Being a Hero Comes with a Cost

The Burnout Epidemic in Medicine

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Objectives

* To be able to define and characterize professional burnout in Medicine
* To understand the prevalence, consequences and damage that result from burnout
* To have awareness of and strategies for mitigating stress and burnout during residency training

Conflicts of Interest

* No financial conflicts
* Research supported by Agency for Healthcare Research and Quality
* Partnering with American Medical Association, American College of Physicians and Association of Chiefs and Leaders in General Internal Medicine

Let's start with you…

3. Using your own definition of "burnout", please choose one of the answers below:

1. I enjoy my work. I have no symptoms of burnout.

2. I am under stress, and don't always have as much energy as I did, but I don't feel burned out.

3. I am definitely burning out and have one or more symptoms of burnout, e.g. emotional exhaustion.

4. The symptoms of burnout that I'm experiencing won't go away. I think about work frustrations a lot.

5. I feel completely burned out. I am at the point where I may need to seek help.

About me…

* Board certified:
  * Internal Medicine since 2002
  * Hospice and Palliative Med since 2007
* Hospitalist, Palliative, Hospice clinical practice
* Healthcare reform advocate in a variety of capacities:
  * Palliative Medicine
  * Advanced Illness Care Model development
  * Advance care planning development (Respecting Choices)
* Organizational Clinician coach/mentor (2013-2016)

About me cont'd…

* Self identified as burned out MD in 2016
  * Left Palliative practice under duress in 2016
  * Grew professional interest in physician burnout through reflection and research on topic

* Joined Hennepin County Medical Center (HCMC) in July 2017
  * Palliative Medicine Division Director
  * Joined Office of Professional Wellness (OPW) Aug 2017

Definition

* **Burnout**: A State of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations*
  * A **collection** of symptoms associated with emotional exhaustion
  * A **Process** which is **progressive,** and includes:
    * Prolonged exposure to job strain
    * Erosion of idealism
    * A loss of sense of achievement

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*Pines et al, "Burnout: from Tedium to Personal Growth", NY Free press, 1981

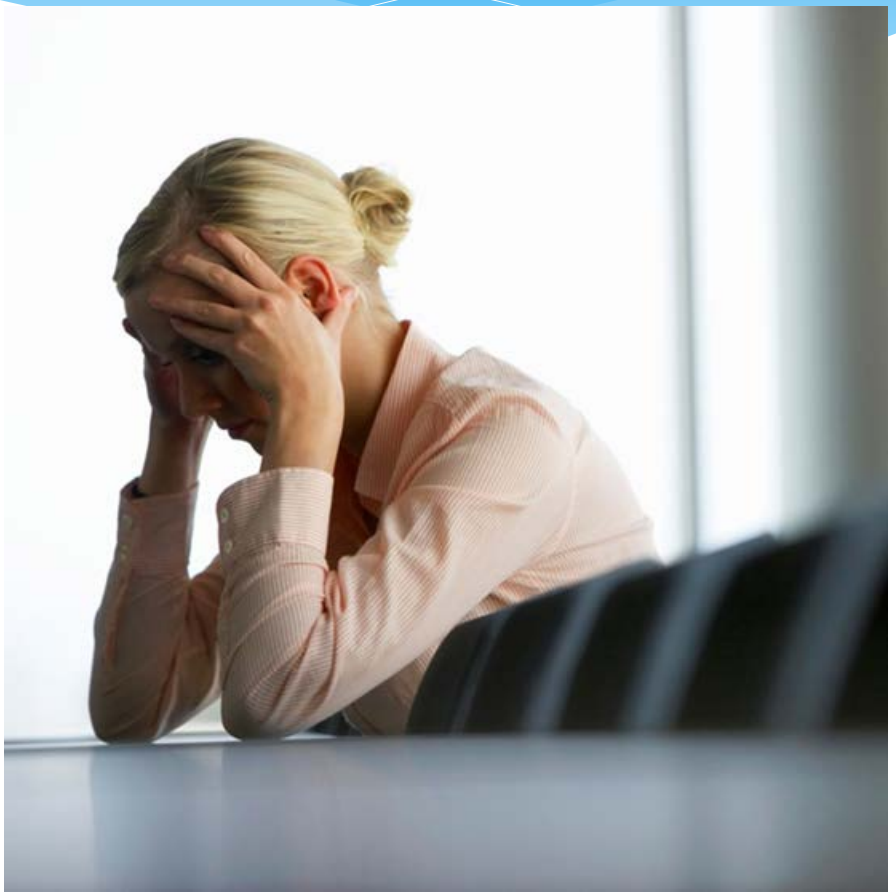
Burnout in Medicine*

"(Burnout) is a syndrome that primarily affects individuals such as physicians, nurses and social workers, whose work involves constant demands and intense interactions with people who have great physical and emotional needs."

*Balch et al; "Stress and Burnout Among Surgeons"; Arch. Surg, Vol 144, #4, Apr. 2009

"Classic Triad" Symptoms of Burnout

- Emotional exhaustion
- Depersonalization
- Loss of sense of personal accomplishment



Maslach C. *J Appl Psychol.* 2008; Maslach C. *Ann Rev Psychol.* 2001.

A system wide problem: Physician Burnout at nearly 50% in 2014

ORIGINAL ARTICLE

MAYO CLINIC

Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014

Tait D. Shanafelt, MD; Omar Hasan, MBBS, MPH; Lotte N. Dyrbye, MD, MHPE; Christine Sinsky, MD; Daniel Satele, MS; Jeff Sloan, PhD; and Colin P. West, MD, PhD

Abstract

Objective: To evaluate the prevalence of burnout and satisfaction with work-life balance in physicians and US workers in 2014 relative to 2011.

Patients and Methods: From August 28, 2014, to October 6, 2014, we surveyed both US physicians and a probability-based sample of the general US population using the methods and measures used in our 2011 study. Burnout was measured using validated metrics, and satisfaction with work-life balance was assessed using standard tools.

Results: Of the 35,922 physicians who received an invitation to participate, 6880 (19.2%) completed surveys. When assessed using the Maslach Burnout Inventory, 54.4% (n=3680) of the physicians reported at least 1 symptom of burnout in 2014 compared with 45.5% (n=3310) in 2011 ($P<.001$). Satisfaction with work-life balance also declined in physicians between 2011 and 2014 (48.5% vs 40.9%; $P<.001$). Substantial differences in rates of burnout and satisfaction with work-life balance were observed by specialty. In contrast to the trends in physicians, minimal changes in burnout or satisfaction with work-life balance were observed between 2011 and 2014 in probability-based samples of working US adults, resulting in an increasing disparity in burnout and satisfaction with work-life balance in physicians relative to the general US working population. After pooled multivariate analysis adjusting for age, sex, relationship status, and hours worked per week, physicians remained at an increased risk of burnout (odds ratio, 1.97; 95% CI, 1.80-2.16; $P<.001$) and were less likely to be satisfied with work-life balance (odds

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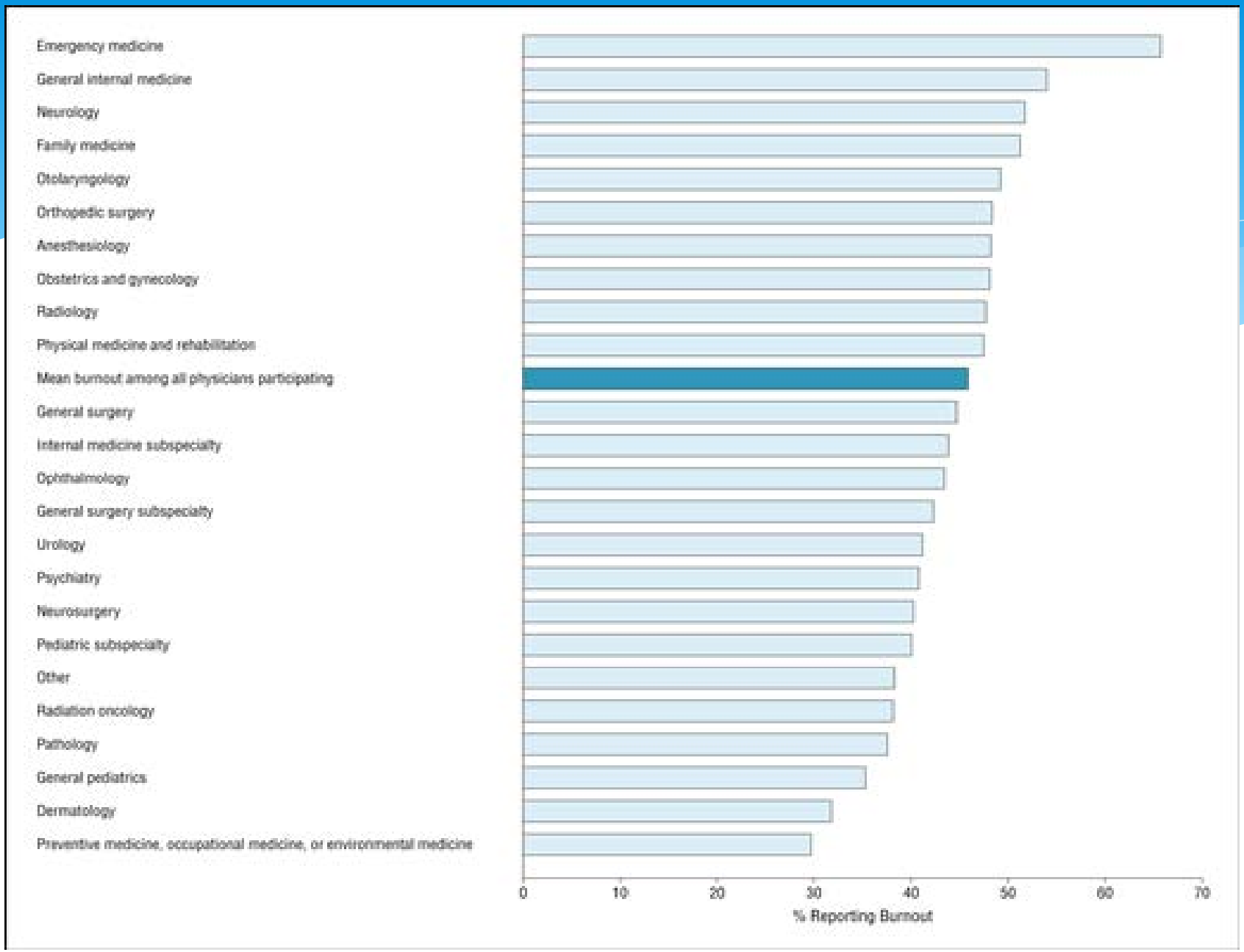

