Reflections About ''Burn-out''

To the Editor

One may question why *Academic Emergency Medicine* would feature resident portfolios that seem to disproportionately dwell on negatives. However, resident portfolios, by their nature, often represent themes of ambivalence, uncertainty, and challenges to the young professional. Ignoring these will not make the issues less real. In these two submissions[1,2] lie ripe fodder for reflection by program directors, faculty, and thought leaders in our specialty. These include issues of properly advising medical students for optimal career matching, training preparation for a healthy 30+-year career in emergency medicine (EM), and defining how our specialty will evolve.

Both submissions express frustration, an element of helplessness, and arguably, the seeds of burn-out. But what are our (the academic community's) contributions to this process, and can we address this through the selection and preparation process? During our monthly core lecture series for fourth-year medical students (before clinical contact begins), the students are asked ''Why do patients seek care in the emergency department (ED)''? Invariably, ''drug seeker'' surfaces, usually well before the ''because they have a REAL emergency'' (implying there are many ''not-so-real emergencies''). Somehow, the students come to our specialty already primed with biases. Can we trace the seeds of frustration to medical school? If so, do we reinforce those biases during their EM experiences?

In seeking commentary, I turned not to the academic thought leaders in our specialty, but instead to the ''end-products'' practicing in the environments encountered by 85% or more of our resident graduates, the community ED. These four authors graduated respectively in 2008, 2003, 1993, and 1983, providing a perspective across decades. Each was asked to reflect about how they avoid ''burn-out'' and what advice they would give to the resident authors and to their faculty.

In terms of career selection, perhaps our advising role needs to focus equally on the positives and negatives of our specialty (true ''informed consent''). Students may fail to realize that the Level 1 training center housing most residencies is not the ''norm'' (unlike the references to the television show ''ER'' that so often appear in residency application personal statements). Applicant personal statements abound with words such as ''excitement,'' ''adrenaline,'' ''trauma,'' and ''life-saving.'' This perception may be more likely in those who worked in the emergency medical services (EMS) sector, particularly as a paramedic in urban areas. As advisors, shouldn't we assure that the students have a true understanding of the specialty we are encouraging them to pursue?

Perhaps we faculty should place additional attention on teaching and modeling a critical truism in EM. While we cannot select the patients that we care for, we can control how we choose to react to those for whom we provide care. This is a powerful tool to protect against helplessness and permits the provider to exert an element of control over his or her workplace. It is important to acknowledge that certain patients will frustrate, frighten, offend, sadden, or anger us. We are distinguished as professionals by our ability to control how we modulate these normal human emotions. For when we deny our own humanism, we can no longer effectively serve our patients.

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2008 EM GRADUATE

So what is the reward for years of training to become an emergency physician? That depends. In one sense, the reward for long, stress-filled, at times thankless hours is more, long, stress-filled, thankless hours. From another perspective, the reward is the privilege to be a practitioner of medicine in its purest form. The difference between these two points of view is often a very fine and frayed line. Those who have done this job vacillate between believing they have the greatest job on earth and wanting to walk out the ambulance bay doors without looking back—often during the same shift. While there are extrinsic factors influencing these emotions, to have any ''staying power'' in this career an anchor of purpose is necessary. If this anchor is your egocentric comfort, then a miserable shift awaits every time. If it is acknowledgement of the opportunity to make a positive difference in your patients' lives, then there is hope.

Residency training is tough. Having only recently completed this, the sounds of a call night in the intensive care unit and the sensations of navigating an endless sea of ''learning opportunities'' are still fresh in my mind. Residency was full of long, hard hours and in many ways, the hours are just as long and hard in the ''real world.'' I am grateful for the challenges of residency for providing the toughness necessary to perform my current job. The author of *The House of God* portfolio[1] talks about focusing on the quality of hours spent during residency training as a protection against burn-out. I agree completely. Having quality hours will prevent burn-out in my career. The question

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then becomes, what are quality hours? If quality is dependent on extrinsic factors such as patient characteristics, perceived abuses of the ''system'' (or more appropriately, the ''nonsystem''), and level of acuity, then don't expect fulfillment in EM. If quality comes from a sense of care and appreciation for your patients, despite their many flaws, then you will have no shortage of quality hours in this specialty.

The authors focus much interest in the question of what defines an emergency. Despite attempts by administrative and legislative bodies to quantify this entity, controversy still surrounds the issue. This perspective must not be used as a measuring stick to pass judgment on our patients. While it is important for us to ascertain our patients' concerns and expectations, we cannot believe our time too valuable (and the patient too unworthy of our time) based upon our acuity biases. When we allow these feelings to have primary influence on our attitudes toward the practice of EM, we do everyone a great disservice.

