

Episode #8: Who's Caring for the Caregiver? Strategies for Reducing Clinician Burnout

SPEAKERS

Heather Howard, Dr. Bryant Adibe, Dr. Wayne Jonas

Heather Howard 00:02

Hi, and welcome to the Princeton Pulse Podcast. I'm Heather Howard, professor at Princeton University and former New Jersey Commissioner of Health and Senior Services. On campus and beyond, I've dedicated my career to advancing public health. That's why I'm excited to host this podcast and shine a light on the valuable connections between health research and policy. Our show will bring together scholars, policymakers, and other leaders to discuss today's most pressing health policy issues, domestically and globally. We'll highlight novel research at Princeton, along with partnerships aimed at improving public health and reducing health disparities. I hope you'll listen in as we put our fingers on the pulse and examine the power and possibilities of evidence informed health policy.

Heather Howard 00:52

Job burnout affects every industry but none as profoundly as health care. Up to 54% of nurses, physicians and other clinicians experienced prolonged occupational stress. They suffer exhaustion, low job satisfaction, lack of achievement, and other consequences that not only compromise their personal well being but also the care they provide to their patients. That's why clinician burnout is a concerning public health issue, and the topic of today's episode.

Heather Howard 01:21

Our discussion spotlights the drivers of clinician burnout along with the rising costs. We'll look at absenteeism, high turnover, and other repercussions that have led to staffing shortages and ultimately threaten access to quality health care in the U.S. and beyond. Most importantly, we'll brainstorm strategies for reducing clinician burnout through a systemic approach that leverages actionable data.

Heather Howard 01:44

Here with me in the studio is Dr. Bryant Adibe, Sugarman Practitioner in Residence at Princeton's School of Public and International Affairs. Dr. Adibe has done extensive research on this topic and put together a summit here at Princeton. This first of its kind event is uniting thought leaders with various backgrounds, including scholars, health care providers and policymakers to advance the collective pursuit of clinical wellbeing. Also joining us is Dr. Wayne Jonas, a practicing family physician and researcher in the areas of pain, stress, and human performance. Dr. Jonas is president of the Healing Works Foundation, which is co-sponsoring the Systems Summit on Clinical Wellbeing. Dr. Adibe, Dr. Jonas, welcome to the show.

Dr. Bryant Adibe 02:30

It's great to be here.

Dr. Wayne Jonas 02:31

Thank you for having us.

Heather Howard 02:32

So let me start with Dr. Adibe. It's been such a pleasure having you in the community here at Princeton as a practitioner in residence, working on the problem of physician burnout. Can you tell us how you came to this issue?

Dr. Bryant Adibe 02:45

Again, thanks for having us. This is something that I think has been near and dear to my heart for a while. In medical school, I had a dear friend who was a mentor and was several years ahead and was someone who encouraged me quite a bit. And he, inevitably, I learned, suffered from a tragic suicide. That was really the first time that I began to look into this issue of who's caring for the caretaker and this problem of physician wellbeing. I started my career as a chief wellness officer at a small college in Los Angeles, where I came face to face with a lot of issues around food insecurity and other challenges, and then later moved on to a similar role in Chicago. I think it was in Chicago, where I really got to see the breadth of what we're facing with physician suicide, mental health, as well as burnout, turnover and impacts on organizations at the system level.

Heather Howard 03:46

You worked at a big hospital system, right? Was it?

Dr. Bryant Adibe 03:49

Yeah, I was at Rush University System for Health in Chicago, with close to 20,000 employees. So big place, right in the heart of the city, serving the west side of Chicago, Southside of Chicago and everything in between.

Heather Howard 04:02

You were chief wellness officer, right?

Dr. Bryant Adibe 04:03

I was.

Heather Howard 04:05

Were you the inaugural chief wellness officer?

Dr. Bryant Adibe 04:07

I was. I started there at the end of 2018, before the pandemic started. We had no idea what was up ahead and how important having a wellness office would be in health care.

Heather Howard 04:21

Now, Dr. Jonas, you're a family physician, but you've got this really interesting, diverse background in practice and research. You were at NIH, WHO, and now the Healing Works Foundation. Can you tell us about what you're doing there and what brought you to this issue?

