In May of 2016, the MSSNY created a Stress and Burnout Task Force. This Task Force was charged to formulate a strategy and plan of action to fight burnout and reduce stress among the constituents of the MSSNY. The following article is the fourth of a miniseries that addresses the following topics: the problem of burnout, current state of the State (burnout survey), solutions at the individual and organizational level, and opportunities for advocacy.

Physician Burnout – Systemic/Organizational Issues and Solutions – A Roadmap for Leaders

Previous articles in this series examined various aspects of physician burnout, including: the definition of burnout; the endemic nature of burnout among physicians; the impact of burnout on institutions, organizations, patients, and physicians and their families; and, in broad strokes, the drivers of burnout among physicians in New York State and elsewhere in the country.

Until very recently, most of the physician burnout research and literature focused on strategies that individual physicians could employ to help reduce the effects of burnout. However, many observers of the current healthcare ecosystem believe emphasis on the individual may be tantamount to “blaming the victim” (1). This belief has given rise to an evolving view that we must look with a critical eye at the causes of burnout intrinsic to our professional work units, systems and organizations, and the broader health care environment. Over the past several years, Dr. Mark Linzer and Dr. Tait Shanafelt, and their respective colleagues, have made important contributions to our understanding of how these dynamics contribute to physician burnout by identifying the various drivers as well as strategies for mitigation (2, 3).

There is mounting evidence that burnout and loss of well-being among physicians and the concomitant loss of joy and purpose in our work, diminishes patient safety, patient satisfaction and the quality of care (4). These factors, coupled with an increase in physician turnover, early retirement and/or abandonment of direct patient care, contribute to a public health crisis that should capture the undivided attention of our organizational /systemic contributions to Burnout.

Figure 1

<table>
<thead>
<tr>
<th>Rank</th>
<th>Description</th>
<th>% Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Length and Degree of documentation Requirements</td>
<td>65.99%</td>
</tr>
<tr>
<td>2</td>
<td>Extension of workplace into home life (E-mail, completion of records,...)</td>
<td>58.27%</td>
</tr>
<tr>
<td>3</td>
<td>Prior Authorizations for: Medications/Procedures/Admissions</td>
<td>54.74%</td>
</tr>
<tr>
<td>4</td>
<td>Dealing with difficult patients</td>
<td>51.89%</td>
</tr>
<tr>
<td>5</td>
<td>EMR functionality problems</td>
<td>51.05%</td>
</tr>
<tr>
<td>6</td>
<td>CMS/State/Federal laws and regulations</td>
<td>44.33%</td>
</tr>
<tr>
<td>7</td>
<td>Lack of voice in being able to decide what good care is</td>
<td>40.39%</td>
</tr>
<tr>
<td>8</td>
<td>Hospital/Insurance company imposed Quality Metrics</td>
<td>38.87%</td>
</tr>
<tr>
<td>9</td>
<td>Dealing with difficult colleagues</td>
<td>31.49%</td>
</tr>
<tr>
<td>10</td>
<td>Requirement for increased CME/Maintenance of Certification</td>
<td>31.49%</td>
</tr>
</tbody>
</table>

A comprehensive (even though it does not claim to be) roadmap can be found in the article by Shanafelt and Noseworthy (7).

FIRST: “WE CARE ABOUT YOU”—ADOPTING PHYSICIAN WELL-BEING AS AN ORGANIZATIONAL VALUE

Knowing that an institution cares about the wellbeing of its employees does matter. It need not be one of the core values of the institution, but stating it, inquiring about it and, more importantly, acting on it, sends a strong message to physicians and staff and boosts productivity.

This may take form in circulated statements, town hall meetings, leadership rounds and, most importantly, in reporting the state of burnout to the leadership and medical staff on a regular basis.

Hence, the second measure.

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SECOND: MEASURE IT – NO MEASUREMENT, NO IMPROVEMENT

There are a few validated measurement tools that are available. The key is to make sure that the measurement is systematic, periodic and easy to administer. A systematic approach to measurement (and later, improvement) is not only a sign of rigor but also of commitment. It can include forming a committee or designating a champion or a “wellbeing officer” who would be in charge of measurement and implementation of the interventions and subsequent reporting.

Periodic measurement is necessary to evaluate for improvement (or worsening) of burnout. There are no strict guidelines about the frequency of measurement but yearly or biennial measurement is acceptable. The measure needs to be anonymous with respect to identifiers traceable to the individual physician in order to be accurate and honest. Online versions of the tools involve a third party that ensures anonymity of the source but makes available aggregate data to institution administrators.

Administrators must keep in mind that, getting physicians to reveal what the stressors are, must overcome the culture of medicine that includes a culture of endurance, silence and complaining/whining, and it begins with physicians in training.

Administrators must keep in mind that, getting physicians to reveal what the stressors are, must overcome the culture of medicine that includes a culture of endurance, silence and complaining/whining, and it begins with physicians in training. (10) Yet, identifying the organizational problems is the critical step to ease these burdens as well as improve safety. Ease of administration of the measure is an important factor to consider. The longer the survey the less likely to obtain complete answers or a high response rate. Format is also another factor. In a small unit, it might be easier to use a paper format, but in larger institutions an online survey might be easier to administer.

In sum, measurement is an essential step that can guide leaders to the direction of change and to the effectiveness of interventions.

