Physician Burnout: Past, Present, and Future

November 6, 2018

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Financial Disclosures

• None
Objectives

• Understand the scope of the problem of physician burnout.
• Summarize contributors and consequences of physician burnout and distress.
• Describe evidence-based local and national approaches to prevent burnout and promote physician well-being.
What is Burnout?

Burnout is a syndrome of depersonalization, emotional exhaustion, and low personal accomplishment leading to decreased effectiveness at work.
Depersonalization

“I’ve become more callous toward people since I took this job.”
Emotional Exhaustion

“*I feel like I’m at the end of my rope.*”
Brief Summary of Epidemiology

• Medical students matriculate with BETTER well-being than their age-group peers
• Early in medical school, this reverses
• Poor well-being persists through medical school and residency into practice
Mayo Multi-center Study of Medical Student Wellbeing

Student distress:
• 45% Burned out
• 52% Screen + for depression
• 48% At risk alcohol use
  • Compared to 28% age matched MN & 24% age matched US pop

Dyrbye Acad Med 81:374-84
Burnout among Residents

National Data (Golub et al., Acad Med 2005)

Otolaryngology-head and neck surgery residents, 2005 Survey

- Burnout: >53%
- Emotional exhaustion: 33%
- Depersonalization: 53%
Burnout among Practicing Physicians


<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2014</th>
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<tbody>
<tr>
<td>Burnout</td>
<td>45.8%</td>
<td>54.4%</td>
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<tr>
<td>Emotional exhaustion</td>
<td>37.9%</td>
<td>46.9%</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>29.4%</td>
<td>34.6%</td>
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Dissatisfied with work-life balance: 36.9%, 44.5%
But Don’t Burnout and Distress Affect Everyone?
# 2014 AMA Survey

## Employed Physicians vs. Employed U.S. Population

<table>
<thead>
<tr>
<th></th>
<th>Physicians n=5313</th>
<th>Population n=5392</th>
<th>p</th>
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<tbody>
<tr>
<td>Male</td>
<td>62%</td>
<td>54%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age (median)</td>
<td>53</td>
<td>52</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hrs/Wk (median)</td>
<td>50</td>
<td>40</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Burnout*</td>
<td>49%</td>
<td>28%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Dissatisfied WLB</td>
<td>49%</td>
<td>20%</td>
<td>&lt;0.001</td>
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* As assessed using the single-item measures for emotional exhaustion and depersonalization adapted from the full MBI. Area under the ROC curve for the EE and DP single items relative to that of their respective full MBI domain score in previous studies were 0.94 and 0.93.

Objectives

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• **Summarize contributors and consequences of physician burnout and distress.**
• Describe evidence-based local and national approaches to prevent burnout and promote physician well-being.
Consequences of Physician Burnout

- Medical errors\textsuperscript{1-3}
- Impaired professionalism\textsuperscript{4-6}
- Reduced patient satisfaction\textsuperscript{7}
- Staff turnover and reduced hours\textsuperscript{8,12}
- Depression and suicidal ideation\textsuperscript{9,10}
- Motor vehicle crashes and near-misses\textsuperscript{11}
- Total costs: >$5-10 billion dollars/year\textsuperscript{13}

\textsuperscript{1}JAMA 296:1071, \textsuperscript{2}JAMA 304:1173, \textsuperscript{3}JAMA 302:1294, \textsuperscript{4}Annals IM 136:358, \textsuperscript{5}Annals Surg 251:995, \textsuperscript{6}JAMA 306:952, \textsuperscript{7}Health Psych 12:93, \textsuperscript{8}JACS 212:421, \textsuperscript{9}Annals IM 149:334, \textsuperscript{10}Arch Surg 146:54, \textsuperscript{11}Mayo Clin Proc 2012, \textsuperscript{12}Mayo Clin Proc 2016, \textsuperscript{13}JAMA IM 2017
A Public Health Crisis!

