More Than Burn Out (MTBO) – New Strategies for Clinician Well-Being & Retention in a Post Pandemic Healthcare World

Transcript

[Upbeat theme music plays]

Dr. Szot

Welcome to Rounding@IOWA, the continuing medical education podcast developed by and for healthcare teams. I'm your guest host, Dr. Joseph Szot, Professor of Internal Medicine and Associate Dean for Continuing Medical Education and Integrative Education here at the Carver College of Medicine. Today, we will discuss the state of our health workforce and strategies to address significant health workforce shortages we are all experiencing. Our objectives today: We want our participants to be able to first acknowledge how much the pandemic and societal shifts post-pandemic has changed the healthcare work environment. Second, recognize the health workforce retention and well-being will be major factors in the future success of any healthcare system. And third, be able to advocate for the development of a system approach for healthcare employee retention and well-being through an organized plan that encompasses a broad set of initiatives. Our guest expert today is our usual host of Rounding@IOWA podcast, Dr. Gerry Clancy. Dr. Clancy is a professor of psychiatry and emergency medicine in the Carver College of Medicine. He staffs psychiatry services in our emergency department, and he is also a psychiatrist for clinical services across the University of Iowa hospitals and clinics, including our intensive care units. He serves as the college's Senior Associate Dean for External Affairs. Dr. Clancy has been a U.S. Air Force flight surgeon, a college dean for eight years, and a university president for 12 years. Pertinent to our discussion today, he is tasked with helping coordinate plans and programs for employee retention and well-being for the 17,000 employees of the University of Iowa Healthcare. Gerry, welcome again to Rounding@IOWA.

Dr. Clancy

Well, thank you, Joe. It's a pleasure to be on this side of the microphone again. All the pressure's on you.

Dr. Szot

[laughter] Thanks. So Gerry, in the past we have talked about clinician burnout, particularly as we came through the COVID-19 pandemic. I noticed that you have responsibilities around employee well-being and retention. How is well-being and retention linked and why is this such an important topic?

Dr. Clancy

Well, Joe, it's a great question to start with. And you know, as we came out of the pandemic, there was a lot of hope that a lot of our world would go back to normal. And unfortunately, it really didn't. We lost a huge number of highly talented clinicians and support staff in healthcare during the pandemic. And things have not rebounded particularly yet from that. And so we have significant staffing shortages. And these staffing shortages have risen to the top as the number one stressor for our physicians across the US. And that has led to really a reevaluation of what is the work environment like and the realization also that staffing and well-being and retention all go together. And I like to point out that when I started talking about well-being in our institution, at first, there'd be some in the room that were very interested in it, but some that were not nearly as interested. But when I paired well-being and retention together, suddenly all the numbers people got very interested in what we're doing, because how a health system operates is so dependent on the people, so dependent on the people, and you can be the most numbers-oriented, really not particularly interested in wellness individual in an organization, or you can be very old school about these topics and say that the docs just need to pull themselves up by their bootstraps. But I will tell you, other organizations are taking this very seriously. And if you do not address this, you are vulnerable to losing your staff and your clinicians to other organizations that are doing this at a much higher level. So it's really important to put these all together, address them, because if you don't, you're going to be behind as far as being able to retain your folks.

Dr. Szot

Overall, how are we doing in Iowa regarding retention of clinicians?

Dr. Clancy

Another great question, and it's very much a moving target. In Iowa, we have roughly 3,500 active physicians. These are physicians that are practicing most days. And on an average year over the past 10 years, we have about 400 physicians a year stop practicing in Iowa. So a little more than 10%. When you look over the past 10 years, what are the reasons for physicians not practicing? You would think it was retirement. But that's not the top reason. The top reason is actually relocation out of Iowa. Physicians are going somewhere else to

practice at 44% of that 400 are leaving Iowa by continuing to practice. 35%, so second, it is to retirement. And over the past two years, it looks like that retirement number is starting to catch the relocation number, and that retirement number is encompassing younger physicians as well. So we certainly are following what's happening across the country, that the younger physicians are contemplating retiring and are a significant part of our staffing shortage. Individuals that we thought would work till 70 are thinking about working till 55 instead, and so, losing a significant amount of time from them practicing with us. So these are major issues and they've really got to be addressed again at that link between retention and well-being and burnout.

