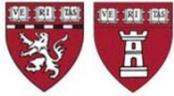

HMS/HSDM Faculty Council

Faculty Council Minutes
April 13, 2022

Present: Abrams, Adelman, Becker, Blackwell, Caradonna, Chang, Chen, D'Amico, Da Silva, Daley, de Girolami, del Carmen, DePace, Desrosiers, Gaufberg, Giannobile, Goldstein, Hatfield, Huang, Ingelfinger, Irani, Klig, Lee, Molina, Mullen, Murray, Nayak, Okereke, Park, Patel, Rodriguez, Silver, Solomon, Spring, Stone, Subramanian, Wagers

Guests: Drs. Greenfield, Hundert, Jones, Muto

Staff: Mss. Hecht, Ryan, Williams

This Faculty Council meeting was held virtually, via Zoom, due the COVID-19 pandemic.

Dr. Marcela del Carmen called the meeting to order at 4:05pm. She asked for and received approval for the March 9, 2022 meeting minutes.

Dr. del Carmen reviewed the meeting agenda and welcomed Drs. David Jones and Shelly Greenfield who were invited to speak to the Council on the COVID-19 pandemic, physician burnout, and mental health.

Dr. Jones began by discussing the history of pandemics and their impacts on humans. In March 2020, he noted in an article he published that catastrophic epidemics that killed millions of people are exceedingly rare in human history, and he thought it was extremely unlikely that we were at the start of one. He went on to say he was clearly wrong about COVID-19, which is still going strong with nearly 1,000,000 deaths in the United States and even at our current reduced mortality rate of about 500 deaths a day, that will still generate 200,000 deaths in a calendar year, which would leave COVID-19 in third place behind heart disease and cancer as a major cause of death continuing in the United States.

As a historian, he described horrors that have happened to humans through human history, shedding some light on where COVID-19 stands in comparison to events such as:

- the plague in the 1340s Europe killed roughly a third of the population of Europe.
- the flu pandemic in 1918 killed 675,000 people at a time when the US population was a third of what it was now. Dr. Jones stated that proportionally, the mortality rate was much higher from the flu in 1918 than COVID-19 is now. Worldwide, 40 million people died from flu of a population of 2 billion people versus 6 million so far for COVID-19. He also noted that the flu was a very fast epidemic in most cities, with the worst effects playing out over just two or three months, and we're now two years into COVID-19 related morbidity, mortality and disruptions. The flu killed many young adults, whereas COVID-19 mortality in the United States has largely been concentrated in older populations.
- World War II killed roughly 80 million people, many of whom were young adults.
- AIDS has killed 36 million people, many of whom were young adults.

Despite these horrors, Dr. Jones stated human societies have often found ways to bounce back and he describe the resiliency of the United States throughout time.

Dr. Jones then discussed the healthcare workforce, which seems to have been hit hardest by COVID-19, especially in terms of burnout. He mentioned it's important to remember that the problem of physician burnout is not new and that concerns have been brewing since the 1970s, with recent surveys suggesting it was getting much, much worse in the 2010s with very high rates of burnout across medical specialties.

So why is it that healthcare workers have been so shaken by this pandemic? Dr. Jones listed a few factors that have been used to explain why COVID-19 has been so disruptive:

- high patient volumes created an extreme strain on the health care system
    - hospitals were overflowing with patients
    - hospitals were unable to admit more patients
    - lack of available resources
    - ICU patients having to be managed in emergency rooms
- disruptions caused by masking and infection control procedures.
    - Many nurses have explained how they felt like they were unable to provide proper caregiving for their patients because they had to be so distanced and so masked because of COVID-19 precautions.
    - there's been many discussions of the kind of moral injury that providing health care in these circumstances has imposed on these health care providers.
- persistent anger among some health care workers about patients who remain unvaccinated or otherwise neglected
    - Classic accounts that people intubating patients who continue to deny that COVID-19 existed even as they were being intubated.

These all added significantly to the stress of an already overburdened healthcare workforce. Being a clinician has been more stressful, less rewarding and sometimes guilt inducing when the clinicians felt like they were unable to provide good care for their patients. Dr. Jones stated that any response to the burnout being seen now can't simply focus on what COVID-19 has done. Instead, it's essential to address the issues that had existed, that had caused burnout, before COVID-19. COVID-19 has made things worse because it was all those factors that set up health care workers for experiencing the crisis they have experienced during COVID-19.

Studies have identified many relevant factors to burnout, and Dr. Jones mentioned a few.

