Ep68 | Advocacy as a Bridge from Frustration to Hope with Dr. Damian McHugh Transcript

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Healthcare Conflict and the Spark Framework

If you work in healthcare, [music] you already know this. Conflict is everywhere. In the O, [music] in labor and delivery, in committee meetings, between physicians, nurses, administrators, and teams that are all trying to do the right thing. But here's [music] the problem. Most of us were never trained to handle conflict well. We learned procedures. We learned diagnostics. [music] But we didn't learn how to navigate the moment when Q professionals strongly disagree.

That's why I developed the [music] Spark Framework. Spark stands for stop, pause, ask, don't assume, reflect, and respond, and create a path forward. It's a practical system [music] designed specifically for high stakes healthc care environments through keynote talks, residency workshops, and spark master classes.

Scalpel and Sword Introduction

I teach physicians, nurses, and healthcare teams how to [music] turn destructive conflict into productive conversations that strengthen teams and improve care. If your hospital, residency program, or medical conference is [music] looking for a speaker on conflict, communication, and leadership, and healthcare, [music] I'd love to work with you. You can learn more in the show notes. Because in medicine, conflict is inevitable, but [music] handled well, it can make teams stronger.

[music] >> [music] >> In every operating room, in every ward, in every clinic and every team meeting, a silent battle bruise, conflict, negotiation, [music] identity. Welcome to the Scalpel and Sword podcast, where I, Dr. Lee Chararma, physician and conflict analyst, explore the hidden negotiations beyond modern medicine. Let's trade burnout for boundaries and learn the art of healing with precision and [music] power.

Hello my peaceful warriors and welcome to the scalpel and sword podcast. I am your host Dr. Lee Chararma, physician and conflict analyst. And I will tell you that one of the reasons I started the podcast and why I've really tried to immerse myself in this world of really trying to be a voice for physicians is as a physician I felt very helpless. I was looking at a system that was crumbling around me. I was looking at patients that were suffering and waiting for medications.

Why Physician Advocacy Matters

I was looking at colleagues who literally I would sit and cry with because they did not know how they were going to make it to their next day of clinic. And at a certain point, you say to yourself, "How am I going to help? What can I do?" And as we look at the frustration that builds with being in our system, we start to find people and ways of being able to speak and do and help. And I can't think of anybody that I would rather have to share that discussion with us today than Dr. Damen McHugh. Dr. McHugh is a retired emergency room physician who lives in Raleigh, North Carolina. He did his medical education in the UK at the University of Manchester and he is very active in many levels of advocacy. He is currently involved with the Clinician Burnout Foundation. And you may remember my episode with Jodie Green who is the CEO of the Plenician Burnout Foundation and she was kind enough to connect us today. Damian, thank you so much for being here.

>> Lee, it's a pleasure to be with you. I've been looking forward to this and I'm so glad that Jodi in the midst of her mischief put us in contact together.

This is going to be fun. >> It is going to be fun and I love how you phrase that. Yes, she has a wonderful mischievous spirit about her and I love her for that. I feel like the word advocacy, when we use that word, people think about being on Capitol Hill, people think about the idea of being a lobbyist, but tell me when I use that word

advocacy with you and with the work that you do, what comes to mind?

>> You know, I think you're right, Lee. First of all, in the traditional sense of the word, advocacy tends to overlap with politics, with, you know, legalities. But I'm just looking at really quickly just a basic definition of an advocate being a person who supports, pleads, or speaks in favor of a specific cause, a group, or an individual. And I think most doctors went to med school because they were driven to advocate for their patients both individually and collectively in the community.

>> Absolutely. Was there a point in your career that you said to yourself, you know, obviously as a physician you feel that's part of your calling, but was there a point that you felt that it was time for you to get interested and advocate in a more formal fashion?

You know, I've reflected on that. I don't recall one particular day. There was no kind of aha or burning bush moment. But having been a fierce patient advocate, I saw many of those colleagues of yours and mine who were struggling.

