The Hidden Epidemic: The Moral Imperative for Academic Health Centers to Address Health Professionals’ Well-Being
The Blue Ridge Academic Health Group seeks to take a societal view of health and health care needs and to identify recommendations for academic health centers (AHCs) to help create greater value for society. The Blue Ridge Group also recommends public policies to enable AHCs to accomplish these ends.

Contents

Report 22. The Hidden Epidemic: The Moral Imperative for Academic Health Centers to Address Health Professionals’ Well-Being

Introduction ........................................................................................................... 2

Executive Summary ............................................................................................ 3

I. Problem Statement: A Growing Threat ......................................................... 4

II. Drivers of Burnout .......................................................................................... 8

III. Impacts ............................................................................................................ 10

IV. Solutions and Interventions ........................................................................... 12

V. Recommendations ............................................................................................ 19

VI. Future Directions ........................................................................................... 21

VII. Rationale and Conclusion ........................................................................... 22

References ............................................................................................................. 22

About the Blue Ridge Academic Health Group ................................................... 26

Previous Blue Ridge Reports ............................................................................... 27

Reproductions of this document may be made with written permission of Emory University’s Woodruff Health Sciences Center by contacting Anita Bray, Woodruff Health Sciences Center Administration Building, Suite 400, Atlanta, GA, 30322. Phone: 404-712-3510. Email: abray@emory.edu.

Recommendations and opinions expressed in this report represent those of the Blue Ridge Academic Health Group and are not official positions of Emory University. This report is not intended to be relied on as a substitute for specific legal and business advice. Copyright 2017 by Emory University.
That physician will hardly be thought very careful of the health of his patients if he neglects his own.
—Galen (130–200 AD)

Introduction

Over the past 20 years the Blue Ridge Academic Health Group (BRAHG) has made observations and recommendations on a number of topics important to the special roles of academic health centers (AHCs) in American society. The AHC uniquely integrates the missions of education, research, and clinical care and aspires to create and apply new knowledge for the broad benefit of the communities it serves. The AHC in its many iterations is the developer of strategies to take advantage of opportunities and to mitigate mission risks in a changing environment; it is the organizer of operational plans to implement mission strategies; and it is the steward of the human capital without which well-functioning AHC their activities intersect.

Each of the mission domains are specific, in the interests of patients, and not one’s own interest, is the rule. Our observation is that altruism is difficult even for the most committed professionals when one is working in a maelstrom. As you read this report, we suggest that “Getting the Physician Right,” along with all members of an interdisciplinary professional team, will require “Getting the Physician Well,” “Getting the Nurse Well,” and “Getting All the Team Members Well.”

Classical and scriptural proverbs have consistently addressed wellness in physicians and, by association, all professional care givers. The Greek playwright Aeschylus in Prometheus Bound has the chorus saying “Like some inferior doctor who’s become ill, you’re in despair and are unable to discover, by what medicine you yourself can be cured.” “Physician, physician heal thine own limp” is found in Genesis Rabbah (23:4). The additional scriptural quote, “Physician, heal thyself,” is found in the gospel of Luke (4:23), who himself was a physician. These proverbs apply to all professional caregivers. Each suggests that one must be emotionally and mentally healthy if one is to provide compassionate, exceptional clinical care to patients. However, it is clear that the “healing” of caregivers cannot be accomplished solely through “self-help.” Just as the best care for patients is achieved through team work and support, addressing the challenges of burnout and advancing the wellness of health care providers will also require AHC leadership and institutional commitment to achieve optimal results.

In this report, we explore and make recommendations to address what is becoming a crisis in health care delivery. We recommend that AHC leaders take immediate steps in addressing the real human stresses in the “human capital” upon which their AHCs and all health care organizations depend.

Executive Summary

With this background, the BRAHG views it as an essential duty of professional health providers to maintain their own well-being, so that they can be effective healers of others. As a recent British Medical Journal editorial phrased it, “doctors have a professional responsibility to be at their best.” Hippocrates himself captured a version of this commitment when he asked the new physician to vow, “In purity and holiness I will guard my life and my art.”

It is a failing of our health care system that we have made it increasingly difficult for so many clinicians to meet this primary imperative despite the growing focus on quality and outcomes. There are many causes, but one growing result: clinician burnout. We pay a staggering cost in lost productivity, risks to mental and physical health, eroding quality and safety, diminished patient satisfaction, staff turnover, and lost dollars. At the extreme, we have an unacceptably high personal toll of depression and suicide.

The alarming rate of clinician burnout might well be called a hidden epidemic. Although the phenomenon is well known in the health professions and is even increasingly recognized in the lay press (e.g., “The New York Times,” US News & World Report special report), it is still not adequately acknowledged by many health system and academic leaders that their physicians, nurses, and administrators are at substantial risk in day-to-day dealings with each other and with the public.

In this year’s report, the BRAHG confronts this widely debilitating and sometimes lethal phenomenon head-on. We declare that the time is ripe for us as AHC leaders to claim a central role in acknowledging, owning, researching, understanding, and defeating the epidemic of burnout.

The role of AHCs in addressing this issue is especially important because we educate, train, and acculturate each new generation of health professionals, including physicians, dentists, nurses, and all other health professionals. Our faculty model—in their lives, practices, and classrooms—the disciplinary values and professional lifestyles that our students will emulate in their own careers. In our organizational life, we help to create the norms and expectations that define our professions’ canons, credentialing protocols, and societal commitments. We must address the burnout crisis or risk ongoing problems not only among our current cadre of providers, but also among our next generation of health care professionals.

