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The BULLETIN

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Public Health

Physician Burnout as a Personal & Public Health Issue

Impacting Health Beyond Your Office Door

Ending HIV by 2020: The New York State Plan

Practice Transformation for Primary Care in NYS

2017 Edward Mott Moore Award Recipients



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Physician Burnout as a Personal & Public Health Issue: *The need to reassess best use of resources*

by Michael R. Privitera, MD, MS

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Physicians and other healthcare professionals are the proximal reason for the quality of care provided to patients. What effect does increasing high-level and chronic occupational stress imposed from multiple uncoordinated sources have on them personally and ultimately the patients they serve? There is overwhelming evidence that the effect is devastating, but the level of awareness of this fact is slow to be recognized by the clinicians, the healthcare systems, and the sources of the stress.

The human condition of burnout is the same across many healthcare professions, but the specific stressors differ by profession. This article will focus upon physician burnout as a personal and public health issue, calling the question to reassess the best use of resources and better understanding the forces involved.

The widespread problem of physician burnout has made it into many lay press outlets including the *New York Times*, *Time* magazine, *US News and World Report* and *Forbes* magazines, to name a few. Our patients know we are going through this dilemma as a group and now so do health care institutions.

From the period of 2011 to 2014, burnout in physicians rose from 46% to 54%, while burnout in the general population remained about the same. Work/life balance went up in the general population and decreased in physicians during the same time ⁽¹⁾.

The forces involved in creation of burnout are often considered nebulous, sometimes subterranean, because they are an accumulation of a massive number of factors. Our own medical cultures of endurance and somewhat super-human internal perceptions of ourselves and external perceptions others have of us have contributed to the delays in awareness of how stressful and toxic the healthcare work environment has become. As author Dike Drummond, MD states, “It’s not a fair fight”, as final acknowledgement that in total the job description has become actually impossible to achieve. He also describes the multiple factors as “death by a thousand paper cuts” as an imagery to try to understand this accumulation effect ⁽²⁾.

The emerging evidence of how clearly burnout affects the healthcare system and the quality and safety of the care

provided to our patients now squarely promotes the needed opportunity for collaboration among educators, administrators, quality and safety advocates, patient experience advocates and the healthcare industry. It has become clear that The Triple Aim ⁽³⁾ framework of costs, patient experience, and quality in healthcare is an incomplete view of what is needed to occur for sustainability of practice and safety in patient care. Since many decision makers in healthcare and the support industry to healthcare are non-clinicians, a “perfect storm” occurred of over-expectation of demands of healthcare workers, and internally, over-expectation of human capabilities by the healthcare workers themselves. Two publications on The Quadruple Aim framework ^(4, 5) include the fourth aim: improving the experience of providing care—such that the healthcare workforce of physicians, nurses and employees find joy and meaning in their work. This framework addresses the human factors in the delivery of care that are essential to the success of the other three aims of patient experience, cost, and quality of care.

Six categories of work stress that can contribute to burnout:

1. Excessive workload: physical, cognitive and emotional
2. Lack of control in being able to influence work environment
3. Poor balance between effort and reward of material and in tangible rewards
4. Lack of community culture of mutual appreciation and team work (This gets worse the busier the physician becomes.)
5. Lack of fairness of resources and justice
6. Value conflict: moral distress of having to participate in suboptimal, unethical circumstances ⁽⁶⁾.

Conflicting perspectives to be reconciled:

1. Physician burnout is the doctor’s problem. They need more grit and resilience. We need to select better candidates. They just need more mindfulness and yoga.
2. Physician burnout is physician abuse, and the organizations need to do something about it.
3. Burnout can’t be a major problem. Plenty of people still go to medical school and doctors still show up for work.

Two recent meta-analyses analyzed comparisons of individual and organizational interventions to reduce burnout ^(7, 8). The strongest evidence for effectiveness was those organizational interventions to modify resources, working environment and work tasks to decrease stress. If physicians for a moment go

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back to their pre-med experiences and the motivating factors to become a physician, it becomes fairly clear that becoming a physician is a calling and not a series of transactions that may be the focus of the business of medicine. This cognitive dissonance needs to be better acknowledged and reduced, but is beyond the scope of this article.

