Fixing Healthcare Podcast Transcript

Interview with Jonathan Fisher

Jeremy Corr: Hello, and welcome to our Fixing Healthcare podcast show "Breaking Healthcare's Rules." I am one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast and CEO of Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of The Permanente Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author of the bestselling books Mistreated: Why We Think We're Getting Good Health Care—and Why We're Usually Wrong and Uncaring: How the Culture of Medicine Kills Doctors and Patients. All profits go to Doctors Without Borders. If you want information on a broad range of healthcare topics, you can go to his website RobertPearlMD.com.

Our guest today is Dr. Jonathan Fisher. He is a Harvard trained, clinically active cardiologist who has devoted much of his medical career to identifying the origins of burnout, finding solutions to this growing problem and returning joy and purpose to the practice of medicine.

Robert Pearl: Hi, Jonathan, and welcome to Fixing Healthcare season seven.

Jonathan Fisher: Hey Robbie, thanks so much for having me. I'm really excited.

Robert Pearl: This season is dedicated to breaking the rules. The rules we're talking about aren't the ones found in textbooks or learned in academic lecture halls, and they're not the legal or regulatory ones. They're the rules that we learn in medical school and residency training by observing our senior residents and attending physicians. Most are never spoken, but all are communicated effectively. We know they're a rule because we watch doctors across the country doing them even when the data says there are better ways to provide medical care. Let's start at the beginning. Can you tell the listeners about your path through medical school, residency and fellowship and when you first veered from the expected trajectory?

Jonathan Fisher: Absolutely. The story for me goes back a little bit further than that. Robbie, I am the youngest of seven children. I grew up in suburban New Jersey, and if you go to Livingston, you'll find a sycamore tree with a shingle hanging from it, says Hyman W. Fisher, M.D. My dad started a practice there around 1950 and one by one, the six older siblings followed in my father's footsteps. They went on house calls with the old leather doctor's bag, and it eventually became clear to me that this is what the Fisher family did. We were all physicians. There were two cardiologists, my two brothers. We have an infectious disease specialist, my sister Laura. David and Andrea are radiologists, and Naomi is an infectious disease endocrinologist. My dad was the family doctor, the town doctor for a town of 25,000 for many years until he started several other endeavors.

People used to ask when I was about 15 years old, do you feel any pressure to become a doctor? My answer was always, no, there's no pressure and I'm sure I wanted to communicate my own sense of autonomy. But in retrospect, Robbie, there was quite a bit of pressure to follow in the family footsteps, to put on a good show in a sense, because this is what we did. In fact, when I was a resident up at the Brigham, we were invited to be on Good Morning America. They had me fly down from Boston to New York with my scrubs on because it looked good for Diane Sawyer to tell the story about how this whole family went into medicine. Literally, it's in my blood.

I started out at Mount Sinai and I was pretty early on acutely aware of the competition that was there. We had, fortunately, a cutting edge pass/fail system. We didn't have the pressure of having to get straight As, but I was acutely aware of my rotations that I needed to get honors if I was going to go on and be successful as it was defined then. I remember my surgery rotation in third year. We had a very well respected general surgeon, resident and a fellow, and I felt like I was in the military, which was a very bizarre thing. I had gone to a liberal arts school and studied art history, a bit of science and biology and physics. But then I found myself having to walk quite erect, almost like a group of ducklings following this senior surgical resident to speak in exactly the way that he spoke, to present in a way that was expected. This was the first time I remember this jarring sense that there were certain rules that were established, rules of behavior if we were to fit in and to excel.

I also remember in medical school that I expressed an interest in going to one of the Harvard hospitals for my residency, and the program director where I had been said, "You're never going to get in. You should just give up. You don't have the grades, you don't have the merit. You're not number one in your class." I felt early on from my own leaders and teachers that I wasn't necessarily supported and nurtured and encouraged. It was sort of a regimented black and white, and that didn't quite fit with my personality.

Moving on to my residency, I had such a wonderful experience. I was at a place where Eugene Braunwald was, godfather in cardiology, Elliott Antman, also preeminent cardiologist. And so, it helped me see my future where I wanted to be. Yet at the same time, we had just had these new laws that said residents were allowed to sleep for four hours a night, and this was a revolution at the time. In retrospect, it's kind of disgusting in a way that this was meant to be viewed as a generous practice that acknowledged the need for sleep, but we were still exhausted. There were plenty of experiences that were formative for me during my residency where I watched patients get sick and die.

It was a rare experience where I had a resident or a fellow come up to me and said, "This is an important moment here. We need to talk about this." And so, I felt this growing rift inside of myself between my identity as a human being who went into this field to care for other people and these external sets of rules of how I was to behave if I was to earn merit and to move on to bigger and better things.