Dr. Szot

Can you put a cost or dollar amount to these retention issues?

Dr. Clancy

You know, I haven't found a great number yet. But I think if somebody did the master study and the meta-analysis, the number would probably be in the billions across this country as far as what we've lost as far as workforce potential within healthcare over these past three years. And you think about how much does it cost to recruit somebody? How much does it cost as far as moving expenses? How many individuals do you recruit and you don't hire and they still cost you? Then you also have to think about how much you lose in clinical volume when someone leaves and you've got open positions. Within nursing, you've got to think about how much does it cost to backfill with a traveling nurse that costs more. And then we're dealing with inflation in healthcare that is improving a little bit, but still is almost double what was seen in the general population as inflation. So these costs to the health system of not being able to keep their people is significant at multiple levels. So it's got to be close to the billions as far as total cost across the country.

Dr. Szot

We have talked about physician burnout for years, yet the pandemic and environment post-pandemic had such an impact. Does our previous concept of burnout still hold up?

Dr. Clancy

So I think we're dealing with two syndromes that have some overlap. The pre-pandemic numbers around the number of physicians with burnout were steadily rising over the past decades. And before the pandemic in 2019, the reported number by the experts at Stanford and Mayo, it was around 39% of physicians were experiencing burnout. And that definition came from an ICD-11 definition that included energy depletion and exhaustion from and at work, increased distancing from their work, kind of a mental distancing, an increase in

negative and cynical attitudes, and really reduced efficacy. They just weren't able to work very well. That was the old burnout. And some of the drivers included all the administrative duties and pre-authorizations we had to go through and working through the EMR. And I think those issues are still there, but we've got new stressors that add to this syndrome and actually in a way, maybe something different, and we need to call it something different than burnout. And one phrase that I'm using around sometimes is MTBO, which stands for more than burnout, what we're experiencing right now. And it really then points to what do you do about it? And in the past, there was a lot of effort around resilience training of physicians, in a way, kind of putting it on the physician that it is up to you to figure out how to be stronger as you practice. And we're getting away from that resilience factor as well, because the stressors are different.

Dr. Szot

So what is different now regarding physician burnout? You just mentioned some new stressors. What are some of those new stressors people are facing?

Dr. Clancy

I think as the pandemic peaked and we saw so much suffering and unfortunately so much death, there was a sense of post-traumatic stress and maybe even real post-traumatic stress among some of our clinicians. Then we had to deal with a society that just ran rampant with misinformation, and we would have to be, in a way, coaxing our patients back into reality as far as information around what needed to happen as far as staying healthy during the pandemic. We've seen an increase in violence in the workplace and an increase in harassment and an increase in even trolling online. So these stressors are unlike stressors we've really seen before. And so I think they add to, and the old definition of burnout really just doesn't hold up to these additional stressors. And then a new one on the horizon that I worry about very much that is not near as pandemic related, but it is the corporate influence on healthcare, where huge national multi-industry, multi-sector industry companies are buying up healthcare and applying their principles and values to delivering medicine and healthcare. And we're also seeing private equity groups get into this. So Amazon, Walmart, CVS, even UnitedHealthcare as an insurer is now getting into healthcare delivery. And then you've got private equity as well, buying up into healthcare. And there was a wonderful New York Times report on this last weekend, and it'll be in our show notes, that talked about the moral distress from this, that physicians are feeling, that they feel like they are cogs in a wheel that actually is moving much toward this business model of medicine, rather than delivery of care and compassion and empathy, and really the reason they went to medical school and what they were trained to do. That disconnect, I think, is very much adding to it.

Dr. Szot

What is the impact of these stressors on the mental health of healthcare workers?