Table 1 breaks down the three criteria for burnout and correlates how each factor affects staff-patient interaction.

Burnout Criteria	Effect on Staff-Patient Interaction
<ul style="list-style-type: none"> Emotional Exhaustion 	<ul style="list-style-type: none"> Delay of needed interactions with patient Less tolerance, irritability Not much left to give Decreased Patient Satisfaction
<ul style="list-style-type: none"> Depersonalization/ Callousness 	<ul style="list-style-type: none"> Withdrawal from patient Decreased compassion Decreased listening to patient Increased cynicism and sarcasm Increased risk of patient-on-staff workplace violence
<ul style="list-style-type: none"> Decreased Efficacy <p>Perception of decreased efficacy becomes reality as burnout becomes worse</p>	<ul style="list-style-type: none"> Poor occupational confidence Think making poor decisions Later, actually making poor decisions Cognitive Flexible Memory (CFM) switches to Habit Memory (HM) causes less differential diagnosis and poorer care plan HM: Reflex responses to stimuli—survival mode Cognitive impairments of decreased executive function: Decreased attention, focus, situational awareness, long term perspective, ability to anticipate patient and family needs & other patients on unit

The impact of clinician burnout is costly.

There are multiple dose-related relationships; the higher the burnout, the higher the incidence.

Institutional and Patient Toll

- Increased medical errors and malpractice claims
- Disruptive behavior
- Reduced empathy for patients, patient satisfaction
- Reduced patient adherence to treatment regimens

Financial Toll

- 27% drop in patient satisfaction scores
- 40% of turnover costs attributed to work stress
- 114% increase of medical claims by employees
- 30% of short-term and long-term disability costs

Personal Toll

- Reduced career satisfaction
- Higher suicide rate among physicians - 400/year
Rochester: Three physician suicides 2014-2016
- Substance abuse
- Divorce
- Coronary heart disease
- Depression

What has not been sufficiently publicized is that physician career satisfaction and patient health care satisfaction are highly correlated ⁽⁹⁾.

The Hamburg Burnout Inventory (HBI) scale is used in European studies on burnout. This inventory has been able to pick up other important factors that co-occur with burnout, including emotional exhaustion, detachment and depressive reaction to stress. In addition, the higher the burnout, the aggressive reaction to stress goes up in a dose-related manner. ⁽¹⁰⁾ This finding supports the observations by those who study disruptive behavior that found core factors of burnout occurring in most of the disruptive individuals.

Figure 1 on page 16 displays the current health care system ecosystems of interacting factors. The Macro level describes national state industry and regulatory factors. Meso level is at the hospital or healthcare system factors. Micro-level describes individual clinicians with other staff and with patients and their families. Exo level describes the individual physician and their family in daily life outside of medicine.

The individual physician is surrounded by an environment that promotes the medical culture of endurance — the hidden curriculum that complaining is whining; self-effacement such as how you feel does not matter; remain professional at all times (as opposed to

acknowledging your feelings but choosing your behaviors). Internally, there is a sense of altruism, workaholicism, perfectionism, and obedience to authority. There is also the well-known fact that everyone is evaluating their competence around them, and they don't want to be seen as 'weak' with so much at stake with all the personal sacrifice, debt, and a family that is depending upon them.

Some factors are well intended for patient care but are not coordinated or harmonized, and by these mechanisms, are paradoxically making patient care less safe. With the rapid roll out of healthcare reform, and many involved who are not clinicians making decisions, a 'halo bias' made adoption of too many measures an attempt to quantify quality. Just because someone calls it "quality" we tend to think it must be good (since the word 'quality' has a halo over it). The tsunami of these measures slipped by sufficient scientific scrutiny. Too many chaotic and unproven quality metrics are not good and in fact are harmful ⁽¹¹⁾.

