**EPISODE 205 - Healing the Heart and Mind: Breaking the Stigma of Physician Mental Health - A Cardiologist’s Story**

**With guest Dr. Jonathan Fisher**

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HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hey there, and welcome back to the Doctor's Crossing Carpe Diem podcast. I'm your host, Heather Fork, and you're listening to episode number 205. Today, we're diving into a critical conversation around mental health and well-being for physicians, a topic that's long been overshadowed by stigma.

Breaking through the silence is more important than ever, and I couldn't be more honored to have a remarkable guest with us today, Dr. Jonathan Fisher. Dr. Fisher is a cardiologist with a unique focus on healing the heart, both physically and emotionally. His experience with anxiety and burnout profoundly changed his approach to medicine, leading him to become a mindfulness meditation teacher, physician coach, and a leader in organizational well-being.

He is the clinical physician executive for the Office of Well-Being and Resiliency for a healthcare system with 38,000 team members. Dr. Fisher is also a best-selling author of the book, “Just One Heart: A Cardiologist's Guide to Healing, Health, and Happiness.”

In today's episode, Dr. Fisher will share his personal journey and offer valuable insights on breaking the stigma surrounding mental health in the medical profession. We'll explore practical steps physicians can take to prioritize their mental well-being while navigating the complexities of their careers, especially when facing the difficult decision of whether or not to disclose a mental health condition, a topic that often is fraught with risk and uncertainty. It's my distinct pleasure and honor to welcome Dr. Jonathan Fisher to the podcast. Welcome, welcome, Jonathan.

JF: Wow, what an introduction. Thanks so much, Heather. I'm really happy to be here, and episode number 200, and many, many, hopefully many more with the great work you're doing. So, thank you.

HF: Well, thank you. That was very generous, and I'm super excited to have you. I recently heard you on Dr. Dike Drummond's podcast, and I reached out to you because this is a topic I haven't covered in depth, and I was so happy when you said yes right away.

JF: Dike Drummond is amazing for anyone who doesn't know him. He's a physician and a coach, and he helped me without ever meeting me with his book called “Stop Physician Burnout”, which I ordered off Amazon 10 years ago, and I worked through it. And that was when I first started meeting so many amazing physician coaches who are really trying to help our colleagues out of some pretty tough spots, and it even inspired me to do some of that work myself.

HF: Well, that is an excellent book, and I remember when it came out. It was ahead of its time. And so, we'll be getting into your story of why you even needed that book, but I'd love for you to take us back to your earlier days and childhood because you have a very interesting family of origin story.

JF: Well, the sycamore tree still stands in the suburban home in Livingston, New Jersey, where I grew up. My dad, Hyman, was the town doctor. It was a small town, 25,000 to 30,000 when he moved in the 1950s there after doing his medical residency in Honolulu, Hawaii, and he had my oldest brother, Eddie, who later began on to become a doctor.

And then after Eddie was born, my sister, Laura, was interested in medicine and took my dad's medicine bag and went with him on house calls just like Eddie around the town, and Laura became a doctor. And then Naomi was born, and she followed them and became a physician. And then David was born, and he became a doctor. And Andrea after that became a doctor, and Davy became a doctor.

And so here I am, this little kid, five years old, looking around the house, and everybody's a doctor in the house, and it was natural that I became really curious about what is this field that my dad is doing, my brothers and sisters are doing, and eventually I headed in the same direction.

HF: I know, that is wild. All of you, all seven siblings became physicians?

JF: Exactly, exactly. And you'd ask, “Well, was your mom jealous?” And mom actually was very happy about it. I think she wanted us to be either doctors or lawyers, and mom was a nuclear physicist.

HF: My gosh.

JF: She was a pioneering woman in the late 50s and 60s, one of the first women to go into that field, and she just wanted us to work hard to make contributions to society, and we all tried our best to live up to our parents' very high expectations.

HF: Now, is this a Guinness Book of World Records for number of physicians in a family?