Dr. Clancy

It's significant. When you look at virtually every study, you see a big, big bump up in these factors. The folks at Stanford and Mayo report a rate of burnout among clinicians at 63% in 2022. It looks like it's come down a little bit. The AMA is tracking this very carefully. When you look at nurses, a recent large survey of over 10,000 nurses reported that 30% of them endorsed that they were not mentally healthy. And 66% of nurses report that over the past year they'd been threatened or assaulted or bullied by patients and family as well. So there's a lot of pressure and a lot of impact of the past three years continuing on as far as our workforce. And what's different than the previous version of burnout is that it looks like the younger clinicians, both nurses and doctors, have been impacted at a greater degree than others. And there's a large number of both nurses and doctors that are only 10 to 15 years post-graduating from training that are contemplating leaving the field altogether. So these, again, are really worrisome things.

Dr. Szot

Let's discuss a little bit about the risks at hand that we're currently facing. Can you talk a little bit more about moral injury and distress and their link to PTSD? And I think we really need to talk about suicide risk and rate that healthcare workers are facing.

Dr. Clancy

Yeah, I couldn't agree more, Joe, that this is really important. And I think we're on the edge of something that could get a lot worse if we don't address it. And let’s start with the term you used, moral injury. And I was in the military for six years active duty and 20 years as a reservist. And that's where the term moral injury and distress really started, where psychiatrists in the military noted that certain military members were experiencing a new level of distress by being involved and participating in activities that did not match with their most core values as far as who they are. And that definition really came to greater light after they noted that the 9-11 combat veterans really had a lot of moral injury and moral distress in their surveys. And that moral injury is very strongly linked to post-traumatic stress and is a setup for alcohol use disorders, substance use disorders, and as you alluded, actually suicide as well. And as we've talked before, the only early cause of death where physicians are higher than the general population is suicide. So if we already had that before the pandemic and now we add this new stressor of moral injury and maybe that that's setting us up for post-traumatic stress, this is something that has to be watched very, very carefully. And I think some comparison is really important. The 9-11 combat veterans,

when surveyed, 46% of them endorsed moral injury. COVID healthcare workers that were involved in critical care during the pandemic, 51% endorsed moral injury on their surveys as well. So it does line up pretty significantly what the combat veterans went through and what some of our healthcare workers have gone through as far as really tough, tough stuff and witnessing a huge amount of suffering.

Dr. Szot

You previously mentioned MTBO, or more than burnout. Can you define that a little bit more for us?

Dr. Clancy

Yeah, this is a work in progress. We'll see if people really agree with it or not. And we'll have to see if the name has already been registered as well and copyrighted and such.

[laughter]

But what I'm getting at is that it encompasses that old version of burnout, but layered on top of it are these new concerns and experiences around just being safe in the workplace as far as physically, am I going to get struck today? Or am I going to get harassed for my religion or for my ethnicity? the moral distress that we just talked about, the PTSD symptoms, having to battle against misinformation, and at times that sense of helplessness and loss of autonomy over the work I do every day. And then right on that horizon is this push for RVUs and the corporatization of healthcare that may really take off over this next decade as well. So I think that is why I'm calling it different than the old burnout, because the stressors are different. And I think the symptoms from it are different, and then obviously the solutions to it have to be different. And as one of my great teachers, Bill Coryell, said, without a diagnosis, you don't know where to go as far as treatment. And really, we're describing something different among our clinicians that we've never seen before. So let's kind of describe it as a diagnosis that then can point us toward the right treatment of these problems.

Dr. Szot

Do you have any cases or examples that you've seen among clinicians that help describe this MTBO phenomenon?

