MSSNY's Stress and Burnout Task Force

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 and institutional leaders [5]. This makes the issue of burnout as "burning" (pun intended) as the financial pressures that healthcare institutions need to overcome. In a previous article [6], we showed based on a survey of NYS physicians that the majority of stressors emanate from organizational or systemic roots. [Figure 1]

Figure 1

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

This leaves plenty of room for improvement in terms of identifying ways of either eliminating or mitigating them. As mentioned by Shanafelt and Noseworthy, the imperative to address these issues goes beyond any economic advantage; it is a moral imperative [7].

While it is always important to identify the causes and reasons to intervene, the purpose of this article is to share with healthcare leaders what could be a simplified roadmap for their institutions to follow and guide them in the adoption and implementation of burnout-reducing interventions.

Figure 2 gives an overview of concepts involved in addressing organizational /systemic contributions to Burnout.

Figure 2

Organizational Intervention Concepts for Burnout Reduction

- **Overcome the medical culture of endurance**
- **Leadership style and concern is effective**
- **Establish: Wellness Initiative Strategic Planning Work Group**
- Include **human factor** issues in healthcare delivery
  - **The Quadruple Aim Framework:**
    - Costs, Quality, Patient experience, and **Fourth Aim: Experience of providing care.**
- **Understand the front line problems:**
  - **Anonymous survey** to learn key pain points
  - **Round table discussion** of findings
  - **Leadership commitment to action.**
- **Encourage stronger administrator/physician partnerships, with participatory management (see Responsibility Matrix)**
- **Use clinician wellness and career satisfaction metrics**
  - Tie these into quality of care, reduction of malpractice, errors and patient satisfaction.
- **Organize completion of all mandatories, regulations**
- **No reporting of seeking mental health care on:**
  - licensure
  - malpractice carrier
  - credentialing applications or renewals.
- **Confidentiality in seeking help**

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.

(Continued on page 19)

MSSNY's Stress and Burnout Task Force

(Continued from page 8)

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 [8]. 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

(Continued on page 20)

Figure 3 - Responsibility Matrix

Physician Responsibility		Administrator Responsibility	
Action	**Comment**	**Action**	**Comment**
Acknowledge Change	New issues, understand their impact, understand how to adapt	**Validate Suffering**	Empathy, validate feelings, recognize impact; you will navigate with them as partners
Own Safety and Quality	Acknowledge variability of care and its impact on outcomes, improve care delivery	**Communicate**	Keep physicians informed and the "why" behind decisions. Is two way street: In addition to sharing information are you listening to what they say?
Promote Accountability and Peer Mentoring	Must hold each other accountable, and be proactive to advance this responsibility	**Help Physicians Understand the Business**	Help educate our physician partners so they better understand the things we do.
Stop Bad Behavior	Have to stop yelling, bullying, lack of follow-up, not responding or outright verbal or physical abuse.	**Be Inclusive**	If you want physician support for key decisions, **include them in the real decision making.**
Practice Humility	Respect the knowledge and skills of our non clinical colleagues.	**Recognize the Need for Symbiosis**	Recognize the need for tandem roles of physicians and administrators for quality of care and maintaining health of the business
Lead By Example	Physicians are looked up to for guidance and advice and people closely follow their actions.	**Beware of Trigger Issues**	Before executing something new, understand the mood of your physicians and the effect the change will have relative to other recent changes and ensure appropriate consultation and communication.

Adapted from Merlino J. August 19, 2015: www.beckershospitalreview.com

(Continued from page 19)

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].

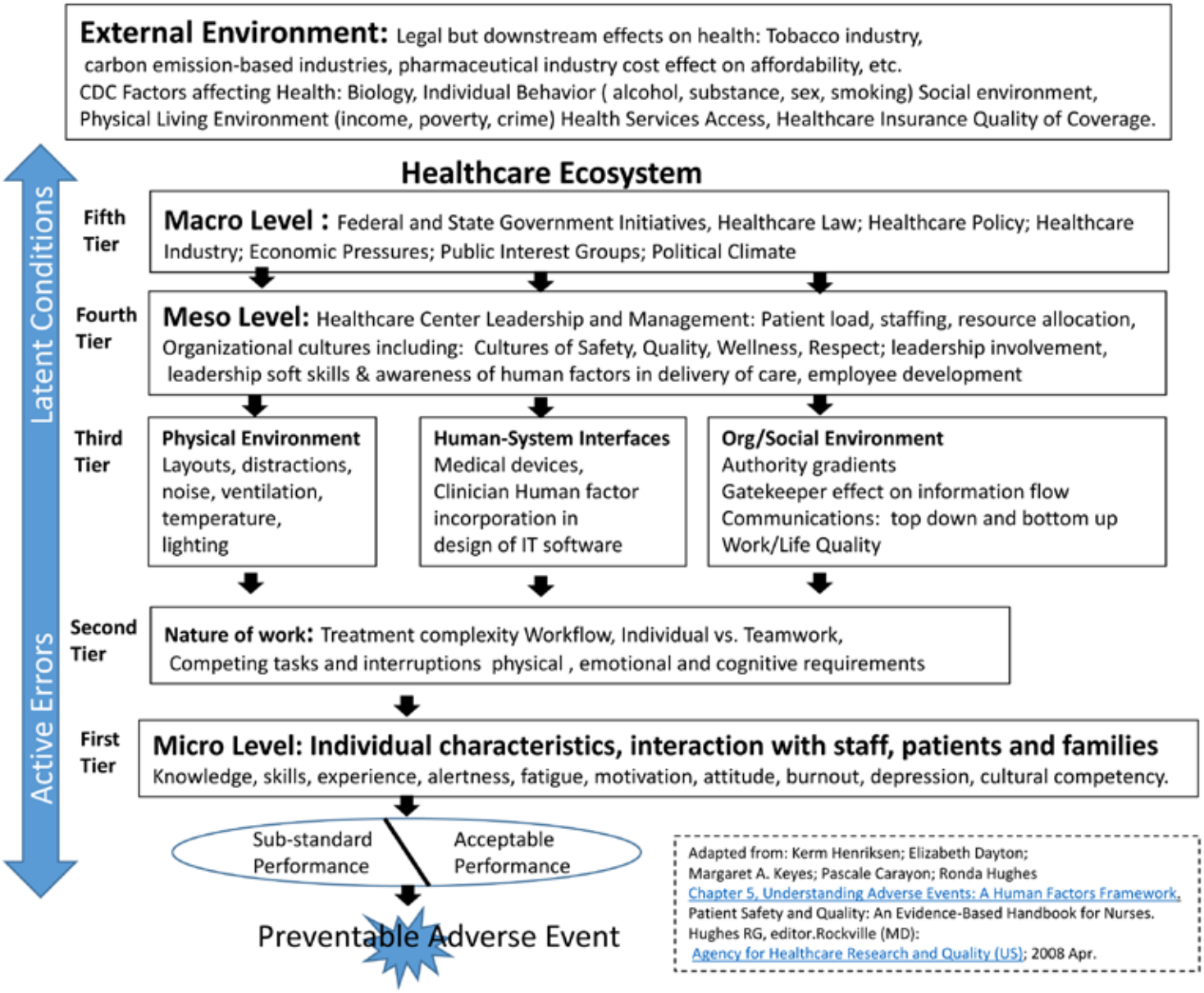
For additional strategies, please consult the article by Shanafelt and associates on executive leadership and physician wellbeing [7].