JF: Good question. We're close. I believe we're number two. If you recall, I'm not sure which physiology textbook you used, but the one that I used was by Professor Guyton. And so Guyton, if I have it correctly, had 11 children who were all physicians, I believe. So I think we're number two, so we missed Guinness Book by that much.

HF: Oh my gosh, you could adopt. I don't know. Well, this, again, is truly remarkable, and I think your whole family was on TV. Which show was that that your whole family was on?

JF: We were on Good Morning America. I was a medical resident at the Brigham, and they flew me down and picked me up from the airport and took me to a hotel, and I said, “What do you want me to wear?” They said, make sure you bring your scrubs and your white coat and your stethoscope, and I felt ridiculous bringing it all on the airplane. It was all for show, of course, but we were interviewed by Diane Sawyer on Good Morning America.

HF: That is amazing. Oh my God. All right, tell us just a little bit about your growing up and connect the dots between how you ended up needing Dike's book and then working in that area of mental health.

JF: If I look back, I suppose that as a kid, I was awkward in that I didn't feel like I fit in. I was incredibly nerdy. I tried to take after my father. My father's a very quiet man. He was of that generation, and I also tried to take after my mother, which was to study all the time. You might imagine that somebody who values academics above all else maybe didn't do so well at parties.

I also am a natural introvert, and so if I was to go to a party, I'm much more comfortable at the edge of the room rather than in the center talking to everybody. On top of that, there was a tremendous pressure. Some of it was a wonderful pressure. A wonderful pressure that my parents put that we should all do something meaningful with our lives.

The downside of that is that I could never relax. It was never okay just to take it easy, to have fun, to even laugh out loud for fear that it was a frivolity. My parents literally were born and grew up in the Great Depression. That was their generation. You can imagine a small child who's kind of an introvert, a nerd, academic, doesn't fit in socially.

I played to my strengths, and my greatest strength was this empathy and curiosity for what was happening in the minds and hearts of other people. I focused on that. I realized that if I put that together with my knack for science, following in my mother's physics footsteps, there was a career out there, which I had seen a well-worn path in medicine, where I could not only be successful, but I could put my natural talents to use.

That's the upside. That's how I ended up getting into Harvard and having all of these accolades after my name. The downside wasn't so pretty. The downside, if I look back, was the beginning of what started as worry, then rumination, then severe neuroticism, and eventually full-blown anxiety in high school, and ultimately isolation socially and depression in college.

These were not terms that I used at the time. These only came up later when I found the courage and was helped to find the courage to break the stigma within my own family against mental health disorders to see a therapist as a medical resident. It was that therapist, his name was Phil, in Boston, who sat with me a couple days a week for about a year and helped me unpack a lot of the stories that I had believed about who I was supposed to be in the world and what it meant to be successful and effective. We worked through a lot, and I'm forever grateful for the work that Phil helped me through.

HF: Wow. Okay, there's a lot here. Could you paint a picture for us, Jonathan, of what it looked like when you're having this anxiety and the neuroticism? How did that show up for you?

JF: If you were to ask, how does it show up personally? Anytime I was in a social situation, particularly around girls, but also around guys, I didn't feel like a typical guy. I didn't follow football or sports. I couldn't understand the fascination. Around women, I felt very uncomfortable. “What does this person think of me?” I was very slow to develop in terms of sexual activity and those interests because, again, I was in the library all the time. I was a late bloomer, you would say, a very late bloomer.

If you put that together with an overactive imagination, which I had, I would often be in a social situation, and before someone else would say a single word to me, I had created an entire scenario about how they thought that I was a loser, that I didn't fit in, that I was awkward. If I could go back and ask half of those people, I'm sure they would have said, “Yeah, maybe he's shy”, but the other stuff is just BS. I had created this whole world in my mind, in my imagination, that was a self-fulfilling prophecy.

What do people do when they think that the world feels that they're awkward? Well, they stay in the corner. I led, in a sense, to my own outcome, which was a downward spiral of worsened social isolation, worse than rumination and neuroticism and anxiety.