The story goes on into my fellowship. Then as an attending physician, I can share with you that one of the most jarring moments was when I began my current job 15 years ago at a large multi-state system. It was after a week of work that I got an email with an Excel spreadsheet on it with 35 cardiologists. And I, after working my tail off to get to this point in my career, found myself at the very bottom of this thing that was called productivity. My RVUs, which I found out later were my relative value units were much less than my more invasive higher ticket partners. This set me up for a bit of confusion for my first decade of practice, Robbie.

Robert Pearl: You've really defined these unwritten rules so beautifully. There was a rule in the Fisher household, you had to become a doctor. I'm sure it was not written any place, but as you said, you might not even aware of the rule and yet you had to follow it as did you and all your siblings. You described beautifully the experience of being the resident and having to walk in a certain way, speak in a certain way, and not talk about other aspects to it. We can come to the RVU issue in a second because that is, I think, a fundamental reason for the burnout that doctors are feeling today, this sense of being on a hamster wheel. But let me ask you, there's an unwritten rule to never admit you're tired or experiencing psychological problems as a physician, whether in training or in practice. You broke that rule early in your career. How and why did you do that?

Jonathan Fisher: I had help is the answer. I had a loving, caring, kind best friend who saw me suffering during my residency, and that happened to be my sister Andrea. Andrea saw that who she had known as a sensitive, artistic, creative photographer who maybe wrote a little poetry on the side, I was losing something of my identity and my personality, and she saw that, and she helped me express it, at least to her, in secret because in my own family of origin, it was not okay to talk about these harder feelings. It might have stood as a mark or a blemish against a stellar image of the perfect family, let's say, so that actually helped me have the courage, Robbie, to go on and see a therapist.

I will never forget, I was a resident at the Brigham and I called and I tried not to over-identify myself, and when I first went to the therapist's office, I wore a coat so that I could cover part of my neck, and I wore a hat so that nobody in the neighborhood, other residents would know that I was going to see a therapist. There was a lot of secrecy and there was a lot of shame that was there. I knew very little about the impacts of shame, Robbie, which really literally means to cover up. That's the origin of the word.

There was so much covering up that I was doing that eventually, I was unable to feel positive feelings. I had been so busy covering up the shame, the fear, the anxiety, which I had, which was not okay. Then what I found out later was depression. And so, I'm always careful when I'm speaking about burnout with different audiences to talk about the fact that it's easy to talk about burnout. It's harder to talk about the fact that there's a high level of depression among doctors and nurses and other clinicians who are burned out and the treatments

are different. But that's where things got started there and I can share in any direction that you like.

Robert Pearl: Well, you're obviously not a psychiatrist, but you've researched and experienced and written about and talked about and heard about this issue. How do you see burnout and depression as being different, and how do you see their treatments as being distinct?

Jonathan Fisher: Christina Maslach did wonderful academic work in the '70s and '80s in talking about the triad of the sense of either personal incompetence or being obstructed in our desire to function. She talked about exhaustion and then really the most sinister aspect of burnout is cynicism. There are these three aspects of burnout, and we know that burnout, first of all, is a workplace phenomenon, and that's the way that the word was intended to be used. Fortunately, the conversations coming back around now to put the responsibility for the majority of burnout on organizations, processes and cultures.

Depression is quite different. Depression is this sense of anhedonia, this inability to experience pleasure for days and weeks on end, which really is independent of work. It's a loss of interest in the things that we used to find joy in. It's associated with a sense of hopelessness about the future. There's an overlap between burnout and depression, but one is a workplace phenomenon, often driven by a certain set of known factors that Tait Shanafelt and others have described beautifully, whereas depression is more of a psychological diagnosis.

What I find interesting, Robbie, is, and this is all recent, there's some neuro imaging work that's been done looking at the neural pathways involved in doctors and nurses who are burned out, and there are overlaps there with the clinical spectrum of depression as well as anxiety. I believe that these are on a spectrum. I believe that there's an overlap. At least 10 to 20% of doctors who are burned out are experiencing some form of depression. If you look at Medscape's poll from last year between what we call clinical depression and then either subclinical depression, it's beyond 70 to 80% of all doctors across 29 sub-specialties reported depression at some point in the last few years.

Robert Pearl: When I think about individuals who experience chronic pain from a musculoskeletal, arthritic type situation, or potentially from a cardiac type problem, over time you do get depressed. On the other hand, when I think about people who have depression, there's a tremendous amount of data that says you're more likely to develop a variety of other medical physical type problems. I'm not quite sure that the line between these two entities, they may start at very distinct points, but it seems to me that over time, they end up overlapping quite a bit. Your thoughts?