They were bereff. They were crying. They just weren't coping very well. And I realized that in order to do better for all, there should be people advocating for our peers and trying to edify and support them in this difficult work that doctors in practice do each day. >> Was there a point in your career as you were looking at being that person, that voice, did somebody advocate for you and did that inspire you even further? >> You know what a great question. Having spent my career spanning both two specialties and two countries, it's inevitable that I had at least a couple of good, capable mentors who, for whatever reason, saw something in me and chose to support me. As I mentioned to you, I consider myself to be one of the most fortunate physicians in the country because very few people get to come from Great Britain and have a wonderful clinical and administrative career in the USA. So, I'm very grateful to those that helped me. I've always been interested in medical malpractice and that was the area that really stirred me initially to begin to get active and to advocate for physicians. And I think it's important to say I do believe fervently that patients should be compensated to the extent they can if they are harmed by a rogue provider. But from my own personal observations of our malpractice system, so often the cases that are brought to trial are not bad providers. They're just bad illness, bad medicine, or bad trauma. So that was really when I first started to advocate for physicians and educating myself in that sphere and trying to, you know, let folks know, hey, there is help when you're faced with this mammoth threat. And then things just moved on from there. I took different leadership roles. I spent some time in medical regulation and when my later career having had my own career tinged by the flames of burnout, I became a speaker on burnout and an advocate for those physicians that are still facing the flames at the front line.

>> Okay. There's so much that's amazing about what you just said. One of the things that I think is really awesome is that a lot of times when people start talking about physician advocacy, sometimes I think people feel like it's one or the other.

Medical Boards, Boundaries, and Patient Protection

You're either advocating for physicians or you're advocating for patients. And one of the things you articulate really beautifully is that no, you advocate for both. You advocate for physicians and patient. It is not an eitheror. And I think that's a really important point because sometimes when people think about advocacy, they think it's very one-sided where you can only advocate for one group. But when we're talking about advocating for healthy doctors, by definition, that means we're advocating for healthy patients, right? >> Absolutely. I first came to that realization when Governor Cooper gave me a seat on the North Carolina Medical Board. And until that point when I sat on the board, I had mispersceived like so many of our colleagues that the the board was kind of a big bad or that was a threatening cloud that would hang over doctors. And in anticipation of serving on the board, when I really read around the board's mission, certainly as it applies to North Carolina, our board serves purely for the benefit and protection of the people of North Carolina. And all physicians, all PAs are patients, so we should all want the board to do its job. And it just struck me more and more that if you see a triangle of success with patients and the community at the top, then the medical board and the physician and PA community should all really be a vibrant corner of such a triangle of success.

And you know, in one of my blog writings, I wrote a provocative piece about could the medical board be an ally of physicians? And I still think the principle is important. I've learned to see the good work that's been done by each state medical board and then under the umbrella of the federation of state medical boards and of course they always as regulators have to put the well-being of patient first but I think the patients well-being is upheld when doctors are healthy both physically and mentally >> 100%. And part of your advocacy, of course, is that you were willing to serve when Governor Cooper called upon you to serve, that you were willing to do that. And what you're expressing in terms of how physicians perceive medical boards, I think, is definitely something I've also heard in Alabama because I have several friends who are on Alabama state medical board. So I have some knowledge or interest in kind of the topics that they're talking about, but of course those come up at our state medical society meetings. Mhm.

