"Breaking Bread" to Combat Burnout

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Primary Care Progress
Women Writers in Medicine
Center for Behavioral Health Integration

We were into our dessert course when a physician in her early 40s stood up to summon the attention of the dozen guests around the table.

"I've been practicing for 15 years and I've never felt more connected to my colleagues than I do at this moment," she told those gathered. "I came here tonight ready to leave medicine. And I'm leaving here tonight feeling like I've finally found my tribe."

Her colleagues in the room clinked glasses, wiped tears, and nodded in agreement. Within a few minutes, as plates were cleared, plans were made for book clubs, storytelling nights, and workplace incubators. Three hours and four courses later, community was beginning to form.

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In early 2018, Primary Care Progress — an organization working to strengthen the health care community — embarked on an initiative to better understand the community of care in the

trenches of American medicine. We wanted to go beyond the well-documented drivers for the rising rates of burnout and professional dissatisfaction; instead, we were curious if there were consistencies in drivers of fulfillment. Our study took us to 34 states to interview hundreds of primary care clinicians, host more than 50 dinners with health care providers, speak at dozens of gatherings, and facilitate 15 focus groups.

In our pursuit of clinician fulfillment, we indeed discovered a powerful and prevailing theme — connection. But where we found the greatest spaces for connection — the presence of connection *and* the opportunity to cultivate greater connection — was perhaps the bigger surprise: dinner.

The Power of Breaking Bread

There's little doubt that the experience of sharing a meal can be transformative. It's part of our collective experience — even our history, what Winston Churchill coined "dining diplomacy." In June 1790, over *boeuf à la mode*, Thomas Jefferson, Alexander Hamilton, and James Madison negotiated a deal for the federal government to assume state debts. One hundred and seventy years later in New Orleans, over spicy gumbo at Dooky Chase's, Rudy Lombard, Cecil Carter Jr., Lanny Goldfinch, and Oretha Castle planned a sit-in down the street at McCrory's whites-only lunch counter, a key moment in the fight against segregation. And then there are the examples in Biblical tradition — from the bite of an apple to 5,000 fish to the Last Supper.

Again and again, food has been a vehicle for connection, community, and social change. In the medical world, the connection is even more direct, with Hippocrates saying, "Let food be thy medicine and medicine be thy food." Which begs the question: Could this simple act of breaking bread be a tool in the fight against burnout?

So far, the answer is a resounding "yes."

The Decline of Community

In a recent article in the *Annals of Family Medicine*, Dr. John Frey bemoans professional loneliness and the loss of the doctors' dining room. Frey notes of his early days in medicine, "On the second floor was the . . . cafeteria. At 11 pm, the cafeteria was opened. Probably 60 house staff and almost equal numbers of medical students showed up every night to talk about admissions and stories from the day and drink coffee. We were exhausted, but life was vivid and memorable and collegial . . . . When I started practice at a community health center in a new family medicine residency program, the four faculty members at the clinic would have lunch most Wednesdays at the corner booth at a local Chinese restaurant . . . . We talked, as Lewis Carrol put it, '. . . of many things: Of shoes — and ships — and sealing-wax — Of cabbages — and kings.'"

In many ways, Dr. Frey is describing the bygone era of salons. With their roots in 16th-century Europe, salons were gathering places to quite literally feed a person's quest for connection, inspiration, and insight. They were a blending of the emotional intimacy of the family meal with the drive for professional engagement and social change.

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Fast forward to modern America, and along with salons, we've lost so many vehicles for connection and social change: the closure of churches, fraternal societies, and bowling leagues, as well as the loss of both colleague lunches and family dinners.

Many point fingers at technology, beginning with the advent of air conditioning that moved people from fanning themselves on front porches with their neighbors to closing windows and doors to keep the cold air in. And then there's the mobile phone that has diverted eyes from people to screens and hands from pats on backs to taps on keyboards. For clinicians, the electronic health record (EHR) is routinely and justifiably blamed as accelerating the demise of the patient-provider relationship.