Jonathan Fisher: Yeah, I think we're really still, even after 110 years since Sigmund Freud, 130 years, we're still in our infancy of understanding the final frontier, which is the workings of the human mind. You and ZDogg have spoken so beautifully about

these cognitive blind spots that we have, this difficulty in true self awareness. In my speaking with experts in the field, there's an acknowledgement that we're still at the beginnings of understanding the neuroscience of emotions. My friends who are psychiatrists and psychologists say the same.

I can tell you Robbie, though, for me, the important part after we've acknowledged that there are emotional impacts on our physical functioning. When we experience whether it's burnout or depression, and we are trying to help other people, which is why we went into this field in the first place, our ability to do that is impaired on a number of levels that are often unrecognized from our ability to focus the parts of the front of our brain, attentional pathways. Our ability to regulate our mood, which is centered in the limbic system, in the amygdala, is often dysregulated because of chronic levels of stress and also certain cognitive features where we tend to interpret situations as a threat, when in reality there may be no real threat.

And so, there are at least five different pathways that are dysregulated when we become burned out that can negatively impact patient care, patient experience, patient outcomes, and our own experience of a toxic system. Our own level of resilience goes down, even though we certainly don't want to acknowledge that as doctors, it would be the last thing that we would want to talk about for fear that we would be blaming ourselves for the problem that we're in. That's not my intention.

My intention here is to communicate that even though systems may be dysfunctional and we have a lot of work to do, we still have to look inside of ourselves and see how accurately we're perceiving our environment, how effectively we're communicating with others for the change that we talk about at the water cooler, but we so infrequently actually see. My hope is that we can lay out steps for people who are struggling, doctors and nurses, et cetera, and for their leaders to help us heal, to reduce the rates of anxiety, depression, and burnout among our healers so that we can then create a system of true care.

Robert Pearl: You trained for a decade to become a cardiologist, to take care of cardiac arrhythmias, to take care of cardiac vascular shortages leading onto heart attacks and chronic heart failure, and now you're spending a lot of your career in the area of personal performance and burnout, running what I believe to be the nation's best symposium each year on burnout. How did you make this pivot? How do you think about the work you're doing now versus the decade you spent training?

Jonathan Fisher: Thank you for saying that, Robbie. I have to say that the reason that we've been successful in this ending clinician burnout community is you, to a large part, you've been there since the beginning, sharing your books, your voice, your powerful message, and helping guide me, personally. I want to say thank you for that. The way it happened for me, I'm going to be selfish here and tell you the real answer. This was part of my own healing journey, and it came after listening to Brene Brown of all people. Brene Brown is an incredible writer and leader,

and part of my own self-help discovery was learning about her work about vulnerability and shame.

I certainly had trouble showing vulnerability and I walked around with a lot of shame with negative impacts. What she said, and a lot of psychologists know, is the only way to deal with shame is to share, to share your story, to find one person who you feel comfortable enough with that you can talk to it, maybe a coworker or a friend or a peer support person at your hospital system, whoever it is, we have to get what we think are deep, dark, dirty secrets up and out.

I realized that in order for me to walk my own walk, I needed to share that in a more public way. Once I had done my own healing, once I had healed from my own wounds, I knew that the work that I wanted to do was to make it okay for others who were suffering to do the same work. In order to do that, I kind of wanted to model this behavior, the behavior that will change a culture, which says we can no longer stuff down, ignore emotions. We are human animals, and if we don't acknowledge the power of emotions in day to day interactions, we are going to suffer the consequences.

We see it in the division in our nation. I think a lot of the conflict we see political and otherwise has to do with the unresolved emotional past of many people, and they're outwardly projecting inward suffering. Not to get off on that tangent, but to say that this for me was a practice of putting a toe in the water of social media, Robbie, and I had not been on social media in any meaningful way until about three or four years ago when I realized that my story might help other people who were afraid to share their own.

And so, during COVID, I shared pictures of having to take off my wedding ring as I came home to my wife who was a breast oncologist, and she did the same because as you know, at the beginning, we didn't know the rates of transmission and the modes of transmission even. I tried to show day to day experiences of what it's really like to be a doctor on the front lines or on the second lines of care. I found a tremendous response in the comment sections and emails and people saying, "Thank you for being honest, for showing us behind the curtain," if you will. Kind of like the Wizard of Oz, like showing what's really like to be on the lines of care.

That led me to meet somebody amazing, Kelcey Trefethen from Stanford, who reached out on LinkedIn and said, "Maybe we can do this work on a global scale." I think part of the problem we're facing in healthcare is that we're all siloed. We may be siloed in our own institution thinking that we're doing it best. We may be siloed in our own specialty thinking that we're better than others and we know the jokes that the orthopedists tell about the internists and the cardiologists tell about the neurologists, and it's funny, and at the same time, these silos are what are going to keep us from healing our healthcare system.

