



## The Case of the Fatiguing Fourth Year

Case by Dr. Loice Swisher

### Case

Dr. Loice Swisher

### Objectives / Questions:

Dr. Teresa Chan

### Expert Commentaries

Dr. Glen Bandiera  
Dr. Nicole Battaglioli  
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Dr. Alkarim Velji

### MEdIC Project Lead

Dr. Tamara McColl  
Dr. Teresa Chan

### ALiEM Editor-in-Chief

Dr. Michelle Lin

It was 4 a.m. and George had just sat himself down into a hard plastic chair to catch up on some charting. This was his second rotation at a small, inner-city emergency department. The night shift was George's chance to 'run the department', with only him and one attending on for the night. Now that he was near the end of his fourth year of residency, he was really trying to push himself. George had thought it would be great to feel 'in charge'; the run of six 12-hour shifts, however, was gruelling and starting to take its toll. It seemed there was never a chance to rest. The respite of a weekend off was just three hours away and he couldn't wait.

As soon as George sat down, the ambulance doors opened to the sound of high pitched screaming. The woman on the stretcher was yelling expletives and demanding pain medicine. George sighed heavily; having seen her twice already during his rotation, he knew she didn't have an acute medical problem - she just wanted opioids.

Sitting back down to complete his charting, George surveyed the department. A few intoxicated patients occupied beds and stretchers, and the man who had just refused a dental block for his toothache paced the hallway, agitated. If it weren't for the poorly-controlled asthmatic breathing nebulized albuterol in the resuscitation bay, there wouldn't have been a single emergency in the entire department.

Suddenly, George turned to the attending blurting out, "Dr. Jones, how do you do it? Doesn't it get to you? All the drug-seekers, drunks, and noncompliant patients... isn't it exhausting?"

George's outburst caught Dr. Jones off-guard. George had seemed to be managing the department admirably.

"Well, its tough at times but things will certainly get better when you start making more money," Dr. Jones said with a chuckle, fumbling for words.

"I hope so," George unenthusiastically replied. George got through his shift and was about ready to collapse by the end. On his way home, George's eyelids grew heavy and he drifted onto the shoulder of the road several times. As he struggled to focus on the drive, his mind raced and he began to worry about his future.

Was it possible that he was already becoming burnt out, after just four years of residency? He had gone into emergency medicine wanting to 'make a difference by helping patients', but on nights like this, dealing with patients felt like a chore and only seemed to make him miserable. Could he keep this up long enough to pay off all of his loans? And what then? When George arrived home, his wife listened sympathetically while he unloaded his frustrations of the night and his concerns about his future in emergency medicine. "You're just exhausted," she reassured him. "Sleep and then see how you feel. You're off tomorrow; we can do something fun. I'm sure you'll feel better then." Nodding his head unenthusiastically, George couldn't shake the nagging feeling that there might be something more. Neither his wife nor Dr. Jones seemed to understand. Exhausted, George crawled into bed, eager for a brief reprieve from the frustration of his grueling schedule.

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### Questions for Discussion

1. What are the signs and causes of burnout?
2. How can an attending recognized fatigue and sleep deprivation? What fatigue mitigation strategies can be adopted?
3. What resources may be available to a resident who feels too fatigued?
4. How does burnout and sleep deprivation affect patient care and physician health?

## Competencies

| ACGME   | CanMEDS                                      |
|---|--|
| Professional Values (PROF1)<br>Team Management (ICS2) | Professional<br>Communicator<br>Collaborator |

## Intended Objectives of Case

1. Discuss and identify factors that can lead to physician burnout (including but not limited to: fatigue, sleep deprivation).
2. Describe an approach mitigating fatigue and burnout, including identifying local physician-help resources.
3. List ways in which physician burnout and wellbeing can impact patient care and outcomes.