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<tr>
<th>Burnout in U.S. alone:</th>
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<tr>
<td>&gt;40,000</td>
<td>Medical Students</td>
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<td>&gt;60,000</td>
<td>Residents and Fellows</td>
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<tr>
<td>&gt;490,000</td>
<td>Physicians</td>
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Plus other health care and biomedical science professionals

Individual or system problem?
Are physicians at inherent risk? The “Physician Personality”

TRIAD OF COMPULSIVE VENESS

Doubt

Guilt

Exaggerated Sense Responsibility

Gabbard JAMA 254:2926
The “Physician Personality”

**Adaptive**
- Diagnostic rigor
- Thoroughness
- Commitment to patients
- Desire to stay current
- Recognize responsibility of patients’ trust

**Maladaptive**
- Difficulty relaxing
- Problem allocating time for family
- Sense responsibility beyond what you control
- Sense “not doing enough”
- Difficulty setting limits
- Confusion of selfishness vs. healthy self-interest
- Difficulty taking time off

Gabbard JAMA 254:2926
Physician Distress: Key Drivers

• Excessive workload
• Inefficient work environment, inadequate support
• Problems with work-home integration
• Loss autonomy/flexibility/control
• Loss of values and meaning in work
Burnout
  • Exhaustion
  • Cynicism
  • Inefficacy

Driver dimensions

Workload and job demands
Efficiency and resources
Meaning in work
Organizational culture and Values
Social support and community at work
Work-life integration
Control and flexibility

Less optimal
More optimal

Engagement
  • Vigor
  • Dedication
  • Absorption

Objectives

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Individual Strategies

• Identify Values
  • Debunk myth of delayed gratification
  • What matters to you most (integrate values)
  • Integrate personal and professional life

• Optimize meaning in work
  • Flow
  • Choose/focus practice

• Nurture personal wellness activities
  • Calibrate distress level
  • Self-care (exercise, sleep, regular medical care)
  • Relationships (connect w/ colleagues; personal)
  • Religious/spiritual practice
  • Mindfulness
  • Personal interests (hobbies)
Delayed Gratification: Life on Hold?

• 50% residents report “Survival Attitude” - life on hold until the completion of residency

• 37% practicing oncologists report “Looking forward to retirement” is an essential “wellness promotion strategy”

• Many physicians may maintain strategy of delayed gratification throughout their entire career

Shanafelt, J Sup Oncology 3:157
Individual Strategies

Recognition of distress:

- Medical Student Well-Being Index (Dyrbye 2010, 2011)
- Physician Well-Being Index (Dyrbye 2013, 2014)
  - Simple online 7- or 9-item instruments evaluating multiple dimensions of distress, with strong validity evidence and national benchmarks from large samples of medical students, residents, and practicing physicians
  - Evidence that physicians do not reliably self-assess their own distress
  - Feedback from self-reported Index responses can prompt intention to respond to distress
- Suicide Prevention and Depression Awareness Program (Moutier 2012)
  - Anonymous confidential Web-based screening
- AMA STEPSForward modules
  - Mini Z instrument (AMA, Linzer 2015): 10-item survey
Physician Well-Being Index
https://www.mededwebs.com/well-being-index
Physician Well-Being Index
https://www.mededwebs.com/well-being-index
Individual Strategies

Risk of exclusively individual focus:

- Deepen cynicism through perceived message that physicians must “toughen up” to cope with a toxic working environment, rather than addressing the toxic working environment itself.

- Sydney Morning Herald, July 5, 2017:
  - “The ‘con’ of building resilience has left junior doctors vulnerable to mental illness and suicide by ignoring the systemic failures of the medical profession …”
  - “… the current focus on building resilience ignored the deleterious culture of medicine and dangerous working conditions to which junior doctors (are) subjected.”
Organizational Strategies

- Acknowledge and assess the problem
- Harness the power of leadership
- Develop and implement targeted work unit interventions
- Cultivate community at work
- Use rewards and incentives wisely
- Align values and strengthen culture
- Promote flexibility and work-life integration
- Provide resources to promote resilience and self-care
- Facilitate and fund organizational science

