal care for a complex patient reinforces the role of the trainee as a learner, rather than as a small spoke in the productivity wheel. Development of individuals for independent practice is the goal, but competency rather than the financial bottom line should drive the experience. Faculty should endorse control of care by allowing the learner to choose the clinical plan alongside a supervisory safety net. On occasion, allowing the learner to choose his or her teacher may encourage meaningful feedback, personal development, and mentorship.

Culture

The use of the term *provider burnout* suggests that an individual's failure to cope is a personal frailty rather than a flawed system creating collective discontent. The creation of an "emotionally intelligent learning community," described by Cohen-Katz et al[6] in this issue of the *Journal*, begins to shift the cultural framework of the graduate medical education environment. Creation of mindfulness and self-care programs, as well as building the skills to recognize depersonalization and emotional exhaustion in others, is essential. Ey et al[1] detail a comprehensive wellness and suicidal prevention program that has demonstrated an increase in utilization of its resources from 5% to 25% over 9 years. This may reflect an evolving culture of trust; it may also reflect the increasing distress experienced by our providers during this time frame.

How can we create the curriculum necessary for a healthy workplace? Developing and articulating a learning environment and a culture that fosters learning, teamwork, and reflection will almost certainly improve well-being.

The first step in managing the problem is measuring it. At my home institution, Hennepin County Medical Center, burnout among providers is measured and addressed as an organizational metric. The MEMO Investigators and my institution use the single-item burnout measure, which correlates well with the Maslach Burnout Inventory.[7] This single-item measure allows for a more succinct survey tool that likely leads to greater participation. This program has led to several institution-wide initiatives, including the creation of an Office of Professional Worklife, a Provider Wellness Committee with champions from virtually all specialties, and a Provider Dining and Wellness Center that promotes reflection and healing.

Several Hennepin County Medical Center graduate medical education programs have surveyed their trainees as well. Creative initiatives to reduce burnout have arisen as a result. Follow-up surveys are demonstrating improvement in burnout rates after just 1 year. One residency program created a clinic immersion month. This experience is designed to reduce continuity clinic–related stress through the incorporation of wellness activities, more opportunities for residents to bond with clinic staff, and more time to build connections with patients. Another program is incorporating mindfulness training into the resident curriculum. In 2016, all incoming interns received an introduction to narrative medicine (the use of stories and art to aid reflection) during orientation, with the goal of improving reflection and empathy throughout their careers. For clinical practices, the Healthy Work Place study has shown that targeted interventions can be successful in reducing burnout and improving the professional satisfaction of physicians.[8]

The Accreditation Council for Graduate Medical Education (ACGME) annual faculty and resident/fellow surveys are an opportunity to measure wellness. These surveys can provide a national baseline to define the current status and future data to follow targeted interventions and policy recommendations. The ACGME Clinical Learning Environment Review program has added wellness as an area of focus. Prioritizing the clinician experience alongside quality and safety initiatives is a promising beginning to improve overall trainee and physician wellness.

We must shine the light on our teachers and our learners, see their distress, and change the system that is fostering depersonalization, emotional exhaustion, and reduced personal accomplishment. The graduate medical education community needs to put its collective wisdom toward wellness: this is critical for the future of our training programs and our profession.

It is time to pull the Andon cord.

References

1. Ey S, Moffit M, Kinzie JM, et al. Feasibility of a comprehensive wellness and suicide prevention program: a decade of caring for physicians in training and practice. *J Grad Med Educ*. 2016;8(5):747–753.
2. Raj KS. Well-being in residency: a systematic review. *J Grad Med Educ*. 2016;8(5):674–684.

3. Linzer M, Manwell LB, Williams ES. Working conditions in primary care: physician reactions and care quality. *Ann Intern Med*. 2009;151(1):28–36.
4. Reiner BI, Krupinski E. The insidious problem of fatigue in medical imaging practice. *J Digit Imaging*. 2012;25(1):3–6.
5. Karasek R, Baker D, Marxer F, et al. Job decision latitude, job demands, and cardiovascular disease: a prospective study of Swedish men. *Am J Public Health*. 1981;71(7):694–705.
6. Cohen-Katz J, Sternlieb JL, Hansen SE, et al. Developing emotional intelligence in the residency learning environment: a case study in cultural transformation. *J Grad Med Educ*. 2016;8(5):692–698.
7. Rohland BM, Kruse GR, Rohrer JE. Validation of a single-item measure of burnout against the Maslach Burnout Inventory among physicians. *Stress Health*. 2004;20(2):75–79.
8. Linzer M, Poplau S, Grossman E, et al. A cluster randomized trial of interventions to improve work conditions and clinician burnout in primary care: results from the Healthy Work Place (HWP) study. *J Gen Intern Med*. 2015;30(8):1105–1111.

Meghan M. Walsh, MD, MPH, is Chief Academic Officer and Designated Institutional Official, Hennepin County Medical Center.

Corresponding author: Meghan M. Walsh, MD, MPH, Hennepin County Medical Center, 701 Park Avenue, Minneapolis, MN 55415, 612.873.2296, fax 612.873.1981, meghan.walsh@hcmed.org