Dr. Wayne Jonas 04:41

Yes. Well, thank you for having me. And it's great to be here. Before all those things you just mentioned, I was in the military as a military physician for 20 years. And I still see patients in the military, see a lot of veterans and talk about resilience, and burnout, and PTSD, and the things that health care workers are faced with now. Because they're on the front lines, literally fighting the battle of disease. We saw a lot of this in the military, and I still see a lot of it. It's not a matter of stress, it's not a matter of too much work. It's really a matter of whether you're in a situation where you can actually accomplish what you're there to do. And I think the big challenge that we have right now in the area of burnout... and it's not simply burnout, by the way. You didn't mention one little statistic, which is that 20% of health care workers have left during the pandemic. And so we have a huge shortage. It's not simply getting people that really aren't up to snuff to do their job. There aren't people there. There's a huge shortage, and it's going to grow as more physicians retire and leave. And there's a nursing shortage that everybody is familiar with, so you won't even be able to get basic health care.

Dr. Wayne Jonas 06:04

The challenge here is not so much about burnout, in my opinion, which is a consequence of not actually having a system that supports the wellbeing and the ability of health care providers to do their job. They're mopping things up constantly, because we have a system that's designed to actually wait until disease occurs. And then we've got to throw a lot of stuff at it. And that stuff is usually very expensive and very profitable for certain ones. But clinicians see what's coming down the pike; they see how these things could be prevented, and they see what needs to be provided in order to not only prevent that, but to actually reverse many of those conditions. A lot of it is out of their control, but they're at the tip of the spear. And so they see it every day. And this, I think, is the fundamental underlying problem. So I've been involved in what I call "whole person care," because I think we have to pay attention to those invisible aspects that are causing that issue. I just described something that I experienced and saw and still see a lot in the military, but it's happening in health care. It's called moral injury. That's what just happened, what I just described in these areas. But we also need to make sure that mental health components are key, that we have support for mental health, that we don't just shove it aside either by stigma or other kinds of consequences. And we need the social and emotional support, where people can acknowledge that they also need healing when they're facing trauma on a day to day basis.

Heather Howard 07:42

Is that what your foundation focuses on?

Dr. Wayne Jonas 07:44

Our foundation focuses on "whole person care" in order to facilitate healing, which I think is where health care has to focus if we're going to solve this problem.

Heather Howard 07:56

So Dr. Adibe, Dr. Jonas has brought us back to how we define this problem, and how what we name it can really help to get the attention of policymakers. He said that we shouldn't talk just about burnout. How should we talk about it?

Dr. Bryant Adibe 08:15

That's a good question. Look, I think you'll hear this issue described from both sides of the same coin. Right? On the one hand, it's an issue of burnout and the other it's an issue of clinician wellness. How we term it doesn't really matter. The important thing is that we recognize that there's a real problem going on in health care. This issue isn't something that cropped up during the pandemic. This isn't something that comes as a surprise to many folks. The issue was obviously worsened by the conditions in the pandemic, but a well established body of literature has been looking at these kinds of challenges for decades, including moral injury that Dr. Jonas described. I think, at its core, though, it's only recently that we've really started to understand what's at the root of these problems. When we look at the studies that have been done - we call it the first chapter in the space -- a lot of it [the research] focused on quantifying the problem, on how widespread burnout was. The second chapter, I think, we started to think through our early interventions... mental health support and support that is largely focused on the individual. I think a lot of the work that I have done here, and certainly that Wayne was just describing that his foundation has done, is this emerging third chapter that we're entering, which is a focus on the system, and recognizing that clinician wellness isn't this separate problem, this separate entity from the workforce, social support, housing and food security for our patients, or separate from the operational realities of a health system. It's actually at the root of it. And in our definition, and the way that I see this problem, a true systems approach to this says that unless we can provide a system where providers can be at the bedside doing the work that they love, taking care of patients in the right way, they're going to continue to experience the disillusionment. They're going to continue to suffer under the administrative burden that, as Wayne mentioned, is driving them away from our field, which ultimately has a downstream impact on public health.

Heather Howard 10:19

So you both use the term clinician. Does that mean, Dr. Adibe, that this is not just about physicians? What do we know about the how broad this problem is?