The Evidence in Total

• Systematic review on interventions for physician burnout, commissioned by Arnold P. Gold Foundation Research Institute (West Lancet 2016):
  • 15 RCT’s, 37 non-RCT’s
  • Results similar for RCT and non-RCT studies
The Evidence in Total

- **Emotional exhaustion (EE):**
  - -2.7 points, *p*<0.001
  - Rate of High EE: -14%, *p*<0.001

- **Depersonalization (DP):**
  - -0.6 points, *p*=0.01
  - Rate of High DP: -4%, *p*=0.04

- **Overall Burnout Rate:**
  - -10%, *p*<0.001

Benefits similar for individual-focused and structural interventions (but we need both)
The Evidence in Total

• Individual-focused interventions:
  • Meditation techniques
  • Stress management training, including MBSR
  • Communication skills training
  • Self-care workshops, exercise program
  • Small group curricula, Balint groups
    • Community, connectedness, meaning
The Evidence in Total

- **Structural interventions:**
  - Duty Hour Requirements for trainees
    - Unclear but possibly negative impact on attendings
  - Shorter attending rotations
  - Shorter resident shifts in ICU
  - Locally-developed practice interventions
Mayo RCT’s (2012, 2014)

- Compared to a wait-listed control group, a small group topic-oriented discussion intervention improved:
  - Depersonalization
  - Personal accomplishment
  - Overall QOL
  - Depression
  - Meaning from work
  - Social isolation at work
  - Job satisfaction
  - Likelihood of leaving in next 2 years

- Initial intervention shows benefit with sustained changes over subsequent 6 months.

- Physician Engagement Groups funded by Mayo
  - [http://peg.mayo.edu](http://peg.mayo.edu)

Mayo RCT #2 (2014)

- Sample Discussion Topics:
  - Meaning in work/job satisfaction
    - Specific experiences
    - Think about one of your most satisfying days at work over the last month. What made this day so professionally satisfying? Share with your colleagues.
  - Teamwork/Social support/Collegiality/Relationships/Work-life balance and integration
    - Relationships and support
    - Brainstorm ways to promote collegiality in your hallway or work unit.
  - Personal strengths/Problem solving/Coping/Resources for thriving and flourishing
    - Choose one stressor that you can control, come up with 2 concrete ways you can reduce it, and commit to trying 1 approach within the next week.