Additionally, we share in and are subject to the same environmental and organizational pressures that impinge on every health professional and health practice, whether inside or outside of the AHC.

We have a special responsibility—as educators, researchers, stewards of community health, and managers of large-scale health systems—to address and defeat burnout. The leadership of our health centers, in particular, have a special and acute obligation to place this issue front and center, recognizing it as among the most important issues they must address. AHCs are not fulfilling their fundamental obligation to society if they do not epitomize the optimal practice of medicine and that of every other health profession. The danger of burnout is not only impairment of our own health professionals; it is also the erosion of quality in the delivery of health care to our patients and a fraying of morale and institutional effectiveness at every level of our organizations. Optimizing the well-being of individual professionals and the teams they work in is a requirement if we are to meet the
I. Problem Statement: A Growing Threat

Burnout in health care is a threat to all of us. It hurts quality of life, the morale of groups and teams, and the productivity of organizations. It costs money through inefficiency, ineffectiveness, and the unnecessary and premature turnover of highly trained professionals representing substantial societal investment. It threatens the health of patients, in the form of suboptimal outcomes as well as avoidable errors, and it threatens the health of practitioners, through a spectrum of outcomes that range from exhaustion and depersonalization all the way to depression, suicidal ideation, and all too tragically, suicide itself. The insidious spread of burnout, reflecting a perfect storm of personal, professional, academic, and societal factors, is so relentless that it might well be termed epidemic. Concerted action will be needed to recognize, analyze, and reverse it where present today and to prevent it in the future.

The Societal Impact of Physician Burnout

This report describes the many causes and dimensions of physician burnout. No matter its full scope, there is one consequence that health care executives and policymakers must understand and account for: it costs money. We are not aware of any analysis that has tallied the full bill for the United States. For this report, the Blue Ridge Academic Health Group asked consultants from The Chartist Group (who also assist BHAHG in planning and facilitating its annual meetings) to help run the numbers. Their calculation is based on several assumptions and extrapolations reflecting the limited cost analysis completed to date. Within this context, the dollar signs become extraordinary: Physician burnout costs as much as $150 billion per year. That formidable sum amounts to more than 4.7% of the nation’s $3.2 trillion expenditure on health care—an enormous sum that could have great consequence for the future of our health care system and the directions of health reform, were there a way to save or redeploy those dollars.

There are both quantitative and qualitative factors driving the cost of physician burnout. Through this analysis, we estimated the additional costs that are reasonably attributable to burnout and its effects on mental health and job performance in the following areas:

- **Turnover.** Various studies have estimated the cost of turnover at $500,000 to $1 million per physician. Current studies estimate the overall rate of burnout at about 54% among the nation’s 750,000 active physicians.11 The rate of early retirement has increased from 12% to 18%.11 Based on the approach to calculate the organizational impact of burnout outlined in Shanafelt et al.,12 the increased rate of turnover due to burnout is 2.4%, which equates to an annual cost of $9 billion to $18 billion for the nation.

- **Productivity loss.** This is an extrapolation based on a comprehensive analysis of Canadian physicians by Dewa and colleagues.13 Comparing burnout rates between the two countries, which are virtually identical,14 and adjusting for the much larger physician pool in the U.S. (approximately nine times that of Canada), we come up with a productivity loss figure of $1.7 billion.

- **Quality of care, patient safety, and medical errors.** Shanafelt and co-authors15 found that each one-point increase in a surgeon’s self-reported emotional exhaustion led to a five-point increase in reported errors. The same effect was doubled for every one-point increase in the surgeon’s depersonalization score. Extrapolating those marginal increases to the entire active population of physicians, more than half of whom are found to be suffering from burnout, we made assumptions about the overall increase in reported medical errors by all physicians in the country. Using the denominator of $735 billion to $980 billion as the total annual cost (both direct and indirect) of medical errors in the U.S.,16 we estimate the portion of medical errors attributable to burned out physicians as $97 billion to $129 billion.

A full outline and explanation of the methodology used by Chartist has been posted on the Blue Ridge Academic Health Group website: http://whsc.emory.edu/blueridge/publications/reports.html as an appendix to this report.

The preceding analysis of the total cost of burnout to the American health care system, though it results in a formidable dollar figure, is undoubtedly partial for two reasons:

- First, many important factors have not been quantified, even to the sometimes-tenuous extent of the aforementioned drivers. They include the following:
  - Increased diagnostic testing and specialty referrals
  - Rise in malpractice risk and cost
  - Degradation in patient experience
  - Erosion in organizational morale and harm to organizational culture
  - Long-term increase in physician shortages due to fewer entering the field
  - Negative impact on physicians’ families’ lives
  - Total cost and impact of physician suicide due to burnout as a risk factor; more research is needed to quantify.

Second, a critical caveat: this computation made no attempt to assess the societal impact of burnout on the part of other health professionals, including nurses, pharmacists, dentists, therapists, physician assistants, and all other members of the care team. Any and all professionals anywhere along the chain of care can experience burnout contributing to increased errors, from misdiagnosis to mistreatment, as well as suboptimal patient support.