Dr. Clancy

Yes, it's really been a very important three years for me kind of weighing in and being involved in the pandemic and post-pandemic period. Because I run around the hospital taking care of psychiatric issues throughout the hospital, not just on the inpatient units, I've

seen a lot of healthcare workers in a lot of settings around this. And what we've seen so far is just as I started to address burnout when the Delta variant hit, I just kind of gave my first workshop on how to get through this phase of the pandemic, a request came out of the woodwork of, will you help this work unit? And will you help this program? And will you help this hospital across Iowa? So I've had requests for workshops on physician burnout, this new version of burnout. Just constant. I've given 64 workshops on burnout here and outside of our healthcare institution, and 22 workshops on violence prevention in the healthcare workplace. So just lots and lots of requests. So I think the need for it is very high. Interestingly, in a day and age of when people can survey and write whatever they want on the survey, really no negative comments so far. And I can't imagine that my workshops are that good. I just think what it is just people are hungry for information and direction on this. Kind of adding to that, lots and lots of individuals asking for one-on-one help, lots of curbside discussions with people across this hospital. And one of the most telling experiences was when I was doing a consult up in the medical intensive care unit, and four residents from internal medicine kind of came up to me and casually just said, you know, how's it going? And then the conversation turned pretty serious, and one of them asked, Dr. Clancy, do you think we will all have PTSD from this? because they were all talking about that, they were having nightmares about their patients from all that went on. So there's a desire, there's a need out there to describe this and give it a definition and then start putting together some options as far as making things better.

Dr. Szot

So you know I don't like to hear just about problems. What I'd like to hear is tell me some of the solutions and at least where can we get started addressing.

Dr. Clancy

So I came prepared for that, Joe. I knew you'd ask that question. Never have I walked into a meeting with Joe Szot and not had solutions alongside some of the problems. We call that the Szot rule. So in trying to describe this to non-psychiatrists within our institution, but also across Iowa to other health systems, I started with the framework of Abraham Maslow, where if you remember from high school psychology, he put together a pyramid of human needs. And at the foundation of that pyramid, at the lowest levels of that pyramid, were the most basic human needs. And then social and connection needs were kind of in the middle and personal development. And then at the top of the pyramid was really an ability to work on the behalf of others and work for the next generation, which he described as self-actualization. And the first layer is really physically safe and psychologically safe. The second layer, or the first layer is actually just the most basic physiologic needs, air, food, and water, and oxygen, and those things, and heat and cold. Then is those physical and

psychologic safety. Then is your health and mental health. Then is your social needs. And then you move into really professional development and then being able to work as an organization for the benefit of society. And the pandemic blew that all up. The pandemic blew up our physical safety. At times, we were physiologically worried about just how would we get food. It clearly disrupted our social networks. And so the framework that I've been using to put together a program is off of Maslow's higher needs of let's take care of the basics first. Let's create a safe place to work. Let's create a place that is without harassment. Let's create a place where access to mental health services is available and the culture is pro getting help. Let's create an environment where on the positive side of promoting mental health and promoting physical health, it's easy. And then on professional development as well. So that's really been our framework to do this work. And we've laid out a pyramid. And in that pyramid, we are working at each one of those levels as far as specific programs on that in an almost mosaic way. And every time I've talked about well-being and burnout, what I notice is that for each individual in that workshop, what's number one for them may be different than what's number one for somebody else as far as these issues. So you have to have a comprehensive plan as well.

Dr. Szot

Are there public policy issues that can improve our conditions at work?

Dr. Clancy

I think, you know, at the onset, is what's called the Save Act. That's a federal bill that is working its way through that creates a federal crime if you assault healthcare workers, similar to the federal crime that is already on the books as far as assaulting airline workers. And when that happened, the federal crime as far as assaulting airline workers was put into action, the amount of assaults on airlines dropped dramatically, dramatically. So there's strong support from the American Hospital Association, American Medical Association for something that protects our healthcare workers to be out there. So that's one that is in action. One that I am working with our legislators more locally here is a more aggressive loan payback program. If you're going to serve in Iowa, let's figure out a way to get your loans paid off quicker as you serve. I do think there is an opportunity for telemedicine payment to be clarified. It's always kind of an unknown of how long is that going to stay up and strong. And then lastly, even for some starting physicians, maybe we want to help recruit into Iowa, maybe we want to give them some tax credits. The years that they are really having to pay off student loans, let's at least give them a state income tax benefit. And for those physicians that are older, you know, 65, 66, let's give those physicians a tax credit for staying in practice as well. But we've got to have some public policies in place that makes Iowa a very attractive place to come and practice and to come and stay and

practice. Because back to one of my original comments, staffing is such an issue for everyone across Iowa right now. We've got to think out-of-the-box as far as staffing.