The upside of that was, as a doctor, as you know, one of the most important skills, at least in clinical practice, is to develop a differential diagnosis. And so, I'm very good at worrying. I can create a hundred scenarios about what might go wrong when I'm meeting you. And while that might serve us, medically speaking, where I can know what might happen and how to figure it out, you can imagine in my own life, as Mark Twain had said, I've had a thousand bad outcomes, and none of them ever happened, and they were all in my own mind. That's a little bit of a picture about what the anxious, neurotic, worrisome mind looked like for me.

HF: Well, I know you're not alone in this, first of all, because I think medicine, in some ways, selects for this type of personality where we prioritize doing things that are purposeful, and when we're doing something that feels more frivolous, there's something wrong with that. And sad to think, as a kid, even laughing somehow felt like that was frivolous, but it does paint a picture. I'm curious, Jonathan, so when you were in medical school or doing your residency, how was this affecting your clinical work?

JF: On the one side, it made my clinical work outstanding, because when some of my colleagues may have been going out to parties in New York City during medical school, I would stay in my comfort zone. And my comfort zone was developing my mind, accruing information, learning thousands of drugs, microbiome, everything you want to know about the cardiovascular system, anatomy.

So, how it played out was I ended up towards the top of my class. On the flip side, how it played out is that I wasn't part of the social group, and, in fact, I never really valued it to the same degree, so that when I went on into my residency, while I had a couple of friends and I was respected, I never quite felt as though I had a social life.

I had a sense that medicine was something I was going to do on my own. I had to pass my own tests. I had to be at the top of my own class, and the bar for success, the way I measured my success in my own life, had very little to do with whether I had friends or people who were there for me in the middle of the night.

That was not it. And we tend to get what we are aiming for, and I was aiming for academic success, and I got it, and what I also got was being alone on a Saturday night, playing video games in my residency apartment up in Boston, as opposed to being out dancing with friends, which I did from time to time. It wasn't all miserable and lonely. I certainly had a couple of friends, but just to give you a sense, that's sort of how things got to the point where they were. Not even at that point. Things got much worse before they eventually got better.

HF: How did they get worse?

JF: While I was going into my fellowship and then moving on into my practice in New York City, it was a busy practice. My first year, second year out, third year out, it was maybe 500 to 1,000 patients a year, and by my fifth year or so in practice, I was seeing 2,000 to 3,000 patients a year in the clinic. Again, while struggling to go on a date and to find friends that I could hang out with on the weekend.

And at the same time, my sister, who was my best friend, who was also the person who helped me overcome my own stigma for seeking mental health, because I think she had some anxiety as well, and she could see how much I was suffering, and she loved me so much, she said, “Johnny, can you just be kind to yourself and maybe take a risk, maybe get help?”

So, it was Andrea who had encouraged me to see a therapist in residency, and it was also Andrea who, at the age of 40, after giving birth to her first child, developed blurry vision, and a month or two later, as a radiologist, read her own CT scan of the brain and discovered that she had a tumor the size of a golf ball that was inoperable. And so, over the next four years, my best friend and only deep, deep supporter in life who had helped me come out of a dark place was now gone, and so my life again was in a very dark place.

HF: Oh, that's such a tragic story. I'm so sorry about that. How awful to read your own scan that shows you this fatal condition. I can't even imagine that.

JF: Yeah, yeah. It's hard to put it into words. It was part of what prompted me to turn my sister's suffering and turn my suffering and turn my whole family's suffering into something meaningful. And so, the quest that I began after my then-new wife literally met me on the floor of our New York City apartment while I was weeping uncontrollably, and she said, “We'll get through this. Not sure how, but we'll get through.” And I read a lot, and I did a lot of work about grief and how do we move on from a loss like that.

While I also was developing skills to work with anxiety, I began to understand what depression was, and eventually a friend recommended the practice of meditation, which was awkward but also kind of neat because it was something that I could do, and it was rules that I could follow, and I like the idea of training my mind. It turns out meditation had very little to do with the mind itself, but that's another story.