THIRD: IDENTIFY YOUR BURNOUT PHENOTYPE

Depending on the setting in which physicians practice, the phenotype of burnout might be different. For example, in a busy office practice, administrative burdens might be the main culprit. In a unit where practice focuses on chronic disease management or palliative care, dealing with compassion fatigue might be the main issue. The predominant burnout drivers can differ by units, and will present clues to interventions. One way to identify the main issues that are problematic in the workplace is to simply ask the staff “What matters?” as discussed in the IHI white paper, “Finding Joy at Work.” (9)

FOURTH: START WITH LOW-HANGING FRUIT

Some interventions may be easy to implement, gain favor among physicians and help “break the ice.” For example, carving out time for practitioners to catch up with administrative duties without asking them to make up for that time can go a long way. Additional interventions may include a mingle dinner for staff to “vent” and get to know each other better, a peer support or second-victim program, or a retreat

**Figure 3 - Responsibility Matrix**

<table>
<thead>
<tr>
<th>Physician Responsibility</th>
<th>Administrator Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action</strong></td>
<td><strong>Comment</strong></td>
</tr>
<tr>
<td>Acknowledge Change</td>
<td>New issues, understand their impact, understand how to adapt</td>
</tr>
<tr>
<td>Own Safety and Quality</td>
<td>Acknowledge variability of care and its impact on outcomes, improve care delivery</td>
</tr>
<tr>
<td>Promote Accountability and Peer Mentoring</td>
<td>Must hold each other accountable, and be proactive to advance this responsibility</td>
</tr>
<tr>
<td>Stop Bad Behavior</td>
<td>Have to stop yelling, bullying, lack of follow-up, not responding or outright verbal or physical abuse.</td>
</tr>
<tr>
<td>Practice Humility</td>
<td>Respect the knowledge and skills of our non clinical colleagues.</td>
</tr>
<tr>
<td>Lead By Example</td>
<td>Physicians are looked up to for guidance and advice and people closely follow their actions.</td>
</tr>
</tbody>
</table>

Adapted from Merlino J. August 19, 2015: [www.beckershospitalreview.com](http://www.beckershospitalreview.com)
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for emotional and cognitive rejuvenation. Regardless of the cost or complexity of the intervention, it should be targeted and well-implemented.

**FIFTH: SUPPORT AND DEVELOP YOUR LEADERS**

Strong leadership is undoubtedly one of the essential elements of reducing burnout in the workplace (10). Characteristics of effective leaders include good listening skills, accountability, a sense of fairness and being supportive. Leaders who share the core values of physicians and staff increase engagement throughout the organization, which helps reduce feelings of helplessness that come from loss of control (10), and “leaders who engage their teams meaningfully create work environments more likely to engender a sense of well-being and less likely to engender burnout.” (11).

For additional strategies, please consult the article by Shanafelt and associates on executive leadership and physician wellbeing (7).

Linzer and associates (12) proposed several realistic solutions from their Healthy Work Place Study, including workflow redesign and improvement in communication. Improving workflows reduced burnout 6-fold, targeted quality improvement projects addressing clinician concerns reduced burnout 5-fold, and improving communication between team members improved professional satisfaction 3-fold. (12) Specific interventions include use of medical assistants for data entry, pairing of medical assistants (MAs) and physicians, providing adequate time for MAs to perform tasks previously done by physicians, improved teamwork, and routine clinical meetings to discuss important topics and surveying physicians for their “wish list” issues. Other potential organizational steps include promotion of part-time careers and job-sharing, protected time for meaningful personal activities, maintenance of manageable primary care panel sizes, hiring physician floats to cover predictable life events and allocation of adequate resources to primary care clinics. (14)

More recently, Shanafelt and associates (15) outlined the business case for investing in physician well-being by analyzing costs associated with burnout. These include physician turnover, lost revenue due to decreased productivity and organizational threats posed by lower quality of care, decreased patient satisfaction and reduced patient safety. It is estimated that the organizational cost to replace a single physician is between $500,000 and $1,000,000 when con-
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sidering costs of recruitment and lost revenue. Studies have also shown that loss of a physician causes increased burnout for colleagues and other members of the care team.

It’s important for organizations to understand the factors that drive burnout and to realize that they can make substantive changes in many of these drivers, and often at relatively little cost. Nonetheless, even low-cost interventions can be challenging because change is always difficult. This dynamic highlights the importance of change management and the capacity to lead an organization through change. See Figure 3 for a responsibility matrix that addresses physician responsibilities and administrator responsibilities in improving physician/administrator relationships. The business case to reduce burnout, when coupled with the moral and ethical imperatives, creates an even more compelling argument for organizations to act.

Despite the IOM’s 1999 To Err is Human report and its clear message of how organizational/systemic issues cause the majority of errors, most of the efforts, investigation, training and blame have focused on end actors i.e. the clinicians (16). A similar story has emerged that ‘blaming the victim’ has been the approach in reducing burnout until recently. The majority of stressors affecting physicians are organizational/systemic (6). In quality and safety arenas, as well as burnout reduction programs at hospitals, we have a quality and safety opportunity as well as a moral responsibility to look at and improve systemic/organizational contributions to error and burnout.

Beyond the institutional and organizational factors, we have considered in this article, many important drivers of physician burnout and dissatisfaction are external to the organizations in which we work, yet are systemic ills in the healthcare ecosystem. These include laws, rules and regulations imposed upon the practice of medicine by state and federal governments as well as public and private payers. Without attempting to address these issues as well, the positive consequences of organizational change will be limited. Organized medicine in general, and MSSNY in particular, have a history of effective advocacy efforts to change public policy, and this will be the subject of the fifth, and final, article of this series.

REFERENCES

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