Nearly every person who presents to the ED is there because of something that he or she perceives as an emergency; while we often disagree based upon physiologic rationale, the perceived need remains. People come to the ED scared, tired, frustrated, hurting, and wanting. It is our privilege to investigate and address to the best of our abilities the causes of these feelings. We are not always successful. We can't and shouldn't always provide our patients with what they want, but should try to provide what they need if it lies within our professional sphere of influence. While reassuring concerned parents that no testing is indicated, refilling a prescription for metformin, or refusing to support a narcotic addiction might not result in a cheering crowd or make for great TV, these make a difference. If you believe that your patients are ''beyond your ability to help them,'' then you participate in a self-fulfilling prophecy.

On a larger scale, we as EPs are providing acute treatments for an ailing health care system. It is our opportunity to offer some temporizing measures and alleviate some of the immediate symptoms. Certainly many patients could be treated more efficiently in a primary care office or urgent care clinic (if access was a viable option) or just by paying a visit to the local pharmacy. Part of the responsibility of practicing in this field is finding ways to improve the system. We have the unique opportunity to see American health care for what it really is not. The greatest danger of EM lies in blaming our patients for these struggles.

These factors are all combining to create a firestorm in EM. The heat of this storm can serve as a motivating dynamic or the root of burn-out. Our patients need us now more than ever. The opportunity to be on the front lines and provide care at all hours, for all levels of acuity—this is the privilege of EM. All of us may have *House of God*[3]–type thoughts, but when these concerns become the focus of our practice, we lose the hope of our specialty.

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2008 EM graduate, practices at St. Alphonsus Regional Medical Center (50,000 visits/year) in Boise, Idaho, and Elmore Medical Center in Mountain Home, Idaho (8,000 visits/year)

2003 EM GRADUATE

The most striking element I find in both resident commentaries is the insight into the daily frustrations of being an EP. The feelings expressed by them accurately reflect many of the difficulties I deal with daily as an EP in a smaller community hospital. Some of this is inevitable … work is, after all, work, and in some respects the grass is always greener. However, taking a different perspective leads to a more rewarding experience for both patient and physician.

One of the most rewarding skills for the EP is to differentiate between sick and not sick, to determine which patients have a serious injury/illness and which do not. To have the compassion to understand that the majority of people do not have the same training, knowledge, and insight as to what constitutes an ''emergency.'' This is a large source of the perceived waste or misuse of resources; but for a young mother whose first infant has a fever at 2 AM, the word ''emergency'' has an entirely different meaning. Just as we are tasked with making decisions about sick versus not sick, and picking the ''zebras'' out of the camouflaged crowd of varied ED presentations, similar skills can find fulfillment in our ED patient interactions. Taking a few moments to discuss childhood fever with a young mother, seeing the relief in her eyes, and having her say ''no one ever explained that to me before'' is rewarding in its own way. Different than a critical trauma patient requiring multiple procedures perhaps, but in community practice, the opportunity for ''simple pleasures'' occurs far more frequently than chest tubes, lines, and intubations. EPs are uniquely positioned to have a positive effect on nearly every patient, regardless of the reason for the visit. The reward that the patient and physician take away from the interaction is simply dependent on the attitude brought to the bedside.

The overall (perceived or otherwise) acuity for the community ED is lower than what residents find in training. Residency programs are located in tertiary-care hospitals and trauma centers. The presence of ''fast tracks'' further removes the experience of lower acuity patients from residents and from those considering EM in medical school. The second author addresses the need to change this perception and redefine ''emergency.''[2] It is unlikely that public expectations about ED accessibility will change in the near future. It is surprising how often a patient initially is perceived to be using the ED ''inappropriately,'' but when the right questions are asked, there is a more rational reason (especially from a lay perspective) for the visit. This is an important skill for the EP, especially as nurses, techs, and ancillary staff are often frustrated with patients perceived to be ''abusing the ED.''

The resident portfolios emphasize the need for training in the ''art'' of medicine during medical school and residency. This art is best learned through experience and example and illustrates the importance of having teaching faculty with a broad base of work experience instructing in the ED. In doing so, hopefully each resident will develop the compassion and understanding to meet each patient with a clean slate. It is great that the

authors have the insight to explore and discuss these issues, and their awareness of these issues should help them develop as physicians.