All of these divides need to be bridged. We need to begin the bridging. And so, that's really the motivation for my work. Selfishly, it's for the care that I may

receive 10 or 20 years from now when I know we're expecting a physician shortage of 100,000 doctors by the year 2030. It's the care that my children will receive. And so, this is about the future of healthcare for me. This is about my father's legacy who was the town doctor with that shingle that's still up. I think that's what drives a lot of my passion.

Robert Pearl: Beautiful story, Jonathan. Many of our colleagues have not wanted us to use the word burnout. Feeling that that implies that the problem is inside the individual caused by the, I'll say the victims, and they've wanted to embrace moral injury as the wording for what's going on right now. You've expressed some concerns about the use of that term. Why?

Jonathan Fisher: Because as any doctor would do, if we narrow the differential diagnosis, we will be blinded to the solutions. And so, if we narrow how we describe a certain situation, which I see as we're going to call it generically the suffering of our healthcare providers and our healthcare leaders. I think, at its root, there's a disconnection. If we use a narrow term like moral injury, it's a focus on one person, which is the healthcare provider who is injured. I would say that there's a connotation there, that there is an injurer. Once we have that connotation, there are elements of blame, of blaming the system. I've watched this for 10 years.

Well-meaning doctors who have no recourse, spend hours of their time talking about us versus them, us versus the system. I think a lot of the feedback and the popularity of the term moral injury, which is a very useful term, and we should talk about where it came from. I think the popularity comes from a sense of hopelessness and frankly bitterness, which oftentimes is appropriate, but after a while becomes dysfunctional.

And so, I'm hoping that our healthcare providers can fully embrace the suffering that they're going through and also move beyond the sense of there is an injurer and an injured moving towards solutions. And so for me, the term burnout, there's nothing inherent. There's nothing inherent about the word, "I feel burned out," to say that it's my fault, and at least through my lens. There are, as Maslach put it, it's a matter of the match or the mismatch of an organization and an individual where burnout comes from.

You may have a wonderful organization, Robbie, a healthcare organization doing everything, and there still may be an individual who has a background of either personal trauma, unresolved anxiety, cognitive distortions, which lead them to get burned out. And so, I would hate to have that person suffer and have solutions be lost because everything is chalked up to a single element of moral injury, when I would say that many of my frustrations happen because of excessive number of clicks during my day, and I hate to make that a moral issue. I think moral issues should be reserved. I prefer to reserve that term for a different spectrum, if you will.

Robert Pearl: I really like that view that there is a much broader set of inputs. You mentioned earlier, some of the "jokes" that really, you laugh at them, but they're really not that funny because they deprecate hardworking clinicians, but that certainly has to contribute to some of the dissatisfaction and lack of fulfillment at work. We saw during COVID, specialties like OB-GYN and pediatrics, ones that have a higher proportion of women, watched burnout rates soar, not because of anything at work, but because they added 8 to 10 hours a day that they were spending at home having to take care of their kids who are no longer in school. If we narrow our focus too far, and one of the areas that I believe is so important is how do we do the things to improve how we're feeling. Even if they're not the etiology, we still need to, as physicians, as human beings diminish pain. Those opportunities could get overlooked, as you say, in a mindset of victim mentality.

Jeremy Corr: There are so many books out there and people out there speaking about physician burnout. One of the things I've seen on social media and even heard people say in person is along the lines of looking at physicians is almost being entitled for complaining about their burnout or you might hear people say, "Physicians make six-figure salaries, have great homes, cars, vacations, might even have a stay-at-home spouse to help raise the children. When I work 60 or 70 hours a week for a $50,000 a year salary at a factory or hotel or a farm, why should I care about physician burnout when I'm just as burned out for a lot less money and quality of life?" What are your thoughts on that?

Jonathan Fisher: My first thought, if I'm being posed with that question, is to listen to the emotions behind that question. The response there, the first response is not some defense of why physicians are so concerned about burnout. The first empathic response is to recognize that workers in every industry are suffering, our working class is suffering. We have countless jobless in this country. We have political divide, which are driving people to greater and greater levels of division and resentment.

And so, just to recognize that for a moment before we make this about physicians versus non-physicians and saying that a rising tide lifts all boats is how I would say this. My hope is that we need to help all industries here. I'm agnostic that we don't just need to help healthcare and burnout in healthcare. Burnout is a universal phenomenon across all industries in the west since the industrial revolution and the separation of the laborer from the leader of the organization. We've known this for over 100 years.

And so, while my roots and my shoes are in healthcare, I'm concerned about workers in general. As a cardiologist, I see heart attacks because of burnout in the financial industry and in other industries. But then, once I've made that connection with the person that's asking the question, I will say simply that the old story of physicians making six figures and playing golf a half a day a week and having a non-working spouse, that doesn't match with the reality that I'm seeing right now. It doesn't match with the reality that I'm seeing right now.