Dr. Bryant Adibe 10:29

Yeah, it's a great question. It's broad. There's evidence that suggests that a single member of a health care team, even someone like a nurse or a respiratory therapist or anyone taking care of patients, who is experiencing burnout actually increases the rate and risk of burnout of other members of that team. And that can have a downstream impact on patient quality. So no, this isn't only a physician problem. This is a big issue in nursing and in many other disciplines.

Heather Howard 11:08

So, Dr. Jonas, how does burnout impact quality of care? Can you talk us through how we see that playing out?

Dr. Wayne Jonas 11:17

That actually should be pretty obvious to someone who's walked into an office and the person [caregiver] is not listening to them, doesn't know what their particular problems and needs are. The caregiver doesn't talk to them as a person but is just sort of going through a checklist and throwing out pills and procedures in those areas... if the patient can actually get in to see them. They may have to wait six weeks to even get into to the office. Then they get five minutes, and they get interrupted in the first 30 seconds. These are the attempts to stay on the treadmill, when somebody is not really engaged and taking care of the person, but is just trying to deal with the disease in front of them, the disease du jour. People experience this all the time, and it leads to dissatisfaction. They don't like those kinds of encounters. Clinicians don't like those kinds of encounters. By the way, if you ask about the most rewarding thing in their practice, and they look back, it's about relationships.

12:16

We're going to have a stellar talk today on the economic cost of not focusing on the relationships. You can't do that if you're burned out. You can't open your heart, you can't have empathy, you can't have compassion, you can't hear what really matters to the patient, and you can't provide the kind of care they need in order to get healthy. And so it's pretty obvious to anybody who walks through it. People are dissatisfied with that. The satisfaction scores are not related to the individuals. They're about what happened when they walked into the system. Then they try to get back in the system, and they get an automated recording and no call back. This is because of the shortage and the attempts to shortcut these areas.

Heather Howard 13:13

I hear you on it's disrupting access to care. Yeah, it's it's diminishing quality. Can you can you quantify safety?

Dr. Wayne Jonas 13:21

Yes, I mean, safety has been a problem for years. It decades, I would say. I mean, there was a landmark study done by the National Academy of Medicine over two decades ago, maybe 25 years ago, showing that errors in medicine are somewhere between the third and the seventh cause of death in the United States, not a disease but the medical interventions that we get. And some of that was due to burnout, fatigue, etc, which we have tried to to correct. Some of it is just the complexity of actually delivering health care, which requires that you be at the top of your game. And if you're not at the top of your game, and you don't have a system that then corrects the usual human errors, it continues on. I think that a recent update on that study indicated that we've made very little progress in that area. Safety still remains a problem, despite all these attempts to correct it within the current system.

Heather Howard 14:23

So access, quality, safety, and then the big one for policymakers is costs, right? We know already that our health care system costs more than other wealthy nations, and we get worse outcomes for it. What are the cost implications?

Dr. Bryant Adibe 14:39

Yeah, I'll take that one. Listen, just to piggyback on what Dr. Jonas was just sharing, I think another important consideration on the quality, safety piece is really simple. A burned out physician, we know

statistically, is more likely to commit errors. It makes sense just like a burned out, exhausted driver on the road is going to be more likely to commit traffic error. And so there are real implications not just for the patients that they serve, as the safety measures that he mentioned, but for the health systems, right -- the implications for them, as well as for the families and for the providers themselves. When we think about the guilt and shame and moral injury that they experience, it's really a significant issue. When we look at the problem of cost, which is what my body of work here Heather at Princeton has focused on , we know that burned out physicians are statistically way more likely to turn over and leave. And so if you leave, let's say, in primary care, you lose a primary care physician, you don't just lose and replace that physician, right. A new physician has to establish a new relationship, as we mentioned, and that often leads to unnecessary additional testing, additional costs, imaging -- costs that then translate to the health system. It's been well documented that burnout leads to higher rates of turnover, which leads to greater health care expenditure, costs. So this isn't just a problem that impacts the individual health system, what we call little s, but also big S, right. There's actually been documentation that this increases costs at the national level.

Heather Howard 16:11

And this happening in nursing as well, right? We heard during the pandemic about rural hospitals needing to rely on traveling nurses. Is that still the case?