Some factors are actually not well intended, and are devised to wear down the physician as a means of cost control. These are hassle factors that physicians experience in trying to achieve

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care for their patient. There really is no justifiable room for the continuance of these purposeful wear-down methods by the healthcare business industry given the serious consequences of burnout.

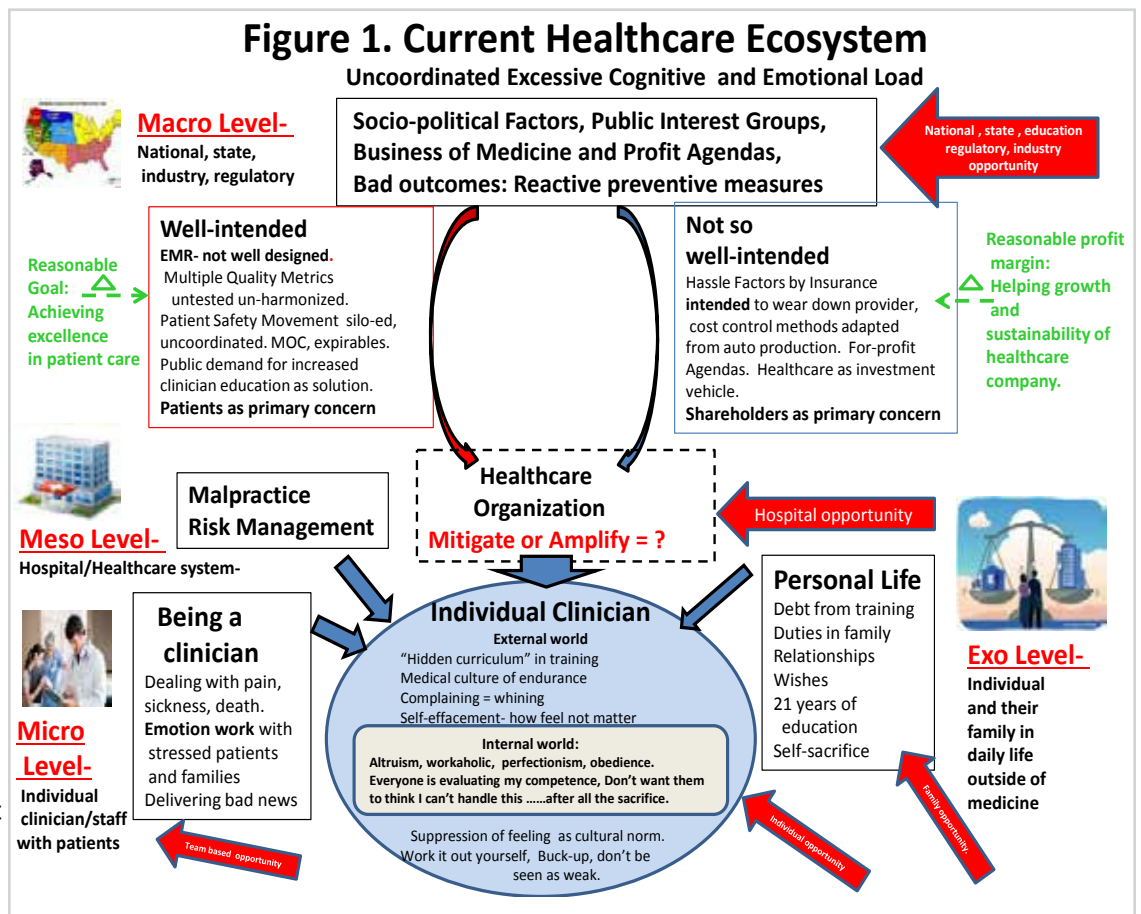
Human candidates who become physicians

College graduates who are enrolled in medical school have lower burnout and depression ratings than the general population. Two years into medical school, this group has higher burnout and higher depression than the general population⁽¹²⁾. At the beginning of internship, the incidence of depression is about 3.9%. Three months into internship, it becomes over 6 times higher at a rate of 27.1% and stays high throughout internship⁽¹³⁾. Suicidal ideation before internship is at 2.5%. At 3 months it becomes 4.0% and at 6 months it becomes over four times higher at 11.1%. It stays high throughout the rest of internship⁽¹⁴⁾. We also know that acute and chronic depression can affect medical decision making, increasing the rates of errors. We need to examine what we are doing to these humans in both the educational experience and in the early years as a physician.

