

## Letters to the Editor

### Encouraging Medical Students to Explore Career Tracks Within Medicine May Help Them Avoid Burnout

**To the Editor:** Forty percent of young physicians report that they would not go to medical school if given the choice again.<sup>1</sup> Twenty percent of physicians are dissatisfied with their careers,<sup>2</sup> while 34% meet criteria for burnout.<sup>3</sup> An explanation for these staggering numbers may be found in a study revealing that those who spend less than 20% of their time on their most meaningful activity (i.e., patient care, research, or education) have significantly higher rates of burnout than do physicians who focus on their most meaningful areas.<sup>3</sup> This suggests that optimizing career fit would substantially increase physician satisfaction. Since medical school is often the first opportunity for future physicians both to explore the various career tracks within medicine and also to experience burnout, it would be an ideal place for medical students to pursue their unique interests to ensure a good fit.

The creation of individualized tracks as a supplement to a standard medical education would allow students to self-select the area most in line with their particular strengths and interests. Students in the research track could be exposed to biostatistics and clinical trial design and work individually with a faculty mentor on a structured research project. Those in the education track would have the opportunity to help develop the medical curriculum for students under the guidance of clinician-educators. Finally, the majority of students would be in the clinical care track, which would feature added elective time in community-based settings and also allow students to learn about the business aspects that drive medicine. Important components of this educational prototype would be strong faculty advising and the flexibility to change tracks, such that students could make informed decisions and navigate their paths as they recognize changing interests.

This approach would enhance the current paradigm in which we

teach medicine. The current medical education system focuses the vast majority of its time teaching students about the various fields within medicine, but fails to encourage students to discover the environment within which they would like to practice medicine. A large part of medical school is about students discovering their interests, yet, too often, students have limited opportunities to see which culture of medicine fits them best. The individualized track model we propose would allow students to see which area of medicine most corresponds to their unique strengths and interests. Just as important, students might discover areas they find particularly unsatisfying. These experiences would enable students to make better decisions when considering which residency programs best align with their interests. It is our hope that early exposure to the different aspects of medicine might also save students from facing burnout later on in their careers.

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- 1 Brown S, Gunderman RB. Viewpoint: Enhancing the professional fulfillment of physicians. *Acad Med.* 2006;81:577–582.
- 2 Buchbinder SB, Wilson M, Melick CF, Powe NR. Primary care physician job satisfaction and turnover. *Am J Manag Care.* 2001;7:701–713.
- 3 Shanafelt TD, West CP, Sloan JA, et al. Career fit and burnout among academic faculty. *Arch Intern Med.* 2009;169:990–995.

#### In Reply to Kwatra and Rimoin:

Burnout in medicine is a problem. At some career stages, it can be traced to overwork and excessive work-related anxiety. Homogenization in medical education is another contributor that prevents many physicians from developing their distinctive abilities and contributing as much as they could, and it is certainly desirable,

as Kwatra and Rimoin propose, that medical schools help physicians-in-training achieve a better fit between their innate interests and the specific career paths they pursue. Medical education and practice need to be less one-size-fits-all and more tailor-made.

As we probe further into reasons for burnout, however, the problem turns out to be still more deeply rooted in a lack of clarity of purpose. Too many physicians are pursuing their careers as businesspeople, and not responding to a deep sense of vocation or calling. Properly understood, medicine is not a career but a profession, and the most promising deterrent to burnout is rich and sustained vocational reflection and conversation.

We in academic medicine need to provide medical students, residents, and practicing physicians opportunities to think about the deep social, psychological, and spiritual needs that drew them to careers in medicine in the first place and that constitute the wellsprings of resilience and inspiration from which they all need to be drawing throughout their lives. Only when physicians deeply understand why they are physicians and how they contribute to the lives of others will they find full fulfillment in medicine and life.

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#### “Surely, We Can Do Better”: Scaling Innovation in Medical Education for Social Impact

**To the Editor:** A paradigm shift is under way in medical education—or so the myriad responses to *Academic Medicine's* 2011 Question of the Year<sup>1</sup> suggest.