I think some of that is rooted in a resentment towards our healthcare system. We've had a breakdown in trust, which happened even before COVID and got much worse. Can we trust our elected officials? Can we trust our healthcare leaders? And so, I'm hoping that one conversation at a time between patients, doctors, and leaders, we can restore that fabric of trust, which is the bedrock of a healthcare system and a healthy society. Then after that, I would point to the statistics, the suicide rates among doctors, and the simple fact that unless we care for this very real problem of burnout, we will have a shortage of healthcare providers. The lines to get in when little Jimmy has a broken leg are going to be longer and longer. And so, for practical reasons, I would encourage people to take this very seriously.

Robert Pearl: You've been a big proponent of a variety of solutions to the burnout crisis that we face over the past several years. People look to you for major leadership, for thought leadership, for programs, for direction. What are some of the approaches that you've seen that work and why do you favor them?

Jonathan Fisher: I see a common driver for unhappiness, Robbie, and it has to do with human disconnection, this sense of isolation. And so, I tend to view solutions through that lens. For me personally and many of the people that I work with, there's individual work that needs to be done in order for us to become leaders in our lives. I believe that even if we don't run our practice or have an executive role, every healthcare provider is a leader, whether they know it or not. The moment they step into an exam room with a patient, they are leading the energy in that room, which has an impact on healing and outcomes. And so, for me and many others, there's a beginning of the journey as an individual one, almost a selfish one, where there's a looking inward.

And so, many of the remedies that I teach and guide workshops in have to do with self-awareness and overcoming these natural blind spots that we have to our own patterns of behavior. This means looking at our past, it means looking at how other people experience us and it means doing something that doctors often don't do. In our culture, there's a rule that says you will become a physician, you will have a 30 or a 40 or a 50-year career and you'll retire. We don't start with this premise that we must have growth in our lives.

I think other industries do this better than healthcare. In healthcare, we get our MD and it's almost like off to the races, we'll see you in 30 years. And so, the work that I encourage has to do with personal growth, not for a short period, but over the course of one's career and lifetime. That means committing to curiosity and learning about our own behavior, committing to improving our ability to communicate. For me, Robbie, that's the key.

You could say, "Well, the reason our healthcare system is broken is because executives don't know how to talk to doctors and nurses. It's because doctors don't know how to communicate effectively with their colleagues, and they're so busy with infighting that they can't lobby for meaningful and unified change." The problem in our healthcare system is that patients are left out in the cold.

They need to have special advocates help them because they feel so shut out in the cold from a system that doesn't listen or communicate.

And so, so much of the work for me begins in becoming aware of patterns of communication, studying the work of Marshall Rosenberg, who was the founder of nonviolent communication in the 1950s Detroit. He wanted to know why, as a Jewish man, surrounded by antisemitism and also race riots, why it was that people couldn't communicate with each other. And so, he developed a system of communication that is very effective, yet I don't see us learning that. It's often taken for granted that because of this thing called the Dunning-Kruger effect that we all think we're better at any skill than we actually are. We all think we're better than average at communicating and being self-aware when we all have the blind spots.

One of the skills is self-awareness. One of the skills is communication. Another skill is developing empathy. I want to be really clear here. I don't know anybody more empathic in the world than the people I trained with, the people that I work with. But empathy is a dynamic process with an input and an output. Over time, over medical school, we know there's a dramatic drop in empathy of these human beings who set out to be healers. And so, I begin with reestablishing a sense of empathy for ourselves, for our own suffering, whether it's from our family of origin or the training that we went through, or a toxic system that just didn't know any better and practicing things like self-compassion and kindness towards ourselves.

Because I know in my own experience, Robbie, that it wasn't until I started to treat myself and speak to myself in a kind, loving, supportive internal voice, that I was truly able to be present for patients in a way that made them feel not only not threatened, but in a way loved and supported. As a cardiologist, I'm fascinated by what I like to call interpersonal neuro cardiology, which is I know for a fact that how I hold space for my patients has an impact on their ability to heal from heart attacks, heart failures and arrhythmias. There's no doubt in my mind. And so, that is often rooted in a practice of mindfulness or meditative contemplative awareness. There's a reason that more than 90% of all Fortune 100 companies in this country have some kind of a meditative practice. It's because it strengthens the power of self-awareness, self empathy, and there's a natural emanation of empathy and ability to communicate to others.

Jeremy Corr: I know when I or my son go to the doctor, I'm always extremely polite and show gratitude for the care that we receive. Is there anything patients can do to help alleviate physician burnout?