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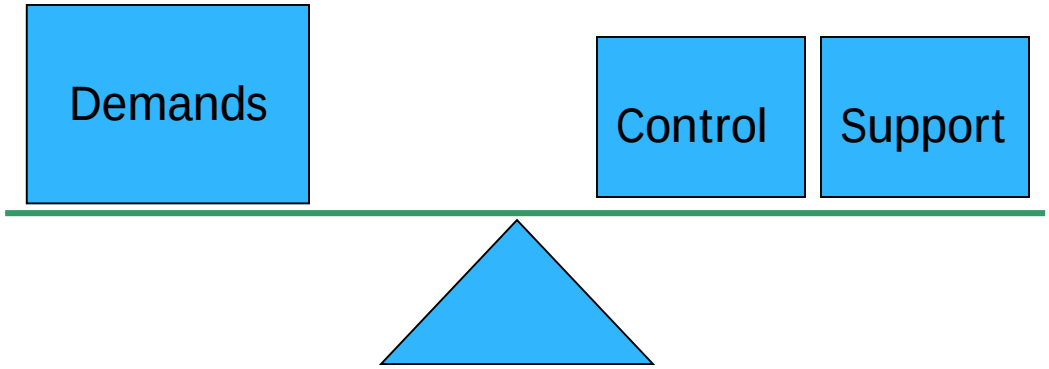
Demand-control model of job stress

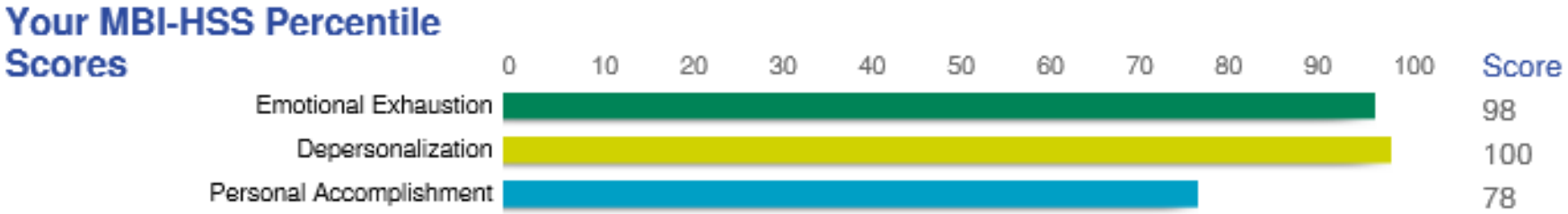
* Demands are balanced by control
* Stress increases if demands rise or control diminishes
* Support can facilitate the impact of control: more support, less stress
* Bottom line… support and work control prevent stress

(Karasek et al. *Am J Public Health* 1981;71:694-705)



About me, again…

* I scored high on Maslach Burnout Index (September 2016)



* Moral Distress/Residue is also a very powerful negative aspect/stressor

Physician Worklife Study* (1996-1997)

* Well powered (2326 primary care and subspecialty MD participants)
* Work demands associated with stress
  * Case Mix, Time pressure, Solo practice
* Social Isolation also increased stress
* Social support mitigated stress

*Linzer et al; Physician Stress: Results from the Physician Worklife Study; *Stress and Health 18: pp 37-42, 2002*

Stress from EMRs: Babbott, JAMIA, 2013

* Assessed EMR use in physicians in upper Midwest and NYC, 2002-2006 (MEMO)
* Two main findings:
  * 1. As EHR becomes more mature in a practice, stress worsens, then decreases, but not to where it started.
  * 2. With fully mature EMR, shorter visits associated with stress, burnout and intent to leave .

Bottom line: **EMR takes time; consequences of not allowing that time are severe.**

The "20% Rule": A minimum of meaning

* Shanafelt et al* studied physicians, assessing burnout and association with aspects of work that were most meaningful to them.
  * 34% of physicians studied were burned out
  * Most (68%) identified direct patient care as most meaningful for them professionally.
* Physicians who spent less than 20% of their time doing work they found meaningful had substantially higher burnout rates (54% vs. 30%)

*Arch Intern Med. 2009;169(10):990-995.

What Does Burnout Do To You?

* Increased suicide risk in Surgeons noted strongly associated with higher MBI scores*
* Increased incidence of Medical Errors and Malpractice associated with burnout**
* High risk of reducing work hours or leaving practice altogether

*Shanafelt et al; Arch Surg. 2011 Jan;146(1):54-62.
**Shanafelt et al; Burnout and Errors among American Surgeons; Annals of surgery 251(6):995-1000 · November 2009;
Balch et al; J Am Coll Surg. 2011 Nov;213(5):657-67.

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Other Consequences

* Rising MBI scores in Emotional Exhaustion or Depersonalization strongly correlated with reporting of medical errors*
* Burnout scores associated with higher mortality rates, decline in pt safety scores, more hospital acquired infections**
* Pt adherence to tx regimens, prescribing habits, and post discharge recovery time also correlated…

**Welp A, Meier LL, Manser T. Emotional exhaustion and workload predict clinician-rated and objective patient safety. *Front Psychol*. 2015;5:1573.; Welp A, Meier LL, Manser T. The interplay between teamwork, clinicians' emotional exhaustion, and clinician-rated patient safety: a longitudinal study. *Crit Care*. 2016;20(1):110. Bakker AB, Le Blanc PM, Schaufeli WB. Burnout contagion among intensive care nurses. *J Adv Nurs*. 2005;51(3):276-287. Cimiotti JP, Aiken LH, Sloane DM,Wu ES. Nurse staffing, burnout, and health care-associated

Am J Infect Control. 2012;40(6):486-490.

The Economic Costs of Burnout

* Shanafelt et al* published economic analysis of costs of burnout in 2017. Physicians leaving or reducing FTE analyzed
* Reasonable cost estimates to replace a physician leaving a practice:
  * 2-3x annual salary
  * $250k-1M, depending on time of vacancy
* Physician leaving practice increases risk of burnout and leaving practice in other clinicians in that practice…

*"The Business Case for Investing in Physician Wellbeing"; JAMA Intern Med, Sept 2017

Other effects

* Associated with perceived errors by medical housestaff (West C. *JAMA*. 2009;296:1071-78)
* 1.6 x higher in women physicians

Consequences Summary

* For Clinicians:
  * Higher incidence depression, chemical abuse, suicide risk, relationship problems, “viral effect”
* For Patients:
  * Increased risk of errors, less likely to follow treatment plans, lower satisfaction
* For Healthcare Systems:
  * Higher litigation rates, lower quality scores, higher costs associated with lower productivity and increased turnover (also “viral” impact)

Moving Upstream: Burnout in Residents

* Common – 40-75%
* Predictors:
  - perfectionism
  - coping skills
  - lack of control
  - lack of time for self-care
  - complex patients

(Eckleberry-Hunt J. Acad Med 2009;84:269-77. Martin S. Acad Psychiat. 2006;30:352-55.)

Table 4

Characteristic	Medical students, ages 22–32 (n = 4,032)	Population, college graduates, ages 22–32 (n = 736)	*P* value	Residents/ fellows, ages 27–40 (n = 1,489)	Population, college graduates, ages 27–40 (n = 992)	*P* value	Early career physicians, ages 31–47 (n = 806)	Population, employed, ages 31–47 (n = 1,832)	*P* value
Burnout index, no. (%)*									
Emotional exhaustion: high score	1,647 (41.1)	511 (31.8)	<.0001	557 (37.6)	260 (26.4)	<.0001	243 (30.5)	462 (25.3)	.01
Depersonalization: high score	1,084 (27.2)	297 (18.5)	<.0001	528 (35.7)	164 (16.6)	<.0001	181 (22.6)	302 (16.6)	<.001
Burned out†	1,976 (49.6)	573 (35.7)	<.0001	739 (50.0)	310 (31.4)	<.0001	297 (37.3)	545 (29.9)	<.001
Screened positive for depression, no. (%)	2,337 (58.0)	761 (47.5)	<.0001	753 (50.7)	406 (41.1)	<.0001	319 (39.9)	801 (43.9)	.06
Suicidal ideation in the last 12 months, no. (%)	375 (9.3)	171 (10.6)	.25	120 (8.1)	86 (8.7)	.58	53 (6.6)	132 (7.2)	.55

Burnout Among U.S. Medical Students, Residents, and Early Career Physicians Relative to the General U.S. Population

Dyrbye, Liselotte N.; West, Colin P.; Satele, Daniel; Boone, Sonja; Tan, Litjen; Sloan, Jeff; Shanafelt, Tait D.