---

The phenomenon of occupational burnout, especially in the human services and helping professions, has been recognized since 1974, with the work of psychologist Herbert Freudenberger. Christina Maslach and colleagues at Berkeley wrote a seminal 1981 study of physician burnout, identifying its cardinal symptoms as emotional exhaustion, depersonalization (or negative feelings toward patients and clients), and loss of personal accomplishment (or feelings of com-
petence).20 They found that the consequences of burnout include lower quality of care, along with such damaging symptoms as insomnia, drug and alcohol abuse, absenteeism, marital and family difficulties, and job turnover. This work led to the development of a written instrument, called the Maslach Burnout Inventory, which has become a standard means of testing for the problem. It typically takes no more than 10-15 minutes to complete.21

In recent years, surveys have shown that the levels of burnout are high and continuing to climb in the health professions, especially medicine, creating a special issue—and problem—at the heart of a system that is designed to improve the health of individuals and communities.

The first large-scale study of U.S. physicians, conducted in 2011, found that burnout was more rampant among physicians than in the workforce at large, with 45.3% reporting at least one symptom.22 A 2014 survey found an even higher rate, of 54.4%, with authors Shanafelt and colleagues concluding, “More than half of US physicians are now experiencing professional burnout.”23 Burnout also affects other health professionals, including RNs, NPs, PAs, and medical assistants, among others.

**Personal dimensions**

**Joy in work**—The notion of “joy in work” speaks to the sense of fulfillment that is most highly prized by individuals as well as teams that are working to their highest capacity. While difficult to define precisely, it is the sensation of hitting on all cylinders that often is most highly prized in retrospect, when one steps back to take a breather. Many positive qualities contribute to this sensation, which might also be defined as the converse of burnout.

As the Institute for Healthcare Improvement put it, “The most joyful, productive, engaged staff feel both physically and psychologically safe, appreciate the meaning and purpose of their work, have some choice and control over their time, experience camaraderie with others at work, and perceive their work life to be fair and equitable.”24

**Risks to mental health, including suicide**—When joy is lacking and burnout is present, the stakes are high. It would be difficult to quantify the overall impact of all the negative impacts of burnout on residents, physicians, nurses, and other health professionals. But at the extreme, the impact of suicide is the most catastrophic. A recent study of 381,614 residents in more than 9,000 training programs nationwide, covering the period from 2000 to 2014, found that suicide was the second-leading cause of death in that period, behind only all forms of cancers.25 Overall, 66 residents were reported to have died of suicide, though the authors noted there were possible ambiguities about some other categories, such as accidental poisonings, that may have led to under-reporting of suicide. (While high in absolute terms, the overall rate of death among residents, as well as the rate of death due to suicide, were both significantly lower than age- and gender-adjusted rates in the general population.) Nevertheless, the authors lament the failure of the health care system to detect such extreme distress among doctors in training. It is noteworthy, for instance, that suicides peaked during the first quarter of the first year of residency and were also higher in the first quarters of the third and fourth years.

“Our findings present the education community with an opportunity to reduce unnecessary deaths by increasing preventive strategies, scheduling preemptive education, and fostering access to counseling and confidential mental health services for residents,” they write. “In addition, all of those who are engaged in the clinical learning environment—both faculty and residents themselves—need to watch for signs of resident burnout, depression, social isolation, or significant changes in performance.”26 Equally devastating is the annual toll of suicide among practicing physicians. The American Foundation for Suicide Prevention estimates that 300-400 practicing physicians die of suicide every year,27 also citing a 2004 meta-analysis showing a heightened suicide risk ratio of about 1.41 times (for male physicians) and 2.27 times (for female physicians) when compared with the population at-large.28 While this is an area ripe for further research, it is shocking to consider that the estimated loss equates to two to three (or more) graduating classes of medical students. This should be regarded as a grievously high and unacceptable number by everyone concerned with the health of health professionals—not to mention the safe and high-quality functioning of the American health care system.

While suicide is not an immediate outcome of burnout, a Venn diagram would show areas of overlap between the categories of burnout, mental health disorders such as depression, and suicide.29 Hence the importance of early recognition and mitigation strategies. While well-designed studies show that entering medical students, on average, score higher than their peers in the general population on measures of mental health, follow-up studies show their mental health has fallen below the mean after two years of medical school. Something has gone awry—whether in the “hero culture” they imbibe as part of the hidden curriculum, the extreme zero-sum competitiveness of some traditional models of medical education, or other factors that chip away at their resilience, perhaps by isolating them from peers and support networks. Indeed, focused education and support of health care provider resilience is an important component of the strategies that can counter the forces that often lead to burnout.

**Professionalism**—“A profession...is an occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than a profit orientation, enshrined in its code of ethics,” writes Paul Starr in *The Social Transformation of American Medicine*.30 This definition captures essential characteristics identified by most scholars, including that a profession is

- Based on required intellectual training in specialized knowledge
- Oriented toward public service
- Rooted in a code of ethics
- Not strictly profit-oriented
- Infused with common, collegial norms
- Authorized by society to operate as a relatively autonomous, largely self-regulating occupation.