Jonathan Fisher: I got an email yesterday from the service line leader where I work, and it was saying, "We just got this email yesterday from a patient of yours, Dr. Fisher, and it was a note of appreciation for the care that you've given for years, the fact that you got him to the heart surgeon just in time, the fact that the heart surgeon and the invasive cardiologist did their job." I'm sure it took my patient maybe three minutes to type out a message. This is now percolated through the

entire system. It's certainly given me a personal lift. It's lifted everybody, 75 cardiologists have seen this appreciation for the work that we're doing and a little bit of appreciation, Jeremy, goes a heck of a long way. It's not just to your healthcare providers, I would suggest that if you go to Dunkin Donuts, say, "Thank you." Just this practice of being more grateful help us realize that the suffering that we're immersed in really can be balanced by an appreciation of the small kindnesses that people show us each and every day.

Robert Pearl: You and I were just on a panel on lifestyle medicine, very, very well received by folks. You spent some time exploring this issue you just mentioned of mindfulness. Can you tell readers and listeners more about it?

Jonathan Fisher: Mindfulness, it's an English translation of an ancient Indian word from 2,500 years ago. There was a book among many that was written down from the works of the Buddha. It basically means being aware of what's happening in this very moment, not getting lost in thoughts, being aware of what's happening internally in my own body and in my own mind and externally. Among the thousands of inputs, information, data points that are happening in each moment, it's turning up my ability to become aware of them in a non-reactive way. That's the key. That's generally speaking, mindfulness is total awareness of this moment with full acceptance, not rejection. It's often misunderstood. People say, "Well, does that mean that you just accept being treated poorly and you accept the way that..." That's not at all what mindfulness is about. It's not passivity.

In fact, it sets individuals up for a very powerful new way of experiencing their environment. A moment of choice opens up when we pause and we become aware of our own reactivity. I spent a good 35 years in reactivity. I'm not happy with this. I'm overwhelmed by that. I'm stressed out by this. I angry about that. If it weren't for this practice of mindfulness, I could have spent the entire rest of my life wrapped up in my own narrow emotions and set of awareness. And so, for me, just sitting quietly, noticing the flow of information in an observing way, this is what Sigmund Freud called witness consciousness or the observing ego.

This is the core skill of all modern psychotherapies is developing that ability to watch our own experience as an observer and then re-engaging with emotions that we want to engage with, the positive emotions, pro-social love, kindness, compassion, and maybe making a different choice when we notice the earliest ember, the earliest flames of anger, frustration, and resentment, and choosing to relate to those emotions differently using some of the practices of the ancient stoics.

In a nutshell, that's what mindfulness is. This is not woo-woo. There's tens of thousands of research articles. It's been used by the United States Marine Corps and used widely across other industries and in healthcare systems. In Australia, at Monash University, there are thousands of medical students, students being trained in mindfulness beginning at year one because the data are so strong that adding this to the curriculum improves patient care and outcomes and also

reduces the incidence of burnout and improves the wellbeing of medical students. I've spoken to mindfulness teachers around the world who've shared similar stories.

Robert Pearl: I'm very impressed by that story. In my book Uncaring: How the Culture of Medicine Kills Doctors and Patients, I report data from first year medical students. These are medical students who haven't used a computer to provide patient care yet. These are individuals who have not had to get prior authorization. These are individuals who haven't yet actually seen patients, and yet the burnout rate after year one is large and increasing year over year. This idea of starting training so early in the medical process could avoid some of the loss of empathy that you describe that occurs across the medical training experience. I love it.

Jonathan Fisher: Yeah, absolutely. Robbie, I wanted to throw in a couple of other pieces. In addition, we talked about mindfulness, we talked about communication. These are ways that we will change the culture. People say, "Well, you have to change the system." I point out that a system is nothing more than a collection of individuals. If our individuals don't have the presence of mind and the ability to impact change and influence the thoughts, feelings, and actions of other people, then we won't have a generation of leaders who can make these changes that people so desperately want.

I think that coaching has a role, and we talked about this in the lifestyle conference, but there's a trend in American healthcare now, which I'm very heartened by out of the Cleveland Clinic and elsewhere, in my own institution at Novant Health, there's a culture of coaching beginning even from incoming medical students, and I coach our residents with the head of our wellness department, Dr. Tom Jenike, and we take trainees just before they've started, and we say, "We're going to set you up for success and growth throughout your career and we're going to support you." And so, this is a shift in our culture that I'm happy to see.

One other element I think that's necessary is an awareness of this field of positive psychology. I'm really surprised when I speak to audiences in healthcare and I say, "How many of you have heard of this field?" And no hands go up. Just a word on positive psychology, this is the science of what it means to live a good, fulfilling and joyful life. So much of the work of Tait Shanafelt and others in burnout is rooted in this positive psychology, this awareness of basic human needs. Forget the fact that we're doctors and patients and executives, we are humans first. Any solutions have to be rooted in a deep awareness of human needs and human commonality.