And with the basic practice of meditation, I had this just slight calm that I hadn't had before, where I could begin to view my own inner experience and inner life with some slight distance, some slight dispassion, which I hadn't had before. And I realized that I didn't have to follow every thought down its avenue.

And then subsequently, when I was reading about mindfulness and meditation, I saw a book called “The How of Happiness”, which was just a fascinating title, and I was googling, literally googling, how can I be happy again? And so, that began a 10-year journey to learn everything I could about the science of human happiness, thriving, and peak performance.

On the one hand, I had been doing work to come out of the darkest place, and now as I was neutralizing things, getting to a steady state so that I could at least show up to work without being a jerk or cold or aloof, which I was told I was, which is very much against my nature, I then decided I would dedicate the rest of my life to this question of how do we flourish in this one precious, very brief life? And in order to do that, we have to find something meaningful. And for me, that meaningful thing is helping other physicians, nurses, and people in health care and outside do the same work, which is understand the spectrum of well-being from the lowest place to the highest, and understand that there's no one-size-fits-all solution, and put it all together. That's eventually what led me to write my book, which I released recently.

HF: Wow, so much here, and quite a story for sure. And I love that you have this calling, and you're answering the calling. And I think often when we suffer deeply, there's often something that happens that triggers us to want to help without suffering for others. For example, they say we often teach what we want to learn or what we are learning and continuing to transform through.

Now, you have had your own experience, and through the work you do, you also help a lot of other physicians who have different challenges. I'm curious if you see any common threads in why some people struggle with this more, and also thinking about your own situation of what's at the root of a lot of this struggle with anxiety and our relationship to ourselves.

JF: Yeah, the way that I approach it is, the first question is whether we're talking about people who are in health care versus people who are not in health care. Because I think the more specific and granular we can get, the closer we come to solving and helping people solve their own problems.

The second question, if we take a broader issue, which is anxiety, mental health struggles in general, like so many of the aspects of our humanity, there is the congenital or hereditary or genetic piece, and then there's the acquired piece. Is it our nature that we're anxious, or is it something that we were nurtured towards or against? Which is where many of us had very insecure attachments to our parents.

There's a whole field, many of your listeners are familiar with it. I'm sure many may not be familiar with it. In my studies, in my work with therapists and lots of reading, this idea of adult attachment theory says that you may be born with some predetermined tendency towards being a little nervous or neurotic, but if you have parents who are fully attuned to your needs, and who help you express your emotions and find words for them in a healthy way and find outlets for them, and show you that they're there for you when you need them, and are okay with uncertainty, you tend to develop a more secure attachment to your parents, which becomes a later template or roadmap for how you relate to your friends and your romantic partners.

Essentially, we're playing out our whole lives, these earliest relationships. That is to say, there's a, I believe in terms of your question is anxiety, there is certainly a genetic piece, and some people would go back further and say there's an intergenerational piece where it's so-called inherited trauma of our parents, our grandparents, our great-grandparents, with higher rates of anxiety or depression in people who may be descendants of Holocaust survivors, for example.

We don't fully understand how that happens, but there are theories that these conditions are not just existing in the mind, but they're stored in our bodies, and they become encoded in our DNA to some degree.

The optimistic part of that story, the one that I choose to focus on, is the fact that we are not destined to follow our genetic code. And I know this as a cardiologist, this was revolutionary 25 years ago when I finished medical school. The fact that just because your father died of a heart attack at age 50, it no longer meant that you were going to die of a heart attack at age 50. You could turn on and off certain of your genes. And so, as I became more interested in mental health and the field of psychocardiology, which has emerged over the last 20 years, the connection between our thoughts, the feelings, beliefs, attitudes, and cardiovascular and general health, the more I realized that the same principles apply to mental health. We are not destined to live out a mental health condition just because of our genetics.

HF: Now, if a physician is listening to this and they identify with struggling with anxiety, or maybe it's another type of condition, bipolar, or even like the imposter syndrome, I think that it's common for a lot of physicians. And it's been going on for a while without having to wait for something as devastating as happened to you to get help. What are some ways that they can feel more comfortable reaching out and getting help and going over that hurdle?