## Mitigating the Risk of Physician Burnout

by Dr. Glen Bandiera BASC, MD, MEd, FRCPC

The experience that George is having is not at all uncommon. It is not unique to emergency medicine, nor to medicine as a career writ large.<sup>1</sup> However, the stresses and challenges of medical residencies and practice make doctors particularly vulnerable to episodes similar to George's. George wonders if this experience is a symptom of early burnout, his wife suggests it is symptomatic of fatigue, and his supervisor is suggesting it is a matter of perspective, balancing reward for cost.

Regardless of the cause, and it is impossible to know for sure what the real driver is, it is important that George has recognized these thoughts and symptoms and is starting to ask himself some tough questions.<sup>2</sup>

One of the major challenges with both burnout and excessive fatigue is that the individual fails to recognize them early and continues to forge ahead.<sup>3</sup> This propensity for 'forging through' their fatigue leads the individual to try harder and harder to persevere until they fail. Those who spot early signs of fatigue can make a drastic change that can prevent major errors via a more deliberate approach, rather than experiencing a major catastrophic event. This is analogous to a sleepy driver who pulls over after veering slightly off their lane, versus the driver who 'forges through' and veers into an oncoming lane.

Both burnout and fatigue can lead to impaired decision-making and performance.<sup>1,4</sup> While it has been shown that sleep-deprived practitioners make more mistakes, it is not clear that these translate into increased harm to patients or adverse events in any way. The system has checks and balances and it is important for individuals to call upon these in times of need when they are feeling less than 'optimized' for work.<sup>1</sup> Actions might include calling for extra support (staff, other residents) to address high risk activities (procedures, etc), activating a second call system when unable to work, alerting other healthcare staff to double check orders and activities, and alerting colleagues that they should take on primary responsibility for key actions and decisions. Nevertheless, it is imperative that individuals, teams, and system leaders take this issue seriously and embed system-wide approaches to address burnout and fatigue risk management.

### Fatigue and Duty Hours

Fatigue among doctors is common. In addition to the typical fatigue-inducing aspects of modern life, residents endure long hours of scheduled clinical time leading to sleep

deprivation, academic work outside of clinical time, sleep irregularities due to stress, and trying to establish or maintain social and family relationships.<sup>3,4</sup> All of this in addition to the emotional toll of providing complex and high quality care to sick and distressed people in a high pressure clinical environment. Duty hours are not the only, and possibly not even the most significant, driver of fatigue.

The dialog in Canada around duty hours has been largely refocused towards fatigue risk management.<sup>5</sup> Some of the personal manifestations of chronic fatigue (noticed by the individual) include feelings of depression, disillusionment, frustration and entrapment, as well as decreased attention to physical and dietary wellbeing. These can certainly lead to questions about personal choices, career fit, and ability to proceed. Behaviour patterns indicative of fatigue (noticed by others) include irritability, lack of focus, lack of organization, decreased attention to detail, decreased demonstration of responsibility, and frank errors.

George is demonstrating some intrinsic thoughts and feelings that could be aligned with fatigue; he is questioning his career choice and wondering if he has the fortitude to continue on, even through the early career phase. He has linked it to his ability to pay off loans, a sign that he is starting to worry about external existential issues and his own sense of security.<sup>1,2</sup> Favoring fatigue as a prime driver for his experience is the recent string of long hours, his intent to 'forge ahead' and demonstrate that he can take on senior responsibilities, and his drifting off (figuratively and literally) while driving.

Key measures George can take to mitigate fatigue risk include:

- Let others know when he is tired (including members of the immediate care team who can lower their threshold for vigilance and feedback);
- Ask for help when needed (maybe the staff physician should be providing closer supervision during this time);
- Force himself to take extra time for key decisions and procedures;
- Double check key steps such as calculations and orders;
- Identify preventive measures such as appropriate sleep hygiene, optimal schedule management, and prioritizing sleep and physical well-being over other elective activities.