Robert Pearl: Another controversial term is resiliency. There are some people who believe it's essential to managing the pain that often is termed burnout, and others see it as simply blaming the victim. What are your thoughts about resiliency and resiliency training?

Jonathan Fisher: I have to tell you that when I first heard that word, I was pissed off. I was going to be offered a program on resiliency when what I needed was some rest and what I needed was some support. I didn't need to be told that I was a problem. And so, I think the challenge here is to frame the conversation properly. Resiliency is a necessary characteristic, and physicians and some of the nurses I work with are the most resilient people that I've ever known. This doesn't mean when we burn out that we are lacking in resiliency. Oftentimes, it has to do with a toxic system. We've spoken about that. And, at the same time, there's a tremendous amount of pride that many of us have as cardiologists, as surgeons, where we say, "I'm resilient. I'm strong. I don't need help."

And so, I want to demystify that and just dissect it for a moment, Robbie. For me, the key is the way we define resiliency. I think we're defining it incorrectly. There's a common idea that resiliency means the ability to bounce back from challenge or, more often, it simply means the ability to withstand harsh circumstances. I think it's that misunderstanding that leads physicians to say, "I can do that. I've been doing it for 10, 20 and even 30 years. Look at me. I'm still here today."

But I think if we look a little deeper, we see often these physicians have maladaptive habits, there are addictive behaviors, there's higher rates of divorce, et cetera. And so, what we're not seeing is true resiliency in those situations. That's more of a sheer bearing through hardship. I'd like us to redefine resiliency for the ability to withstand life's inevitable challenges and suffering, and to come back into a place of growth that is rooted in an outward-looking, pro-social concern for others, even after we've been through our own suffering. That's not what I'm seeing in a lot of people who've gone through suffering.

And so, I would love to continue to embrace this concept of resiliency. I certainly can tell you as someone who was burned out partly by a system that was unhealthy, the system didn't change. I was able to change my own ability to withstand and then to connect with others in a deeply empathic way, which is how you and I met. And so, that's how I think about resiliency.

Jeremy Corr: Jonathan, one of the big trends on social media among Gen Z and even Millennials, is quiet quitting, where you're so burned out or miserable in your job that you just stop caring. You stop caring about your job, you stop going above and beyond, you do the bare minimum to not get fired or even less, and essentially wait for management to notice the poor performance and let you go. Do you fear this trend of quiet quitting either is infiltrating or could infiltrate healthcare professions such as doctors and nurses, and if it did, obviously be extremely dangerous, but what are your thoughts?

Jonathan Fisher: Quiet quitting has been around for a while. We used to call it disengagement, and it is a problem in healthcare, but I think not as much as some other industries. One of the benefits of healthcare is that baked into it, we have almost the ultimate sense of personal purpose and meaning in the work that we

do, which is to improve the quality of lives and perhaps the duration of lives of other human beings. At least for me and my colleagues, I can't imagine anything greater. The threshold for that quiet quitting is a bit higher.

At the same time, I see it. I can see it in response to organizational emails that go out mandating some change to our work schedule or to our responsibilities without first seeking our input in what's happening. This leads to a natural sense of almost rebellion, rejection, frustration, and self-preservation in a way. We certainly are going to see this trend. The only remedy for this quiet quitting is for leaders and sometimes with the help of wellbeing leaders. The CEO of the company sets the tone for the culture, but may not have the full bandwidth to be thinking about how do we help individuals feel fully engaged in their jobs.

And so, with the help of leadership, there will be a proper attention on are individuals here getting to live their own best lives at work? I think there's a great conversation happening. I noticed this on social media. Chief wellbeing officers and workers, in industries across this country and others, in healthcare and beyond, are focused on this exact question, how can we rekindle the flame of personal purpose and meaning that we all went into this job with?

Robert Pearl: I was struck during COVID that clinicians were encountering three and four deaths a day. Medicine is filled with dying as a end point to life, a reality that exists, but the magnitude, I talked to a resident who started a ICU rotation at the start of the month, and by the end of the month, the eight patients that she cared for all were gone. Yet, I don't think that clinicians often, there are exceptions, talked about what that experience was like, losing three and four people in a single day.

I don't know how many hospitals brought in a psychologist or a psychiatrist to work with people in a group environment. I mean, when we know there's a toxic human experience and the failure to save a life is one of those. It's inevitable, but that doesn't mean that it is not real. That to me, are opportunities to address resiliency in the right way to which you are speaking.