Academic Medicine89(3):443-451, March 2014.
doi: 10.1097/ACM.0000000000000134

Comparison of Medical Student, Resident/Fellow, and Early Career Physician (≤ 5 Years In Practice) Respondents to a Survey About Burnout and Distress With Probability-Based, Age-Matched Samples of U.S. College Graduates, 2011–2012

Burnout in Residents

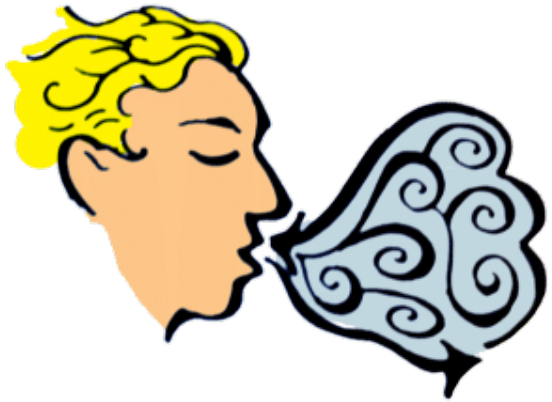
* Associated factors
  - depression
  - lack of career satisfaction
  - self-perceived errors
  - lack of empathy

(West CP. JAMA. 2006;296:1071-78)

(Shanafelt T. Ann Intern Med 2002;136:358-67)

4-7-8 Breathing Technique

1. Exhale completely
2. Inhale through nose - **4** seconds
3. Hold your breath - **7** seconds
4. Exhale completely through mouth– **8** seconds
5. This is one breath



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Resident wellness and work/life balance - Canada

* Need for curriculum in physician health
* Develop centers of leadership in prevention and identification of physician health issues
* Tension between self care needs of residents and needs of patient and residency program should be reframed
  * improved patient care and learning will result from better focus on resident wellness

* *(Edwards S. Resident wellness and work/life balance. FMEC PG Consortium; 2011.)*

Canadian Resident data:

* Predictors of distress:
  * time pressure
  * isolation
  * relationship strain
  * work-home interference
  * lack of self care
  * work demands
  * low autonomy.

* Impact of duty hours restrictions: fewer errors, improved quality of life, decreased depression and exhaustion.

To improve well being in residents:

* Promote resilience
* Increase control/autonomy/input
* Discuss coping strategies
* Flexibility
* Social support
* Places to talk about feelings

* *Edwards S. Resident wellness and work/life balance.; FMEC PG consortium. 2011.*

Or if you like the U.S. Version*

* Workload assessment/adjustment
* Control/involvement in key decisions
* Balance between Effort and Reward
* Community
* Fairness
* Values Alignment

Jennings, ML and Slavin, SJ; Acad Med 2015; 90: 1246-1250

Solutions: Pieces to the Puzzle

* Solutions will require:
  * Meaningful organizational commitment
  * Internal championing and engagement
  * Collaboration/mentorship/structured interventions

How can we prevent burnout?

* Flexible/part-time work
  (Linzer et al. *Acad Med* 2009;84:1395-1400)
* Leaders model work-home balance; value well-being
  (Saleh et al. *Clin Orthop Relat Res* 2009;467:558-65)
* Understand and promote work control
* Alter our "culture of endurance"
  (Viviers et al. Can J Ophthalmol 2008;43:535-46)
* Wellness focus – reflection, exercise, share concerns with colleagues (LeMaire J. BMC HSR. 2010; 10:208)

Where to start: Survey!!

* "Mini-Z" (Zero burnout) is a great tool
  * Research derived, validated
  * Nationally recognized
  * Adds specificity and actionable elements
* "Mini-Z ReZ" is Mini-Z modified to focus on Residents and fellows
* Maslach Burnout Inventory (MBI) is "gold standard" for identifying burnout, but lacks actionable data and is not specific to medical field

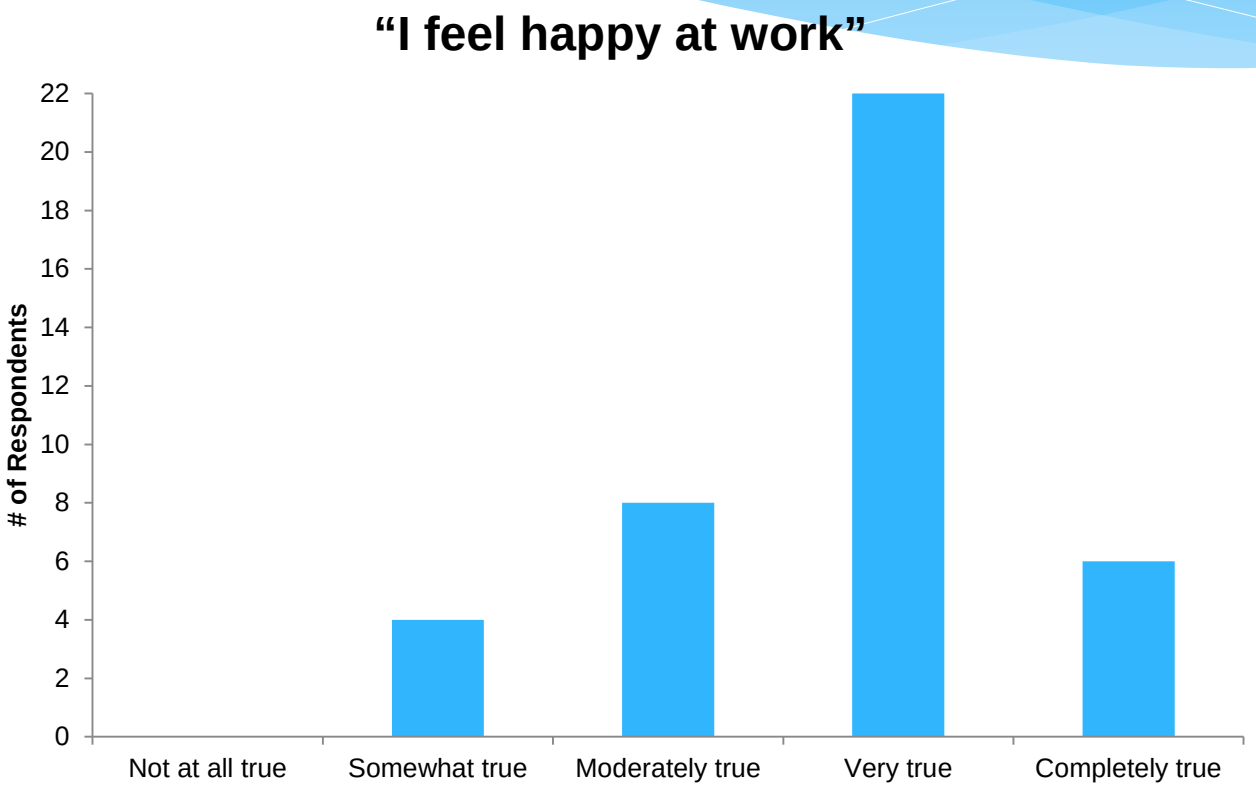
Case Study: HCMC IM Residency Survey

* Demographic information
* Feelings about the practice environment and resident colleagues
* Work-related stress
  * Recognition and appreciation
  * Effect of residency on personal relationships
  * Sense of control
  * Continuity Clinic

Demographics

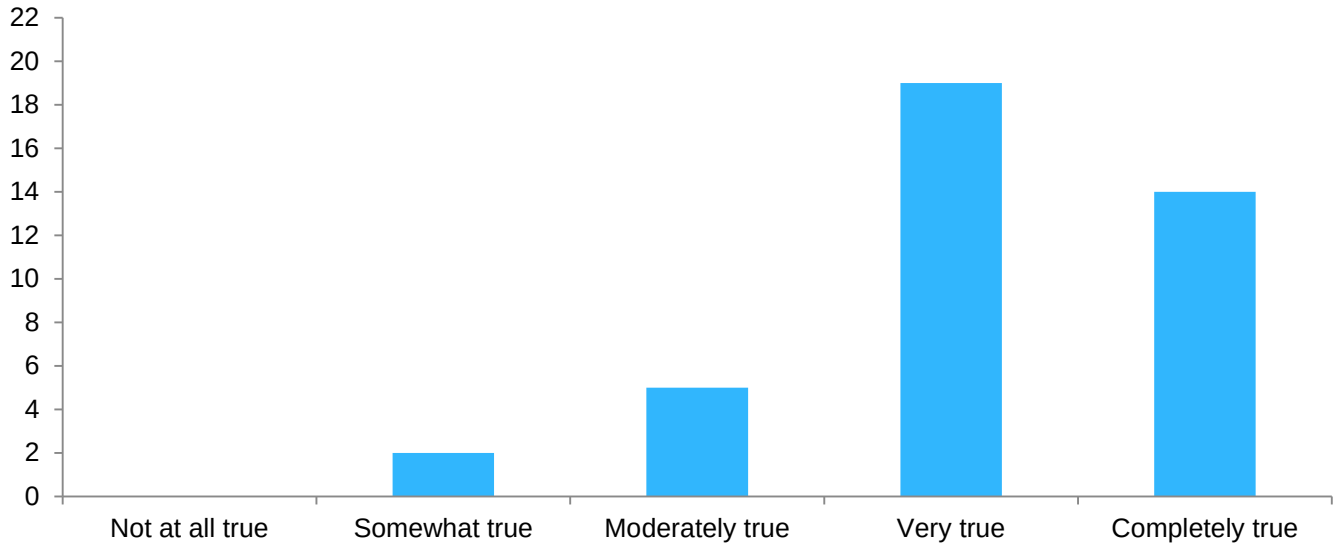
* 40 residents responded (22 men, 18 women)
  * 16 PGY-1, 13 PGY-2 and 11 PGY-3
* 67% aged 25-29, 33% aged 30-39
* 90% have a significant other
* 12.5% are living with one or more children