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<th></th>
<th>Individual</th>
<th>Organizational</th>
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<td>Workload</td>
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<td>Work Efficiency/Support</td>
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<td>Work-Home Integration/Balance</td>
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<td>Autonomy/Flexibility/Control</td>
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<td>Meaning/Values</td>
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<tr>
<td>Workload</td>
<td>Part-time status</td>
<td>Productivity targets</td>
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<td>Duty Hour Requirements</td>
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<td></td>
<td></td>
<td>Integrated career development</td>
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<tr>
<td>Work Efficiency/Support</td>
<td>Efficiency/Skills Training</td>
<td>EMR (+/-?)</td>
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<td></td>
<td></td>
<td>Staff support</td>
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<tr>
<td>Work-Home Integration/Balance</td>
<td>Self-care Mindfulness</td>
<td>Meeting schedules</td>
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<td>Off-hours clinics</td>
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<td>Curricula during work hours</td>
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<td>Financial support/counseling</td>
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<tr>
<td>Autonomy/Flexibility/Control</td>
<td>Stress management/Resiliency Mindfulness</td>
<td>Physician engagement</td>
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<td></td>
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<td>Engagement</td>
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<tr>
<td>Meaning/Values</td>
<td>Positive psychology Reflection/self-awareness Mindfulness Small group approaches</td>
<td>Core values</td>
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<tr>
<td></td>
<td></td>
<td>Protect time with patients</td>
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<td></td>
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<td>Promote community</td>
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<td>Work/learning climate</td>
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<tr>
<td>Drivers of burnout and engagement in physicians</td>
<td>Individual factors</td>
<td>Work unit factors</td>
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<tr>
<td><strong>Workload and job demands</strong></td>
<td>• Specialty</td>
<td>• Productivity expectations</td>
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<td></td>
<td>• Practice location</td>
<td>• Team structure</td>
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<td></td>
<td>• Decision to increase work to increase income</td>
<td>• Efficiency</td>
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<tr>
<td></td>
<td></td>
<td>• Use of allied health professionals</td>
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<tr>
<td><strong>Efficiency and resources</strong></td>
<td>• Experience</td>
<td>• Availability of support staff and their experience</td>
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<td></td>
<td>• Ability to prioritize</td>
<td>• Patient check-in efficiency/process</td>
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<td></td>
<td>• Personal efficiency</td>
<td>• Use of allied health professionals</td>
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<tr>
<td></td>
<td>• Organizational skills</td>
<td>• Organizational norms and expectations</td>
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<tr>
<td></td>
<td>• Willingness to delegate</td>
<td>• Equity/fairness</td>
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<tr>
<td></td>
<td>• Ability to say “no”</td>
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<tr>
<td><strong>Meaning in work</strong></td>
<td>• Self-awareness of most personally meaningful aspect of work</td>
<td>• Match of work to talents and interests of individuals - Opportunities for involvement - Education - Research - Leadership</td>
</tr>
<tr>
<td></td>
<td>• Ability to shape career to focus on interests</td>
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<td></td>
<td>• Doctor–patient relationships</td>
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<td></td>
<td>• Personal recognition of positive events at work</td>
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<tr>
<td><strong>Culture and values</strong></td>
<td>• Personal values</td>
<td>• Behavior of work unit leader - Work unit norms and expectations</td>
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<td></td>
<td>• Professional values</td>
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<td></td>
<td>• Level of altruism</td>
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<td></td>
<td>• Moral compass/ethics</td>
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<tr>
<td></td>
<td>• Commitment to organization</td>
<td></td>
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<tr>
<td><strong>Control and flexibility</strong></td>
<td>• Personality</td>
<td>• Degree of flexibility - Control of physician calendars - Clinic start/end times - Vacation scheduling - Call schedule</td>
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<tr>
<td></td>
<td>• Assertiveness</td>
<td></td>
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<td></td>
<td>• Intentionality</td>
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<tr>
<td><strong>Social support and community at work</strong></td>
<td>• Personality traits</td>
<td>• Collegiality in practice environment - Physical configuration of work unit space - Social gatherings to promote community - Team structure</td>
</tr>
<tr>
<td></td>
<td>• Length of service</td>
<td></td>
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<tr>
<td></td>
<td>• Relationship-building skills</td>
<td></td>
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<tr>
<td><strong>Work-life integration</strong></td>
<td>• Priorities and values</td>
<td>• Call schedule - Structure night/weekend coverage - Cross-coverage for time away - Expectations/role models</td>
</tr>
<tr>
<td></td>
<td>• Personal characteristics - Spouse/partner - Children/dependents - Health issues</td>
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</tbody>
</table>

Solutions

- **AAMC**: [https://www.aamc.org/initiatives/462280/wellbeingacademicmedicine.html](https://www.aamc.org/initiatives/462280/wellbeingacademicmedicine.html)
- **ACGME**: [http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being](http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being)
- **AAIM**: [http://www.im.org/p/cm/ld/fid=1520](http://www.im.org/p/cm/ld/fid=1520)
- **AMA**: [https://www.stepsforward.org/modules?sort=recent&category=wellbeing](https://www.stepsforward.org/modules?sort=recent&category=wellbeing)
Charter on Physician Well-Being

Charter on Physician Well-being

Dedication to serving the interests of the patient is at the heart of medicine’s contract with society. When physicians are healthy, they are best able to meaningfully connect with and care for patients. However, challenges to physician well-being are widespread, with problems such as dissatisfaction, symptoms of burnout, relatively high rates of depression, and increased suicide risk affecting physicians from medical training through their professional careers. These problems are associated with suboptimal patient care, lower patient satisfaction, delayed access to care, and increased health care costs.