Along with joy in work, it is equally important to note the definitional importance of professionalism. Cara Lesser and colleagues, writing in *JAMA*,31 note that professionalism entails learning about and respecting a complex web of relationships and obligations—to patients, colleagues, the health care system, and society at large. Further, professionalism is a quality that is enhanced and developed over time, throughout the course of one’s career. In this endeavor, “the principles of emotional intelligence, reflective practice, and mindfulness [are] critical to nourishing professionalism in practice.” These qualities are antithetical to the corrosive experiences of exhaustion, disengagement, and depersonalization that characterize burnout. The enhancement of professionalism may be expected to counteract burnout, while conversely, burnout will corrode the high-quality performance, ideals, and values of the profession. The two qualities are inversely correlated. While professionalism brings great joy, it requires remarkable individual commitment that can be difficult to sustain when complex systems that support clinical care are not optimized.

**Organizational dimensions**

A multitude of factors in the design of organizational systems impinge on the satisfaction, engagement, and effectiveness of clinicians and staff. (See table 1.) These range from productivity targets to the relative efficiency (or not) of the institution's EHR, billing, ordering, and appointment systems; the prevailing values and collegiality (or not) of clinical care teams; the level of support and collegiality; and communication from senior levels of leadership—in short, a myriad of dimensions of bureaucracy and workplace design and culture.

One of the most persistent organizational issues centers on the EHR, which is a large and inescapable part of modern practice, consuming a large percentage of the workday. As Bodenheimer and Sinsky observe: “More EHR functionalities—email with patients, physician order entry, alerts and reminders—intended to promote the ‘Triple Aim’—are associated with more burnout and intent to leave practice.”32 Constant changes in regulatory standards such as “meaningful use” become “meaningless,” as the EHR becomes harder and not easier to use.

**Healthcare delivery impact**

Burnout has a deleterious impact on the health
Drivers of burnout and engagement with examples of individual, work unit, organization, and national factors that influence each driver. EHR = electronic health unit; JCAHO = Joint Commission on the Accreditation of Healthcare Organizations. Adapted with permission from Mayo Clinic Proceedings.
same time as there is growing recognition of the therapeutic need for better work-life balance. For nurses, challenging staffing ratios result in burdensome workloads, and poor management practices and lack of leadership compound their risks for burnout. Nurses may also experience moral distress at dissonance between their beliefs and training about best practice as compared with the actual care delivery they experience. They may also be susceptible to post-traumatic stress (as are some doctors) based on their clinical experiences with vulnerable patients of every age.

III. Impacts

Burnout among clinicians—both doctors and nurses—has substantial consequences for clinicians, the organizations they serve, and patients. The impact is summarized in figures 1 and 2. Many of these issues were discussed in Part I.

For physicians, they include:
- An erosion of the sense of meaning or fulfillment that comes from their experience of medicine as a “calling” with professional status and values
- Less time with patients and ability to nurture caring relationships
- Loss of work-life balance in which they have adequate time for families and intimate relationships, adequate sleep, balanced diet, hobbies and sports, and exercise regimens
- Increase in “pajama time” (i.e., time at home spent on EHR) as evening hours for R&R or even professional literature review are being overtaken by catch-up work on computer medicine tasks
- Growing sense of dissatisfaction, exhaustion, and depersonalization
- Growing incidence of medical errors
- Growing rate of turnover

For nurses, they include:
- An erosion of the sense of meaning or fulfillment that comes from their experience of nursing as a “calling” with professional status and values
- Increasing workloads, longer working hours
- Insufficient staffing
- Juggling personal obligations for an increasing number of single parents
- Wages stagnant for more than 12 years relative to inflation
- Low morale
- Growing rate of turnover

For patients, they include:
- Increased susceptibility to avoidable errors
- Loss of face-to-face time
- Decreased satisfaction
- Increased delays in access to care

For organizations, they include:
- Turnover expenses—$500,000+ for MDs, $60,000+ for nurses
- Opportunity costs associated with not operating at top of license/scope of practice
- Patient safety, quality, and satisfaction decline—with heightened risk of malpractice leading to quality, financial, and brand costs and damage
- Overuse of testing and referrals
- Contagious impact on morale
- Costs to society at large are substantial, given the investment in the education and training of health care professionals. A recent study in Canada estimated that burnout among the current cohort of approximately 70,000 physicians would cost the country $213 million in lost future health services over a 24-year study horizon, based on reduction in clinical hours by burnt-out physicians as well as burnout-induced early retirement. Of course, this does not include many other categories of burnout-related cost that might be imagined, including the impact of lower productivity on teams and organizations, in addition to the direct and indirect costs of sub-optimal care.

A recent study in Canada estimated that burnout among the current cohort of approximately 70,000 physicians would cost the country $213 million in lost future health services over a 24-year study horizon.

Contributors to nurse burnout are slightly different.

Physician burnout can impact patient outcomes, which presents real challenges to the viability and sustainability of a hospital or health system.
Analogies to the National Quality Movement

The publication of To Err Is Human (1999)13 and Crossing the Quality Chasm (2001)14 by the Institute of Medicine (now the National Academy of Medicine [NAM]) were milestone events that over time, catalyzed significantly different ways in which AHCs—and our health care system in general—thought about the problem of medical errors and their impact on the health and safety of patients.

Today, we are seeing the beginnings of analogous leadership on the issue of clinician burnout and wellness by the NAM, together with the Association of American Medical Colleges (AAMC) and Accreditation Council for Graduate Medical Education, in league with the American Medical Association, American Hospital Association, America Nurses Association, and more than 30 other flagship organizations.15

The BRAHG believes it is an urgent priority to address the issue of clinician burnout with the same forthrightness and prominence that characterized the movement understood that fundamental improvements ultimately depend on system changes. With a variety of quality and performance improvement models—including the six sigma movement in several major industries—providing a guiding star, health care began to look at creating checklists, reducing redundancies, and developing algorithms and other types of systems to create safer and more robust processes and controls undergirding fallible individuals. Similarly, much work is needed to understand and mitigate the role of health care systems, as currently designed, in stressing, tiring, and even embittering physicians and nurses, leading to the potential for disengagement, exhaustion, and depersonalization.