Results – Happiness



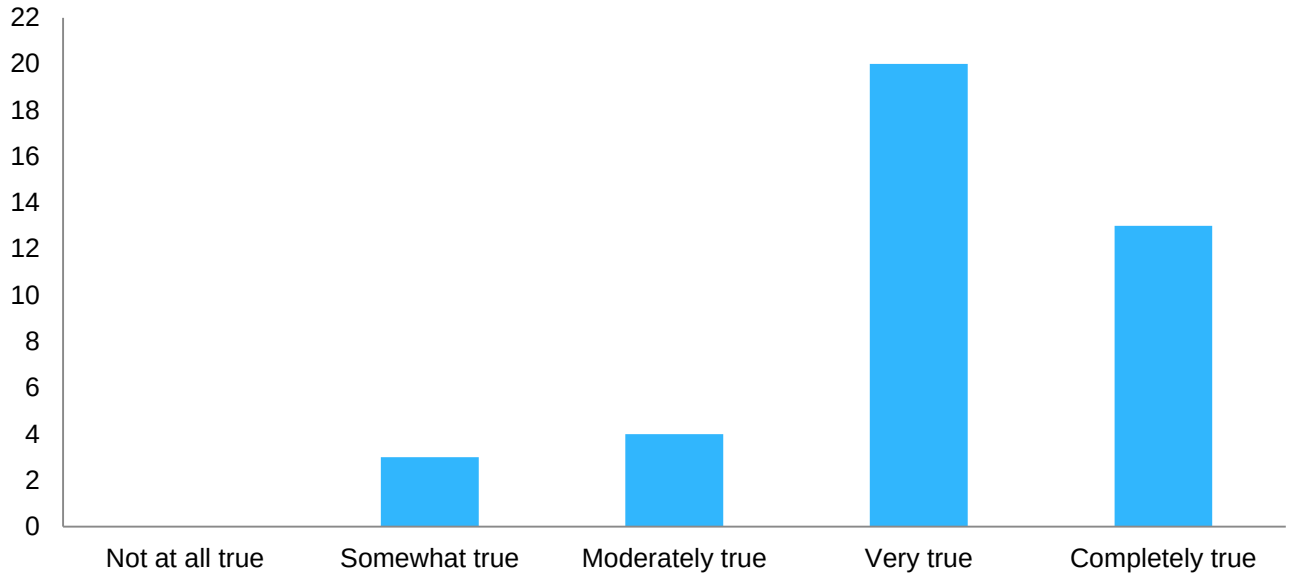
Results – Alignment with HCMC's Mission

"Our organizational goals and values fit well with my goals and values"



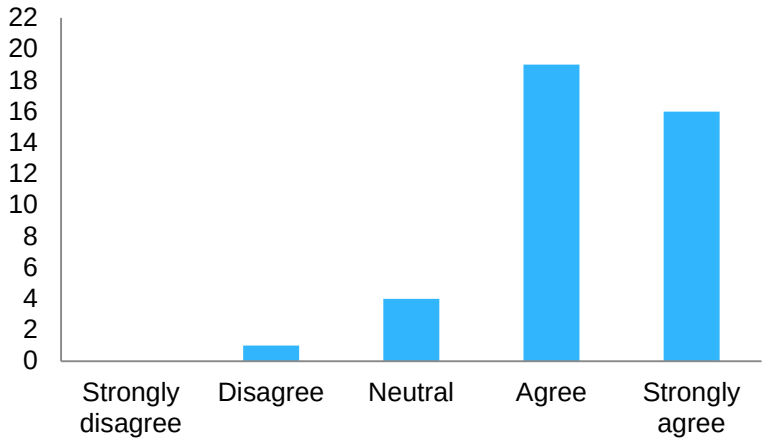
Results – Autonomy

“I am satisfied with the level of autonomy I am granted”

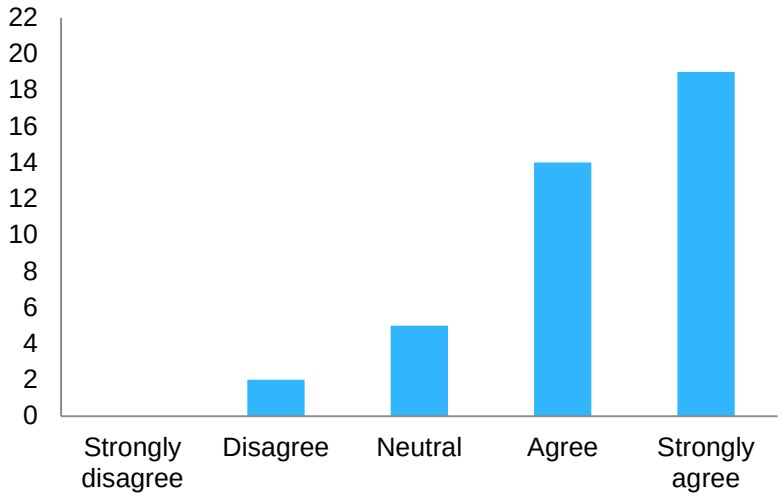


Results – Strong Peer Support

“My peers listen empathetically when I talk about work-related stress”



“My peers pitch in when I need help with my work”

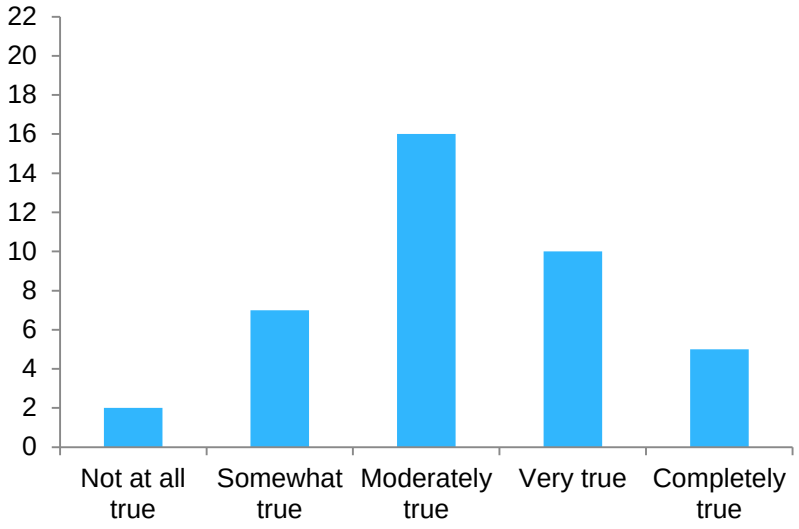


Data Analysis: Program Strengths

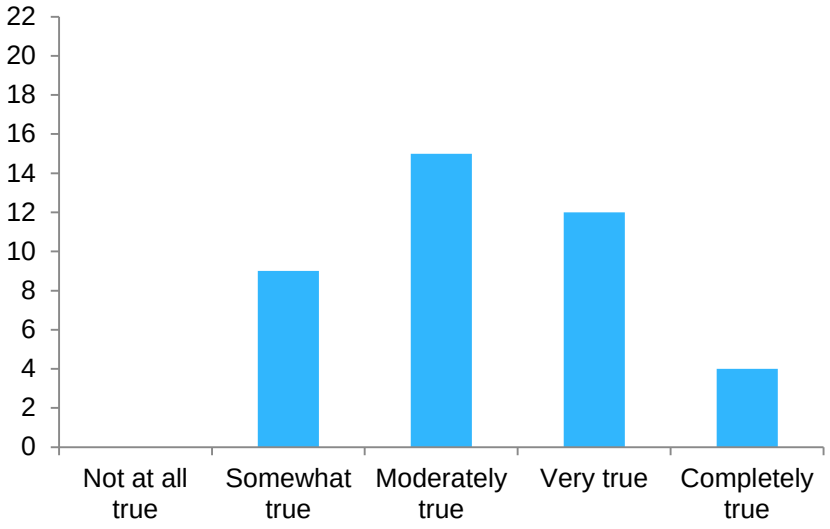
* 90% of residents feel moderately to completely happy at work
* 82-87% of residents feel their peers support and help them at work
* 82% of residents feel aligned with HCMC's mission
* 82% are satisfied with their level of autonomy