>> And I think that's really an interesting perspective because I know looking at the physicians in my state that even people who are involved in the state medical society question the board's intent sometimes when they are looking at things that are really patient protection policy and physicians will say, "Oh, well, you're trying to make me work more." There was a CME that became mandatory two years ago. It was an hour that was talking about physicians and boundaries and it was such an interesting piece of CME because so many of the things that were in there dealt with modern issues. How do we interact with patients on social media? Is it okay to give a patient your cell phone number? You know, forever I gave my postoperative patients my cell phone number. And after doing that CME, it's like, you know what, that's hard to do because the one time that you're out of town or your phone is off and you don't answer a patient's call, maybe you gave them the number a year ago, but then you don't answer and then they get upset because you didn't answer a cell phone call. >> The patient doesn't understand that you're on you're not 247. And I think that was very illuminating for me. And so many physicians got mad about that. So many people in Alabama got mad about the fact they had to do a mandatory CME for one hour for this topic when in reality what that board is doing is advocating for you so that you don't get in a situation where a patient's going to misunderstand the fact that you're not available. >> That's exactly true. And you mentioned this concept of boundary violations and something as simple and fairly innocuous as the sharing of a personal cell phone. That's at the milder end of the spectrum. But one thing that's fascinated me over about the last maybe year to three years when you look both in the lay press and when you look at in some of the regulatory and also the medical malpractice press the amount of boundary violations with prescribing violations, sexual violations both with staff members and patients that for some reason I don't know if it's just over reporting an incident that's remained constant or whether or not the incidents has actually gone up. I suspect the latter in association with all the increased stress of medical practice but it's absolutely fascinating why this is so prominent at the moment. Obviously the seminal cases are folk like Larry Nassa but there are lots and lots of other cases coming to the forefront really from coast to coast and it's very worrisome. And I think it's a sign of increased stress and increased pressure and you know when this is turning over into frank criminal activity and abuse of patients that's a failing on so many parts. >> Absolutely. And so this is an instance where you have people who serve on state medical boards and for if you're a physician and maybe you don't have friends who have done this I think again you've done it. I have friends who have done it. This is not a small time commitment. >> This is a very large time commitment that they are doing. I mean they are spending significant time away from their practices. Of course that sometimes speaks out in terms of decrease in income but they're doing that because they believe in the work that they're doing. They believe in protecting patients and physician. And I think this is one of the questions to get into with the work that you do and with advocacy in general is that there's a very committed group of physicians who believe so profoundly in this work that they make these sacrifices to do it. And so sometimes the response from physicians who maybe understand that commitment will go, "My gosh, thank you so much. My board representative is one of my dear friends and I had the pleasure of renominating her for office this past time and I was happy to speak on her behalf and she texted me while the meeting was going. I'm like you about made me cry. I'm like everything that I said was true. But there are also physicians who feel helpless in this process. It's like they're helpless at work. They're struggling at work. I learned a term a couple weeks ago called zombie. Doctors who are literally going through their day just in survival mode. They have this helpless sensation and yet they don't really understand that supporting the people who are willing to make the commitment actually may increase their voice. Have you ever been in a situation with a colleague where you could tell they were frustrated? You could tell they felt helpless, but they didn't really understand that you were advocating for them or that there was a way that they could find somebody to advocate for them. >> I've seen that several times, Lee. Many examples come to mind but really the more trite example I would share is you know when my now young men's sons were growing up I would always mention to them that whenever they came with a problem I wanted them to articulate the problem but one thing I

would like to challenge them with was to have a couple of solutions thought through and I've always said the same to my physician colleagues a frustrated burned out depressed it's like okay I understand things are hard in this privileged work that we do. What do you see as being a potential solution or two that is available to you right now today? And then you know when those things come up then the very next question is why haven't you done anything to try and move forward to explore one of those solutions and as you say a lot of the times our colleagues feel so helpless they just feel like they're sort of banging their head against a wall that no one will listen and I do believe in the power of physicians coming together in a proactive and productive way and in the latter stages of my career I've also seen again the value of organized medicine in county medical societies, in state medical societies and also in specialty societies and I think when groups of physicians come together in those arenas and they delegate eloquent spoke people to go and lies with community leaders with lawmakers that's the way that really I think it's the most efficient avenue to make change and to make things happen and we all know of our colleagues who are frustrated by the apparent slow speed at which sometimes things do happen or don't happen.

Notwithstanding, that doesn't give us the excuse to be off the hook and stop trying.

Burnout, Silos, and Team Communication

>> I think that's a brilliant point and this is one of those things that I think is so important to draw attention to the idea that the advocacy and the work that we do now, we may not see the fruits of that for months, years, decades, but it doesn't mean that we don't work. It doesn't mean that we don't put the effort in. And one of the things I always think about and I talk about this when I'm working in an advocacy space, it's like I'm not necessarily trying to make medicine better for me, but I darn sure want to make it better for the people behind me. I owe it to them to try to make it better for them. I think about my children being in the health care system. I want my children to have the best healthcare they can. So, how do I do that? I put the advocacy work in now. So, I think that's really awesome.