### The Issue of Burnout

Burnout is a term commonly used to refer to a broad range of attitudinal and symptom complexes but which in fact has a

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specific meaning. Typically, burnout includes the specific aspects of depersonalization, loss of empathy, emotional exhaustion, decreased overall quality of life and lack of meaning in one's work. Individuals suffering from burnout tend to demonstrate chronic negativity and stress related to their work and a shift of feelings of mere frustration to those of not actually caring about important things anymore.

The Maslach burnout inventory is a commonly accepted baseline index individuals or groups can use to assess burnout.<sup>6</sup> If not assessed for and addressed, burnout can lead to more severe conditions such as depression and major anxiety disorders. It has been shown that one of the 'Big 5' key personality traits, emotional stability, is a predictor of burnout risk. Mitigating the risk of burnout also involves achieving balance between work-life and non-work-life to ensure that one's physical and mental health are tended to. It is therefore important for those at risk or affected to seek counseling and advice and attempt to re-establish the value they once saw in their work through adjusting workplace demands and activities (reduce hours, limit practice, find supports to offload unrewarding duties, recruitment to right-size workforce, engage with workplace support groups and councils to exert some control and influence over workplace decisions).

An ounce of prevention is worth a pound of cure when it comes to burnout. Preventative measures include having a strong support network, establishing some involvement in decision-making early, working on reinforcing the positive aspects of work (George is frustrated by the cases he thinks he provides little value-add to, but is likely not adequately influenced by those lifesaving interventions he has made during his shifts), and seeking counseling around coping strategies and attitudes towards work.<sup>6</sup>

Finally, establishing boundaries around what one can and cannot influence in the moment are important. A major source of stress for caregivers is the perception that they should be able to solve all problems all of the time. No individual can own all of the problems that originate from

'systems level problems'.<sup>6</sup> Therefore doctors should have a good sense of what is within their locus of control and delegate the rest as appropriate.

George is taking the first steps towards identifying and addressing burnout which are noticing his struggles and thought patterns and asking tough questions of himself.

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## About the Expert

Dr. Glen Bandiera (@glenbandiera) has degrees in Engineering, Medicine and Education. He completed residency in Emergency Medicine and Trauma Resuscitation, followed by ten years as a staff emergency physician and Trauma Team Leader at Toronto's St. Michael's Hospital. Glen is currently Chief of Emergency Medicine at St. Michael's Hospital and Associate Dean, Postgraduate Medical Education at the University of Toronto. His academic interests include: faculty development, systems improvement and competency assessment; he has published widely in these areas. He is a Full Professor of medicine at the University of Toronto and the inaugural patron of the Renaissance Project at McMaster University.

## Recognize the Red Flags of Physician Burnout

by Dr. Nicole Battaglioli MD, FAWM

### A Red Flag for Burnout

Burnout and inadequate wellness are issues that currently plague many professionals in the field of medicine, and unfortunately its negative effects are being seen in earlier stages of education and training. A study by Dyrbye et al. suggested that of the medical students surveyed, 49% of them reported symptoms of burnout prior to starting residency.<sup>1</sup> A recent meta-analysis reported depression in medical students at 27%.<sup>2</sup> What is even more worrisome, is that 13% of them reported recent suicidal ideation.<sup>2</sup> Burnout is classically described as exhaustion, development of cynicism, and a decreased feeling of personal accomplishment and performance; however, burnout can manifest itself in a multitude of ways. The resident in this case, George, is exhibiting some classic signs of burnout including his increased cynicism and frustration towards his patients - behaviors that should be a red flag to those around him. It is true that George may just be exhausted from a string of long shifts- but if his negative attitude towards his more "non-emergent" patients continues despite sleep and the respite of a weekend off, George's attending should be concerned about his level of burnout running deeper.