Results – Personal Recognition and Appreciation

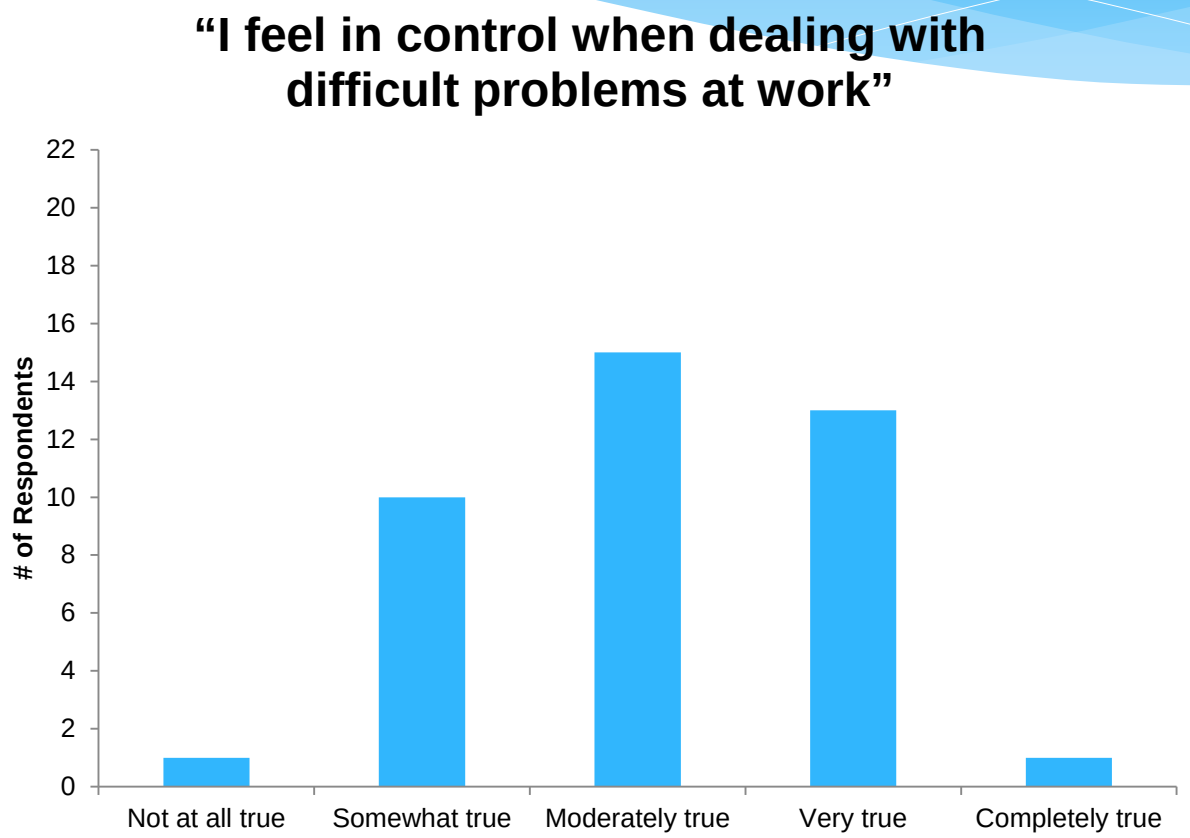
“My contributions at work are recognized”



“Patients and their families appreciate my efforts”

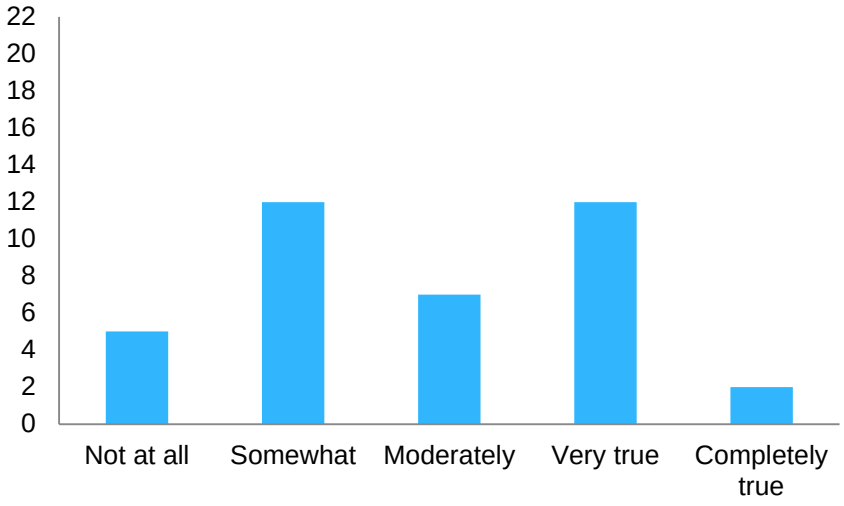


Results – Having Control

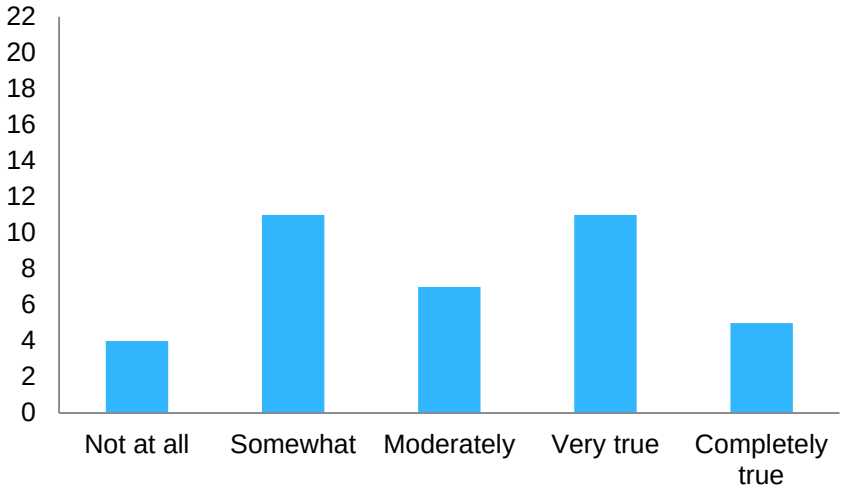


Results – Personal Relationships Are Often Deprioritized

“My job has made it harder for me to nurture existing personal relationships”



“My job has made it harder for me to develop new personal relationships”



Data Analysis: Areas For Improvement

* Residents are not recognized or appreciated enough for the hard work they do
* Only 35% of residents felt very much in control when dealing with difficult situations at work
* 87% feel residency has made it difficult to nurture relationships with families, partners and friends and form new relationships
* The contributions and sacrifices made by families and partners often go unrecognized

Open Response

1. What suggestions do you have that would improve your well-being? (19 responses)

2. If you could change one thing to improve your work life, what would it be? (18 responses)

More Opportunities For Social Time

"Providing structured social time with other residents—residency has been very socially isolating and it would be good to talk with others going through the same challenges."

"More dedicated opportunities to spend time with and get to know the other residents in the program"

"Spend more time with colleagues in non-work settings"

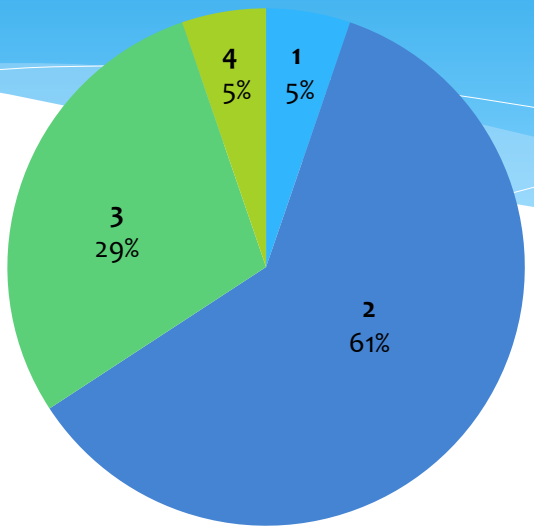
"Try to engage in more activities outside of…work"

Programmatic Transparency

"Make the reasons for changes transparent"

"A better system for distributing work. Inequality breeds contempt"

Summative Burnout Assessment



Answer Choices	Responses	
I enjoy my work. I have no symptoms of burnout. (1)	5.26%	2
Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out. (2)	60.53%	23
I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion. (3)	28.95%	11
The symptoms of burnout that I'm experiencing won't go away. I think about frustrations at work a lot. (4)	5.26%	2
I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.* (5)	0.00%	0

Adapted from: Don Freeborn (1994), Eric Williams (1999), Mark Linzer (2009)

Fostering Wellness: Control and Work-Life Balance

* Find innovative ways to make resident schedules more **predictable**
* Find ways to improve time pressure and work-flow in resident continuity clinic
* Acknowledge families and partners
* Check in often
* Form an Organizational Wellness Committee, and put a resident on it

Fostering Wellness: Recognition

- Recognize and appreciate resident work
  - Personally and publicly
  - Acknowledge the contributions and sacrifices of families and partners too

- Make feedback frequent and useful
  - A work in progress
    - Modifying feedback tools
    - Re-measure; don't assume you "fixed" it (?PDSA)

Fostering Wellness: Improving The Balance between Effort and Reward

* Golden weekends for senior residents on ward months
* Recognition of residents: in person, via individual emails, or publicly in newsletters
* Thanking residents for their work
* Recruiting enthusiastic teachers
* Providing feedback
* Organizing scholarly resources to help residents succeed

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Fostering Wellness: Community

* Arrange and fund social outings for residents
* Continue program sponsorship of resident sports teams
  * Volleyball, soccer, broomball
  * Running club?
* Upgrade the fitness center?
* Promote transparency and fairness
* Stay connected, be available

* Being a great colleague at HCMC is as important as being a great doctor

Comparison: Burnout at Mayo (2002)

Ann Intern Med. 2002 Mar 5;136(5):358-67.

Burnout and self-reported patient care in an internal medicine residency program.

Shanafelt TD[1], Bradley KA, Wipf JE, Back AL.