- Do people feel like they're working to the mission driven institution?
- Do they feel like the values of the institutions are aligned with their own values?
- Do they feel like they can provide the level of care that they desire to provide to their patients?

Dr. Jones went on to say there have been longstanding concerns about each of these issues. Doctors complain that they spend more time with electronic medical records than they spent talking to their patients. They complain about the financial pressures that hinder their ability to provide care. They do not always trust the leaders of their institutions share their values, especially with the growing intrusion.

While we will presumably get through COVID-19 just as we've gotten through far worse problems in the past, Dr. Jones noted that it will depend on what trajectory the pandemic follows going forward. If COVID-19 is something that causes wave after wave after wave every three months, that will be a very different problem. And if COVID-19 eventually does come under some kind of control, whatever we do to address this problem to enhance wellness and resilience needs to address the

structural problems in health care that existed before COVID-19, because those will persist if and when the pandemic fades.

Dr. del Carmen thanked Dr. Jones and introduced Dr. Shelly Greenfield to discuss burnout, mental health through the COVID-19 pandemic including increase in alcohol use/misuse.

Much like physician burnout, the mental health crisis did not start with the pandemic. Dr. Greenfield explained there was a major mental health crisis in the United States before the pandemic began, and when you already are in the midst of a major mental health crisis and then you have a global pandemic, that is really a recipe for what is currently being seen right now in the United States and right here in Boston and at HMS and in the affiliated hospitals. Dr. Greenfield reminded the Council that before the start of the pandemic, the United States had three ongoing mental health crises, with rising rates year over year. Crisis of suicide, crisis of opioid overdose deaths and the crisis of rising rates of alcohol use. She went on to say that in 2018, nearly 58 million Americans had a mental health or substance use disorder including 32 million women and there was a vast treatment gap where people with any mental illness over the age of 18, 57% of them received no treatment in the same year.

Dr. Greenfield spent some time focusing on women and alcohol. Pre-pandemic, there was a concerning rise in alcohol problems in the US starting back in the 1990s among American women, but it was also seen in women in Western Europe, Australia, New Zealand, and some other countries. Prior to the 1990s, alcohol problems were primarily prevalent in men at a rate of 5:1. By 2010 it was less than 2:1. Researchers and clinicians were already concerned about women's health and alcohol related issues, especially knowing that women are twice as likely to have depression or anxiety, well before the COVID-19 pandemic happened.

When the first wave of lockdowns began March to June of 2020, the pandemic disrupted all these social routines and support for women who provide 90% of caregiving in the United States, including childcare and eldercare. Much of the burden of the lockdown and home schooling and other COVID-19 related issues were disproportionately experienced by women. Unfortunately, alcohol use also became common.

Dr. Greenfield noted that advertising before the pandemic had been directed at women and men, but when the pandemic happened, alcohol was pushed forward by advertisers and social media as a good way to deal with the stressors of the pandemic. It was really amplified by social media, but liquor stores were also considered "essential services" and home deliveries of alcohol was considered a necessity and businesses delivered. Alcohol sprang up, and people found themselves at home and isolated, and drinking more in that context to cope with stress. All of this contributed to an increase in what was already not a good problem prior to the pandemic. When looking at the early part of the pandemic, there had already been an increase of 14% in the overall drinking rate in the United States in 2020 compared to before the pandemic with a 17% rise in women. Women had already increased, in the first months/beginning of the pandemic, their heavy drinking days by 41%.

Dr. Greenfield then discussed where things are now. In the pre-reading she sent along to the Council in advance of the meeting, she included a recent study showing that alcohol related deaths for both men and women had increased 25% in one year from about 78,000 in 2019 to 99,000 in 2020.

She spent some time discussing ways to help combat this problem. One of the first things that can be done is to lower the stigma related to all of these illnesses. They're common illnesses, and the more we can talk about them and the more we can lower the stigma and have conversations, the better it is for people in general. And the more we can normalize the struggles that people had in the last couple of years and talk about them, and make others know that these are common struggles that people have had, the better it is for people. Another thing that would be helpful is to identify other forms of coping, helping people learn that using alcohol and drugs to cope with stress is actually not normative and not actually helpful for their well-being.

Dr. Greenfield mentioned there are fantastic treatment resources available online. The NIAAA has a wonderful clinician guide called "Rethinking Drinking". There's also a manual on their website: https://www.rethinkingdrinking.niaaa.nih.gov/ for patients who can actually utilize tools to help themselves- consider how they are using alcohol, how they're drinking, and whether it is harmful to their own health.