JF: I think about all physicians and all nurses or really anyone who's having struggles on a spectrum. So there are those who don't need to see a therapist. There are certain people who don't even need to ask someone else for help. They may be thriving in their life and having a low period for a month or a couple of months, and perhaps they just need to ramp up their self-care. And really, it can be as simple as someone doing more exercise, eating more healthily, getting better sleep, et cetera.

More often, people and colleagues that I work with are in a darker place. So they're sort of what I would call below that healthy line. And in those situations, the first assessment that I make is, “How comfortable are you asking for help? How comfortable are you asking for help?” And people tell me, they say, “Well, not at all. I got through this life my own.” These are often people who maybe didn't have the most supportive parents, or maybe they were more isolated or independent, let's say. We're all raised in a society and a culture that celebrates autonomy and independence and the idea of me.

And so, if that's the limiting factor, I then simply focus on the pain. I hate to say it, but the question that I get a lot, the one that I'm getting from you sort of is, “How can you help someone who does not want help? How can you get someone to seek help when they feel too much shame to even admit or to report that they're having a problem?” And that's a really important question. And this gets into work around shame and embarrassment and guilt and wanting to hide ourselves from others for fear that we're the only ones.

And so, how do I do that? At first, I say what you said to me, which is, you may think you're alone and you're the only physician or nurse that ever had this problem, but I can tell you, you are not. And the very nature of what you're suffering from narrows your perception and forces you to believe that you're alone. So our perception narrows.

And then to answer your question even more simply, if somebody needs a deep emotional and mental health support, I would refer them to a therapist or a psychiatrist or EAP. If somebody is more having a spiritual crisis, there's lacking meaning in their life. If they're spiritually oriented, I'll refer them to chaplain services. If somebody is having neither one of those, but they just need a little bit of help getting balance in their life, I will help them with coaching, either one on one coaching or our system invests significant amount of money each year on taking physicians and nurses and executives off site for three days at a time in groups of 20 and doing intensive coaching and 360 degree analysis and helping people write the next chapter in their lives in a more proactive way. So, there's a whole spectrum of interventions to paste on what our assessment is of how much someone's struggling.

HF: I love how you gave the spectrum of where people can be at and what the intervention that would be helpful could be, because you're right. There are people who just need to get more sleep and get some exercise, the one and other people who probably are actively suicidal and really need a very strong intervention.

I want to shift a bit and talk about how to navigate this terrain where there can be consequences if someone who might be hiring us or our employer knows that we have some type of mental health condition. But before we dive into that, I want to share a resource for you.

Hello, my dear listeners. As you know, I talk about our sponsor, PearsonRavitz, which is a great company to help you with your disability and life insurance needs. And we often think of disability as a physical condition, an illness that could be cancer or chronic medical condition, but it could also be a mental health issue.

I've definitely worked with physicians who have been on disability for burnout and for depression and other conditions. So, it's important to make sure that you're protected if there is some need that you have for disability insurance.

PearsonRavitz was co-founded by a physician, Dr. Stephanie Pearson, who had her own injury while delivering a baby that ended her career. She did not have the type of disability coverage that she thought she did, and it was a terrible outcome. It affected her family financially. She had to find a whole new career. Luckily for us, she developed this great resource through her company, PearsonRavitz, which can help you.

If you're interested in scheduling a complimentary consultation to discuss current disability coverage or something new for yourself, please reach out to pearsonravitz.com and I will put that link in the show notes.

All right, now back to our wonderful guest, Dr. Jonathan Fisher, and we're talking about how to navigate this terrain when you do have some type of mental health condition and you're concerned about anybody finding out about it.

Jonathan, I get this question not infrequently when a physician may be applying for a new job and there's sometimes a box that you have to check or something they want you to disclose, and they're saying, “What should I say here? When do I tell people? Or should I even mention it in an interview?” And as we all know, this can be a question when we renew our license.