⊕ **Author information**

Abstract

BACKGROUND: Burnout is a syndrome of depersonalization, emotional exhaustion, and a sense of low personal accomplishment. Little is known about burnout in residents or its relationship to patient care.

OBJECTIVE: To determine the prevalence of burnout in medical residents and explore its relationship to self-reported patient care practices.

DESIGN: Cross-sectional study using an anonymous, mailed survey.

SETTING: University-based residency program in Seattle, Washington.

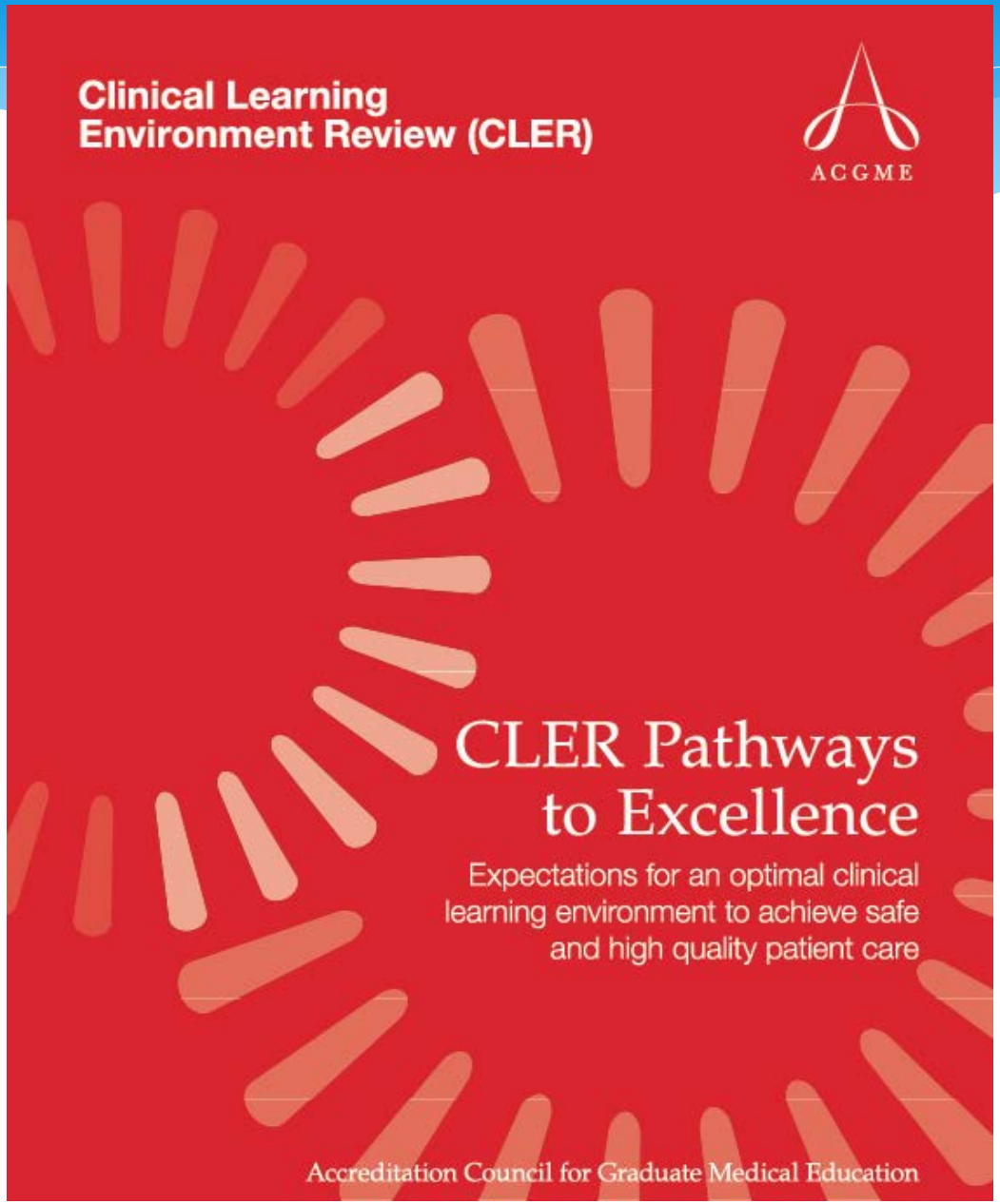
PARTICIPANTS: 115 internal medicine residents.

MEASUREMENTS: Burnout was measured by using the Maslach Burnout Inventory and was defined as scores in the high range for medical professionals on the depersonalization or emotional exhaustion subscales. Five questions developed for this study assessed self-reported patient care practices that suggested suboptimal care (for example, "I did not fully discuss treatment options or answer a patient's questions" or "I made...errors that were not due to a lack of knowledge or inexperience"). Depression and at-risk alcohol use were assessed by using validated screening questionnaires.

RESULTS: Of 115 (76%) responding residents, 87 (76%) met the criteria for burnout. Compared with non-burned-out residents, burned-out residents were significantly more likely to self-report providing at least one type of suboptimal patient care at least monthly (53% vs. 21%; P = 0.004). In multivariate analyses, burnout--but not sex, depression, or at-risk alcohol use--was strongly associated with self-report of one or more suboptimal patient care practices at least monthly (odds ratio, 8.3 [95% CI, 2.6 to 26.5]). When each domain of burnout was evaluated separately, only a high score for depersonalization was associated with self-reported suboptimal patient care practices (in a dose-response relationship).

CONCLUSION: Burnout was common among resident physicians and was associated with self-reported suboptimal patient care practices.

More support for engaging in assessment and solution development in this area



DF Pathway 2: Resident/fellow and faculty member education on fatigue and burnout

Formal fatigue-management educational activities create a shared mental model necessary for residents/fellows to work consistently in a safe manner.

Properties include:

- Residents/fellows and faculty members are aware of general and site-specific strategies for managing fatigue and burnout.
  The focus will be on the extent to which residents/fellows and faculty members are aware of the clinical site's strategies for managing fatigue and burnout, and the proportion of individuals who receive information on strategies that are specific to the clinical site's service units and high-risk situations.

DF Pathway 5: Clinical site monitoring of fatigue and burnout

Periodic monitoring of physician fatigue and burnout is essential to identifying vulnerabilities and designing and implementing actions to enhance patient safety.

Properties include:

- The clinical site's administrative leadership monitors for resident/fellow and faculty member fatigue and burnout with regard to addressing patient safety.
  The focus will be on having mechanisms in place to assess resident/fellow and faculty member fatigue management and wellness (including potential burnout), the periodic conduct of assessments, and formulation and implementation of mitigation strategies to address patient safety.

Preventing physician burnout

Improve satisfaction, quality outcomes and provider recruitment and retention

STEPS forward™
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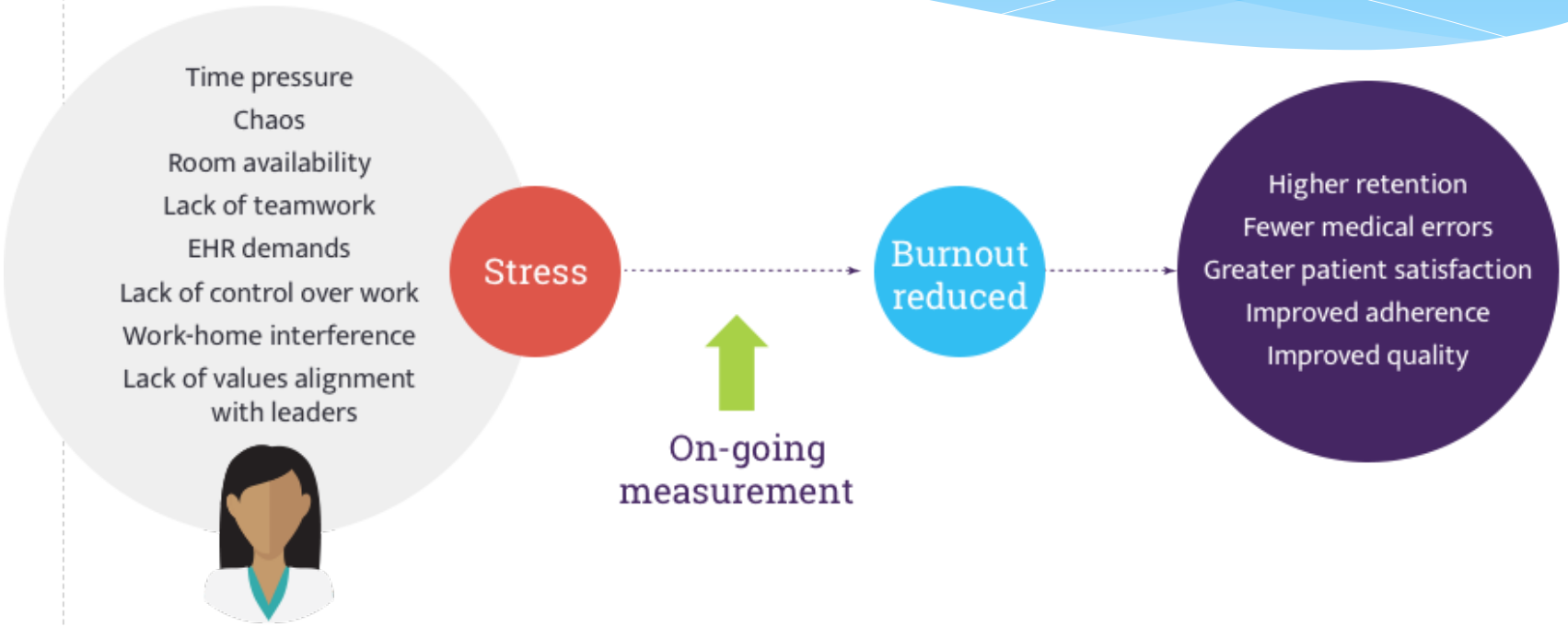
FIGURE 1. Conceptual model of the quality improvement feedback look to prevent physician stress, burnout and turnover.