But whatever the culprit, community is the victim. And when we lose community, we lose so much more than the soul enrichment and physical benefits of connection; we also lose a kind of fellowship that breeds insights and innovation. We no longer make the time nor have the space for people to come together to think, connect, and be restored.

The Rise of a Disconnected Workforce

This loss of community is painfully evident among America's burned out health care workforce. A September 2018 report from the Physicians Foundation found that 78% of doctors report the symptoms of burnout. Physicians have the highest rates of suicide in the nation. Interns experience a tenfold increase in depression in the first year alone.

This comes at a time when we're seeing increasing attention paid to the epidemic of isolation nationwide (the objective measure of how large a person's social network is) and loneliness (a subjective perception of how a person feels). The former is a risk factor for the latter, and the latter touches one in three older Americans. Former Surgeon General Vivek Murthy, MD, calls loneliness the greatest epidemic of our generation. In fact, loneliness is nearly as prevalent as obesity and

even more deadly — as risky to health as smoking 15 cigarettes a day, shortening our lifespan by 8 years. Doctors understand better than anyone how our solitary existences impact health, with health systems leaders like Sachin Jain, MD, exploring ways to push for the prescription of friendship through interventions like weekly "phone calls, home visits, encouragement, and connection to community-based programs" for patients who report being lonely or who have limited social ties.

Most interesting for these epicurious researchers is that according to the U.K. Campaign to End Loneliness, 35% of individuals experiencing loneliness report that sharing a meal is the activity they miss the most.

The Factors Driving Fulfillment

As Primary Care Progress listened to stories of burnout and fulfillment, it was clear that the themes playing out nationally — crises of community and feelings of loneliness — were especially felt in health care. It was like the space of the clinic was a distilled amalgam of America's ills.

> *It was remarkable how buoyed they became when they discovered that they weren't alone — when their ideas were listened to and their values and aspirations welcomed with curiosity and exploration."*

As we engaged in conversation after conversation, a pattern emerged. Like Tolstoy, who posited that, "All happy families are alike; each unhappy family is unhappy in its own way," we discovered that across specialty, geography, career stage, and job type, the drivers behind burnout were varied. The driver behind fulfillment, however, was the same: connection — to patients, to purpose, and to peers.

Health care leaders, to their credit, are jumping on any shovel-ready project with a modicum of promise and some element of "togetherness" — from mandatory mindfulness sessions to group yoga. We also understand the power of a phenomenon known as positive contagion — that is, the organic spread of positivity. Just take the findings of a report in the American Psychology Association: People with happy partners are significantly more likely to report better health, experience less physical impairment, and exercise more frequently than participants with unhappy partners.

The question, then, becomes: How we can create community among health care providers that has the power to spread?

The Birth of a Movement

David Brooks argues in a piece in the *New York Times* that a renaissance is occuring in American communities across the country. Citing James and Deborah Fallows' book, *Our Towns*, he finds that "as the national political climate has deteriorated, small cities have revived. As the national scene has polarized, people in local communities are working effectively to get things done."

Could that be true of the increasingly polarized and dysfunctional health care system? Could hundreds of nationwide, local gatherings over dinner salve the healer's soul and ignite a kind of revival of connection and purpose in health care? The jury is still out, but the early wins are compelling.

Just take one dinner we hosted in the fall of 2018. As we were enjoying barbecue and beer with a dozen residents and faculty in rural Arizona — strangers to each other despite having worked in the same area for years — it took clinicians only a few appetizers before they began connecting around the things they have in common: shared experiences, similar backgrounds, what they love about their work, how they deal with their frustrations. The stories kept coming and coming. It was remarkable how buoyed they became when they discovered that they weren't alone — when their ideas were listened to and their values and aspirations welcomed with curiosity and exploration.

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It was intended to be an hour and a half; they stayed for nearly three. They moved from the complaints of the present to the possibilities of collective action. And in that experience, a community of peers and change agents was born.