De-stigmatization—If systems are to be improved, individual practitioners must be able to candidly acknowledge making mistakes and freely discuss how to remedy them and improve in the future. The analogy for physicians, nurses, and other health professionals being willing to acknowledge and seek help for early warning signs of burnout, stress, depression, and anxiety—without becoming stigmatized—is obvious.

End the shame—Given the “heroic” nature of the medical impulse, and the perfectionist nature of many physicians’ personalities,21 we need to promote fundamental changes in how some physicians—and physicians-in-training—regard themselves and relate to others on the care team, as well as patients and colleagues.

Empower team members—The same logic that recognized the importance of empowering all members of a surgical team, for instance, to stop a procedure immediately if mistakes were about to be committed—without fear of repercussion—find their analogy in addressing the issues of burnout. Team members must be mindful of the problem and watchful for symptoms, in themselves and others.

C-suite leadership—The quality and safety movement required governing boards and CEOs to acknowledge the need and elevate it to the top of their agendas. The same must be said of clinician burnout. All over the country, in organizations of varying sizes, we now have chief quality officers, housed literally or figuratively in the C-suite, empowered to intervene in any situation or any crisis precisely at its most uncomfortable point, and reporting directly to the CEO. In years to come, the same should be true of chief wellness officers. Indeed, they may find themselves working closely with chief quality officers on many points of mutual interest.

Sustained work over time—Many years after publication of the milestone IOM quality reports, the issues of quality and safety have not been definitely solved. Six sigma remains an elusive goal in health care. But the quest is critical. It will continue. The same must be said of the problem of burnout.

IV. Solutions and Interventions

The “triple aim” of quality improvement first articulated by Don Berwick and then institutionalized with the establishment of the Institute for Health-
In fact, coursework in Eastern practices—such as Tibetan Buddhist compassion cultivation and mindfulness training—is becoming more common. Emory, for example, has been offering free cognitively based compassion training courses since 2014 to medical faculty, staff, and students. Stanford Medicine offers compassion cultivation training, incorporating both meditation disciplines and scientific study. The Washington Post reported finding similar programs at Massachusetts General Hospital, the University of Virginia School of Nursing, and Georgetown University School of Medicine.47

AHC leaders can work to reduce the potential stigma often associated with professionals seeking help for stress or other kinds of psychological issues. Thomas H. Lee, chief medical officer of Press Ganey, offers a striking model of the opposing forces—rewards and stresses—that converge every day on the individual clinician (see figure 3). While symptoms of burnout (exhaustion, cynicism, depersonalization) are obviously one common response to being in the middle of all these tensions, Lee finds grounds for another and more positive set of responses in the “positive psychology” movement, which includes such leading exponents as Martin E. P. Seligman, director of the Penn Positive Psychology Center at the University of Pennsylvania, and author Angela Duckworth, also a professor of psychology at Penn, who has written the bestselling book Grit: The Power of Passion and Perseverance.

Lee sees grounds for cultivating resilience and grit through pursuing four key psychological assets:

- Interest—following your curiosity
- Practice—with the goal of improvement
- Purpose—the intention to contribute to the well-being of others
- Hope—that efforts can improve the future.48

As applied across individuals, teams, and organizations, pursuing improvement on these four dimensions leads to the matrix depicted in Table 2.

Team focus
Burnout for everyone on the team, from physicians to nurses to all other allied health professionals, can be mitigated through a number of strategies. Perhaps most important are cultivating and respecting collegiality and values in which each member feels respected and has clearly defined job descriptions that call on his or her competencies in meaningful ways. An optimal organization will also maximize the opportunity for each team member to practice at the “top of their license,” enhancing their sense of pride and professionalism.

There is no doubt that one significant dimension of addressing the problem of burnout is to give individuals the tools, skills, and motivation they need to practice self-care and wellness.

Yoga mats and grit
Many leaders of the well-being movement caution institutions who are entering the fray anew not to “lead” with such well-intentioned announcements as free yoga classes for all. Clinical staffs who are already ragged with cynicism and exhaustion (by definition) may resent what they perceive as an attempt to foist institutional failings onto the back of already-overburdened clinicians.

And yet there is no doubt that one significant dimension of addressing the problem of burnout is to give individuals the tools, skills, and motivation they need to practice self-care and wellness. If half of all physicians are experiencing burnout, and half of all nurses, and half of all allied health professionals are overburdened clinicians, then they need to practice self-care and wellness.

AHC leaders can work to reduce the potential stigma often associated with professionals seeking help for stress or other kinds of psychological issues.
Emory Critical Care Center Tackles Burnout Syndrome

The publication of a white paper on Burnout Syndrome (BOS) last year by the Critical Care Societies Collaborative precipitated a wide range of actions by leaders of the Critical Care Center at Emory Healthcare in Atlanta. As the paper documented, studies consistently show that physician intensivists and critical care nurses rank near the top for symptoms of burnout in their respective disciplines. Up to 86% of all critical care nurses display one of the symptoms of BOS; 45% of critical care physicians have symptoms of severe BOS; and 49% of pediatric critical care physicians scored at least some symptoms of high burnout in a recent national study. In response, Emory Healthcare’s chief of the critical care service, Timothy Buchman, and Emory’s chief nursing executive, Sharon Pappas, agreed on a series of steps and measures designed to measure, assess, and mitigate BOS in the Emory Critical Care Center (ECCC).