Addressing physician well-being benefits patients, physicians, and the health care system. Governing bodies, policy makers, medical organizations, and individual physicians share a responsibility to proactively support meaningful engagement, vitality, and fulfillment in medicine. Fulfilling these ideals within the culture of medicine and across its diverse members may help to strengthen health care teams and improve health care system performance.

On behalf of the Collaborative for Health and Renewal in Medicine (see acknowledgment), we set forth guiding principles and key commitments as a framework for key groups to address physician well-being from medical training through an entire career (box).

Governing bodies and policy makers could use this charter to help advance a high functioning health care system by ensuring that policies and regulations align with best practices that promote physician well-being. Organizations could use this charter to help identify, strategic priorities and interventions that may, in turn, provide better patient care and practice high-quality medicine.

Physician Well-being is Related With the Well-being of All Members of the Health Care Team

Physicians practice within a matrix of important relationships with patients, members of an interprofessional team, administrative leaders, and in some settings, learners and educators. The entire team is affected by the health of each of its members. Approaches to address physician well-being are most effective when contextualized within efforts to enhance the well-being of all health care team members.

Physician Well-being is a Quality Marker

Enhancing physician well-being likely benefits health systems seeking to provide high value care. For example, physician burnout has been estimated to contribute one-third of the cost of physician job turnover to the health care system. The “Triple Aim” for health system improvement, optimizing the care experience and population health while reducing the cost of care, should be supplemented with well-being, the fourth component of a “quadruple aim” and an essential metric that should be tracked and included in organizational performance reports. Healthy organizations use systems improvement tools to identify factors associated with reduced well-being, including assessments of physician well-being in the planning stages of systems improvement initiatives.

Physician Well-being is a Shared Responsibility

Physician well-being is a collaborative effort involving...
Charter on Physician Well-Being

• Guiding Principles
  • 1. Effective patient care promotes and requires physician well-being
  • 2. Physician well-being is related with the well-being of all members of the health care team
  • 3. Physician well-being is a quality marker
  • 4. Physician well-being is a shared responsibility
Charter on Physician Well-Being

• Key Commitments
  • 1. Foster a trustworthy and supportive culture in medicine
  • 2. Advocate for policies that enhance well-being
  • 3. Build supportive systems
  • 4. Develop engaged leadership
  • 5. Optimize highly functioning interprofessional teams
  • 6. Anticipate and respond to inherent emotional challenges of physician work
  • 7. Prioritize mental health care
  • 8. Practice and promote self-care
Charter on Physician Well-Being

• Key endorsers and supporters (among others):
  • AAIM – Alliance for Academic Internal Medicine
  • AAMC – Association of American Medical Colleges
  • ABIM – American Board of Internal Medicine
  • ACCME – Accreditation Council for Continuing Medical Education
  • ACLGIM – Association of Chiefs and Leaders of General Internal Medicine
  • ACP – American College of Physicians
  • AMA – American Medical Association
  • APA – American Psychiatric Association
  • ASA – American Society of Anesthesiologists
  • CMSS – Council of Medical Specialty Societies
  • IHI – Institute for Healthcare Improvement
  • SGIM – Society of General Internal Medicine
  • SHM – Society of Hospital Medicine

• Why not you and your organizations as well?
Recommendations

• We have a professional obligation to act.
  • Physician distress is a threat to our profession
  • It is unprofessional to allow this to continue
    • Evolve definition of professionalism? (West 2007)
  • SHARED RESPONSIBILITY

• We must assess distress
  • Metric of institutional performance
    • Part of the “dashboard”
  • Can be both anonymous/confidential and actionable
Recommendations

• The toolkit for these issues will contain many different tools.
• There is no one solution …
• … but many approaches offer benefit!
Physician Distress: Key Drivers

- Excessive workload
- Inefficient environment, inadequate support
- Problems with work-home integration
- Loss autonomy/flexibility/control
- Loss of values and meaning in work
Thank You!

• Comments/questions

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