The central argument made by the authors of those responses: The academy must broaden the societal reach of academic medicine to prepare trainees for today's health care system. To paraphrase Porter and Teisberg<sup>2</sup>:

Surely, we can do better. The challenge is determining how to achieve their collective aim. How do we move from the white paper to the white coat?

We believe there needs to be real-time integration of the authors' varied solutions into a cohesive whole, one that emphasizes translational action. And we need evidence to prove that this transformation is both attainable and desirable.

To achieve these goals, we offer a potential model: the VA Connecticut Center of Excellence (COE) in Primary Care Education, established in 2011 by the Veterans' Health Administration (VHA) Office of Academic Affiliations as one of five national centers focused on interprofessional medical education. We maintain that the principles within this model, stated below, offer potential answers to the challenge before us.

First, the foundation of efforts to broaden the societal reach of academic medicine must rely on interprofessional collaboration—a rich and essential component of modern U.S. health care.

Second, the curricula for this effort, taught in medical schools, must emphasize the unique skill set that enhances such collaboration, with frontier concepts in public leadership, health policy and economics, negotiation, conflict resolution, improvement science, and political advocacy key to that effort.

Third, the education must be immersive, with the longitudinal exposure to meaningful clinical and didactic experiences necessary to equip trainees with skills to generate broad social impact. Team-based delivery models—such as the COE's clinical practice in the VHA's Patient Aligned Care Teams, supported by the integrated electronic medical records and global payment systems inherent to the integrated delivery system—may add value.

Fourth, modalities linked to improved clinical outcomes, including shared decision making and sustained application of performance and systems improvement strategies,

must be integral components of such efforts.

Finally, these models must serve as “exemplary care and learning sites,” intended for replication with the potential for rapid, dramatic scaling upward.

Achieving the paradigm shift we seek in medical education demands evidence-driven, patient-centered results. Restructuring of traditional medical and nursing education models away from a “siloes” approach toward collaborative learning experiences—within meaningful educational homes—may be the first step. This shift must also include integration of improvement science into all actions and deliberate skill development in policy, management, leadership, and public service.

Critics may suggest that it is impossible to integrate these disparate elements into medical education. Our initial experience with the COE model argues otherwise. The societal challenges of our time demand action. Educational models that transform interprofessional education while simultaneously preparing trainees to meet those challenges may be the solution.

*Disclaimer:* The views expressed in this letter are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs.

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academicmedicine/Fulltext/2011/11000/Proposals\_to\_Strengthen\_the\_Link\_Between\_Medical.I.aspx. Accessed August 27, 2012.

- 2 Porter ME, Teisberg EO. *Redefining Health Care: Creating Value-Based Competition on Results.* Boston, Mass: Harvard Business School Press; 2006.

## They Don't Always Do What They Say, and Sometimes We Don't Either

**To the Editor:** The following observation prompted us to write this letter.

As part of a research study, we have been providing automatic blood pressure monitors and hypertension education to underserved patients. Almost across the board, those enrolled have verbally consented that they would increase physical activity, assess blood pressures at home, and change diets. However, we noted several participants who have not changed their diets or assessed their blood pressures as promised.

How common is it for people to verbally agree to do something and then not do it? It's probably more common than we think. Do we physicians really follow the guidelines that we tout to our patients? Do we watch our salt intake and increase our physical activity? Do we take our medicines, or do we even seek medical attention for problems we may have? What are we communicating to our students? Are students taking us less seriously when they see behavior inconsistent with what we are teaching? We may be losing credibility when they “hear” us say one thing and they “see” us do another.

This is not just an issue of students' perceptions, as our patients probably observe the same thing. Are patients in our study jaded because our body mass indices fall outside the normal range, or is this just what folks tend to do—“teach” it and not “live” it? What about adherence? Are we sending nonverbal messages to our patients about how we really feel about behavioral changes?

The reality of the matter is that we doctors are human too. Just because we have completed medical training and we “know” what we should do and we understand the consequences of nonadherence doesn't mean that we are always compliant. That