Dr. Szot

What are some physician safety improvements that we could make?

Dr. Clancy

Yeah, I encourage each either multi-physician specialty group or each health system to put together their physical safety system in place. What are you doing as far as a strategic plan to keep your employees safe? Because it has gotten rougher out there. We've had a 47% increase in workplace violence in healthcare settings. And it starts with being able to report concerning patient interactions, and then tracking those concerning patient interactions if this is someone that continues to threaten and be dangerous to those that are on the front lines. It involves alerts to the clinicians that if this patient has a track record of assaults on healthcare workers that we know it when we open up the medical record. I think we are moving toward an environment where we have metal detectors in emergency rooms as a pretty regular thing now. Unfortunately, shootings at hospitals have become a place where those that are really disturbed and want to make some statement, they do it in a public setting like a hospital. And 80% of admissions to the hospital come through the emergency room. We do have law enforcement presence in the emergency room. They're great. They're wonderful. They are very good at de-escalating. But if someone is really not willing to comply and be a good patient, they do have arrest powers as well. We have a rapid response team for the disruptive patient called Code Greens that works really well. We have teams around pain management, both acute and chronic. And then one of our newest additions has been putting the psychiatrist in the emergency room to try to make the emergency room a safer place, but also patient flow go much better. And we've seen a dramatic drop in assaults, code green calls, restraint time, and waiting time for patients in the emergency room when we put the team in the emergency room. So again, it's not one thing. It's lots of things working together to create a system that is safer as well.

Dr. Szot

Are there any improvements in inclusion that might address some of these problems that we're facing?

Dr. Clancy

That's a great question, Joe. And as a consultant across the hospital, I have seen a disturbing trend of patients making more offensive and threatening comments to parts of our healthcare team. And more often than not, that is around race or around religion or

around ethnicity. And that really leads to this sense of psychologic safety or not having psychologic safety. I'm really proud of our team in the College of Medicine that has put together training around patient-initiated harassment and how do you address it in a safe, respectful way with some of the patients. And I've gone through that training and really feel better capable of addressing this with some of my patients. And when a patient really makes a threatening, offensive comment to one of our team members, me as a more senior member, as a white man, I feel an obligation to actually be the one that speaks up. And with that training, I know what to say when I've heard something that is sometimes just mean-spirited, but sometimes it's truly threatening toward a team member and try to set the setting of how we're going to do patient care with this patient in a respectful way both ways. So getting ready for that and seeing it ahead of time and knowing what you want to say when you get it right in front of you is really important.

Dr. Szot

With all this mental distress that healthcare workers are facing, how are we doing with access to mental health services?

Dr. Clancy

I think we've got a ways to go, and we'll talk about this later as well. But clinicians in general don't like to get help. They're busy. The hours of a lot of the services that may be available to them may not match their schedules. And they're worried about it. And there's always stigma as well, but they're also worried about reporting of them having to seek counseling and mandatory reporting. The best practice around offering counseling, coaching, and true psychiatric services to the healthcare team is at Oregon Health and Sciences University. They're fantastic. They have their own clinic with their own team for the employees with a confidential record that's off-site but close and free, and it works wonders. At one point, when they started up the program, up to 20% of their resident physicians were using it. And at one point, when they first started using it, required at times 12 visits to kind of resolve the issue. But if you look over the years, as the years went by, the number of visits it took to resolve the issue dropped down to four or five because people were coming in early, getting the issues taken care of. We developed something similar in Oklahoma which was approved by the Oklahoma Board of Medicine, that physicians could have up to six coaching sessions to work through issues that really didn't count as mental health visits. And it worked absolutely beautifully as well. So there's ways to do this that brings that stigma down and eases the worries of the clinician in asking for help.