She also said building opportunities to promote resilience in our communities within our hospital systems, the Medical school and within the University is really important. Some of these things can actually be as simple as creating group opportunities for people to come together and actually just have open conversations about how they're actually doing. Dr. Greenfield mentioned they started one of these in the early months of the pandemic at McLean for faculty and trainees, and they've run them every month since the pandemic began. They're drop-in groups, people come, and what people say is that in the course of their day, they have very little time. They talk to colleagues about how things are actually really going for them, and that has helped them. Most meetings that they're in are on Zoom, like this Faculty Council meeting, where the meeting is focused on what the outcome is and what the agenda is, where opportunities for people to get together and actually discuss how things are going for them are rare. Talking about their own lives, their families and those things have actually proven to be useful and helpful to people.

Dr. del Carmen opened the meeting up to questions for both Dr. Jones and Dr. Greenfield.

After the discussion, Dr. del Carmen mentioned that the Council would break out into small groups to continue the conversations they started at the January 12, 2022 meeting on burnout. 4 suggested topics were provided before the members split into their groups:

1. Share best practices or technology or other tools that have emerged through pandemic that relieve burden
2. Share bright spots of pandemic.
3. Resources—how best used.
4. Accountability for faculty development and support of activities that "feed" faculty.

After spending roughly 30 minutes in small groups, the Council came back together and each group reported out.

Dr. del Carmen reported for Group 1. Group 1 had a lot of discussion around the tools that have become that have immersive pandemic to relieve burden. The one that came up first was telemedicine and the ability it gave for both research and clinicians to work from home. The flip side is that the work never ends, but they also found that it allowed for more equitable conversations because there's the opportunity to actually comment away in via the chat. Opportunities were created for people to give opinions and share knowledge in a way that maybe would have been more challenging if it was an in-person engagement. This group also talked about

technology and this concept of digital travel allowing a few things to be easier. One is interviewing (candidates for medical school, residency, fellowship training, research positions, etc.) became easier on both candidates and interviewers. It created a more equitable experience especially for candidates who may have had challenges making those trips for in-person interviews. Those who were interviewing candidates were able to continue to do some of the day-to-day work that they would have had to discontinue, if there were engaged in interviewing in person. This digital travel has allowed more faculty to participate in local or internal meetings, but also created more of an opportunity for external meeting participation, including attending professional society meetings. However, obviously that comes at the expense of all of the networking and the opportunities that come from being in person. The group also talked about the framework for creating joy at work, including initiatives around creating/bringing joy to the work that they do. They talked about how important it was within that framework for there to be institutional buy-in and leadership in supporting, bringing or restoring joy, but also having local champions that would take that work on and actually create meaningful experiences for the smaller communities. They also discussed the data from Dr. Shanafelt describing increased wellness when physicians spend at least 20% of their time engaged in meaningful work.

Dr. Joshua Goldstein reported on Group 2's discussion. He shared bright spots and covered a lot of the same territory that Group 1 did. One of the highlights was they didn't hit traffic nearly as much. Telehealth created a lot of opportunities for both clinicians and patients that they didn't have before. Giving talks became much easier for people to do without traveling, it also saved time. A one hour talk just takes an hour instead of two days to fly somewhere and then fly back. People who previously couldn't travel can still have the same academic growth opportunities as those traveling and speaking, than before. Faculty with children could give national talks. Of course, managing a day worth of meetings when someone has to cover the children, made it challenging, especially when one couldn't leave the house. Another bright spot was faculty meeting attendance shot way up. People are able to attend meetings of our groups much more. The downside to this, it is harder to engage than in person, but people put stuff in the chat and speak up in a way that they might not have before at an in-person meeting. Residency applicants didn't have to travel, which made their lives much easier and the interviewers lives much easier. Interviews for jobs, for faculty searches, etc. were done remotely and created opportunities that weren't there before. For medical students applying to residency, they can be at Med school longer if they don't have to spend all their time flying to interviews. Working on academic projects, there were certain advantages to working on manuscripts and research projects with all the remote tools. People could work together on a project on the screen together. Some of the technology, like breakout rooms the Council just had, was something that before if we had tried to have a meeting we would have used Skype or phone calls or teleconferences. And here we have this much fancier tool where people can break into these small groups and then come back to the big group. That was pretty nice for faculty development. People can obtain faculty development much more easily remotely. We can get content from other schools, from other locations, and bring them in and access them much more easily. It's definitely easier to work with distant collaborators. It's just like working with your nearby collaborators right there on a screen. Either way, whether they're in Boston or North Carolina or California, so that was an advantage. Last, he mentioned that one could have a meeting and sit outside on one's deck and attendees were in the backyard with you and your dog. We're appreciating that. There was a lot to be said for that. All of a sudden, we get to see people's houses and their kids and their pets. It created a little bit more personal engagement with the people that we interact with. Which was very nice.