the idea that you give people that temporal perspective of the work that you're encouraging them to do. >> Yeah. I remember an instance fairly early in my career around about 2005. I had read a very poignant article in JAMAMA that I think was entitled something like who will deliver our grandchildren and the authors were lamenting about the reduction in numbers in active OBS who were doing deliveries and this was paired with the increasing torque pressures that were coming into many states. And right around 2008, North Carolina was really beginning to feel the heat of all those combined pressures and physicians were called upon to go downtown in their white coats, but more importantly to liers with our state representatives and, you know, share stories of why there were counties in rural North Carolina where obes were packing up and leaving and that poor ladies in labor were having to drive 50 to 75 miles to the closest hospital. That's inhumane. And when that's happening as a result of unpleasant malpractice laws, that's harming both physicians, but more importantly patients.

>> Absolutely. One of the things that you also talked about when you were talking about sort of the power of organized medicine was this idea of starting at sort of the county level. It's not necessarily the people who are going to go to nationals that are going to move the needle.

people who are in their counties, who are in these small groups and then have somebody who can be, as you said, that eloquent spokesperson who can kind of move up and the county north of ours, Russell County, has a small hospital still there where back about 20 years ago, every single physician in that county had lunch together every single workday. So, Monday through Friday, they all met in the doctor's lounge. They had a seated lunch every day. And if there was an emergency, then they were going to be there the next day. And if one was gone, then they would, where is that person? We're going to go find that doctor. And I remember loving that story so much as a child because it was when I was in high school hearing that story. And I think about now that there are physicians in my county that I haven't seen in over a year. I may talk to them occasionally for a referral, but I don't ever see them. Do you feel like that sort of siloed practice of medicine has been a big part of why we have a hard time coming together as advocate? >> I really do and I think my own personal opinion is that's you know the two major contributors to physicians finding themselves at that impass are you know first of all we have absorbed the pressure to become more busy. We have been told that the busier we are, the more patients we see, the better we are being as physicians and that may or may not be true. And then secondly, I still really lament the intrusion of the electronic medical record where I may be working in the ER. I may call you as an OB consultant, but you know, we each see the patient, but we don't see the whites of each other's eyes. And you know, you may leave a consult in

the EMR suspecting that I will read it. I may or may not have time to read it. And that to me is just very suboptimal patient care. The best physicians that I've worked with as consultants have always been those that have, sure, they put their nose in the record, but they've come by and they've just, you know, if I was in a critical situation, they've just waited. They've been kind enough to wait, come outside and say, "Hey, I just want to update you. this is what I feel about Mrs. Smith and it's okay to do X Y or Z. Does that make sense with you? And that physicianto physician communication that's second to none and I think that the electronic health records have to be held responsible for eroding quite a significant amount of that >> 100%. So, I love how you're speaking to this and I do think it's so important to talk about the fact that sort of electronic communication and EMR in particular has eroded trust and relationships and that has had a direct effect on burnout and how we can come together for advocacy. I also think that when physicians get siloed, when they are in their own little bubble and like you said, we perceive the busy physician as being the good physician. If I'm busy, I'm good. And as physicians, we sort of all got here because we're all very hard workers. We're very type A personalities. You know, you ask us to jump, we say how high. It's just kind of how we are. But it's also kind of why we're in this profession. And I think as we've lost those relationships, things like EMR have just eroded the relationships that we have. We have to work a little harder to actually reconnect with people to keep good relationships. We have to work a little harder with our patients. Not in the sense of working harder just in terms of just powering through. But in terms of changing the way in which we interact with people, being willing to pick up a telephone and talk to somebody on the phone rather than just sending a secure messaging or being able to it's like I don't want to just play a portal war just going back and forth with somebody.

I want you to come in and I want to actually look at you. Do you think the silo has also had an effect on the hope that we have in our medical system? Has it also kind of eroded our ability to be hopeful about what the medical system can be? >> I think inevitably that's the case. One of the things where I always felt great I don't know gratitude or joy in my day was when I came together with other professionals on the team and we put in a visible cohesive effort for the benefit of the patient and you know be that a resuscitation in the trauma room be that an OB patient that was going downhill in the ER and you know the OB team were on their way down I would always feel that working together with people really enabled us to harness the power of the group and to have capable individuals committed to a common cause.