Dr. Szot

To build on that a little bit, as you mentioned, physicians have always been hesitant to receive mental health care, in part over worries regarding mandatory reporting to medical licensing boards and possibly adverse impact on their medical license. Have we made any progress on easing the stigma in the physician worries around this?

Dr. Clancy

I think, yeah, this is really something out of the pandemic that has been one of those silver linings. Unfortunately, Lorna Breen, who was a physician in New York City during the peak of the pandemic, died by suicide. And her family took that and said, we're going to make a better system and make it easier for clinicians to get help. And that was really the start of a big push at the federal level and at the state level to be more compassionate and promoting of getting help rather than a field of medicine that was more policing and watching over each other for mistakes. The AMA, American Medical Association, has jumped on board and has been fantastic in this. And then the Federation of State Medical Boards as well has really set some standards of what are the best ways to assess if someone is struggling, but at the same time promote them getting care? And they actually have a ranking system now that within the questions that are asked as far as licensing and re-applications, rather than just asking, do you have mental health concerns, do you have mental health needs, or did you seek counseling, it's much more nuanced of where they use the words only if impaired or only if a current issue, and they promote having a safe haven for non-reporting. And the language within the reapplication process is much more supportive of getting help. So I think we're making progress. Most state medical boards now, I think the majority of them, I think we just passed 26, 27 of them now have much better language around this. But there's other layers out there that we still have to be concerned about. The hospital re-credentialing and the hospital privileges and such are still areas where this will pop up. I just did one of these a year ago on one of our junior faculty, and I was surprised to see how intrusive the question was as far as how that physician was as far as their mental health. So we're doing well, but we've still got a ways to go.

Dr. Szot

What workflow improvements do you think could help alleviate these stressors?

Dr. Clancy

Yeah, you know, the workflow is one of those issues where if I'm in a group of 100 physicians, there's going to be a pretty strong component of those 100 physicians that their issues are workflow first and foremost. And how do we triage better? How do we get the right patients to us? How do we have physicians not doing things that really could be done

by someone else? I think it really starts with being organized as far as team and on that team, allowing everybody on that team to be able to practice at the top of their level of training. And one of the things that we've done here within our primary care clinics is do some advanced training for our medical assistants, where they do more of the visit. And the medical assistants really like it as far as taking some of the basic information, but it frees up so much more time for the physician. And in going through a visit with my primary care physician, he had more time with me. And it really makes a difference. We have a team of psychiatrists, social workers, and nurse practitioners within the emergency room for our psych service. It works really well because it's team oriented. I think there's always room as far as the electronic medical record. What I'm proud of here is that we've got leadership in our information and informatics and medical informatics folks that are honest about what's not going right. And they've put out surveys on where are the trouble spots and have taken them seriously. So there's a lot that can be done on workflow. Obviously, it's specialty specific, but I do think a greater reliance on how we work as teams.

Dr. Szot

So I work in two different health systems.

Dr. Clancy

Yes, you do.

Dr. Szot

I'd love to hear your impressions or thoughts on the annual compliances that we are all faced with every year.

Dr. Clancy

Yep. So I complained about this enough to the point that I was assigned to try to get a handle on this. And I'm going to get at least something started on this. I unfortunately needed to have a knee replacement, and that has kind of sidelined me for a little while. But this is one of those areas where, as the AMA describes it, get rid of the stupid stuff. Get rid of the stuff that just is not value-add, not advantageous. Compliances are mandated at so many different levels. Some of it is federal, some of it is state, some of it is accreditation standards. It's a really complicated set of who is mandating us to do this level of training. But there is some flexibility in that. And so my hope is that we can look at each line of compliance and say, does this have to be here? Does it add anything to it? Is it one of the ones that are optional? Does it need to be this frequent? Does it need to be this long? and really try to at least reduce down the burden of so much compliance. I have seen, at least for us, improvements in the content that is coming at us and improvements in the length of

some of the compliance trainings. But I still think we have a ways to go. I hear the most from people like you that actually work in a state hospital and a federal hospital at the same time with two long sets of compliances. I think one of our internal medicine physicians told me that he had over 50 different compliances to keep updated every year. And he calculated it was close to 80 hours, which is amazing. If you think about the lost access to care, what 80 hours available of a physician across an organization that has 1,500 physicians, you could increase access so much if we just reduce down some of that 80 hours to 40 hours. It's pretty dramatic when you look at the numbers of where we could go. We'll see if I have any success with this. There's pretty powerful forces on this, but we'll see how we do.