Dr. Wayne Jonas 16:21

You bet. I was actually in the hospital yesterday, and a nurse came in that I didn't recognize. I found out later that she was traveling nurse. The supervisor came in and was trying to get her up to snuff on the system and how it was working. So the efficiencies were much less, the costs were higher, they were paying her more than the employed nurses that were there. So it is absolutely a continuing, ongoing problem.

Heather Howard 16:45

We're also seeing across the country, and nearby in New Jersey, more labor strife in the health care industry. Does that surprise you that this has happened? Do you see that as connected to this issue, Dr. Jonas?

Dr. Wayne Jonas 16:59

Yeah, absolutely. I mean, first of all, if there's a shortage, and you can't get people to come and fill in, that means that the workload is higher for those that are there. So that's strife right there. I'll use your example of the traveling nurses. When you do bring them in, and they're paid at a much higher rate, the nurses that are there see that and say, "Wait a minute, I'm doing the same work, maybe even more than this person is doing, and she's getting paid a lot more. I just don't have the flexibility to travel all over the country and do that type of thing." That causes some animosity also. So there's strife from both the physical burnout and the workload, as well as the emotional toll on the team to really work well together.

Heather Howard 17:48

So this is very depressing. But let's shift.

Dr. Wayne Jonas 17:52

Let me talk a little bit about cost, though -- the bigger cost,. Not just the cost of burnout, because the cost of burnout is a tip of the iceberg for overall costs. You mentioned that we spend double the amount spent by any other health care country in the world, and yet our health is worse and is getting worse. Life expectancy is dropping compared to other countries significantly. So it's not that there's not enough money here. There's too much, in fact, but it's not being focused on the things that would keep us healthy. It's focused on mopping up the leak, while we haven't gone over and repaired it on the floor. We're just hiring more janitors, right? And so it requires a redesign and a refocus, not more money, but a focus on what actually works to create health.

Heather Howard 18:41

Well, policymakers would like to hear that. Because it's always hard when you go to a policymaker and say that you need more money. So that, it seems to me, is a wise approach. Let's dig in there. You mentioned, Dr. Jonas, that 20% of clinicians have left. Is the focus now on getting people to come back in, or retaining those we have?

Dr. Wayne Jonas 19:05

Eldar Sharif has written a book called "Scarcity." He talks about the mindset of scarcity, how the sense that you don't have enough actually drives you into behaviors that perpetuate the fact that you don't have enough. I think health care is in that situation right now. He [Shafir] gives an example of an operating room that was overloaded, lots of the delays and that type of thing. His solution was to open up a bed and then don't use it, to make it only for the emergencies that come in, and then that will help the other flow. People were saying that they have to use every single bed, etc., in these areas. That mindset actually needs to be shifted. It's not a matter of taking resources away. Nobody wants to not have their heart attack stopped if they're in the middle of it, right? We need emergency care services. But if that's all we're focused on, and we're not focusing on preventing those things, then it will be an endless stream of increasing costs and poor outcomes.

Heather Howard 20:19

Dr. Adibe, you mentioned this earlier... that while there's really important work to be done working with individual clinicians and supporting them, you've shifted your focus to thinking about the systems answer. What are some suggestions? What are some of the things that you're working on?

Dr. Bryant Adibe 20:35

I'll start with just a simple analogy. The big question in this space is often how to improve resiliency. So more meditation, more yoga, more mental health support, more resources to address the problem. And what I say is this: "Listen, if every day you go to work and get hit in the head with a hammer, the solution isn't more resilience. The solution is to get rid of the hammer." Getting rid of the hammer, in my mind, is building a better system. For health systems, there are a couple of things that we can do. The first is to recognize that this issue of clinician wellbeing is a truly operational issue. Up until recently, that wasn't clear to a lot of us. And so what that means is, if we do not care for the wellbeing of our workforce, they will leave, our costs will rise (because we'll have to bring in traveling nurses), our patients will leave, or our expenditures will go up to manage the same amount of patients. And so when you think about the health care environment that we exist in now, where margins are so razor thin,

where costs are rising, or where medical inflation -- which, by the way, has continued to outpace general inflation for the past two decades -- continues to be a factor, the true way that we're going to accomplish this is by building a system that allows us to retain the best providers and keep them at the bedside to take care of our patients.

