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The Blue Zones as a Model for Physician Well-Being

We need a new model to understand physician burnout. At present, we have a disease model. Physicians are broken. Physician burnout has been hovering around 40%-50%.[1] We are increasingly aware of the costs to patients and physicians alike. Physician burnout has been associated with increased errors, unprofessional behavior, and poor patient satisfaction. Personal characteristics are well known. Burned out physicians tend to be younger, unmarried, and engaged in certain specialties such as emergency medicine.[1]

For years, physician burnout had been seen as a personal weakness. We were burned out because we were not spending enough time coaching our kids' soccer games and or doing enough yoga. In recent years, the focus has shifted. Institutional leadership now recognizes the importance of workplace culture as a mitigating force for burnout. We are all in this together. Intervention studies that emphasize individual skill-building such as mindfulness and institutional support have shown modest improvements in burnout prevalence. However, these studies tend to have small sample sizes, are of short duration, with questionable widespread applicability.[2]

We need to re-frame our question. What does a happy physician look like? Who is thriving in medicine, and what do they do? There are scant data on this question. We would do well to borrow from the *National Geographic* journalist Dan Buettner. Buettner first made his mark by describing those communities with a high prevalence of centenarians, such as Sardinia, Italy, Okinawa, Japan, and Nicoya, Costa Rica. People in these communities tend to eat modest, mostly plant-based diets, and engage in moderate, daily physical activity. Importantly, these communities also foster family connectedness and broad social engagement.[3]

Expanding the scope of this project, Buettner explored the happiest countries on earth. His "Blue Zones of Happiness"[4] describes his model for a happier society. He highlights 5 domains that shape a happy country: physical health, purpose in life, financial stability, social connectedness, and community support. He describes happiness as a country where its members feel like they are engaged in their work, make enough money to support themselves, and have a solid baseline of physical health. Importantly, they are sustained by a web of friends and family, in communities that support these connections. He highlights Denmark, a country with strong public education and universal health care. Taxes are heavy for the rich, which makes it less desirable to pursue a highly remunerative job relative to a job you might actually love. You might pursue carpentry rather than the law. Lawyers might make more money, but after taxes, the income might be closer to that of a carpenter. The message: do what you love.[4] Buettner also highlights Costa Rica, a country with a still-developing economy where poverty is common. Yet, Costa Ricans are happier than Americans—and live longer too. Costa Rica forgoes a standing military and instead invests in health care and education. Its citizens are healthier and more literate than Americans, at a fraction of the gross domestic product. Buettner attributes Costa Rica's success to their greater social connectedness and community support, which informs where they invest their resources.[4]

The 5 domains Buettner highlights—purpose, finance, physical health, social connectedness, and community support—can be applied to our own medical institutions. Much of our workplace happiness is derived from our microculture—the community of nurses, techs, social workers, physicians, and others with whom we rub elbows throughout the day. Think the medical intensive care unit, the night crew in the emergency department, or the gang who works in the clinic pod. We need to recognize the importance of these bonds, foster them, and reflect critically when these bonds break down. The Okinawans call this *ikegai* and the Nicoyans call this *plan de vida*, which roughly translates as "Why I wake up in the morning."[5]

The Blue Zones translate into other aspects of an institution. To enhance one's purpose, there should be a culture of training and growth, creating easy opportunity to enhance skills. There is so much new technology and innovation—bedside ultrasound, complicated new diabetes meds. We want to learn. By lowering the bar for these opportunities, everybody wins. Physicians grow. Institutions reap the benefits of more engaged, better-trained physicians. Beyond a

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salary, institutions should provide retirement programs, tuition support, loan repayment programs, and good financial counseling. In the domain of physical health, we need to think about the food in the cafeteria, access to outdoor spaces, and how physical activity can be incorporated throughout the day. Also, health care plans should be appropriately priced, with incentives for healthy lifestyles. To maintain healthy families, we need affordable childcare and good parental leave policies. No single program will enhance our *ikegai* or *plan de vida*, but taken together, I believe these projects would foster a strong message of institutional support and begin to move the needle.

Some will say that this costs money. But I submit that the cost of replacing burned out physicians and increased medical errors far outweighs the cost of these programs. One study estimated the yearly cost due to physician burnout to be approximately $4.6 billion per year. At the institutional level, the cost is $7600 per employed physician per year.[6] Happy physicians can save institutions serious money. Gone are the days when American corporations provided fat pensions and soup-to-nuts health care plans. Perhaps the pendulum has swung too far?

How do we apply these Blue Zones to our institutions? First, we need data. Burnout should be tracked the same way we track catheter-based line infections, falls, and bed sores. The data drive the conversation. If a patient falls, there is an inquiry. What happened? How can we do better? In the same way, if there is an area within the institution that is burned out, we need to ask why. Is it a question of resources? A leadership crisis? Second, well-being needs to be prioritized at the highest level. We have Chief Financial Officers, Safety Officers, and Diversity Officers who ensure standards and highlight important aspects of health care. We need wellness officers too. Third, the solutions should come from the front line. I attended a well-being hackathon recently. Teams came together, identified problems, and came up with innovative ideas. Appointing well-being officers is a start, but every microculture needs to empower local champions with the resources to implement these ideas.

There are weaknesses in applying the Blue Zones model to an institution. Institutions are not nation-states. They cannot be expected to provide all the services expected of a Denmark or a Costa Rica. Their point is to care for patients. Health care institutions are bound by government regulations, insurance requirements, and labor unions. But are not governments bound by similar forces? We need to move past a disease model. We know physicians are burned out. We need a thriving model, a Blue Zones model. It works for Costa Rica and Denmark. It could work for us as well.

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