Thomas Short, MD, 2003 EM graduate, practices at Community Hospital in Anderson, Indiana (31,000 visits/year)

1993 EM GRADUATE

Let me congratulate the editors on publishing these resident reflections. While portraying some of the ''messy'' aspects of our specialty, they both represent honest emotions based on real experiences. Neither is fictional; neither is theoretical. Both resident authors wrote courageously about concerns that every EP eventually faces. They just had the wisdom to speak up sooner.

Rather than being a mark of moral inadequacy or a poor ''fit'' with the specialty of EM, I believe the candor of these physicians is commendable. I hope that residency directors do not construe their comments to represent a failure of either ethics or education. Nothing could be farther from the truth. In addition, suppression of the ideas in the letters would be tantamount to altering evidence in a scientific study simply because the result did not fit one's hypothesis.

I believe that what the authors wrote was very insightful. What do we do with our frustration? What do we do with the emotions brought on by EDs and waiting rooms that are always full and often include individuals whose conditions are anything but emergent? What do we do with when fatigue and hopelessness meet our intrinsic, regulated, legislated lack of control over our working conditions? I suspect that is what you are really saying, or rather asking.

These are difficult questions. Most of us went into EM with visions of gunshot wounds, whirling helicopter blades, flashing lights, and dramatic battles to save life and limb. Those scenarios are still a part of what we do. The reality is that they constitute a minority of patient encounters. As much as we would love to surf adrenaline every day, we do not get the opportunity. One day you will see that it is, oddly, a kind of blessing. Adrenaline only carries us so far. Beneath adrenaline, beneath excitement, we have to endure the monotony of normal, work-a-day, ''pay the bills'' practice, involving less exciting illnesses and injuries in a ''clinicesque'' environment.

What we sometimes fail to see is the great gift we give to society by our very presence and readiness. We bear the weight of the system on our shoulders. In a time of massive changes in medicine and economics, we are the only hope for many patients. We are often the one chance they have to interact with the health care system. We are their advocates and their saviors, and sometimes we are their family practitioners. We console them and reassure them; we tell their families bad news and (sometimes) good news.

How can we best assist our residents? By being their advocates. We can also let them vent and give credence to their problems. Further, faculty must set an example, including an active role in clinical care. Leadership is best accomplished from the front; ask a Marine. But most importantly, someone has to help our residents to find love and compassion inside themselves. Compassion is unscientific and nonquantifiable. It laughs in the face of practicality and efficiency. Somehow, our future practitioners will have to learn how to recognize the humanity, worth, and need of all patients, even the most maddening. Every rule, up to and including EMTALA, is simply a prop against inadequate love and compassion. When love and compassion are absent, rules stand in, but they are a poor substitute. If anything has changed my practice, and helped me to endure difficulty and surmount burn-out, it has been learning to love even those I dislike—and learning to remember that every patient is, or was, someone's child.

It is vital to encourage residents to reach into their personal world views to find reasons for compassion. That world view may involve faith, with patient care a response to the divine. It may invoke a liberal-progressive values set that calls for helping others as a way to improve society. No matter what is the motivation, they will need something powerful, because other rewards, such as financial, are poor shelter from burn-out and frustration.

Of course, along with true compassion and love comes honesty. One author said ''while getting angry at patients is never right, it happens.'' I would counter with, ''sometimes it is alright.'' Anger is a normal emotion, an honest one, and not intrinsically wrong. Our uses of it may be wrong; our responses may be wrong. But anger itself can be a virtue. It may provide the motivation for positive change. Compassion, truth, and honesty mean telling our ''customers'' that they are not always right, and they cannot always get what they think that they need. We have to say ''no'' as well as ''yes,'' even to other professionals, consultants, and politicians, when they ask us to provide what is not in their medical best interests. A great deal of frustration comes from helplessness, from always being told what to do and never being able to say ''no.'' But ''no'' is as essential as occasional anger. Instructors must give residents freedom to be angry and freedom to say ''no.''

Thank you for having the courage to enter this specialty. I do not regret being an EP. I say this 15 years into a busy practice. I have been driven to near insanity by some patients and also nearly driven to tears of sadness and joy by others. I am honored by my calling, as you should be by yours. Not every medical student is made for our job. If you can do it, you are truly elite.

Your frustrations are reasonable and real; do not make the mistake of denying them or letting anyone else suppress them. Remember at the heart of it all that you are caring for human beings, who are the most frustrating and valuable creatures on the planet. It will never be easy. But it will get easier.