### Checking In

In the moments following George's outburst there was an opportunity for Dr. Jones to explore the possible triggers that precipitated his outburst. External stressors involving family life, relationship strain, personal health problems and lack of self-care can be underlying issues when individuals are being disruptive or "acting badly." Dr. Jones' advice that everything will get better once he starts making more money is misguided and not well founded. As someone who suffered from burnout towards the end of my residency training- hoping that there was something better waiting for me after graduation was a pervasive thought. The truth is that an increase in income is not the ultimate solution to burnout, and should not be considered the path to improving resilience. To steal from Jason Brooks, PhD, an expert in performance psychology, one way to define resilience is one's ability to adapt to their surroundings. As providers in the field of Emergency Medicine on a daily basis we enter an environment of external conditions that we have little to no control over. We don't have control over the patients who present to the Emergency Department- the drug seekers, the homeless, the intoxicated, and the non-compliant patients. If you cannot change your surroundings, then you need to be prepared to adjust and cope with the external conditions that you face within your practice environment. To build resiliency in my own life I have adopted a few practices that focus more on positivity and what makes my work enjoyable rather than on what I cannot change. Each day I try to think of at least 3 things

that I am thankful for and I send thank you cards to colleagues, friends and family to let them know that I am thinking of them and that I am thankful they are a part of my life and/or practice.

### Take Care of Yourself to Take Care of Others

Sleep is a precious commodity in residency, and getting enough quality sleep in addition to good self-care is imperative to remaining resilient and providing high quality patient care. In this case, George is stressed and overtired which is a perfect storm to foster burnout. Residency training in any specialty is hard and training and working in the field of Emergency Medicine can be exceptionally grueling. We provide care to sick and medically complex patients, difficult patients, and sometimes ungrateful patients. We are often witnesses to immeasurable suffering and loss. We work long, hard hours away from our family. We often neglect our own health and well-being. For all of these reasons and more emergency medicine has been cited as a specialty with one of the highest burnout rates, as high as 60%.<sup>3</sup> Findings of a study by Shanafelt and colleagues suggests that burnout may influence quality of care by eroding professionalism, increasing the risk for medical errors, and potentially causing physicians to retire early.<sup>3</sup> Burnout also seems to have adverse personal consequences for physicians by putting stress on relationships, causing problems with substance abuse and acting as a nidus for mental health issues.<sup>4</sup> Regardless of whether you are a medical student or consulting staff, you have to take care of yourself in order to take good care of your patients.

While working through my own issues with burnout I had to undo some of the poor habits that I had developed throughout medical school and residency, and replace them with better ones.

### Three Habits

Described below are the **top 3** habits that I learned and adopted to take better care of myself:

1. **Aim for one hour a day that is "work free."** Aim for one hour a day that is work free, and make it more than just work free. Do something that let's your mind actually decompress and wind down- avoid spending the hour checking emails or checking Twitter.
2. **Be grateful and set your intentions for the day.** I am responsible for setting my intention for the day and what I am going to get out of my experiences and interactions with others. I am trying to replace negativity in my life with gratitude
3. **Recognize that sometimes you need help and don't be afraid to ask for it.** We shouldn't stigmatize each other for faltering

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or for needing help. We are all human and have to take the bad with the good. A lot of what I learned about taking care of myself and about why I felt so burned out, I learned because I realized that I needed help. I needed someone to talk to about how I was feeling and what I was going to do to improve my life. I also needed to learn how to use the support system around me and to lean on them when I had to. So if you need help or someone to help you advocate for your quality of life— don't be afraid to ask for it!

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## Additional Suggested Reading:

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## About the Expert

Dr. Nicole Battaglioli (@bat\_doc) did her residency training at York Hospital Emergency Medicine Training Program and is now a faculty member at the Mayo Clinic. Her academic interests include Wilderness Medicine, Resident Education, Physician Wellness and Resiliency. She is involved with the ALiEM Chief Resident Incubator and is presently the Chief Operating Officer of the 2016 ALiEM Wellness Think Tank.

## Recognize the Red Flags of Physician Burnout

by Dr. Tom McLaughlin MD

George's experience is, regrettably, not unique. Feelings of fatigue, whether emotional, physical or psychological, can often be carefully concealed or managed by an individual such that they are invisible to colleagues - until they're not. In this case the coalescing of George's stress, unreconciled sleep debt, and feelings of defeat and isolation manifested itself as an outburst that Dr. Jones was unprepared for. Every resident will be challenged during their education with patients and schedules that test their mental and physical stamina. For residents to thrive personally and professionally during residency training it's important to provide them with skills in fatigue management and mental resiliency.