Mechanisms of impact, medical decision making, and executive function

Physicians are trained to use what they have learned for medical decision making (MDM). Prefrontal cortex (PFC) is the part of the physician's brain that (together with widespread neuronal networks) is responsible for executive function (EF). EF weighs the multiple factors at hand to make the best diagnosis and treatment plan and is a limited resource. EF includes the ability to manage time, attention, switch focus, plan and organize, remember details, curb inappropriate behavior and speech, and integrates past experience (e.g., medical training and experiences) with present needed action to practice medicine of the highest competence. PFC is the most evolved brain region and sub serves our highest-order cognitive abilities. Unfortunately, it is also the brain region that

Figure 1. Current Healthcare Ecosystem



is most sensitive to the detrimental effects of stress exposure. Even quite mild acute uncontrollable stress can cause a rapid and dramatic loss of prefrontal cognitive abilities, and more prolonged stress exposure causes architectural changes in prefrontal nerve cells. This constant prioritization processing induced by uncoordinated mandates and subsequent diminished attentional resources available then increases "goal shielding" that attempts to help the doctor filter out other factors and get overly narrow in focus. Over focus on specifically allocated task-relevant processing (for example, making sure all the Meaningful Use in the electronic record are noted as "marked as reviewed" by properly clicking the appropriate buttons), then detract from cognitive flexible memory (CFM) needed in the clinical moment with the patient needed to weigh factors at hand. Habit memory (HM) then predominates over CFM that would have been used to examine factors in more accurate diagnosis, more comprehensive and effective care planning, as well as the emotional availability to the patient and family.

Cognitive processing capacity of the human mind is limited by the cognitive load put on these capacities. Intrinsic vs. extraneous vs. germane cognitive load are the factors involved in best decision making. Intrinsic load refers to the inherent difficulty of the mental task. Extraneous load refers to a burden of unnecessary information that uses up cognitive processing.

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Germane load refers to an organized pattern of thought that helps in efficient learning and mental tasks.

Excessive extraneous cognitive load will deplete EF away from the ability to make good medical decisions (see reference 15 for multiple supporting references).

Conclusions

1. Individual and institutional/organizational interventions for burnout reduction are effective.
2. This is a call for organizational and human factor/neurocognitive ergonomic science to be used at national, state, industry and local levels in healthcare.
3. Attention to the fourth same (experience of providing care) of the Quadruple Aim framework is critical to the success of other 3 aims of cost quality and patient experience.
4. Effective involvement by leadership is critical for things to improve.

5. “Meaningful progress will require collaborative efforts by national bodies, healthcare organizations, leaders, and individual physicians, as each is responsible for factors that contribute to the problem and must own their part of the solution ⁽¹⁶⁾”

Recommended Reading

Noseworthy J, Madara J et al. Physician Burnout Is A Public Health Crisis: A Message To Our Fellow Health Care CEOs Health Affairs Blog March 28, 2017

Shanafelt TD, Noseworthy J. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout Mayo Clin Proc. 2016;nn(n):1-18

The AMA's Steps Forward program is an excellent source of helping the individual and the organization. www.stepsforward.org/

Table 2 Outlines a number of strategies to be considered to reduce burnout in physicians. The combination of individual and organizational interventions are required to be effective and sustainable.