JF: Yeah, if the question is, how do we approach that? Let's say we have a mental health diagnosis and we have a state licensing board that is asking us credentialing questions every year or so. It's a question that's in flux right now, and it's a legal issue. It really is a legal issue because there are about 25 states or so that still require disclosure of mental health conditions.

And so, if you're sitting there having that wondering what to answer, first of all, I would say before your credentialing comes up again, know what your state laws are. And secondly, look up something called the Lorna Breen Foundation. Lorna Breen, for those who don't know, was a physician who in New York City took her own life at the peak of COVID. And her brother-in-law was an attorney and worked in the Virginia healthcare system, decided that not another physician would take their life because of burnout or because of the stigma of mental health.

And since then, because of their tireless work, they have helped government policy change. There's the Lorna Breen Healthcare Workers Act, which says that healthcare systems may not discriminate on physicians. If you're facing a question like that, and it seems overly invasive, and by that, what I mean is systems may no longer ask, have you had in the past a mental health condition? It has to be relevant to your current ability to practice. The question may be, “Do you have a mental health condition that affects your ability to carry out your responsibilities now?”

And so it's a delicate situation. It's always best to consult with a lawyer if you're in a state where you're required to disclose, because you don't want to lie on a form, because that's going to be even worse, and you can be brought before the medical board. But it often requires help.

But sometimes just knowing that your state is not allowed to simply ask if you have a past diagnosis. It has to be relevant to your current ability to practice. That's where I would start, and I would start with either the Lorna Breen Foundation or other similar groups that are doing advocacy work for physician mental health.

HF: I'll definitely put a link for the Lorna Breen Foundation in the show notes. Thank you for sharing that. Now, a lot of physicians get therapy, and they have no problem with that, and I haven't seen any downstream consequences from that. But is that something a physician should worry about, is seeking out the help of a therapist?

JF: No, because the worst-case scenario in situations where suicide is something that's being actively considered, these are people who need emergency help anyway. So you wouldn't want to hide that. But in terms of therapists, they're not allowed to disclose to your health care system. There's a privacy act. Generally speaking, I would always say it's more important to get the help that you need than to be concerned about repercussions. I'm wondering, have you seen examples where therapists have violated that trust, or are there other concerns that you think physicians might have?

HF: Well, I think it might be where, for example, they're struggling, and maybe they think they might have major depression or something, and they worry that if they then go see a therapist, and then have to answer a question on a medical licensing board renewal, that they have some condition. If they haven't actually spoken to someone about it, then there's no history of actually having some type of condition.

JF: Yeah, that's where looking up state-by-state would be helpful, perhaps even before seeking a therapist. If it's not an emergency, that's what I would do. I would say, “Well, what are my current state licensing board regulations?” And then I would look at what's the current state of U.S. governmental policy, federal policy, because it's rapidly changing. More and more states are being told you may no longer ask these questions. And so, I think I would take it on a state-by-state basis.

HF: Because it just doesn't seem right that if you're struggling, for whatever reason, you should limit your access to help, like seeing a therapist, because of some state issue. Have you seen situations where someone goes to a therapist, and then because of that, they ended up having their license restricted or lost their license?

JF: I agree with you 1,000%. It's completely not right. It's ridiculous to tell people not to seek help that they need. The issue is that we're dealing with an outdated system and a culture that had a very broad stigma against mental health in the 1940s, 50s, and 60s, where people with mental illness were believed to be second-class citizens. Experiments were done on people.

We fortunately live in a completely different time right now. But as we know, health care tends to lag the rest of our society by about 20 years in terms of policy change. I 100% agree that this should no longer be an issue. And I would argue that physicians who seek help for mental health challenges are better caregivers than those who don't and that hide their mental health. Because what we know is that the stress and the anxiety and depression that is there, we tend to self-medicate, usually with drugs, alcohol, you name it. And these people tend to give worse care and are more prone to medical errors if you have uncontrolled mental health issues.