Dr. Szot

What role do you see professional development playing in even preventing some of the stressors and addressing the stressors?

Dr. Clancy

Yeah, you were part of one of our kind of our refreshes of professional development here. You were one of our participants in what we called THRIVE@Carver. And this was a professional development program that was tailored to those young physicians that were hired during the peak of the pandemic. So between 20 and 2022, because they really didn't get that chance to normally bond to the institution and normally learn about the institution and make those connections that would set them on their way to a career that was more than just RVUs. And I think the program we had, we started this year-long program. I thought 8 or 9 would show up and actually we had 40 applications. We were able to take 32 into the program. And it went incredibly well. What it taught me was there is very much this need to kind of do a reset on your career as far as some of our young faculty. Almost all of them wrote within their application to the program, hey, during the pandemic, I just put my head down and went to work every day. Wasn't really thinking long-term. Thank you for opening up an opportunity for professional development that helps me set the course long-term. And that's just a natural human need. We have to know where we're going. And that's a big part of being hopeful and positive and inspired that, hey, I'm here, but I'm going this direction. And professional development allows you to do that. It opens doors, it gives you new skills. So I think we'll see a lot more professional development opportunities within our organization because it's so important as far as bonding to the institution, retention, and feeling like you're contributing higher than just RVUs for the organization. The next version of THRIVE@Carver for faculty development will be focused on value-based healthcare and developing a whole cohort of champions. James Murphy in our quality improvement section is putting together an entire program for the residents as far as quality

improvement initiatives. All of these are really important as far as painting a picture of these are some of the things you can do in the future and here's some of your skills going forward.

Dr. Szot

Do you think compensation plays a role into this? Is more compensation the answer?

Dr. Clancy

I think for as hard as everybody worked, compensation is a huge deal right now. And so you've got to be competitive compensationwise. That said, it's more than compensation these days. When you look at major corporations who have surveyed their employees, what is the most important factor as far as you staying at this organization? Compensation is up there, but it's actually no longer #1. For some companies, it has been work-life balance. For other companies, it has been the flexibility to be able to work when and where I want to. For some individuals, professional development has become much more important. For others, it is the psychologic safety and inclusiveness of the organization. So pre-pandemic, it was #1, compensation, and number 2, professional advancement opportunity as the number one and two reasons in healthcare to stay at a company. Now it's a lot more complicated with a lot of factors that have to be addressed.

Dr. Szot

Do you see work from home options factoring into this going forward?

Dr. Clancy

You know, Joe, great question. I'm kind of old school on this, that I like to be at work physically and I like to be with my peers. But as I continue to study this, it is pretty amazing how effective people can be in working from home and how happy they are. I just looked at a study that compared the different sectors of how many days per week you are at work and versus how many days per week out of five you're working from home. And agriculture was the one that, five days a week, the farmers were working on the farm. Home is the farm. So as you would expect, they were five out of five. But most professional sectors were working from home four days a week now, and only one day a week in the office. My son works for Deloitte. He works from home 9 out of 10 days. You know, it's incredible. So I thought, okay, where's healthcare? Healthcare is gonna be, you know, up around four or five days a week. It's actually averaging right now, healthcare workers average 3.4 days a week at work, meaning 1.6 days a week at home. So this is changing. And so in psychiatry, we're a field that we can do a lot of telemedicine if the telemedicine regulations and compensation holds up. I think you'll see a lot of physicians choosing to do some of their

patient care via telemedicine from home if they can. So I don't think we're going to go backwards on this. Obviously, critical care services and such, there's a lot that we have to do hands-on. One of my other children, though, is involved with a health system that a lot of what they do is virtual care. They do virtual intensive care units. I know the VA has gotten really good at virtual intensive care units to the smaller VA sites from here. So I think the work from home option is, again, something that a healthcare organization needs to be progressive about, because if you don't, someone else will be progressive about it and you'll probably lose somebody because they can get a better gig.