Dozens of gatherings later, and the examples abound. In late August, we hosted a dinner for physicians of color in Atlanta. As we approached the topic of race in the clinic, one clinician offered an incident that had occurred just days prior, when a patient refused treatment, insisting

he be seen by a white doctor. It was a sensitive dialogue. After listening empathetically to the experience, a colleague piped up, "Are you looking for support or a second opinion?" The women spoke of actions and reactions — shared traumas and the impact of bias. It was powerful in a way I didn't understand until several days later when one of the doctors reached out. She had just experienced the very same episode in her own clinic. But rather than being stunned into inaction, she was able to respond in a way that felt authentic and empowering. More importantly, she didn't have to push down those feelings; she slipped into her office and sent her colleague a note.

She had found her tribe — and with it, her voice.

Experiences like these confirm both our beliefs and our research. Will a shared meal with a colleague eradicate burnout and revolutionize care? Maybe not (fixing the EHR and abandoning prior authorization would go a long way). But our army of providers in the trenches of care need to eat. Let's see if we can feed their bodies and their souls, and in doing so, bring community back into care.

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Steve Barrett

Nice article! I, too, have been very concerned about the increasing sense of "isolation" in medicine today, particularly in private practice. Dinners are a start. I think "team-based care" is the central answer.

March 20, 2019 at 11:01 am

Elizabeth Metraux

Thank you! Team based care is absolutely part of the solution; learning how to "team well" is part of the challenge. I'm heartened to hear that clinicians like yourself are embracing a more collaborative model.

March 20, 2019 at 1:36 pm

William Houghton

Terrific article! I'm a retired psychiatrist who did group psychotherapy, out of the office 7 years, and have participated in a number of other political and professional groups. Lots of people need these "breaking bread" groups which the Europeans started in cafes and the Irish in pubs centuries ago. John Frey had it right-on in his article, which matched my experience in five states during the 70's, 80's, 90's. Do you pay for the meals? Fancy or modest? Can I come to some? I have found since retirement that a good many lonely Americans of all ages need something like this and am working to set some such groups up. Thanks for putting it out there for doctors to consider (if only they can get away from their laptops for a bit).

March 20, 2019 at 12:33 pm

pritpal singh

Thanks for an interesting article on connecting with cinio (welsh for food!)

March 24, 2019 at 1:45 pm

David Scott, MD

One valuable aspect of my reserve deployment to Iraq was meals with my corpsmen and fellow providers. It was collegial and an opportunity to decompress.

Now everyone is TOO BUSY, a phrase I’ve come to hate. Most physicians who have served in a combat zone seem to agree that in many ways it’s easier than practice back home.

March 27, 2019 at 10:03 am

Deb Roman

Thank you for this wonderful article. We have been exploring these ideas in our healthcare community in Boise. We offered a facilitated evening "salon" at our most recent conference and rented a local cafe for our monthly physician discussion group (modeled after the Mayo groups).

These forums for connection and conversation have been nourishing in so many ways. They have provided opportunities for physicians to meet with peers in relaxed settings, express shared experiences and renew relationships. In addition, they have inspired many in our healthcare community to work together to address the high levels of physician burnout.

In fact, we recently discussed the value of creating a "movement" rooted in relaxed opportunities for conversation and engagement between physicians and healthcare system executives in an effort to enhance understanding and inspire collaborative action at organizational and system levels. Providing a healthy meal is a given.

March 27, 2019 at 12:30 pm

Anita Hart MD FACP SFHM

Let's not forget the impact leadership at our local societies can have—at the Society of Hospital Medicine Michigan Chapter we've been having dinner meetings quarterly—with up to eight different health systems represented, across 4 different sites using a tech enabled platform. At our largest meeting yet wed had 100 hospitalists show up for dinner, a speaker (Kirk Brower MD) followed a panel discussion with local system leaders) on wellness/burnout. One of our aims has been to create fellowship while sharing updates that impact our practice.

March 31, 2019 at 7:43 am

Felicity Bennett

A very apt and engaging article. I couldn't agree more that sharing experiences over a meal with colleagues is indeed supportive, bonding and inspiring. Having organised many such gatherings over the years I will continue the effort for all our well-beings.

