A Question of Goals: Is Reducing Resident Burnout Enough?

A recent article in the *Journal of Graduate Medical Education* by Busireddy et al,[1] entitled "Efficacy of Interventions to Reduce Resident Physician Burnout: A Systematic Review," presents the established interventions addressing resident burnout. The most consistently successful approach described was limiting resident work hours. Other interventions address additional characteristics of the learning environment, namely "removing excessively burdensome work schedules" and "increasing trainees' sense of control over their work."[1(p299)]

The outcome measured in this systematic review is the rate of burnout among resident physicians. Unfortunately, focusing on interventions in the clinical learning environment to reduce resident burnout would be most relevant *if* residency were the only period during which physicians suffer burnout. A more meaningful outcome would be burnout measured later in a physician's career. This longer-term outcome measure is important since any intervention that decreases burnout during residency, but is not sustained throughout their subsequent years of practice, would represent merely a delay of adverse consequences. This effect may be reflected in the 6th Annual Medscape Lifestyle Report,[2] which showed an increase from 40% to 51% in the percentage of physicians self-reporting burnout, despite reductions in resident workload with the Accreditation Council for Graduate Medical Education work hour restrictions.

Aside from the authors' concerns that reduction in work hours may lead to "inadequate training of physicians or the lengthening of an already long training period,"[1(p298)] it may not be possible to replicate many of the changes in the clinical learning environment in the postresidency environment. This is especially true as long as patient volume is tied to physician reimbursement, such as the use of relative value units and other volume-based metrics for physician reimbursement. Moreover, reducing residency workload may be conditioning residents to work less, putting more pressure on a physician workforce already barely managing the volume of patients. Physicians are increasingly cutting back on patient care responsibilities or retiring early, leading to the equivalent of 36 000 physicians lost over 10 years,[3] which may further exacerbate a projected physician shortage of more than 100 000 by 2030.[4]

The phrase *inadequate training of physicians* belies the true impact of changes in the clinical learning environment by implying a focus on attaining skills and knowledge required for board certification. Beyond board certification, training programs must prepare residents for life after residency; this means training programs should look for ways to train residents to reduce burnout throughout their *entire* career. Maslach et al[5] postulated that burnout stems from disconnections with 1 or more of 6 domains between individuals and the organizations for which they work: workload, control, reward, community, fairness, and values. Rather than focusing on interventions that alter the clinical learning environment, but may or may not alter the postresidency working environment, perhaps we should be teaching resident physicians the skills to negotiate and address future disconnections in any of these 6 areas. Resident physicians who have acquired these skills would be able to adapt to their future working environment, thus reducing the risk of burnout throughout their career.

Pete Yunyongying, MD, FACP
Associate Professor of Medicine, Augusta University, University of Georgia Medical Partnership

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