George is exhibiting all of the signs of burnout. Burnout is most commonly defined as the triad of emotional exhaustion (feeling overextended or exhausted by work), depersonalization (having a reduced or impersonal response towards one's patients), and a reduced sense of personal accomplishment. He remarks on how he started his career with the intention of making a difference by helping patients, and he now has little interest in or empathy for the patients in his emergency department. Burnout is extremely common in residency, with 27-75% of residents exhibiting at least one of the three components.<sup>1</sup> There is evidence to suggest that doctors who are early in their medical career are at a higher susceptibility to burnout than their more experienced colleagues - indicating that perhaps the supports and mental health/wellness needs for trainees may differ compared from those of more experienced physicians.<sup>2</sup> This could be an important consideration for senior physicians who are mentoring junior staff - the signs of burnout in residents may not be easily recognized by those with more experience. Faculty and clinical staff training could be enhanced to include education on how burnout and fatigue manifests for trainees.

George is emotionally exhausted and showing signs of burnout, but he's also physically fatigued from working so many night shifts in a row. It's important to recognize that emotional exhaustion and physical fatigue are related but separate entities. For example, imagine what George's first shift in the ED might have been like as a medical student - he may have left physically fatigued the following day, but he likely left inspired after a night of suturing, giving albuterol, and helping patients in myriad other ways. Fatigue is important not only because of its link to burnout, but also its effect on performance. As outlined in the 2013 RDH Report *Fatigue, Risk and Excellence*, a tired doctor is not necessarily an unsafe doctor.<sup>3</sup> Fatigue can impact performance and is

associated with behavioral and cognitive impairments. However, the relationship between fatigue, medical errors, and the resulting impact to patient safety are less clear.

### Noticing The Symptoms of Burnout

The signs of physical fatigue can be difficult to discern given they may overlap with the signs of burnout. Educators need to be able to recognize trainees who are physically fatigued in order to help them. Signs of physical fatigue typically manifest as physical behaviors or as cognitive changes. Physical signs typically seen include head drooping, eye rubbing, and overall lethargy. Cognitive symptoms include poor communication, reduced coordination, and difficulty concentrating. Significant fatigue can occur at any time day or night regardless of preventive measures taken through preceding sleep/wake cycles and other work variables. Research also shows that the subjective experience of fatigue may not necessarily align with objective indicators.<sup>4</sup> Translation - we are not good estimators of our own fatigue!

Individuals will have variable signs and symptoms of fatigue so it's important to remain both self-vigilant and open to collegially assessing our colleagues' level of fatigue. Attending staff physicians who work with residents should familiarize themselves with typical symptoms of fatigue - mental, physical, and emotional. They should role model self-awareness behaviors such as vocalizing their own fatigue with the team. This reduces stigma related to self-reporting, and helps create a supportive workplace culture for residents to declare their own fatigue. It's imperative in any Fatigue Risk Management (FRM) plan to build a culture where employees and leaders acknowledge that fatigue is a real risk, and that it can be discussed without fear of reprisal. Attendings and institutions should promote education and training around fatigue risk, share FRM resources or strategies, and support the development of policies that clearly assign roles and responsibilities for managing, identifying and mitigating both individual fatigue and team level effects in a clinical care area. Not all attending physicians, clinical supervisors, and educators are aware of fatigue resources or risks - this presents a faculty development opportunity.