April 03, 2019 at 3:34 pm

David Hallman

What a fantastic article which highlights the power of connection and community to combat the moral injury we're all experiencing. While, I am completely supportive of the concepts as presented, one needs to have the TIME to be able to enable these connections. When a practitioner rises at 4:30-5:30 am every day, is subjected to overwhelming workloads and responsibilities non-stop for 12-16+ hours a day (no lunch, no down time, no breaks), with added burdens of after hour activities from meetings to chart work, etc., the prospects of "breaking bread" seems like a pipe dream. Perhaps, this approach will work in disciplines where the work load is easily deflected or not urgent but for real physicians it is not realistic.

April 03, 2019 at 6:40 pm

Marc Rovner

It is realistic, but requires a fundamental change in how we think about ourselves as heroes. It took me years to realize that it was not necessary for me to say yes to everything and that I did not have to do everything or see every patient sent my way. It took me years to get control of my schedule. I used APPs and was happy to let then generate time for me as a start. I do not know what your specialty is, but the first step is learning to really say no, to getting off the treadmill and take a genuine look at what you really want. If it is time, you have to give up revenue. If it is revenue you have to give up time. If we want a life, we have to stop killing ourselves because we think we have to. Your are too valuable to feel this way. It is hard, especially when, if you are employed or in an underserved area, the control is not entirely yours. Good luck!

April 16, 2019 at 10:21 am

Jennifer

I concur with all of your sentiments, David. I am an RN clinical manager for a home health team. Our patients are high acuity, with > 15 meds, multiple chronic diseases, some with memory issues and family members too busy to help. We've instituted daily huddles to discuss patients, which takes 30-45 minutes out of my clinicians already jam packed schedules. Time intensive charting, travel time, new government forms to complete added every year...cuts in to actual treatment time and therapeutic relationships. Nurse burnout —> frequent call outs—> overworked staff —> more call outs —> implement telehealth for less frequent nursing visits—> tech savvy-less older patient population doesn't like the tablet—> "where's my nurse, I don't want a different nurse each visit" —> decrease patient satisfaction score. I truly love patient care and home health but it has become so difficult to manage a team, meet the regulatory requirements of daily operations, do payroll and productivity spreadsheets, field patient complaints and service recovery, on board and train new team members, field team member questions and concerns, lock and calculate charts....the list goes on and on. Now add to my plate patient visits in the field because they need to be seen by a nurse this week, evening triage phone calls and part-time classes to obtain my BSN. All of this equates to a demoralized RN with 10 years of home health experience and 3 years of ICU experience heading to an insurance desk job. Because if I don't, I will be the one taking > 15 meds.

April 20, 2019 at 10:15 pm

J.G. Bhat, MD

I enjoyed the article thoroughly. I do remember the days when every hospital in Queens County in New York used to have dining room/area for doctors in the cafeteria. Food often was free or heavily subsidized. This gave an opportunity for doctors to mingle, talk about their patients, arrange social events, and grab a bite before they went on with the next task.These brief breaks help reduce stress level. These have simply become relics of the past.

April 16, 2019 at 10:05 am

M. Carmen Meerschaert, M.D., M.B.H.L

I support the premise that an interactive professional community is essential to preventing burnout. I believe as do others that "burnout" is foremost a consequence of our obscured professional ethical compass. Since medical ethics are shaped by the collective morals and principles of our colleagues, it is essential that we be afforded the opportunity to informally seek guidance from our peers to alleviate our moral angst.

April 16, 2019 at 3:29 pm

Trudy Bearden

My uncle, Sverre Nielsen, was the executive director of the Norwegian Psychological Association and is still a senior advisor for them. He has always been a proponent of taking lunch together as an organization. There was an unspoken rule at his office that no one was "allowed" to work through lunch. I have seen this in practice at an FQHC when I conducted a site visit, and they invited me to join them at lunch. loved it!

April 24, 2019 at 11:13 pm

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