Significantly, almost all of the steps they took were either free or low cost, requiring leadership backing for new types of organization and new pathways of advancement.

First, a physician assistant and a critical care nurse were charged with surveying staff in the ECCC, using the Maslach Burnout Inventory and the Areas of Work-Life Survey. On the plus side, the survey found high scores among nurses and MDs for feelings of personal accomplishment, community, fairness, and control. However, nurses and MDs alike reported negative symptoms pertaining to emotional exhaustion, workload, and control, consistent with national trends in the field.

For nurses, the leadership took a series of steps to ease staffing pressure, from implementing self-scheduling to reducing floating of critical care RNs in non-critical care units. A new mentorship program is being developed, along with new forms of recognition for outstanding performance by nurses and physicians alike.

In an effort to develop new tracks for professional improvement, including a Clinical Ladder track to develop ethics expertise, with the goal of nurse retention.

One particular issue is a form of brain drain that results in nurses pursuing education in order to move up and out—into research or administration—and leaving direct patient care. Under consideration is the creation of a new position called a Clinical Nurse Leader—a Masters-prepared RN specifically prepared to stay at the bedside in a new role focusing on quality outcomes, the quality-control process, maximizing safety standards, and participating in research and measurement of nursing-sensitive patient care outcomes.

Additionally, heightened communication is being regarded as critical to job satisfaction and retention. The center is creating monthly unit-based leadership interdisciplinary meetings. This includes the unit nursing director, unit medical director, lead affiliate, clinical nurse specialist, unit-based pharmacist, unit-based social worker, director for physical therapy, nutrition support team, and director for respiratory care. Other team members can be invited as appropriate.

Although it is too soon for year-to-year comparisons, feedback from ECCC staff has been positive.

Organizational focus

AHC leadership has the potential, through a wide range of organizational levers and incentives, to promote and encourage the development of resilience. As an outgrowth of the positive psychology movement, our new understanding of resilience recognizes our ability to nurture and grow the capacity of individuals to resist burnout. Resilience is promoted by rewarding and strengthening the traits of interest, purpose, practice, and hope. Leaders can recognize and encourage such positive development by practicing good stewardship and care of clinicians and staff at all levels.

Examples of burnout-mitigating leadership might include setting reasonable productivity expectations, supporting well-being and wellness initiatives, interpreting regulations and billing procedures wisely, adapting EHR systems to local needs and conditions (to the extent possible), measuring burnout and wellness metrics throughout the organization, and setting (and accepting) compensation plans in which well-being metrics are one important component of incentive targets.

A quote from one of the giants of American medicine reminds us that this is yet another area where doing the right thing for organizations and clinicians—minimizing time-consuming drudgery, maximizing professional concentration—is also the right thing for patients. “Medical care must be provided with utmost efficiency. To do less is a disservice to those we treat, and an injustice to those we might have treated,” said Sir William Osler, in 1893.

In search of joy in practice

A seminal study of 23 high-functioning primary care practices by Christine Sinsky and colleagues, sponsored by the American Board of Internal Medicine Foundation, identified several major areas of organizational change and improvement that could help restore what the authors call “joy in practice” and mitigate burnout.

The authors suggest that joy in practice results when physicians are able to concentrate on their fundamental calling in health care, which is “to create healing relationships with patients.” Tellingly, many of the changes and fixes instituted by high-performing groups take work off the shoulders of physicians and give it to others—including scribes, medical assistants, nurses, or office staff—who can perform it equally well or better, while physicians have precious hours freed up and can focus their attention on the patient. Transformative solutions to commonly encountered problems include the following:

- Pre-visit planning: organizing lab tests in time to ensure results are available for discussion and decision-making during the patient visit.
- Spreading responsibility for care: taking tasks away from the physician and assigning them to medical assistants, nurses, and health coaches. These members of the team can handle immunizations, screening and testing, and medication reviews.
- Let scribes help: In some practices, scribes, nurses, and/or medical assistants have offloaded two to three hours per day from MDs in patient documentation and computerized order entry. At Cleveland Clinic Strongsville, primary care physicians are assigned either two medical assistants, or one medical assistant and one nurse. Daily visits increased from 21 to 28, revenue rose 20% to 30%, and satisfaction scores improved from all parties—patients, staff, and physicians. Said one physician: “I leave work earlier every day and have a very fulfilling relationship with my team … We’re having fun.”
- Reengineer prescriptions: Give stable or chronically ill patients a year’s worth of renewals, at the time of their annual conference visit.
- In-box management: Let nurses or medical assistants filter the flow of email to physicians, handling routine requests, reports, and renewals. Also, replace inbox messages with verbal messaging (i.e., talking to each other) for more thorough and efficient exchange of information between physicians and clinical staff. “Fairview Clinic in Minneapolis has decreased the in-box work from 90 minutes to only a few minutes per day for many physicians.”
- Improve team functioning: Locate physicians and medical assistants side by side. Hold frequent team meetings. Minimize the need for e-mail tag. Use systems analysis to map more efficient workflows for complex offices.
- Overall, Sinsky says, it is possible to save three to five physician hours per day through practice re-engineering, as these high-functioning practices have documented.
Societal focus—advocacy efforts
As noted earlier, some of the most onerous drivers of burnout are related to the growing burdens related to regulation, billing, compliance, certification, and meaningful use of the EHR. AHC leaders—individually and corporately—need to advocate continually for meaningful reductions in the burden of paperwork that serves no clear purpose in improving quality and safety for patients.