All trainees (like George), and staff physicians should become aware of common resources available for fatigue risk management. The first line of defense is the ability to understand how fatigue manifests for you as an individual and as a medical professional. Some steps that an individual can take to address fatigue include:

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- Increased frequency of self-assessment of fatigue – Resources such as the Epworth Sleepiness scale (<https://web.stanford.edu/~dement/epworth.html>)
- Getting adequate food and hydration
- Judiciously using caffeine/energy drinks
- Napping
- Taking a work break (what sort of time frame of break?)
- Adjust exposure to working temperature/lighting
- Increase physical activity & social interaction
- Double check tasks/seek a second opinion/increase supervision when you're feeling fatigue

It is important to keep context in mind – some of the suggested controls above may not be optimal for all service delivery sites or clinical practice settings.

It is also important to monitor for the emotional consequences of fatigue and work-related stress, and to build resiliency to prevent burnout from developing. There are ample tools available to promote mental resiliency including mindfulness training, positive self-talk, conscious deep-breathing, setting SMART (Specific, Measurable, Achievable, Realistic, Time-Bound) goals, and mental rehearsal of difficult tasks. Similar to training for a marathon, practice is required to acquire the skills necessary to develop the mental resiliency needed to serve you when you're up against six grueling night shifts like George. Finally, it's important to know your own limits – if you're feeling burned out to the point of having significant symptoms of depression or anxiety, you should seek professional help or counseling.

In the end, our careers in emergency medicine require us to provide care to vulnerable and difficult patients during all hours of the day and night – factors that contribute to the fatigue and burnout seen commonly in providers. However, these same principles are also why medicine can be such a rewarding career. Emergency providers should become familiar with the tools available to combat fatigue and address fatigue risk management in order to develop the mental resiliency necessary to avoid the feelings and experiences that George endured in this case.

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## Additional Resources:

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## About the Expert

Tom McLaughlin (@mclaughlin\_tom) is a fourth year pediatrics resident at the University of Toronto, and chief resident at the Hospital for Sick Children. He was the president of Resident Doctors of Canada (Canada's national residency association) from 2015-2016. He has an interest in fatigue risk management, resident wellness, and child health policy.



# Curated Community Commentary

By Alkarim Velji BSc, BEd, MD, FRCPC (candidate), MHPE(candidate)

This month's case looks at George, a fourth year resident who is having a hard time coping with the physical, emotional, and mental exhaustion of residency. In the middle of a gruelling string of shifts, George expresses his exasperation at the endless line of "drug-seekers, drunks, and non-compliant patients". His attending, unsure of how to respond, offers only platitudes about things improving with a staff's salary. George is unsurprisingly unconvinced. Following this shift, he struggles to safely drive home due to his sheer physical exhaustion. As he ponders his disillusionment, career choices, and financial stressors, George reaches out once more to his spouse. Unfortunately, she also does not hear George's concerns. She offers only a suggestion that things will improve with sleep. Still feeling discontent, George allows his sleep to help escape his thoughts for one more night.

Our readers this week were left to discuss the signs and causes of burnout and how it can affect patient care and physician health. They also provided suggestions about how attendings can both recognize and support residents coping with burnout.

## Burnout Affects Us All

Readers bravely discussed their previous experiences with burnout. Dr. Nadim Lalani shared how he recognized his own sensation of burnout as a loss of self, saying that he felt like a failure with no end in sight. Burnout begets more burnout as residents isolate themselves from their supports and fray their relationships with their loved ones.

Our readers debated the spectrum of burnout to depression. Our learners are innately high performing. Thus they are able to "cope" with burnout and function with fairly significant illness before it grossly impacts their day-to-day lives. It behoves are system and our senior staff to support our learners before the burnout progresses to depression. Dr. Minh Le Cong suggested re-framing the term "burnout" as "existential despair" and thus more correctly providing depth and meaning to the issue. Dr. Robert Primavesi discussed how at his institution many medical students struggle with mental health issues including clinical depression. These challenges are likely continue into residency and practice.

A recent JAMA Article published on Dec 06, 2016 titled "Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students" cites depression or depressive symptoms in as many as 27% of medical students and suicidal ideation in approximately 11% of students. Of those screened for depression, only 15% sought psychiatric treatment.