Edwin Leap, MD,
1993 EM graduate, practices at Oconee Medical Center in Seneca, South Carolina (40,000 visits/year)

1983 EM GRADUATE

As a freshman in college I had the misfortune of having an uncomfortably low draft lottery number. Since it was beginning to look like my second semester would be postponed for Vietnam anyway, I decided to enlist to become a Marine fighter pilot. I reasoned that if I was going to war, I wanted to be at the ''tip of the spear.'' Fortunately my need for eyeglasses made me unsuitable as an aviator and Vietnam wound down before my draft number was called.

A few years later while choosing a residency, I had an analogous experience. If I was going into the business of fighting disease, then I wanted to be at the tip of the spear and for me that meant prowling the ED. Indeed, I spent the first decade of my career studying disease and how to intervene to ''defeat'' it. My inexperience made me quite unsure of myself, but paradoxically, I felt compelled to present an air of certainty during my first patient encounters. I became adept at pretending I knew what I was doing, but never quite fooled myself.

During this phase of my training, I read *The House of God* shortly after its publication. Although I considered it a work of hyperbole, I laughed because it presented a parody of the intern's life I was living. We were all young warriors battling disease, and humor was a foxhole. I could also certainly empathize with the concept of being ''hurt'' by patients. They were the vectors of the disease that I was charged with conquering. Their arrival meant more work and more opportunities to make mistakes.

Throughout these years, fear drove me to read a little more, stay a little later, and pay closer attention, mostly because I was afraid of making a mistake. Fear continued to drive me during my first years of practice when I was calling the shots without supervision. Fear was an effective motivator, and I slowly became familiar with disease and the ways we doctors are expected to intervene. Unfortunately, three things happened that began to seriously erode my satisfaction with EM.

First, the diseases I was battling became boring. After all, disease is faceless. It does not possess emotion or intellect, neither smiles nor questions. Second, the glamour factor of working on the front lines faded with the realization that most of my patients did not have emergent medical conditions or life-threatening injuries. And finally, the by-products of being fueled by fear began surfacing in the form of sleeping too little, drinking too much, and generally being angry at the whole world most of the time.

Fortunately, I was lucky enough to change in a few fundamental ways that allowed me to recover from my burn-out and reignite my desire to practice EM. The first change was to quit fighting disease and start caring for people. Whereas diseases are the same, people are different. Diseases are soulless, while people have personalities that are ever changing and often interesting. Each patient responds best to a particular approach if we are to provide optimal treatment. Formulating this individually tailored approach demands that I continue to evolve and stay interested. This change in perspective transformed the patient encounter from a clash with an enemy into a meeting with an ally with a common goal.

My second fundamental change was to faithfully limit my practice to EM. I came to understand that my primary role was to separate emergent from nonemergent and to initiate treatment in the former and guide the latter out of my ED to more appropriate settings. Just because a patient (or society as a whole) places the burden of providing comprehensive health care at my feet does not mean I must pick it up. The fact is, I am a specialist, and am ill equipped to provide care for most nonemergent conditions. I began to set boundaries for my patients and to explain that the function of the ED was, in fact, limited. To my surprise many folks really did not understand the emergency medical system and were grateful to have it explained. To those who insisted I play family doctor, dermatologist, or any other role for which I felt unsuited, I simply did not.

Probably the most crucial paradigm shift involved acknowledging my limitations and embracing my humanness. If I did not know what was going on with a patient I began to freely admit it, and shedding the burden of pretending to be omniscient was emancipating. However, the confidence to admit my ignorance only came after the experience of seeing a hundred thousand or so patients. Ironically, I needed to become a very competent doctor to overcome the fear and admit how limited are my abilities. I am not sure there is any shortcut to professional humility except to earn it, but it is truly a source of strength that has made practicing medicine much more comfortable.

As I listen to my ''burned-out'' colleagues, I am saddened that they view patients as adversaries. If the complaints seem minor on the surface, they expend more energy fuming about the ''inappropriate'' use of resources than it takes to screen them and send them on their way. My toasted comrades also remain more concerned with diseases than with patients. They interact with ''the heart failure in room twelve'' or ''the PID in sixteen.'' These doctors use the same ''stock'' explanations and discussions, whether they are talking to a college professor or a migrant worker. Many seem irritated when asked to justify their strategy for addressing a clinical problem, often citing ''that's the way I always do it.'' I have watched many such co-workers change professional paths or, worse yet, keep coming to work resigned to being miserable.

I am grateful that with experience came changes in my perspective that allowed me to tolerate and even enjoy my work 25 years after residency. I can truly say that I am proud to do what I do for a living and that I am more at peace now when facing a daunting stretch of long shifts than I was a decade ago.

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