At the level of professional societies, we need to keep advocating for licensing and renewal protocols that do not stigmatize and undermine the prospects of good professionals who have done the right thing by seeking psychological or psychiatric care when needed. Recognizing the need for help and seeking it in a timely fashion is precisely one of the things we need most to encourage to fight this epidemic of burnout and even more damaging associated syndromes and consequences.

The BRAHG notes—and applauds—the leadership role being played by NAM in convening study and action groups aimed at addressing the problem of burnout. We also applaud the leadership of the AAMC in taking special interest in correctable features of the learning environment that impinge on all physicians, nurses, residents, students, and others within the AHC. In particular, we salute the leadership role played by our fellow member Darrell Kirch, president and CEO of the AAMC, who is co-chairing the NAM Action Collaborative on Clinician Well-Being and Resilience. We believe that the forthcoming national report from this collaborative, with buy-in from a growing number of leading industry, professional, and academic groups, may have a transformational impact similar to that of the IOM reports To Err Is Human and Crossing the Quality Chasm.

V. Recommendations

- Create awareness. Every CEO should begin to use his or her leadership platform to raise awareness of the burnout issue. Giving a name to the “burnout” syndrome so much of our workforce is experiencing and talking about it openly and without shame or stigma is a crucial first step. Acknowledge its existence. Insist on its importance.

- Spread happiness. CEOs have the unique ability to change the emotional temperature of virtually everyone they encounter. To the extent possible, they should always be mindful of these opportunities and always aim for positive impact with each encounter.

- Run it up the flagpole. Given our growing recognition of burnout as a personal, organizational, and patient threat, we need to elevate it to the top of every strategic planning session and strategic communication plan we formulate as organizational leaders. Make it a major initiative for the CEO and the organization. While specific metrics may need to be developed, current provider satisfaction and engagement scores are a good start. CEOs and the C-suite team should have incentives and risk built into their compensation for improvement. They should also be consistent and consistent that these same metrics become part of the responsibility and accountability of leaders throughout the organization. AHC leaders need to be prepared to define the impact of these issues on their own institutions and to articulate their importance in convincing and compelling terms.

- Measure better. Several attempts are under way in the health care sector to devise instruments that will quickly assess doctors, nurses, and other clinicians and health professionals for symptoms and warning signs of burnout. The key is to identify key factors associated with successful measurement and make these tools crisp, simple, and quick. It is also critical that such tools become well accepted and routine and that they confer no particular stigma or shame, no matter what the findings may be in any individual case. They must be used clinically, analytically, and routinely to promote the health of individuals, teams, and organizations—all for the sake of our professionals and our patients.

- Take the first step. Acknowledge this will be a multi-year journey requiring organizational focus and commitment to continuous improvement and adaptability. Acknowledge the truism of the Chinese proverb that no matter its length, this must begin with the short steps. Make the steps public and decisive, and insist that they will be followed with many more. Check in regularly. As organizations that are devoted to three principal missions—education, research, and health care—our changes must be multidimensional, including academic and organizational culture, content, and delivery of our curricula for all health professions and for the delivery of health care, with the ability to measure, change, and refine along all three axes.

- Learn the unique role of learning organizations. AHCs have a unique role to play given their central role in educating and training students, residents, and fellows in medicine and all the health professions. An important feature is introducing the concept of “balance” in a professional life. AHCs shape the present and mold the future. Much of the work that has to be done will be in the form of new approaches to education and training.

For instance, progress is being made through innovations as the following: 52, 53, 54, 55, 56, 57, 58, 59.
Allowing, even encouraging, medical students to spend a year or two in a service program such as Teach for America before matriculating.

Encouraging medical students to spend a year or two as medical scribes before matriculating. Not only do they become sophisticated in EHRs, they also develop critical team-based skills from a position other than that of physician.

Replacing over-reliance on MCAT scores with more holistic approaches to admission—considering such issues as “distance traveled” from family of origin to medical school (a good index of grit), to situational judgment tests and interviews.

Dividing large entering classes into smaller units of 40, encouraging participation in so-called societies or academies that provide a sense of community and social support.

Abolishing the zero-sum competitiveness of traditional medical school culture by switching to pass-fail grading.

Ensuring absolutely confidential access to wellness and mental health services and encouraging their use when needed.

Elevate the fourth aim. The issue of promotion in medical school professions—the so-called fourth aim—is sufficiently important that AHCs should consider forming a national organization focused on this imperative. It would be analogous to the Institute for Healthcare Improvement (IHI), whose formation grew out of the National Demonstration Project on Quality Improvement in Health Care in the 1980s. Today, the IHI has growing importance and influence not only in the U.S. but in many other nations around the world. We should aspire to nothing less in the fight to promote flourishing and joy in work and to mitigate burnout among our health care professionals.