Heather Howard 21:52

Does that mean tackling this sort of increasing corporatization of health care?

Dr. Bryant Adibe 21:56

You know, that's a tough one, I have to say, because the truth of the matter is -- and not everyone will agree with this -- but I think there are advantages to both. There are certain things that private enterprise and business can do that others can't. Our summit invited for-profit health systems that are doing great things for the wellbeing of their providers. And there are nonprofits that may not be, so it's a tough question. There has definitely been a rise, as you mentioned, in the space of corporatization, the role of private equity, and it's yet to be determined what that looks like long-term. I don't know that in the short term it has to inherently be negative. I do think we can use private business to solve a lot of the issues that we have.

Heather Howard 22:40

As you look around the country, do you see systems that are doing this well, that are figuring this out? In policy, I teach my students that it's always much easier to learn from people who are doing it well, rather than to create new ideas out of whole cloth. So is anybody doing this well?

Dr. Bryant Adibe 23:00

There's definitely exemplar systems. I don't want to speak for any individual health system, but as a community I think we're all trying to find the next step and operate within these constraints of policy limitations.

Heather Howard 23:16

How about the military? Is the military figuring this out better?

Dr. Wayne Jonas 23:18

The military actually does do it better. And they've shown that because it focuses on the underlying drivers of health. They need to have people who can perform, not simply not come into the emergency room at the hospital. They need to actually perform, and so they have created systems, like total force fitness, for example, that really look at these underlying drivers of health and human performance. The VA is actually doing an extremely good job. It used to get a bad rap 20 years ago, but it has improved tremendously. Now they provide better mental health than the private sector, for example, but we'll get to the private sector in a minute. They also have a program called "Whole Health," which really focuses on behavior, lifestyle, social, and emotional, and what matters to the individual. And they have shown that that lowers costs significantly, and improves health, and lowers burnout, and increases satisfaction. So there are a number of systems that actually do this much better. There are also a number of private, for-profit systems. It's not an issue of the government versus the private sector. ChenMed is an example of that. They look at the poor elderly, and they have a system that saves money and keeps

them out of the emergency room and out of the hospital. It improved health satisfaction in that network, which is largely in the east coast at this point. It's through the roof. The people love it. There's one that was just purchased by Amazon called Iora health care that was doing the same thing. It was a for-profit component. I think there are systems in certain regions of the country, larger systems like Kaiser Permanente, for example, that do an exemplary job and have demonstrated, over and over again, that you can actually improve health for the public and for the population and for everybody that you deal with.

Heather Howard 25:13

Of course, Kaiser just experienced the largest strike in the country in the history of health care workers. So it's not easy.

Dr. Wayne Jonas 25:22

And it's not all Kaiser over the entire country. In the areas where they actually have responsibility for the entire population, like in Northern California, that system performs much differently than one that's in the competition and is just trying to get people through the door.

Heather Howard 25:40

So if it's not the form of the system, it's the features of the system. One key, I think I've learned from you over time, is agency - clinicians having agency. Is that the right way to think about it?

Dr. Wayne Jonas 25:54

That's correct. If I can't give what my patient needs, because the insurance company will not cover it, even though it's the only thing available to actually help them get better, then I have lost my agency. And that happens all over the country now. And that will create moral injury for me.

Heather Howard 26:11

So one thing we always try to do in this podcast is to make sure we visit the health equity implications of a policy. How do you see health equity being impacted by clinician wellbeing? Does it affect certain types of providers more than others? And are there certain communities that are going to be more affected by these access, quality and safety issues?

