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LETTER TO THE EDITOR

Interprofessional teams are crucial to reduce transplantation hepatology burnout

While transplantation hepatology has, to date, largely focused on biomedical and technical solutions for liver disease, recent changes in liver disease epidemiology have resulted in it becoming a de facto behavioral specialty. The tremendous variation in human thinking, habit, and addiction, which directly causes several common advanced liver diseases such as nonalcohol-related steatohepatitis and alcohol-related liver disease (ALD), is increasingly being recognized. What's more, overeating, alcohol use, and intravenous drugs are often accompanied by *additional* psychiatric comorbidity, such as major depression, anxiety disorders, or addiction, which few transplantation hepatologists have the training to recognize, diagnose, or treat.

In this complex and changing specialty, we should pay heed to recently published 2019 data from Pourmand et al. showing that 40% of transplantation hepatologists have high levels of emotional exhaustion (EE).[1] These statistics have likely worsened due to the coronavirus disease 2019 (COVID-19) pandemic and recent increases in ALD.[2] Potentially hazardous alcohol use is also present among transplantation hepatologists with, depending on EE level, 25%–43% of respondents screening positive.[1] Pourmand et al. also found that more than five colleagues, adequate outpatient visit time, comfort with current caseload, and high confidence that previous training was adequate for current position were protective against EE.

Twin specters appear to be antagonizing transplantation hepatology: (1) clinician burnout particularly among the unsupported, hurried, and overworked; and (2) prevalent or surging psychosocial etiologies of advanced liver disease for which hepatologists are too often undertrained and ill-equipped. Said another way (Figure 1), burned out and overworked hepatologists are unlikely to have adequate time and interpersonal connection with psychosocially complex patients, potentially yielding weaker therapeutic alliances and increasing the sense of professional helplessness and EE seen in Pourmand et al. Such insufficient trust and communication with patients, along with inadequate psychosocial expertise and sparse collegial support, mean that hazardous patient behaviors may go undetected and untreated more often, leading to more downstream medical consequences and increased workload and burnout, feeding cycles of EE.

Pourmand et al. and Dr. Jesse's discerning editorial[3] rightfully call for various remedies at the individual, clinic, and system levels. In addition to their recommendations, developing and maintaining interprofessional teams is crucial not just for bringing psychosocial expertise to advanced liver disease patients before and after transplantation but also to better support and train transplantation hepatologists, professionally and personally. Constructing and maintaining such interprofessional teams is neither casual nor easy.[4]

As one of your psychiatric colleagues in liver transplantation (LT), I am a fellow traveler in the uncertain borderlands of psychiatry, addiction, and hepatology. I too have been often overwhelmed by the complexity of transplantation hepatology; my liver and transplantation

FIGURE 1 Transplantation hepatologist burnout from prevalent behavioral and psychological patient factors underlying advanced liver diseases

training in psychiatric residency and fellowship were insufficient for my eventual career in ALD and LT. I have been helped through periods of stress and burnout by my kind hepatology colleagues who professionally train and personally support me. My hope is for many more future and widespread interprofessional bridges linking transplantation hepatology and psychiatry and yielding vital, durable, collaborative, and reciprocal benefits to patients and clinicians alike.

CONFLICT OF INTEREST

Nothing to report.

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