Dr. Szot

So Gerry, as we near the close of our discussion, I've heard you mention the importance of grace as we go forward.

Dr. Clancy

Yes.

Dr. Szot

What do you mean by this term?

Dr. Clancy

So I don't mean grace per se in a spiritual way, but I do mean grace as far as how we interact with each other and that level of compassion and empathy toward others, even mercy when someone has really gone through a whole lot. And I was asked to write an article for the Tulsa World on the 20th year anniversary of 9-11. And they asked me, just give a reflection over the past 20 years, what have you learned from 9-11? And what I had learned on the day of 9-11 was that every one of my employees, I was dean of a medical school back then, had really just been so upset and distressed by what had happened. And I went around to each one of our work units and each one of our clinics and told the manager, you can close the clinic. Because no one wanted to be at work and no patients were coming anyhow. And the look on everyone's faces was really telling. You could see that they were so appreciative of me understanding where they were. And they could see where I was on this. And I refer to this as two-way grace. I offer grace to you because I'm understanding of what position you're in as far as all the stresses you've been through. And your understanding of me comes back to me. So the grace goes both ways. And I think, you know, as we've gone through this pandemic, a little bit of two-way grace could go a long way. If we just step back a little bit and realize, hey, these individuals have been through an awful lot. Hey, these workers have been through an awful lot. If you just show a little grace toward your peers, toward your patients, odds are it'll be reflected back to you as well. So

that's really what I mean as far as grace going forward. I think it's really important to see the impact of all this and the hangover of all this for what it is. And I've mentioned this before. Frank Snowden, who's a Yale historian and teaches a class called Epidemics in Society, wrote a very long book on really studying epidemics over the past 2,000 years. And he notes that epidemics and pandemics really do change history. They change society. They're full of misinformation. And so we've got to see what we've just been through for what it is. We've been through a major jolt in our society and a little bit of grace back at you and you back at me would be, I think, something very welcome.

Dr. Szot

As we finish up this discussion, which I think has been a great discussion, covered a lot of aspects of the current work environment, what would you like to leave with our listeners as your take-home points?

Dr. Clancy

Well, thanks for having me, Joe, as well. And I think one of the points is this is very much a work in progress. This pandemic and the hangover from the pandemic continues to evolve. The merry-go-round has not stopped. And so I think we will have more to learn and more to diagnose as time goes on. But I really think it's important for those that are thinking about burnout, thinking about physician wellness, thinking about retention, that the stressors are different. Yes, it's COVID, but it is a tougher, rougher place to work in healthcare now. There's misinformation still floating around. The staffing issues are significant. And then on the horizon, we have this at least potential for major corporate influence in healthcare, which will be distressing to most of our physicians because they didn't sign up to be corporate. So as I've said before, I do feel like this is something more than burnout, at least from what we've seen before, MTBO. I think also it takes a fresh approach to the strategies to address this. I think Maslow's model is a nice place to start. We're making sure everybody is physiologically and physically and psychologically safe, that the social connections are there, that we're rebuilding community, and then we start working on personal and professional development from there. And then lastly, nothing is one-size-fits-all for this. In addressing retention and burnout and staffing issues, it really is a mosaic of initiatives that have to be deployed. It can't be just one thing. It can't be just two things. It's really 30 things that need to be working in concert with each other.

Dr. Szot

Well, Gerry, thank you for joining us on Rounding@IOWA, and welcome back.

[Upbeat theme music plays]

For our listeners, you can access show notes and instructions for CME at uiowace.libsyn.com. We hope you join us again for another session of Rounding@IOWA.