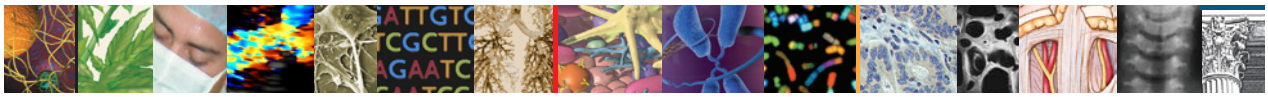

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

To Fight Burnout, Organize

Leo Eisenstein, B.A.

The clinician who coined the term "burnout" was not a primary care physician buried under paperwork, nor an emergency physician beset by an unwieldy electronic health record. He was Herbert Freudenberger, a psychologist working in a free clinic in 1974.[1] Discussing risk factors for burnout, he wrote about personal characteristics (e.g., "that individual who has a need to give") and about the monotony of a job once it becomes routine. He also pointed to workers in specific settings — "those of us who work in free clinics, therapeutic communities, hot lines, crisis intervention centers, women's clinics, gay centers, runaway houses" — drawing a connection between burnout and the experience of caring for marginalized patients.

In recent years, burnout has become a chief concern among physicians and other front-line care providers. But somewhere along the way, the concept was separated from its original free-clinic context. The link between marginalized patients and clinician burnout seems to have gotten lost.

As a fourth-year medical student, I have received ample warning about the sources of burnout: death by a thousand clicks, too many hours at work, feeling like a cog in a machine, too many bureaucratic tasks. As a newcomer to medicine, I feel intimidated by it all. But from what I've observed — both during medical school and before enrolling, when I spent several years working in safety-net clinics — Freudenberger's free-clinic context points to another source of burnout that receives insufficient attention. It is the experience of caring for patients when you know that their socioeconomic and structural circumstances are actively causing harm in ways no medicines can touch.[2] As medical students, we are educated about the social determinants of health and increasingly warned about burnout, yet little is made of how the former may contribute to the latter — for example, how clinicians may feel worn down by the poverty and oppression their patients face; may feel powerless when they cannot offer more than, say, a form letter to a landlord explaining that turning off a patient's heat would be deleterious to her health; and may feel demoralized when they realize that their instruction "Do not take this medication on an empty stomach" translates into patients taking their medications only sporadically because they don't have enough to eat.

This contributor to burnout is not unique to physicians' work. In medical school, though, I've seen an additional problem that may make it especially painful: we are led (and allow ourselves) to believe that we as individuals have more power than we do. Despite a shift toward team-based care, the image of physicians as singu-

lar heroes, as saviors, remains deeply embedded in medical culture.[3] To many people, the white coat and the prescription pad represent the highest form of individual agency, the very picture of social power. But eventually, a physician will encounter patients whose health problems derive from a wicked, multigenerational knot of poverty and marginalization, and even the most astute, excellent physician may well find herself outmatched. Facing patients' adverse social circumstances as an individual clinician is a recipe for disillusionment: the physician who believed she was maximizing her individual agency comes to feel utterly powerless. No longer the lone hero — just alone.

In this link between social determinants of health and burnout, I see a problem, but also a way forward. If individual powerlessness is the crux of this source of burnout, then organizing toward collective action should be part of the solution. Each of us can advocate for our homeless patients to be put on waiting lists for public housing. But what would happen if all doctors with homeless patients organized to demand more affordable housing?

Organizing is both strategic and therapeutic — strategic because our collective labor and voice are greater than the sum of their parts; therapeutic in the sense that the activist Grace Lee Boggs articulated: "Building community is to the collective as spiritual practice is to the individual." When we recognize ourselves not as individual actors each isolated in an exam room, but as a collective joined in common cause, we start to feel less alone.

Some researchers have asked whether physician advocacy should be seen as a professional obligation or an aspirational goal.[4] For me, the link between physician burnout and patient marginalization changes the terms of this debate. Beyond whether we must or should do it for our patients, collective advocacy to address the harmful social determinants of health can buoy physicians' morale and thus be an act of self-care; organizing toward collective action means looking after both our patients and ourselves.

You have probably heard this parable before: A group of friends comes upon a fast-moving river where they find people drowning. The friends jump in headlong to save as many people as they can. But the drowning people keep coming. As soon as the friends rescue one, another comes into view. Eventually, one friend starts heading upstream. Another, exhausted, yells after her: "Where are you going?" The first one says, "I'm going to find out what's throwing all these people into the river."

The classic reading is that this parable is about prevention, but it also points to how upstream determinants contribute to burnout. Here is, I imagine, what happened to the friend who headed upstream: she saw the unending flow of drowning people coming their way. She deduced that there must be some force, hidden around the bend, that was sending people to drown. She noticed herself and her friends getting exhausted, all on the brink of burnout from the urgent, unending work. So she mobilized her friends to go upstream, for the drowners' sake and for their own.

Obviously, it is not new for front-line clinicians to get fed up, organize, and start heading upstream. It's what happened when physicians built collective-action organizations like Physicians for Social Responsibility and Physicians for a National Health Program; it's what happened when clinicians joined the Moral Mondays demonstrations in North Carolina to fight for Medicaid expansion; and it's what happens every Sunday morning in Boston, when residents and attendings, faced with an overdose epidemic, organize with the group SIFMA NOW to advocate for supervised injection facilities as a harm-reduction strategy.

In SIFMA (Supervised Injection Facilities–MA) NOW, health professionals organize side by side with harm-reduction advocates and people who use drugs. The group enables participants to build solidarity and take action in an otherwise overwhelming crisis. Dinah Applewhite, a resident at Massachusetts General Hospital, reflected at a recent meeting on how organizing can be a balm for her as a physician: "Despite my best efforts in clinic, I've had too many patients overdose, get endocarditis, or contract hepatitis C or HIV from unsafe injection practices. Being part of a community of advocates empowers me to fight for solutions to this crisis. It means that I'm energized and grounded, rather than burnt out, by these preventable tragedies."

The social determinants of health — and physicians' sense of powerlessness in the face of them — seem crucially missing from the discussion of burnout. This kind of burnout is the feeling you get when you're trying to rescue the drowning people but they keep coming. And you're torn between competing exigencies: the proximal needs of the people

drowning, and the distal need for naming, fighting, and demanding accountability for the upstream forces that are causing harm.[5] Medical students are trained to think from a vantage point of individual agency, and we become stuck there: "What can I do?" begins as an earnest, ambitious question, but it so often spoils to a cynical one. If medical schools and residency programs are serious about burnout, they have to teach us about collective action — teach us to ask, "What can *we* do?" To fight burnout, we should never worry alone about the social determinants of health that patients face. To fight burnout, organize.

Disclosure forms provided by the author are available at NEJM.org.

From Harvard Medical School, Boston.

This article was published on June 20, 2018, at NEJM.org.

1. Freudenberger HJ. Staff burn-out. J Soc Issues 1974;30:159-65.
2. Hood CM, Gennuso KP, Swain GR, Catlin BB. County health rankings: relationships between determinant factors and health outcomes. Am J Prev Med 2016;50:129-35.
3. Berwick DM. Moral choices for today's physician. JAMA 2017;318:2081-2.
4. Gruen RL, Pearson SD, Brennan TA. Physician-citizens: public roles and professional obligations. JAMA 2004;291:94-8.
5. Krieger N. Proximal, distal, and the politics of causation: what's level got to do with it? Am J Public Health 2008;98:221-30.

DOI: 10.1056/NEJMp1803771