## Contributors

*Thanks to the participants (in alphabetical order) for all of their input:*

Jason Brooks  
Mary Jane Brown  
Teresa Chan  
Megan Stobart-Gallagher  
Nadim Lalani  
Minh Le Cong  
Brian Levy  
Robert Primavesi  
Loice Swisher

This burnout most likely also affects patient care. A burnt-out resident struggles with developing connections to their patients and performing at their peak. When burnout permeates through to staff life, we have an increased turnover in attendings which is a problem particularly in Emergency Medicine.

## Systemic Challenges

Many attendings who commented on the case stated that they felt woefully underprepared to support their junior colleagues. Residency and attending life prepares you for many challenges, however, there is no formal training in how to identify and support colleagues who are struggling with burnout. Dr. Swisher and Dr. Brown point out that while they have the formal training and scripts to identify a multitude of medical diseases, they have never been trained with the scripts, patterns, and strategies to deal with burnout in their colleagues.

Dr. Minh Le Cong astutely argues that the issues are often systemic and cultural. Our system has only just recently started to normalize the idea of a physician as a human being who has their own struggles and challenges. These systemic changes can be exacerbated by nostalgia blurring our senior staffs' memory of how life was as a resident.

Our system demands so much of a resident in an endless cycle of tasks, work, extra-curricular obligations and personal challenges. Our residents are under significant stress to continually perform at their peak. They are clearly aware that they are continuously being evaluated. Unfortunately, as Dr. Levy points out, diligent residents who are struggling are often chastised for underperforming instead of being supported and taught knowledge and skills that they might be lacking.

# Curated Community Commentary

To quote Dr. Cong, “If we aren't helping others cope with the workplace or allowing a malignant workplace to exist, are we not in some way allowing bullying at work?” So, now what?

“We need to look out for each other” demands Dr. Lalani. As discussed by Dr. Swisher and many of our readers, care for a resident is a multifaceted approach. There needs to be a focus on coaching as well as addressing systemic and cultural issues.

Our readers compared residents to Olympic athletes or marathon runners. For residents to perform at peak capacity, they need a team of support, they need coaching, and they need strategies to ensure they remain healthy. For many residents, burnout behaviors are often secondary to their needs not being met and a lack of wellness. When training for a marathon or high intensity sport, more than just practice is needed. Coaching, balance, sleep hygiene, and fitness are all part of the picture.

Dr. Lalani and Jason Brooks both discuss some of the coaching strategies that they use at their respective institutions. They both advocate that it is time to introduce the idea of coaching into residency programs. It encourages wellness, reflection and self-awareness, and resilience. The individual can be taught how to manage their internal responses to external stimuli. These strategies encourage residents to progress on their journey to becoming healthy individuals and to self-actualization.

Several of our readers advocate for systemic changes that ensure residents are supported instead of being held down. Suggestions and strategies that are currently in practice include:

- A wellness curriculum that is spiralled throughout undergraduate medical curriculum so that learners develop healthy strategies early in practice
- A support office such as the WELL Office from McGill or the LAW (Learner Advocacy and Wellness) office from the University of Alberta
- Reflection on resident curriculum and attempts to streamline academic obligations to better support their work-life balance
- Fostering of coaching systems like Dr. Lalani's in Calgary or Jason Brooks and the High Performance Physician Program at the University of Manitoba that help residents develop practices and perspectives to sustain optimal health and performance.

As an editorial aside, I would like to say thank you to all our readers this week. I would like to end the curated commentary with the same speech that I give to all caregivers who I encounter: You are supporting [those around you] much like a foundation supports a house. If the foundation starts to crack, then everything falls apart. Therefore, you must also care for yourself. Otherwise, nothing can stand.

## About

The Medical Education In Cases (MEdIC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

## Did you use this MEdIC resource?

We would love to hear how you did. Please email MEdIC@aliem.com or tweet us @Brent\_Thoma and @TChanMD to let us know.

## Purpose

The purpose of the MEdIC series is to create resources that allow you to engage in “guerrilla” faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

## Usage

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