Commentary on "Burnout, Resilience, and Mindfulness in Healthcare Workers in a Medically Underserved Region During the COVID-19 Pandemic"

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Burnout remains a significant issue among US healthcare workers. According to a recent study, 62.8% of practicing physicians report one symptom of burnout, and satisfaction with work-life integration dropped to 30%.[1] Although alarming, these numbers do not indicate the other costs of healthcare worker burnout, including worse patient outcomes, healthcare worker attrition, and worsening mental health crises among healthcare workers. The unique experiences of healthcare workers in medically underserved areas are an area of inquiry in the literature on burnout and healthcare workers. In this issue of the *Southern Medical Journal*, Mukherjee et al report on the high prevalence of burnout for healthcare workers in medically underserved areas, despite high personal accomplishment, resilience, and mindfulness.[2] This data contributes to the growing literature on healthcare burnout, but also raises questions on the interplay of vicarious trauma and multiprong wellness interventions in mitigating the impact of healthcare worker burnout in the United States.

The American Counseling Association defines vicarious trauma as "the emotional residue" of bearing witness to a patient's distress, trauma, and pain.[3] Good clinical care requires excellent history taking about the factors that contribute to a patient's illness. Doctors have the burden of not only treating diseases but also are repeatedly exposed to narratives about tragic life circumstances such as food insecurity, economic instability, community violence, grief, and homelessness. Physicians have little influence over the socioeconomic barriers to their patients' health; yet, they must heavily consider these factors for medical decision making. Trauma exposure is evident in the examination room when patients disclose their pain, cry out in despair, and look to the physician to help solve problems that may not have an answer. Over time, the emotional burden of caring for patients can become extremely overwhelming and diminish the empathy reserves even the most caring doctors possess.

Vicarious trauma can be thought of as the tension-building process that leads to burnout, which is a distinct, long-term exposure to secondary stress and compassion fatigue.[4] Physicians in medically underserved areas are at particular risk of vicarious trauma and burnout as a result of high patient volumes and a higher concentration of patients who have lacked preventive care. Constantly changing documentation requirements and never-ending battles with insurance companies for treatment coverage take significant time away from patient visits. Administrative stresses coupled with trauma exposure lead physicians to feeling ineffective, overworked, and unhappy. Physician resilience is not enough to mitigate the diminished sense of control doctors feel over the care they provide.

In 1979, Karasek proposed the job demand-control model to describe job strain as an excess of job demands over decision latitude.[5] Although burnout was not directly measured, higher job satisfaction was noted with jobs having high demands and high decision latitude compared with those with low demands and decision latitude. For instance, despite executives and assembly-line workers having stressful jobs, executives had higher job satisfaction, and this was believed to be the result of the decision latitude that executives have. Given that the decision latitude in a clinical job is difficult to alter, the job demands-resources model was developed to demonstrate that through the mobilization of resources such as autonomy, feedback and professional development, to decrease the impact of job demands and prevent burnout.

Wellness interventions are most successful when used proactively to prevent burnout and promote job engagement and satisfaction despite job demands. In the healthcare setting these interventions can be grouped based on their impact on the job demands a healthcare worker experiences: system, organizational, and individual. Systems-level interventions involve hospital administration making changes to the environment healthcare workers

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practice in and can increase engagement by supporting professional development opportunities or promoting provider autonomy. At an organizational level, department leaders can ensure that providers receive timely performance feedback or supervisory coaching to assist them in achieving their career goals. Both systems- and organizational-level wellness have been demonstrated to have the most impact because they are not only providing resources but also influencing the job demands and decision latitude that healthcare workers experience. The last level is individual wellness, which focuses on self-directed interventions such as mindfulness or self-care. Unfortunately, as demonstrated by the article by Mukherjee et al, even in the presence of increased resilience and mindfulness, it was not enough to mitigate burnout.

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