Focus on research. Work on understanding the causes and factors that lead to burnout and on active measures that can mitigate and prevent burnout, is just beginning. We still do not know nearly as much as we need to know about the human factor in care delivery and how we can promote flourishing instead of burning out at a systems level—including individuals, teams, and organizations. Many of the solutions that have been proposed have heuristic underpinnings instead of evidence-based validation.

Advance along a broad front. There is a wide range of solutions that have proven successful in at least some settings. They range from relatively easy changes to ones that will require substantial reorganization.

One class of strategies, recommended by Bodenheimer and Sinsky in a review of the Group Health Medical Home experience in Seattle, involves a thoroughgoing redefinition of team roles, mitigating the frustration and burnout initially experienced by many physicians in trying to meet the massive new documentation and compliance requirements associated with the “Triple Aim.” Among them are engineering team-based approaches to patient care and documentation, using nurses and medical assistants as health coaches, redesigning clinical and office workflow to avoid wasted visits, and standardizing prescription refills, saving physicians up to five hours per week.

Practice at the top of one’s professional license. Create the opportunity for all of the professions in our organizations to do best what they were trained for, working in teams and helping their colleagues and themselves to maximize their contributions to patient care and the advancement of practice through innovation.

Redesign professional positions to create a 20% window to focus on the subject of one’s greatest passion or challenge; experience shows this percent of effort can be critical in making the difference between burnout and fulfillment.

Redesign of reporting relationships: Many health care organizations are using “dyad” (physician and administrator) and “triad” (physician, nurse, and administrator) management models to recognize the breadth of the skill required to make complex clinical operations more effective. These models require specific role definitions for each member of the team and definitions of the rules of the road.

Redesign promotion and tenure criteria: positively, to incentivize personal well-being and the enhanced professionalism that reflects the mastery of “soft skills” related to heightened professionalism, collegiality, and community-building; negatively, to eliminate any stigma that might attach to seeking personal help when it is indicated.

Physically redesign spaces used by health care teams to allow the co-locating of physicians—i.e., semi-circular desks, printers in every room

Redesign of EHR (overlays and wholesale introduction of new, more user-friendly systems)

Create a C-suite office focused on well-being. Like the chief quality officer, the chief wellness officer should report directly to the CEO and represent the CEOs’ stature, credibility, and personal commitment to the cause of enhanced professional well-being as an institutional priority.

VI. Future Directions

Much of what we assume will mitigate burnout and promote professional well-being is intuitive or pragmatic. Evidence-based research is sorely lacking, at every level. We need a form of system engineering that will offer us much better insights into what and how we need to measure and how and when we should intervene. We need to identify and train appropriate experts, and we need to find the resources and funding to make this study a priority.

In 2016, the AMA convened a Joy in Medicine Research Summit, with 32 experts who were asked to establish a national research agenda. The six highest-scoring recommendations emerging from those discussions were the following:

1. “Further establish the links between physician burnout, well-being, and health care outcomes.” We need to understand better the relationships between burnout and quality of care. Do steps we might take to reduce physician burnout actually improve the experience and health outcomes of patients?

2. “Estimate the economic cost of physician burnout.” How staggering is the sum of burnout-related medical error, malpractice litigation, physician turnover, reductions in work hours, and lower patient satisfaction? If we could calculate that toll, would it make a more compelling case for the changes and interventions we need to undertake?

3. “Build alliances to address physician burnout.” Collaborations and partnerships that would propel tangible interventions could include academic and industry groups, private foundations, national agencies and funders, and patient groups.

4. “Use common metrics.” There are at least eight tools and instruments being commonly used to test and diagnose burnout, stress, satisfaction, engagement, and other related concepts. A reliable, common tool should be developed to facilitate meaningful comparisons across occupations and groups and enable faster progress. It can be questioned whether there is a clear vocabulary or consistent measuring rod currently in use, making it difficult to generalize about findings, goals, and recommendations. The develop a comprehensive framework for intervention with individual and organizational components.” An integrated framework of interventions for both systems and individuals should be developed, encouraging healthful individual choices and even more important, beneficial organizational changes.

6. “Share the best available evidence.” A toolkit of strategies that have proven to have at least some efficacy for individuals and organizations should be developed and shared widely.
VII. Rationale and Conclusion

Evidence is overwhelming that burnout is a clear and present danger to our own professional faculties, workforce, students, and trainees—as well as, potentially, to our patients. The human cost of not acting promptly and energetically is clear. The financial costs, while less clear, are still substantial. Mitigating burnout promises, in the long run, to reduce, not increase, the societal cost of health care. Admittedly, there will be some initial costs to redesign of spaces, reengineering workflow, investing in well-being and wellness programs and leadership—to name a few. In the long run, we will reap intangible as well as tangible benefits.

By acknowledging and reversing this tide of burnout, we will create transformative win-wins for our people and our organizations. Most important, we will become true magnet institutions, where our society’s best want to come—to study, to teach, to heal, and to be healed.

References


22


The Blue Ridge Academic Health Group studies and reports on issues of fundamental importance to improving the health of the nation and our health care system and enhancing the ability of the academic health center (AHC) to sustain progress in health and health care through research—both basic and applied—and health professional education. In 21 previous reports, the Blue Ridge Group has sought to provide guidance to AHCs on a range of critical issues. (See titles, opposite page.)

For more information and to download free copies of our reports, please visit www.whsc.emory.edu/blueridge.