Jonathan Fisher: Yeah, I totally agree with you on that. I'm a bit obsessed, Robbie, with this idea of death and dying, and remedying the deficiencies in our system of training so that our healers can be prepared. I mean, this is a huge part of what we do is we watch people either get better or often get worse, get sick, and often die. There was no part of my medical school curriculum that I can remember that helped me for that. And so, I'm interested in the work of palliative care doctors in particular. There's a wonderful, not a doctor, but she's a contemplative practitioner. Her name is Joan Halifax, and she writes beautifully about being with the dying process. I think doctors and nurses, we all can learn a lot from our palliative care partners.

She describes the metaphor, and I know you like metaphors. She describes the metaphor of being with dying as requiring a firm spine, so being grounded in ourselves, being able to be with the heart, emotions that come up within

ourselves. There may be shame or guilt when our patients don't do well. At the same time, what she calls a soft belly, which means keeping that empathy and that compassion open when our instinct is to shut down in the face of death and dying and to send someone off to someone else.

And so, I think the subject that you're bringing up is a very important one. We have lots of room in our early medical school education to help doctors train for this. You wouldn't send someone into battle and not mention the fact that you're going to witness your partners getting hurt, injured and die, and you're going to potentially watch people across the battle lines die. You wouldn't dare talk about that or solve for that problem in advance.

And so, I think with a little bit of planning and intention, Robbie, we can insert into our medical training across the board the skills that exist. These are not very complicated skills that exist that help people be with the difficult emotions of death and dying. While we're at it, being with anger, being with patients and families who are angry and knowing how to regulate ourselves and still maintain open lines of communication with the idea that we are wanting to grow and not recoil.

Robert Pearl: An essential part of the medical culture is denial. It's essential. I mean, think back to the Black Plague when people are dying all around you, a third of all of the people who lived in Europe at the time, you go out into the streets to take care of them. You're risking your life. How do you leave your house except by denying the danger that exists. We saw it during COVID in the early phases when we didn't know what this virus was. We didn't have the protective gear we needed, and doctors still went out there into the ICUs, into the ERs, took care of patients. Patients often coughing in their face, risking the life of the physician. I mean, denial is part of the training. As you say, the hours that we spend, the exhaustion that we experience, we can debate whether it's positive, negative, how do we evolve it, but it certainly exists in that environment.

I think that this process of accepting death and helping patients through it suffers from this use of denial. I think in many times, we can't see the line between treatments and torture. Medicine has advanced so far from when your dad practiced. We can keep people alive as we did for three years on respirators in the COVID time period. We have to sort this out and talk about it. I think we still, as a profession, want to believe we save a life at every cost, at any cost and it's not an economic issue. I think it's a pain issue. It's a psychological issue, it's a family issue, it's a societal issue. I personally believe that we need to have that conversation in great depth and maybe we can have it the next time I have you back on the show. Let me ask you one final question, Jonathan. What are the next set of rules you are planning to break?

Jonathan Fisher: I'm going to focus on finding ways that those who want to go into the healing professions, who want to serve others, I'm going to find ways that those individuals can not only sign up as if they're going into the military for a lifetime, a lifetime of self-sacrifice and martyrdom. I'm going to find rules that we can

create that allow flexibility in their own unique life path so that we are no longer feeling like widgets in an unfriendly, unkind machine. But instead, we bring our full humanity to work. That may look like flexibility in our scope of practice. It may be flexibility within our own specialty, what procedures do we do and can we make sure that a good 20% of every doctor's schedule is up to their own discretion? Because we know that productivity won't go down, productivity goes up when people have this basic human need for agency, autonomy.

The rules of healthcare are going to be around the doctor and the healthcare provider and the patient as the sacred relationship that even as AI and other technologies must enter healthcare to help us make better decisions and to standardize patterns of care, even as that happens, I can't foresee a time when that basic relationship rooted in empathy, compassion, and effective communication, and a respect between the connection and the mind and body, I can't see a time when that will go away. The future of healthcare will be rooted in that relationship and in a respect for the autonomy of the healer as much as for the autonomy of the patient.

Robert Pearl: Perfect way to end today's conversation. Thank you so much, Jonathan, for being on Fixing Healthcare.

Jonathan Fisher: Jeremy and Robbie, thank you, and for what you're doing for healthcare and people not in healthcare and for allowing me to be part of it. This was a lot of fun.

Jeremy Corr: We hope you enjoyed this podcast and will tell your friends and colleagues about it. Please follow Fixing Healthcare on iTunes, Spotify or other podcast platforms. If you liked the show, please rate it five stars and leave a review. Visit our website at fixinghealthcarepodcast.com. Follow us on LinkedIn, Facebook, and Twitter @FixingHCPodcast.

Thank you for listening to Fixing Healthcare, Breaking the Rules with Dr. Robert Pearl and Jeremy Corr. Have a great day.