I think as you've alluded, the way the EHR works and the fact that we all are perceived to be more and more busy, those have tended to detract from that which is high excellence, which is capable physicians coming together. kind of like in a Formula 1 race, that 12 or 15 seconds of pit time represents some amazing people with desperate skills coming together and the amount of work that's done in that short time and then the car is off again and the person's back in the race. I think there are many good analogy parallels between sports and things like that for medicine, but it's tough. But maybe we'll just sound like old-timers with gray hair who will lament in the days gone by. But I think there's perhaps some of the joy in medicine missing, perhaps a little bit of the fulfillment in medicine missing. I think those are inevitable contributors to burnout and disillusionment.

>> Absolutely. And like when you talked about having those moments where you really felt that you were active, productive, and fulfilled in a team setting where you actually were working with a team and you had other specialties involved, but you were able to work together and get a good outcome.

That is a very good feeling. And it's not even just a good feeling. There's actual literature to support that the more physicians work with certain groups of physicians, better outcomes occur. Last year we had a surgical oncologist in Canada Dr.

Building Culture Through Organized Medicine

Julie Hel who was on the podcast who published a beautiful article in JAMAMA where she looked at the surgeon anesthesiologist diad and they actually were able to prove that the more a surgeon anesthesiologist operated together it actually resulted in shorter hospitalizations less o returns and it was brilliant when she was on the podcast because as we were talking about it we were talking about the fact that not only did the team kind of learn to work together They resolved disagreements faster. They were able to have a common point of view. They had an absolutely singular way of seeing something that didn't have to be spoken. They actually understood it without even talking about it. And as we build good teams, we don't have to limit that to the operating room. We can

expand that team mentality within an ER, within a clinic, within a hospital system, within a county, within a state. It's just a question of how we're able to reinforce creating that team.

>> Yeah. I remember seeing on one of your prior podcasts you were fortunate to have Bill Cooper who's an expert from Vanderbilt who talks about teamwork and you know he and Jerry Hixon mention the many catastrophic outcomes that can happen when teamwork is absent or not as present as it should be. And anecdotally, every ER physician knows of certain charge nurses that they absolutely would love to work with in the life-threatening situation. And I think most cohorts of charge nurses know that they would want certain physicians as opposed to others in a difficult situation. One of the greatest compliments that I and some of my other partners have received is that you know after working for 15 to 20 years in ER some patients will come in and they will ask for you by name and that's a great compliment but it's always everything in emergency medicine happens just like in the OA when the physician is leading a capable team. >> Absolutely.

You've had the benefit of working in several clinical institutions. You have seen a lot of teams. You've been in a lot of places. Have you seen or been part of creating a culture that was more conducive to not only that team mentality, but also like you said, how you would talk to your sons about come with me with a problem, but also come with me with a couple of solutions and actually think about how to make that. >> Have you been a part of being in those cultures or maybe even creating cultures that were able to do that? I feel very proud to have worked with a wide range of colleagues and a wide range of hospital administrators. In one of the teaching roles that I have, I work with a dear friend of mine, Dr. Tony Orsini, who teaches a breaking bad news course.

And one of Tony's throwaway phrases that he uses repeatedly is the fish always rots from the head down and the coroller is true that if the head of the organization is at best, then the good culture tends to follow. And in places that I've worked that have had good cultures usually come right from the top, right from the seauite and then through the medical staff leadership.