HF: Hopefully things will keep changing in a good direction. And I have to say just from my own experience, which is just a microcosm, I haven't seen any issues with physicians seeing therapists. And I have a lot of clients who've seen therapists, but I haven't seen any problems with that.

JF: And I didn't answer your question, but I have not seen that either.

HF: Oh, well, that's good to know. We're getting close to wrapping up the podcast. So I'd love to keep going on and on and on because it's such a great topic. But I'd love it if you could share some about the work that you're doing in your organization.

JF: I was not thrilled when I first moved from New York to work for my current organization 16 years ago, because every month we would all get an email, all the doctors in the practice of an Excel spreadsheet, and we were all on it. And it was telling us exactly how many RVUs we had earned for the organization. And in a sense, we were being ranked against each other.

I went from working in what I thought was a team environment to one where we essentially were competing with our partners. And it was a very unhealthy environment. And I eventually became really unhappy with the whole system and was thinking about leaving.

I let some people know that I was having trouble and someone reached out to me, another doctor who started to work with a coach himself. This is a dozen years ago. And the coach helped him kind of see his relationship to medicine in a different way, so much so that he went on to develop a coaching system for our health care organization.

And what began a dozen years ago was really the first of its kind. And our system has one of the first offices of well-being for physicians in the whole country. And we have a chief well-being officer. One of the interventions that he had developed was a three-day coaching course for physicians who were burning out. And so, I got coverage. I left my practice for three days. I went to a hotel retreat for three days. And with two professional physician coaches, I saw my life in a new way. I decided that I was going to stay in medicine. And I was going to commit myself, at least the part of time when I'm not practicing cardiology, to helping other doctors and nurses.

And so, I joined this team about six years ago, what's called the Office of Well-Being and Resiliency. And we have more than 20 different initiatives to help 38,000 employees. As you probably know, or those who are not familiar with the movement towards well-being in health care, most of the challenges we face are because of organizational operational inefficiencies, basically stupid stuff that we're made to do. There's cleric or work. There's electronic medical records that keeps us up at night, that separates us from our patients. We have no control over our vacations. We have no control over our call schedule. We have no control over our clinic schedule.

I could name two dozen reasons why burnout is happening, in addition to the fact that physicians are a funny breed. There were studies in the 1980s looking at the typical psychological profile of a physician, and we're not like other people. We tend to do things by ourselves. We tend to be afraid to ask for help, like we were talking about. We tend to be perfectionists, and we tend to believe that rest is for the weak. This constellation of traits is actually self-selected for among physicians, and now you put that into an organization that does not care about the individual, it's no wonder we have a 55 to 60 percent burnout rate across the country and around the world.

One of the initiatives is to work with teams around the organization looking at operational, what we call the stupid stuff, basically. We work with the EHR team, and we try to incorporate some AI so that we can have real-time AI that's ambient, listening to the patient-doctor encounter and writes the note for us. Imagine not having to write a note. Now it figures out the appropriate billing. Imagine no longer have to click in the billing.

And now we realize that we have to go back to our inbox with 100 messages every hour or two. Well, what if we were to hire somebody specifically to help with that, and they were to use AI assistance to triage some of that? Now we offload the clerical work. And what if we invested some dollars in allowing physicians to take one hour or two hours or three hours off anytime they wanted during the week? Just some mark of flexibility.

So that's the operational side. And then we could talk about this for hours. I'm also interested in how do we help individuals and teams, and how do we help leaders develop skills so that their team members don't hate them. Because what we found out is that doctors and nurses often leave organizations because they don't really get along, and they don't like the way their manager and leader is running things. So we have to train better leaders. That's part of the work we do. We have leadership training.

I teach people the basics of mindfulness. That was part of my own path. I went to Oxfordshire in England to learn how to become an instructor. I've now trained more than 5,000 people in my organization through weekly, monthly workshops on how to really deal with stress, both in the mind, in the body, and in the spirit.

And then I also developed an online course. We have a community of several hundred that meet once a month, and we discuss all of the theories of living a good life, the things that we maybe never were taught as children. So it's a course around positive psychology. Those are a few of the interventions.