Table 2. Burnout Interventions (Need Both)

INDIVIDUAL

- Encourage recognition of Burnout in the face of Medical Culture and “Hidden Curriculum”
- Physicians start off more resilient than general population: **Individual interventions must be paired with organizational interventions**
- Wellness Seminar series as “safe place”
- Avoid blaming the victim
- Normalize self care
- Normalize boundaries between work and home despite technology
- Multiple individual interventions available
 - Mindfulness
 - Resiliency training
 - Gratefulness
 - 3 Good Things
 - Yoga
 - Coaching
 - Employee Assistance- Wellness Division
 - Self Help websites and literature
 - Peer Support
 - Clinician ombudsman to have work/life balance representation
 - Diet, exercise

ORGANIZATIONAL

- **Overcome the medical culture of endurance** where staff must deny stress
- **Leadership style and concern is key**
- **Establish: Wellness Initiative Strategic Planning Work Group**
- Include **human factor issues** in healthcare delivery
 - **Neuro-cognitive and organizational ergonomics**
 - **The Quadruple Aim Framework:**
 - » Costs, Quality, Patient experience, and **Fourth Aim: Experience of providing care.**
- Attempt to **understand the front line problems: Anonymous survey** to learn key pain points for clinicians, **round table discussion** of aggregate findings and **leadership commitment to action.**
- **Encourage stronger administrator/physician partnerships**
- **Use clinician wellness and career satisfaction metrics** and tie these into quality of care, reduction of malpractice, errors, and patient satisfaction.
- Block out time and resources to help **organize completion of all mandatories, regulations**
- No mandatory reporting of seeking mental health care on licensure, malpractice carrier, credentialing applications or renewals.
- **Confidentiality** in seeking help

by Carolyn Cleary, MD

The MCMS Quality Collaborative Pediatric Preventive Care subcommittee recently reviewed the guidelines and got approval of the revised guidelines from the Quality Collaborative.

The purpose of the guideline is to give general recommendations for preventive care for children ages 0 to 19 years. The guideline was modeled after the American Academy of Pediatrics' Bright Future guidelines, and is consistent with HEDIS recommendations and local ACO and insurer recommendations. It addresses appropriate immunizations, screening and counseling recommendations.

In reviewing the guidelines, there were no major changes

needed. The language was updated to be consistent with other MCMS guidelines. In accordance with HEDIS updates, the frequency of well child checks by various ages was updated. We referenced specific standardized developmental screens that are recommended. We reviewed the guidelines for STD testing, and although the routine screening recommendations are primarily for females, we urge males to be screened where appropriate. We updated diet and injury prevention to be current with NYS seat belt law and general AAP Bright Futures recommendations.

We strongly encourage all those who care for children to read the guideline and consider implementing in their practices. We feel that doing so will improve the health of children and young adults.

Community-Wide Guidelines can be found on the MCMS Quality Collaborative webpage at www.mcms.org/QualityCollaborative

QC Guidelines *Continued from page 32*

specialty guidelines don't address regional needs or normal regional variations; for example that our region is faced with a higher rate of HIV than many parts of the country. And national guidelines don't consider time taken to accomplish the task of prevention. An April 2003 study in the *American Journal of Public Health* noted that the average clinician would need 7.3 hours daily to meet all of the USPSTF recommendations – and this was in 2003. The number of recommendations have grown since then. Through our work at MCMS, our region must help prioritize the needs for our clinicians locally.

Finally the work of the Adult Preventative Guideline Committee tackled the daunting task of reconciling and distilling multiple guidelines from various sources. As part of the Monroe County Medical Society, we recognize the process must be more mere regurgitation of national guidelines. To this end the committee reviewed recommendations between the USPSTF as well as other specialty societies and served as a ground to discuss and debate the merits of the data, methods and reconciliation. For example, the committee had discussed whether to recommend Herpes Simplex virus screening. The committee discussed recommendations from the American College of Obstetricians and Gynecologists, in addition to the USPSTF. Previous impassioned discussion have resulted from attempts to reconcile recommendations around breast cancer screening and prostate cancer screening.

It has been an honor to serve as the chair to the Adult Preventative Service Guidelines for the past six years. The process is very much like a large Italian family dinner: sometimes messy, mostly animated, and always out of great caring and respect.

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