Dr. Bryant Adibe 26:37

Yeah, big time. Listen, I think that's a great question. One of the things that Dr. Jonas and I talked a lot about as we were developing and designing this System Summit on clinical wellbeing was the importance of incorporating safety net, under-resourced institutions as part of this gathering. What does the research say on this topic? We know about burnout at Blue Chip institutions, we know about wellbeing at the best and brightest. But what about institutions where there isn't that kind of funding, where overwhelming amounts of their bottom line each year are supported by public dollars, and who are taking care of patients at the lowest socioeconomic levels. The truth of the matter is there's still a lot that's unknown in that space. There are a few things, though, just from our conversations, that we've learned. The kind of providers that practice in these environments are often different. These are often folks who are very much focused on a mission, a purpose. They're not going into these roles for personal financial gain. They recognize that they are going to be treating the most complex patients,

often with the least amount of resources. On the patient care side, though, which I think was the other part of your question about equity, these patients often will be disproportionately impacted. Just last night we were having a conversation about the patient who was essentially in liver failure and struggling at a safety net, under-resourced facility. They could not get this patient to a facility that had a liver transplant program, in part because this patient did not have the right kinds of insurance. Heather, I think that's wrong. I think it is one thing if folks aren't able to be treated because we don't have the means to take care of them. If we don't have the capacity or the skill set. But to sit there and say to a patient or to a family that we can't take that patient transfer, that we can't open up that bed, because we want to know who is ultimately going to pay this bill? That doesn't feel right to me.

Heather Howard 28:45

We're back to the moral injury. If 10% of the people in our country don't have health insurance, how are we going to have an equitable system? And why should we be surprised, after Covid preyed on historic inequities, that this problem is probably preying on them as well?

Dr. Bryant Adibe 29:08

That's right.

Dr. Wayne Jonas 29:10

We can always know more, but we already know enough.

Heather Howard 29:18

You're in an ivory tower where we always want to know more. We always want to research. So tell me more about that.

Dr. Wayne Jonas 29:23

We absolutely know what the solutions are to the equity, the cost, and the health improvement issues. They're all joined at the hip. Even the best health care delivery system only improves actual health by about 20%, and that's been documented over and over and over again. That means that 80% of what people need in order to be and stay healthy, and to flourish, doesn't come from health care. It comes from fulfilling the other aspects of Maslow's hierarchy.... fundamental social support, food, shelter. Safety is at the bottom of the hierarchy. Belonging and social and emotional mental health issues are in the middle. And there are the aspirational issues; people want to be able to do something meaningful in their life. That's the spiritual component. Maslow described, seven years ago, that this is why people flourish if you fulfill those needs. If a child doesn't even have those fundamental food and shelter and safety issues, or if they don't have a loving relationship that actually can prevent adverse experiences, then they are going to get sicker as they go along, and the health care system ends up mopping it up. And certain groups make money off of that. So if we want to solve the problem, we will refocus not just the health care system, but the social safety net components to those fundamental characteristics that prevent disease in the first place. And that will have cost, it will improve equity, and it will improve health in general.

Heather Howard 31:01

But it's not so easy to be able to map it out. In fact, you both mentioned this conference that you've organized here at Princeton. Can you talk about what you hope will come out of it? What are some of the lessons and what are you hoping to inspire going forward?

Dr. Bryant Adibe 31:15

I think we don't hold any illusions that we're going to solve all health care problems in a conference. What I do think is that we want to be really thoughtful about the folks that we invited here to campus. That included some of the top health care organizations in the country and, as I mentioned a moment ago, it also included several safety net, under-resourced institutions that could provide another perspective. I spent a lot of the last year out there on the road, speaking at hospitals, and having these conversations with different clinical facilities. And I often found there were two conversations that occurred. There was this public conversation that was very refined and polished and espoused corporate values. And then, often afterwards, we'd have dinners or conversations where the health care leaders are more frank and honest. They really revolved around the issues. And as I went from facility to facility, I kept hearing the same things. One of the goals for this event was to create a space where we could have those conversations and try to identify potential solutions for moving in that direction.

Dr. Wayne Jonas 32:27

I'm a little bit more modest. I think if we could move a step towards identifying the measures and the metrics that are country values, that we are willing to pay for, and we design policies to actually pay for those things to occur -- policies that involve risk reduction, and reversal of chronic illness. If we made those upfront, and then the designs of systems follow. But the redesign has to follow the values and it has to go beyond health care. It's why we have a whole day on what we call the "big ask," "the big system," or the things outside of health care delivery that are driving health or interfering with that. A lot of the policies are already in place. There is a new report that just came out of the National Academy of Medicine called "Valuing America's Health." It lays out a whole set of detailed policy shifts that would take resources and financing right now -- whether it's private or public doesn't matter -- and invest them in the things that we know produce health. If that were something that came out of this conference, it would be a huge accomplishment.