HF: Well, I bet some of the listeners are thinking, “Why can't we have this program at our institution?” And just real briefly, because we're pretty much out of time here, Jonathan, is this something that shows an ROI? Because I'm curious how it's funded, and if there's a way that someone might be thinking, “I'd love to have this in my program, but how do I make a case that we could actually do this and have it pay for itself?”

JF: Yeah, if you go to the AMA, American Medical Association website, you'll see that there's an ROI calculator for well-being. The economic research is developing. We now know exactly what the cost is for the average physician who is burning out and leaving the organization. It's a simple matter to figure out the ROI. We assess the rate of burnout and retention risk or turnover risk in the organization.

We then assess the dollar amount per physician who is burning out, and we know what that is. And then we develop a model of what's the cost for interventions, and that's variable. And then we measure. We simply have to measure before and after certain interventions. You take that information to the chief financial officer of your institution, or you run it up the chain, and it's not hard. It's not hard to demonstrate the ROI for well-being work.

There is a caveat. There was a good study that was done about two years ago. It was very controversial, and I think it was out of England, that said that wellness and well-being initiatives in the workplace don't work. They don't work, meaning that they were not cost-effective. And there were many problems with that study. Most of what I've seen is that you have to simply prevent five to ten physicians in your organization from burning out and choosing to leave medicine in order to pay for an entire department of well-being, because it's between $500 thousand and $1 million per physician who leaves. And so that's a rough sketch of how you would make the case.

Who pays for it? The organization pays for it. How do we justify it? We do analytics. We have some very smart people on our team who know how to crunch the numbers, and we can measure a whole spectrum of well-being metrics among our 38,000 employees. We break it down by job family. We can do it once a year, twice a year, three times a year, before and after various interventions.

But the question you're asking, unfortunately, the case for these well-being initiatives, the fact that it's simply the right thing to do, is not enough. That's a sad state of affairs. That we simply, by preventing another physician's suicide, you're telling me that's not enough of a case to pay for this? Unfortunately, that's a sad state of affairs. But the good news is that with the right tools and techniques, and many of us are doing this work, you can make the case for a very significant ROI on these measures.

HF: That is so encouraging because it is true what you just said, that they don't really seem to care about physician burnout, physicians leaving, about the satisfaction. And you do have to show an ROI, and that is sad. But I love that you said it's possible. So I love ending on that note. And would you like to share any information about how folks can get in touch with you, if they'd like to connect?

JF: I'm easy to find on social media. You can look up Happy Heart MD. You want to have Happy Heart MD. I'm mostly active on LinkedIn and Instagram. And even better than that, if you want to go deeper into any of these subjects, I spent almost three years researching and writing a book called Just One Heart, which is about the four dimensions of the human heart, the physical, the social, the emotional, and the spiritual. And I talk about burnout, but I also talk about what it means to live a full and rich life when life is really challenging and hard. And how do we continue to care for ourselves and for others so that we can live a life of meaning?

HF: That's so beautifully put. I'm thinking, I think it's time to do a happy dance here, to celebrate all the good news. And I'm glad that you got on that date, whatever it was, to meet your wife. And you said earlier, before we started recording that you have three teenagers. So, your life is a beautiful testament to what happens when we decide to get help and change.

JF: Thank you.

HF: And thank you so much, Jonathan, for coming on the podcast.

JF: Oh, it's been my pleasure. Heather, this has been awesome. I just really want to say thank you for the work that you're doing. We need more people out there like you with a warm, caring voice who's asking these questions and offering so much hope to so many of our colleagues.

HF: Well, thank you for that. I do feel that this is my calling and I'm honored to do it. So thank you, Jonathan.

All right, my dear, lovely, lovely listeners. Just a reminder, our special sponsor, pearsonravitz.com. If you need any help with disability or life insurance, I'll have that link in the show notes. We'll also have all of Dr. Jonathan Fisher's links for you to check out.

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