Dr. Keith Blackwell spoke for Group 3. They discussed the positive aspects of working at home, particularly for researchers, and how it's more efficient but also the need to balance that with

interacting with their research groups and the stresses that they're under and particular problems caused by the pandemic isolation. Loneliness, lack of scientific interactions outside the immediate lab put a lot of stress on instructors and fellows and students that need to be aware of and manage. And at the same time, with respect to physician burnout, it seemed as though many root causes of this had relatively little to do with the pandemic. The issue was raised about the enormous load of gateway messages, all the emails, just the level of electronic paperwork, so to speak. This has gotten out of control and it's not clear how to fix it.

Dean Anne Becker spoke for Group 4. She mentioned when they entered into their breakout room, they discussed whether they should just take one of the suggestions from Dr. Greenfield's talk, which is that it's important to sometimes gather without an agenda and just kind of shoot the breeze with colleagues, or tackle some of the discussion questions. The decided to discuss some of the discussion questions but ended up acknowledging how important it is to find these ways to connect, sometimes very incidentally, with colleagues and ways that may be unstructured but are essential to build in. The group spent time debating whether or not there were bright spots from the pandemic. They talked about the gratitude they feel, now, from being able to come back and really appreciate the things that maybe seemed routine before and also how proud they felt of their colleagues, especially those on the front lines who kept patients safe and who kept staff safe. There was this surge of solidarity and pride in the sense of what we were able to do as a community of care givers. On the flip side of it, there was some debate with some serious discussion about whether we should reject the premise that there were any silver linings from this pandemic, which has been so horrible in many ways. There were some really important lessons for all of us about the pandemic. Certain patient populations now don't have to drive because they have telehealth. From a physician POV, being able to engage with people and see them in their homes, their home setting, and understand really at a different level, how they're doing is wonderful. The group also talked about some of the challenges around reentry after the pandemic and some of the social anxiety that people are hearing about from colleagues. Dean Becker said we have a very large community, very diverse in viewpoint, and people really see this differently in ways that we might not necessarily expect. Some people just prefer or value things, like the Zoom platform for meetings, differently. So a challenge that we face is to recalibrate what our norms are going to be as a community. One of the bright spots about how we learned while adapting to the pandemic is that we've recognized the value of having the space and time to connect with colleagues in a meaningful way and often in a very incidental, informal way. It's the kind of two-minute exchange you might have, right before faculty council starts and you sit down next to a friend or a colleague you haven't seen for a while. It's clear, based on the enthusiasm of response, that people really value the opportunity to check in with their colleagues, even if it's very brief. This is something we need to think about more: How can we as, an institution, as a community, find more ways to structure these opportunities into the way we work in our professional lives?

Dr. Valerie Stone spoke for Group 5. The big take home was they enjoyed their time together and they don't feel like they have enough times like that. It was really nice connecting and hearing everybody's thoughts and sharing how much they would have enjoyed just sitting on the lawn next to the medical school if we had had an in-person meeting. The group learned that all the silver linings one of them brought up, was a negative for other people. For example, Dr. Stone, as a senior faculty member, she liked the fact that she can do grand rounds at places all over the country or speak at national meetings without actually going. But that's negative for the junior faculty who would have otherwise met her when she went to those places, such as some of the other faculty in Group 5. And similarly, the same thing with senior faculty doing remote presentations at national meetings and not showing up at these hybrid meetings where junior folks are showing up. The group members all felt lonely and are pressing for more opportunities to connect. Even though it's

more work and you might have to get on a plane or drive across the city, it's kind of what they're all craving. Dr. Stone mentioned that many of the other fixes have not been so helpful. The technology fixes for their work on Epic and our clinical work, have not really been fixes because the work just continues to explode. While it is fortunate that practices have done things to enable other team members such as nurses to assist faculty with patient message, during the pandemic the number of messages has been much greater than previously, with so many patients asking about COVID-19 testing, vaccines and boosters.

Dr. del Carmen thanked the Council for their participation. She adjourned the meeting at 5:30pm.