Heather Howard 34:04

So you're really broadening the lens here.

Dr. Wayne Jonas 34:07

Well, you're focusing the lens on what matters, on what actually produces health. You align the value of the investment with the values of what you're trying to accomplish, not just doing more of something and paying somebody if it's not actually producing what you're looking for.

Heather Howard 34:24

Dr. Adibe, if I invited you back here next year for a status check, where do you hope we'll be on this issue?

Dr. Bryant Adibe 34:31

I think one of the things that that I learned, at least during my time in Chicago, is that health systems don't really have the tools that they need to address this issue adequately, particularly at the "little s level," or the individual organization . One of the things that I've been working on here at Princeton is a bit of software, called our "wellness dashboard," which enables health systems to quantify the costs of burnout, such that you can understand the impact of indirect costs on the bottom line. It also helps identify where burnout is occurring, why it is occurring. And it provides recommendations on what they can do about it. If you go online, you'll find online calculators that can give you these broad things. But this really gives surgical precision for your exact health care system. My goal would be that tools like this are more widely spread and used, and that health care leaders are actually able to move the needle on this issue using resources like this.

Dr. Wayne Jonas 35:27

I agree completely. Our foundation has been working on tools at a different level. He's talking about system tools, which we desperately need. But I'm still in the trenches, and I need tools I can use every day in my practice. I need to be able to have the conversation with the patient about what matters to them, and what are the underlying personal drivers. So we've created a whole set of tools, tested them, published them. We call them "healing-oriented practices and environment tools." One of them is the personal health inventory, which we adapted from the Veterans Administration. I teach my residents, students and other physicians and clinicians to have a "hope visit." Give them the personal health inventory and have that discussion, and then help facilitate their ability to improve their health. Salute to Genesis in those areas. We need practice tools, day to day boots on the ground, and system tools to measure the impact of that.

Heather Howard 36:23

Well, we're ending on a much more optimistic note than where we began, which is great. And that's the point of this of this summit, right? This has been an amazing discussion. Is there anything else I should have asked you? Anything we missed or any point you want to make?

Dr. Wayne Jonas 36:41

I think there is a big elephant. And it is the profit that is being made off of not doing this. There are huge industries that are just following the rules, that are making a large amount of money off of suffering. We can't take that money away, because people need some of that, but we need to reinvest it so we don't need as much of it. We're going to get a lot of pushback. The policymakers already get a lot of pushback, saying that you can't change this because it'll actually cut into the bottom line of the corporate structure. Here is something that we're going to have to face head on and say, "Does this produce value? Is the health and wealth interchange being optimized? Or is the health producing a lot of wealth, but that wealth isn't going back to improve the community wellbeing?"

Dr. Bryant Adibe 37:41

I'll just say this. I spoke a moment ago about this kind of software tool we've been working on. I think one thing we didn't spend as much time on was this idea of the role of emerging technology in this space, and its potential influence. How do I think about this issue of clinician wellbeing being at the root of where health care is headed? A few things stand out to me. Going forward, we know that there will be increasing demand on health care. We have an aging population and, as of now, we have falling

supply. Our health care workforce is also aging. And we are losing our workforce. As Dr. Jonas mentioned a bit ago, we know that costs are rising as well. We also know that there's this unknown factor of emerging tech, generative AI and the role that it will play in the future of health care. You look at the double AMC report, which said that in the next 10 years we could have a shortage of up to 100,000 physicians. Something that is very important for me, that I've been wanting to advocate for, is to raise awareness to the fact that as that physician shortage increases, the nature of health care will change. It will be increasingly harder for you to see a physician in the community and elsewhere. And as the rise of technology increases, that will only accelerate that trend. I think these are very timely issues. This is a public policy and a public health issue, and I'm hoping we can do something about it.

Heather Howard 39:03

Well, thank you both. This has been a wonderful discussion and good luck with the rest of the conference.

Dr. Bryant Adibe 39:08

Thank you.

Dr. Wayne Jonas 39:09

Thank you. Appreciate it.

Heather Howard 39:12

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