Barriers and Next Steps – 5-10 Minutes

* Speak with your neighbor(s) and reflect on wellness at your institution.
* What barriers do you anticipate as you begin or continue wellness work?
* How might you navigate these barriers if you do encounter them?
* What are your next steps? Write them down!
* What are your goals and how will you accomplish them?
* What resources will you need?
* What questions do you have?

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Summary

* Burnout is:
  * Common (50% of MD's and MD's in training)
  * Damaging to residents, programs, and communities
  * A result of prolonged/sustained imbalance between demands and control and support

Summary, cont'd

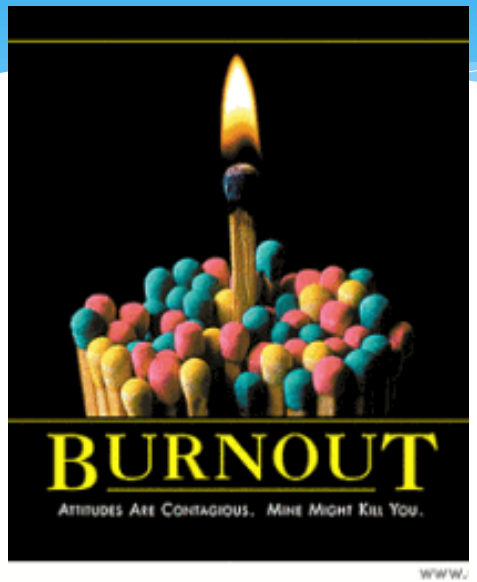
* Key factors contributing to burnout are:
  * Excessive Workload
  * Lack of Control
  * Balance between Effort and Reward
  * Supportive Community
  * Fairness
  * Values Alignment

Summary, cont'd

* To address burnout, organizations/programs should:

* Prioritize it as a quality metric or similar
* Measure it
* Talk about findings with residents/leaders
* Intervene in targeted areas
* Re-Measure it (PDSA)

Discussion



Appendix

MINI-Z ReZ

Mini ReZ survey (for residents and fellows)

For questions 1-10, please indicate based on your experience for the majority of days over the past month...

1. **I have been satisfied with my residency/fellowship program:**

2. Using your own definition of "burnout", please choose one of the numbers below:

6=I enjoy my work. I have no symptoms of burnout.

5=I am under stress, and don't always have as much energy as I did, but I don't feel burned out.

4=I am very stressed and may be suffering some burnout symptoms, such as emotional exhaustion **OR** depersonalization.

3=I am definitely burning out and have more than one symptom of burnout, e.g. emotional exhaustion **AND** depersonalization.

2=My symptoms of burnout won't go away. I think about work frustrations a lot.

1=I feel completely burned out. I am at the point where I may need to seek help.

Mini-Z ReZ cont'd

3. My professional values have been well aligned with those of my program leaders:

1=Strongly disagree 2=Disagree 3=Neither agree nor disagree 4=Agree 5=Agree Strongly

4. The efficiency of my team has been:

1=Poor 2=Marginal 3=Satisfactory 4 =Good5 =Optimal

5. My control over my workload has been:

1 = Poor 2 = Marginal 3 = Satisfactory 4 = Good 5 = Optimal

Mini-Z Rez, cont'd

6. I have felt a great deal of stress because of my job

1=Agree strongly 2=Agree 3=Neither agree nor disagree 4=Disagree 5=Strongly disagree

7. The amount of time I have spent on the EMR after hours is:

1=Excessive 2=Moderately high 3=Satisfactory 4=Modest 5=Minimal/none

8. Sufficiency of time for documentation has been:

1 = Poor 2 = Marginal 3 = Satisfactory 4 = Good 5 = Optimal

Mini-ReZ, cont'd

9. Which number best describes the atmosphere in your work area (for the majority of the past month)?

Hectic, chaotic		Busy, but reasonable		Calm
1	2	3	4	5

10. The EMR (electronic medical record) added to the frustration of my day:

1=Agree strongly 2=Agree 3=Neither agree nor disagree
4=Disagree 5=Strongly disagree

Mini-Rez, cont'd

How have the following items impacted your job satisfaction over the past month?

11. **Work interruptions (e.g. pages greater than expected, etc.)**
12. **Lack of sleep**
13. **Positive relationships with clinical support staff:**
14. **Support by peers**
15. **Recognition by my department**

Preventing physician burnout

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STEPS forward™
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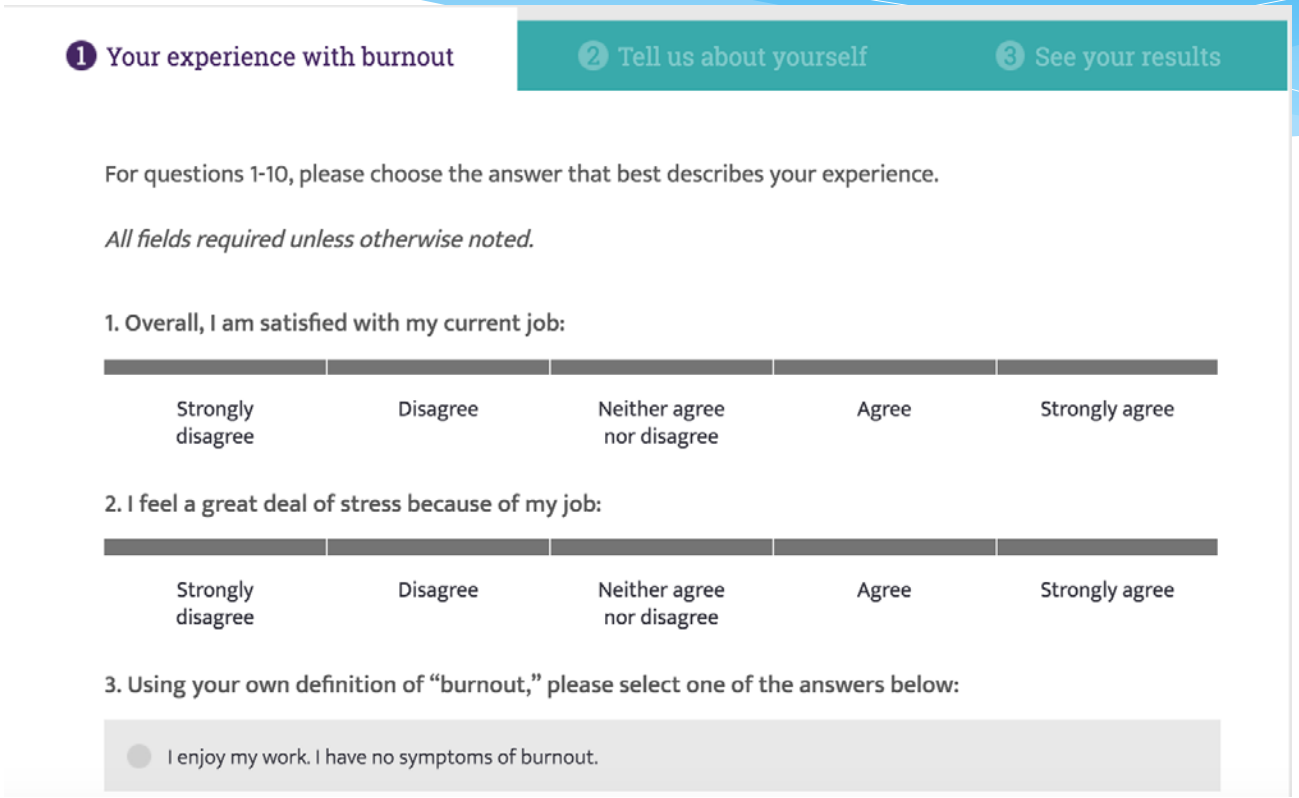
Measure and respond to burnout by:

- Reducing sources of stress
- Intervening with programs and policies that support professional well-being
- Preventing burnout

Take the Mini Z burnout survey:



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Seven steps to prevent burnout in *your* practice

1. Establish wellness as a quality indicator for your practice
2. Start a wellness committee and/or choose a wellness champion
3. Distribute an annual wellness survey
4. Meet regularly with leaders and/or staff to discuss data and interventions to promote wellness