And those are the sorts of cultures that tend to lend themselves well to improvement. They receive criticism in the constructive way in which it's meant to be received and they just tend to perpetuate and get better. And of course, we all know that when that culture and leadership is lacking, places tend to rapidly spiral out of control, which is to the detriment of the staff there. It's seen an increased turnover, but and it's also seen in just general poor patient care. >> I could not agree with you more and I love that phrase. I have to tell Dr. Orsini that I definitely want to footnote that and steal that. And I think because we understand that culture and leadership are created from a top-down situation that the person who is the head of the fish essentially is the one who's setting the tone that it does make us think about we are not just advocating for ourselves like if I'm complaining about the fact that I'm burned out if I'm complaining about the fact that I'm tired I've seen 30 patients today and I don't know that I can see one more in good humor that is going to inevitably trickle down to the other people in my organization that is inevitably going to affect not only my office staff but my patients are going to feel it too. I think a lot of physicians who are very burned out and very frustrated and who are carrying that inside of them and maybe they're trying to muscle through it. They don't realize it's like you know people see that other physicians see that patients see that your staff sees that and that culture carries through. And I guess what I really am hoping is that as we're talking about your work with advocacy that as people are feeling these feelings that they will maybe see organized medicine, their colleagues having lunch in the doctor's lounge as a way to feel a little less alone, but also to advocate for themselves and have that advocacy go forward. >> I think that's critically important. I'm very blessed here in central North Carolina when I think of the Wake County Medical Society and the Durham Orange County Medical Society. They are both good cohesive societies that believe that physicians coming together is beneficial in so many ways. First of all, it's fun. First of all, to be able to talk with fellow intelligent folks who may if they don't directly align with your political or religious views, they'll certainly appreciate some of them and you'll be able to hold good debate even if there is disagreement in that debate. I think that's valuable and I greatly appreciate that in the county medical societies that that I have impact and Wade County and Durham and Orange County. I think then also we talked earlier about physicians not meeting each other in the hallways in the coffee rooms and hospitals and offices but just have that opportunity to talk about a difficult case. You know I may not actually see too many OBGYNS in a day in the ER. So if you and I are at a county medical society having a glass of a beverage beforehand I say hey I saw a patient today and there was this let me pick your brains on this and what's rich and fertile soil for education for cohesiveness. And I think that breeds more of a sense of community. And then of course when there is a need to call upon physicians to go and meet with a senator or a politician or the secretary of state for health and when

those physicians come together and they know each other they present again more of a unified sort of cohesive vocal and valuable force. I love how you talk about taking these opportunities to meet with colleague as rich and fertile soil. >> I love that you talk about this idea is that that this is how we build relationships. If we are feeling like we are head down and buried in what we're doing that there is a way you can reach out. you can just go to the doctor's lounge and have a cup of coffee and see a colleague and maybe sit down and if it's somebody that hey I saw X or Y or you happen to see a specialist walking by oh hey I saw this patient of yours and she has X that is how it starts and then from that rich and fertile soil and we grow these relationships maybe that connection will lead you to want to speak out maybe that connection will lead you to want to share hey I had this really frustrating thing happened with this prior authorization. Tell me who I can talk to. If I really want to work on this issue, I'm tired of complaining about it. I want to do something about it. And all of a sudden, you have a way to make that happen. >> Yeah. You know, there are so many challenges in our daily life. I'm glad that when I coalesce around other colleagues, I see that people have a certain interest. And as you say, when the chips are down, I can know of that person that has an interest here and say, "Hey, can you give me some guidance on this? Whom else might I talk to in order to bring this to a point where the patient can get some help or my team can get some resolution?" And I think that's incredibly valuable. You know, again, one of the benefits of working in an ER for over 20 years was there were many patient problems and I would just look at the call list and many times I would know the physician's cell phone and just give them a quick call on the cell phone. They would know me and they would say, "Hey, no problem. Get this and this." You know, I'm on the way in to help. And it was really, really wonderful. >> That is great. But also too, you spent time making those relationships as well. You had to seek them out. I mean, there was a reason why you had their cell phone number because you have built that relationship. And I don't think you can underestimate the power of intentionally building relationships with people. I have a group of seven female physicians that at least quarterly we try to get together and have dinner and it's inevitable the first glass of wine is not out and we're already talking about I saw this, did you see this? What do you think about this? And of course, it's beautifully therapeutic to have that in your life, >> but also too, if I'm seeing one of their patients or they're seeing one of mine, typically it'll be a quick phone call of, "Hey, I've got this. What do I do?" >> Yep. >> But it's because we've built those relationships because you have taken the time to build a relationship with somebody that you do have their cell phone number and you feel more open and welcome to making that phone call. >> Yeah, I agree. I think that's one of the very pleasant advantages of being perhaps in a smaller community and in a private practice where the physicians tend to know each other. I can only contrast that with the somewhat impersonal large academic places that I've worked where in a week you may not end up talking to the same person twice, >> right? >> Because the places are so big and somewhat impersonal. That's very different from the real life medicine that I enjoyed for the bulk of my career here in North Carolina.

