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# Enhancing Wellbeing in Pediatric Heart Transplantation Providers

Nearly 20 years ago, the late David Foster Wallace addressed the graduating Class of 2005 at Kenyon College with the following parable: “There are these two young fish swimming along, and they happen to meet an older fish swimming the other way, who nods at them and says, ‘Morning, boys, how’s the water?’ And the two young fish swim on for a bit, and then eventually one of them looks over at the other and goes, ‘What the hell is water?’” 1 He goes on to remind us that **“the most obvious, ubiquitous, important realities are often the ones that are the hardest to see and talk about.”** 1

For too long, the vast majority of medical centers and healthcare organizations incorrectly placed the onus of boosting professional satisfaction (“wellness”) entirely on the individual healthcare provider. In doing so, they abdicated themselves of the shared responsibility to address the critical role that organizational factors and the practice environment play in either supporting provider engagement or contributing to burnout.3 While these organizational factors can seem nebulous, this “water” that surrounds and affects all of us has been characterized and grouped by Shanafelt and colleagues into 7 dimensions: workload and job demands, control and flexibility over work, work-life integration, alignment of organizational culture and individual values, social support and community at work, and meaning or purpose derived from work.3 If we approach healthcare provider “wellness” and “wellbeing” from this lens – it transforms these banal concepts into concrete ideas that can be leveraged to improve the entire healthcare ecosystem. Put simply: if the fish in your fishbowl are getting sick, it’s just as imperative to change the water as it is to rehabilitate the fish.

As our society and healthcare system collectively emerges from the throes of COVID-19, the terms “burnout,” “compassion fatigue,” “moral distress/injury,” and “secondary traumatic stress” have become ubiquitous in their use to describe a pervasive epidemic facing healthcare professionals. Even in pre-pandemic years, national studies indicated that at least 50% of both US physicians in training as well as practicing physicians are experiencing burnout.3 Comparable rates of burnout have also been described in non-physician medical disciplines as well, including advanced practice providers, nurses, pharmacists, and social workers.4 Burnout is a well-characterized, psychological syndrome stemming from chronic exposure to work-related stressors. Its three key components are overwhelming emotional exhaustion, feelings of cynicism and detachment from work, and a reduced sense of personal accomplishment and self-efficacy.5 While burnout arises from chronic workplace stress, “compassion fatigue” specifically arises from the emotional and physical exhaustion resulting from repeated exposure to the suffering and trauma of others. It is often described as the "cost of caring" for others in emotional pain and is often characterized as a form of “secondary traumatic stress.”4 In addition, the concept of “moral distress” often exacerbates burnout in that the individual “knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.” 6

Leaving burnout unchecked has immense personal implications for healthcare providers. Healthcare organizations thus have a moral and ethical imperative to address this pervasive syndrome as it has been linked to broken relationships, alcohol and substance use, increased risk for cardiovascular disease, depression, and physician suicide.2,4 In addition to the profound personal repercussions for their employees, organizations have a strong professional, quality-based impetus to address this problem as well. Studies indicate that increased levels of burnout in providers correlate with decreased quality of patient care, increased medical errors, and a decrease in patient satisfaction. Distress in physicians has also been shown to affect prescribing habits, test ordering, and an increased risk of malpractice suits.2 Furthermore, widespread burnout in the healthcare workforce leads to increased physician turnover with the costs of replacing a physician estimated to be 2-3 times the physician's annual salary (when accounting for recruitment, onboarding, and lost patient revenue).2 For those providers who choose to stay in maladaptive environments, burnout affects productivity and professional work effort. A prospective, longitudinal study of >2000 physicians at the Mayo Clinic found that each 1-point increase in burnout (on a 7 point scale) was associated with a 30-40% likelihood that the individual would reduce their professional work effort in the next 24 months, which was corroborated independently with payroll records. 7

Several risk factors for healthcare provider burnout include working in a specialty with "frontline" access to clinical care (ie – pediatric primary care, general internal medicine, emergency medicine), early career status, excessive administrative tasks, electronic health record documentation demands, and increased time spent at work.2,4 These risk factors, coupled with the ongoing emotional toll of consistently bearing witness to the suffering of others places pediatric cardiac transplant providers across the inter-disciplinary care spectrum at high risk for burnout, compassion fatigue, and secondary traumatic stress. Though I work in pediatric palliative care, I have witnessed first-hand the various stressors that my cardiac transplant colleagues face: caring for critically ill (sometimes dying) children and their families, unpredictable schedules, unforeseen complications, long hours, and the decisional burden of transplant listing (among others).4 A recent study of four geographically diverse pediatric solid organ transplant centers across North America sought to investigate burnout and related constructs among pediatric solid organ transplant team members (physicians, surgeons, trainees, transplant coordinators [RN, NP, PA], psychologists, social workers, transplant administrators). Notably, the study was conducted pre-COVID-19 and showed that one-third (34%) of participants endorsed burnout (n = 135) while only 43% reported professional fulfillment with their work. Importantly, 15% of respondents endorsed clinically significant levels of post-traumatic stress symptoms related to patient deaths.4 Unsurprisingly, the rates of burnout and provider distress during the pandemic reached higher rates than were previously reported.4,8 Recent studies indicated that 20% of physicians and 40% of nurses planned to leave clinical practice after two years of the pandemic.8 Given that the scope of this problem is vast and its implications far-reaching, any attempted solutions require nuance, personalization, and most importantly, a blend of both individual and systemic initiatives to address healthcare provider wellbeing.

Although the epidemic of burnout in healthcare has been extensively documented and described for many years, the devastating effects of COVID-19 served as a catalyst for many national and international healthcare organizations to put forth action-oriented plans. As an example, the National Academy of Medicine in the United States offers a strategic blend of institutional and individual initiatives, as outlined by its 2024 National Plan for Health

Workforce Well-Being.8On an institutional level, fostering a culture that prioritizes workforce wellbeing is essential, with leadership playing a pivotal role in setting the tone. The National Plan emphasizes the need for systemic changes, such as reducing administrative burdens, ensuring adequate staffing, and offering flexible work schedules, to alleviate the intense pressures that contribute to burnout. Providing access to mental health resources, including counseling and peer support programs, is also crucial. On an individual level, the National Plan advocates for self-care practices, emphasizing the importance of physical, emotional, and social wellness. Healthcare providers are encouraged to engage in mindfulness practices, build resilience through peer mentorship, and maintain a healthy work-life balance. By implementing these evidence-based strategies, institutions can not only enhance the well-being of their providers but also improve patient care outcomes. 8

For pediatric cardiac transplant teams, the following actionable steps may serve as some "best practices" to consider as tools to prevent burnout among team members. Although there are individual-level suggestions here, please remember that the "water" or practice environment that we work in is equally important to address:

- Ensure staffing is appropriate for the number of patients 2,3,4,8
- Ensure sufficient coverage for leave to allow all team members to properly utilize their paid time off 4
- Ensure all team members are functioning at the highest level of their licensure
- Maximize electronic health record efficiency; consider scribe support 2
- Promote community among team members through social gatherings 2,4
- Ensure that all team members have access to mental health resources (e.g. – 988 National Suicide and Crisis Lifeline in the United States)
- Provide emotional debriefing sessions conducted by trained facilitators after patient deaths or when needed during particularly high-stress situations; include all members of the inter-disciplinary team 4
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