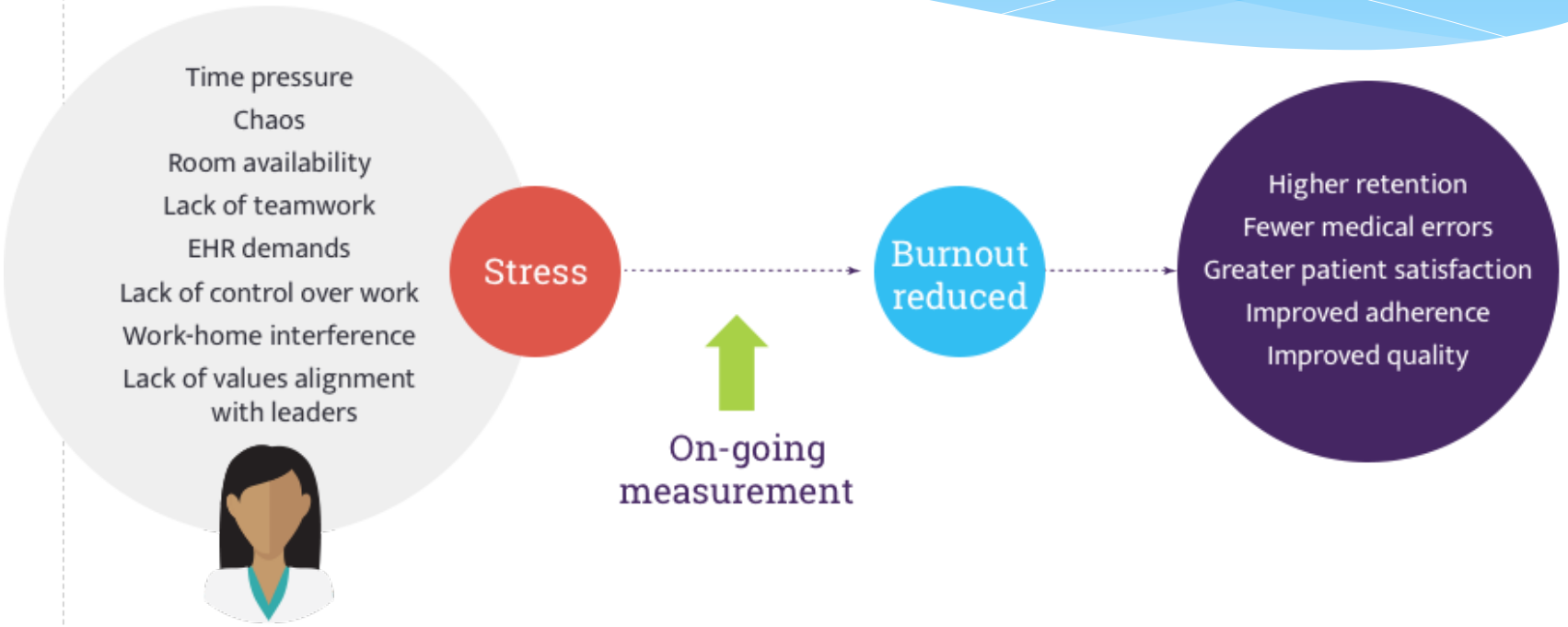
Seven steps to prevent burnout in *your* practice

5 Initiate selected interventions

6 Repeat the survey within the year to re-evaluate wellness

7 Seek answers within the data, refine the interventions and continue to make improvements

FIGURE 1. Conceptual model of the quality improvement feedback look to prevent physician stress, burnout and turnover.



What to do: A Randomized Trial of Worklife Interventions

A Cluster Randomized Trial of Interventions to Improve Work Conditions and Clinician Burnout in Primary Care: Results from the Healthy Work Place (HWP) Study

Mark Linzer, MD[1,3], Sara Poplau, BA[2], Ellie Grossman, MD, MPH[4], Anita Varkey, MD[5], Steven Yale, MD[6], Eric Williams, PhD[7], Lanis Hicks, PhD[8], Roger L. Brown, PhD[9], Jill Wallock, BS[5], Diane Kohnhorst, BS[6], and Michael Barbouche, BS[10]

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BACKGROUND: Work conditions in primary care are associated with physician burnout and lower quality of care.
OBJECTIVE: We aimed to assess if improvements in work conditions improve clinician stress and burnout.
SUBJECTS: Primary care clinicians at 34 clinics in the upper Midwest and New York City participated in the study.
STUDY DESIGN: This was a cluster randomized controlled trial.
MEASURES: Work conditions, such as time pressure, workplace chaos, and work control, as well as clinician outcomes, were measured at baseline and at 12–18 months. A brief worklife and work conditions summary measure
LIMITATIONS: We used heterogeneous intervention types, and were uncertain how well interventions were instituted.
CONCLUSIONS: Organizations may be able to improve burnout, dissatisfaction and retention by addressing communication and workflow, and initiating QI projects targeting clinician concerns.

KEY WORDS: burnout; primary care; quality improvement; work conditions.
J Gen Intern Med
DOI: 10.1007/s11606-015-3235-4

Hennepin Healthcare

From HWP Study

* 3 categories of intervention were effective:
  * Improvements in workflow/redesign (OR 6)
  * Intentional improvements in communication between providers and with leadership (OR 5)
  * QI initiatives in areas deemed relevant by providers and their teams (OR 3)

Moral Distress:

A phenomenon which occurs when policies or routines conflict with (personal) beliefs about (appropriate) patient care*

An incoherence between one's beliefs and values and one's actions**

Occurs when we are told or forced to do things that we fundamentally disagree with or to which we are morally opposed (Mathieu)

*Mitchell, GJ;"Policy, Procedure and Routine: Matters of Moral influence". Nursing Science Quarterly, 14 (2); 110, 2001

** Webster, G.C. et al; "Moral Residue"; from *Margin of Error: The ethics of mistakes in the practice of Medicine;* University Publishing group, 2000

Moral Distress (from Epstein and Hamric*)

"A hallmark of moral distress is the presence of constraints, either internal (personal) or external (institutional) that prevent one from taking actions that one perceives to be morally right."

"Moral distress is the result of a perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action."

*from *Moral Distress, Moral Residue and the Crescendo Effect; J Clin Ethics, 20(4) 330-342, 2009*

Epstein and Hamric, cont'd

* **Internal constraints:**
  * Lack of assertiveness
  * Self doubt
  * Socialization to follow orders
  * Perceived powerlessness
  * Lack of understanding full situation

Epstein and Hamric, cont'd

* **External Constraints**
  * Inadequate staffing
  * Hierarchies in the system
  * Lack of collegial relationships
  * Lack of administrative support
  * Policies/procedures that conflict with care needs
  * Cost pressures
  * Litigation threats/fears

Moral Distress Root Causes/situations*

* Following family wishes to continue life support even though not in patient's best interest
* Initiating life sustaining actions that only prolong death
* Continue to participate in care when no one will make decision to "pull the plug."

* Hamric, A.B. et al; Crit Care Med, 35(2): 422-429; 2007

Role specificity (Hamric et al)

For Doctors, Nurses and Respiratory therapists, the most common cause of moral distress is **"Prolonged, aggressive treatment that the professional believes is unlikely to have a positive outcome"**

Example: NICU RN (Epstein et al)

"My grief comes from walking in the unit and seeing a baby suffering for weeks and weeks and weeks on end; knowing in your mind, knowing what's going on and knowing that that child's not going to survive, so why is this happening?"

Example: NICU Resident MD (Epstein et al)

"There are some physicians that never say die; do absolutely everything, absolutely everything. I remember one physician coding a baby with a pulmonary hemorrhage and the endotracheal tube filled with blood that oscillated with chest compressions, and I was thinking "this is wrong, this is so wrong."

Example: Med Student (Epstein et al)

"This case was a difficult one for me because it was clear that this gentleman would require months of rehabilitation with little hope for significant return of function/improvement… His wife continued to ask the attending if this or that movement was a sign of progress, and the attending was generally optimistic in talking with her, but pessimistic outside her presence. While I understand the importance of hope, I strongly value realistic hope. I felt that the patient's wife was being misled."

Consequences, cont'd

* Implicit psychological characteristics of Moral Distress are:
  * Frustration
  * Anger
  * Guilt
  * Anxiety
  * Withdrawal
  * Self blame

Moral Residue: Prolonged Exposure, lost integrity

Moral Residue is:

"That which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised….

*It is a **betrayal of self**; an act of yielding one's moral values without defending those values…*

*The result… is a loss of moral identity leading to moral residue that is lasting and powerful."**

*Webster G et al; "Moral Residue" from "*Margin of Error: The Ethics of Mistakes in the practice of Medicine*"; University Publishing Group, 2000

Moral Residue

* When reviewing/debriefing a single case with study participants, many stories of previously troubling events were spontaneously shared, particularly by RN's with more years in practice.

* Studies of repeated experiences of moral distress report changes that are personal (**anxiety and depression**) and professional (**avoidance of patients, burnout**)

Example (RN):

"I'm really tired of that whole system… it hurts too much to have to spend a lot of time with those patients because you know you're helpless to change the situation for them… I think what it's done is make me decide to get out of nursing because I don't like being in a situation where I feel helpless or continually have to deal with situations where I have to do things I think are wrong."

One Aspect: Clinical Team Communication (Hamric)

* Question to ICU RN: Have you experienced frustration with the way physicians communicate with you about your patient's end of life care?
  * **YES: 70%**
* Question to ICU MD: has the nursing staff on your unit voiced frustration with the way you communicate with them about your patient's end of life care?
  * **NO: 100%**

Observed responses (Moral residue)

* One study* showed correlation between emotional exhaustion (a burnout correlate) and frequency of moral distress
* Overall, 3 common patterns of adaptation/response to repeated moral distress (i.e. moral residue) have been observed (Epstein et al)

    1. Numbing of Moral Sensitivity/passivity
    2. Conscientious Objection
    3. Burnout and/or leaving the field altogether

*Meltzer, L, et al; American Journal of Crit Care, 13:202-208, 2004

Moral Residue and Burnout

* Burnout is not likely to be caused by the routine burdens of patient care
* It is more likely to stem from the burden of **powerlessness** related to:
  * Hierarchical power structures
  * Ineffective or obstructive policies
  * Dysfunctional communication patterns
  * Lack of resources

Moral Residue and "Crescendo" effect (Epstien)