>> Yeah.

Supporting Burned-Out Physicians and PHP Resources

So, you have, let's say, a young physician who's coming to you and he says, "Damian, I don't know what to do. I've only been in practice for two or three years. I'm a young physician and yet I feel really frustrated. My alarm clock goes off in the morning and I dread having to get out of bed and go to work. And I know I'm not supposed to feel this way. I like what I do. I like my job. I like my patients, but I feel really, for lack of a better term, burnt out. And I think that's part of it. Sometimes we don't always verbalize it well, but it is what that is. What do you encourage that young physician to do? >> First of all, I thank them for coming and say, you know, that's a courageous step that you've made. Then I very soon remind them that they're not alone and that you know I as a person that was tinged by burnout and subsequent challenges I understand exactly the walk that they're on. I'll often times share some statistics either national statistics or specialty statistics to tell them that you know again they're not alone. One of the things that I spend time with talking to residents and medical students is that to some degree these fleas of burnout go with the dog that is medicine. And you know in years gone by physicians of our generation have probably tried to bury this to ignore it. And I think the younger folks are somewhat ahead of us by placing an increased emphasis on their work life balance, by trying to put some boundaries on their time. That leads to difficult challenges. We can't all down tools at 5:00 p.m. and walk out the door. It's not like we're making cars. So just where we develop that blend, that harmony for the future. I'm not sure. But I think just letting physicians know this is okay to vocalize this in a safe space with a trusted colleague and that's the first step and you know allowing them that catharsis of releasing what's on their mind and then sharing with them whatever local resources are available you know whatever books websites specialty society offerings might be available and then you know just assessing

where they're at in that difficult journey I think it's very important to encourage them to let a loved one know what's happening, be that a spouse, a significant other, or a parent. Our job is challenging. We're dealing with sad things happening all the time. We're dealing with many, many frustrations. We know temporal pressure and the risk of things going wrong. So, this is a challenging work that physicians do. So I think speaking out in a safe place and having the courage to ask for help and support, those are incredibly important first steps. >> That is phenomenal advice. And I think it is really important just like you did in this example to create that space for that person to talk. And I do also think that those of us that have been doing this for a while, I don't know if we're a product of that culture, but just oh yes, I'm built to do this and I'm fine and I'm fine and I'm fine. It's like I'm really not fine. I'm really very burned out. And I think it's very hard for us to verbalize that. I do think the younger physicians and students coming up are much better at it. I think they are much better at setting boundaries. I also think they are more aware >> of >> right >> burnout as a problem. And I think we are catching up. I think we are getting better >> at >> being willing to verbalize how we feel and that it's okay to verbalize that there are days, weeks, times that we just we need more help. when you started working with clinician burnout foundation was that also [clears throat] part of your journey as well in terms of now working with these physicians? Yeah. I mean, in medicine, we all learn from those who we consider to be our wise teachers. And if I'm able to watch a skilled emergency physician navigate a difficult airway, then I learn I learn even more when she says to me, "Why don't you try on this next difficult airway?" And then when we talk about the things that we've learned, we do better.

I think the same is true for navigating the challenges of our profession. Even if it's just as simple as I'm struggling with the circadian challenges of swinging shifts post call, talk to somebody that's done it. Find out, you know, what worked for me, what didn't work for me. Learn more about sleep hygiene. >> You know, invest in some noise cancelling materials in your bedroom and some shade, that sort of simple stuff, >> right? And I think you know when bigger problems like burnout and then later depression, mental health problems come in, if you can find a trusted colleague in a safe space from whom you can glean support, that's incredibly valuable. It can be life-saving. >> Wow. I am really really glad that you are doing this work. I'm very glad that you are able to share your wealth of knowledge, especially your wealth of experience with advocacy. with a larger group with the physicians in the state of North Carolina.

It's really amazing that the way that you have been able to take your journey with all of its difficulties and all of its challenges and all of the things that you've experienced and use that journey to bless other people is really wonderful. >> It's just the best way I know to give backly. And you know, I recognize we're coming to the end of our time, and we both could speak about this for days, but I have to sound a trumpet of success for each of the state physician health plans. I have watched trauma surgeons.

I've watched ER physicians. I've watched anesthesiologists save lives. But as I've become grayer and older and wiser, I've also watched physician health plans and states save lives, restore careers, patch of broken marriages. And I can only speak best for North Carolina and the states around. But for a physician that self-identifies as burnout, who has not gotten to the point where they are their practice is causing a risk to patients, they can always knock on a quiet self-referral door to the professionals health plan, walk in and say, "Look, I need some help. I know I'm struggling." And I found that in the states around North Carolina, the PHPs are phenomenal realms of support. And if there was one message I would want to get across to your listeners, it would be to have the courage to lies quietly with the PHP. You can make a selfanonymized referral and as long as your behavior and your weaknesses haven't placed your physicians in danger. The PHP will work with you to help you to keep you anonymous from that regulatory body that's the medical board. And they will help you because they want you to be safe. They want you to relish and have joy in practice of medicine and they want the patients to be safe too. So it tends to be a win-win. And if there is one takeaway that I would hope listeners might get from this is if you detect these issues in yourself, have the courage to reach out to a PHP and ask for help, they're willing to give it and more than capable.

>> Thank you for saying that. And in Alabama, we have the same. One of the pushes in Alabama last year was to take the questions about mental health in terms of have you had mental health issues. Those are no longer part of the licensing questionnaire. You do not have to answer those. And I think that was, you know, the work that the Lauren and Brain Foundation has done, >> I think, has been really huge in helping state medical societies recognize that we don't want physicians to feel stigmatized for asking.

>> Absolutely. We want absolutely understand that this is an open door that they can walk through if they need anything and there is no backlash that's going to come from that. We want physicians to know that those services are available. So I am really glad to hear that North Carolina surrounding states also are having that experience. I've definitely felt that in Alabama as well. in. >> Yeah, >> we are blessed in North Carolina to have a consortium which is a think tank that was really came up from both the medical board and the medical society. It was dormant during co but then the medical board reinvigorated it and fortunately we've been able to benefit from the skills of Corey Feist and Steph Simmons at the Lorna Breen Foundation. >> Yep. and we've really made considerable strides into helping hospitals get their credentiing questions up to date. Again, I'm blessed that the North Carolina Medical Board is a very thoughtful and progressive board and as far back as 2017 when they identified the need to change on boarding questions and annual renewal questions, they took that bull by the horns and did very well. And that's a credit to, you know, the physicians and lay staff serving on the board, but also to the leadership of David Henderson and the team at that time. And North Carolina continues to be a very thoughtful and progressive board, which protects patients, but also supports its licences. And that's a nice triangle to work in.

>> Damian, thank you so much for being here. Thank you so much for sharing your time. If we're going to put the link for the clinician Burnout Foundation in the show notes, >> if anybody wants to reach out to you directly, how best would they find you? >> Jod and I were having some hiccups with my email at the Clinician Burnout Foundation, but I know hers is working.

So, anybody can email Jod and she can direct that to me. And we're just always glad to listen to folks, especially Coldface. And I love to pick up the phone and just give them a call and say, "Hey, thanks for reaching out. What might we do to help? >> That's fantastic. I'm so grateful for the work that you are doing, for the work the Clinion Burnout Foundation is doing, and I can't thank you enough for being here.

>> My pleasure, Lee. Thanks for all that you do, and please keep doing good work. >> Well, it's because of people like you, and I I hope that we can continue to reach positions. I have been very very humbled to see the positive response as this podcast has gotten more and more into really talking about burnout and really trying to offer available resources and I hope we can continue to reach physicians in this way. >> I suspect you will.

>> For everybody who has joined us today on the scalpel and sword, if this episode resonated with you, please share it with a colleague. If you have a friend or a colleague that is in need of help, please give them a safe space and an open hand and share these resources with them. But until next time, be at peace.

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