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. [13] 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-

(Continued on page 21)

Figure 4



MSSNY's Stress and Burnout Task Force

(Continued from page 20)

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

1. Shanafelt TD, et al. "Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014." *Mayo Clinic Proceedings.* 90(12): 1600 – 1613.
2. Shanafelt et al. Burnout and satisfaction with work/life balance among US physicians relative to the General US Population. Arch Int. Med Vol 172 (18) 1377-1385.
3. Linzer et al. Organizational Climate, Stress and Error in Primary Care: The MEMO Study. Advances in Patient Safety (1): 65-77. 2005.
4. Shanafelt T. et al. Addressing Physician Burnout. The Way Forward. *JAMA* Mar 7 317 (9):901-902.
5. Privitera MR, Atallah F. Physician Burnout as an Individual and Public Health Issue. Medical Society of the State of New York's *News of New York*. Vol 73 (7): 6-7, 16-17.
6. Atallah F, Privitera MR. Physician Burnout - The State of the State. MSSNY Talk Force on Physician Stress and Burnout Survey Findings. Medical Society of the State of New York's *News of New York*. Vol 73 (8): 6-8.
7. Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. Mayo Clin Proc. 2017 Jan;92(1):129-146.
8. Privitera MR, Gomez-Ceseare C, Bedient T. Burnout reduction for the Individual Clinician. Medical Society of the State of New York's *News of New York*. Vol 73 (9): 6-7, 12-13. 2017.
9. Perlo J. Balik B, et al. IHI Framework for Improving Joy in Work. IHI White Paper. Cambridge Massachusetts. Institution for Healthcare Improvement 2017. Available at ihi.org.
10. Shanafelt TD, Gorringe G, Menaker R, Storz KA, Reeves D, Buskirk SJ, Sloan JA, Swensen SJ. Impact of organizational leadership on physician burnout and satisfaction. Mayo Clin Proc. 2015 Apr;90(4):432-40.
11. Lister ED, Ledbetter TG et al. The Engaged Physician. Mayo Clin Proc. 2015 Apr;90(4): 425-427.
12. Linzer M, Poplau S. Building a Sustainable Primary Care Workforce: Where Do We Go from Here? J Am Board Fam Med. 2017 Mar-Apr;30(2):127-129.
13. Linzer M, Poplau S, Grossman E, Varkey A, Yale S, Williams E, Hicks L, Brown RL, Wallock J, Kohnhorst D, Barbouche M. A Cluster Randomized Trial of Interventions to Improve Work Conditions and Clinician Burnout in Primary Care: Results from the Healthy Work Place (HWP) Study. J Gen Intern Med. 2015 Aug;30(8):1105-11.
14. Linzer M, Levine R, Meltzer D, Poplau S, Warde C, West CP. 10 bold steps to prevent burnout in general internal medicine. J Gen Intern Med. 2014 Jan;29(1):18-20.
15. Shanafelt T, Goh J, Sinsky C. The Business Case for Investing in Physician Well-being. *JAMA Intern Med*. 2017 Sep 25.
16. Kohn, L.T., Corrigan, J., Donaldson, M.S., To err is human: building a safer health system. 2000, National Academy of Sciences: Washington, D.C.

AUTHORS:

Louis Snitkoff, MD, FACP
Member of MSSNY Physician Stress and Burnout Task Force
CMO, CapitalCare Medical Group, Albany, NY

Fouad Atallah, MD, FACOG
Member of MSSNY Physician Stress and Burnout Task Force
Director of Patient Safety/OBGYN
Maimonides Medical Center, Brooklyn NY

Michael R. Privitera, MD
Chair, MSSNY Physician Stress and Burnout Task Force
Director, Medical Faculty and Clinician Wellness Program
University of Rochester Medical Center

Jeffrey Selzer, MD
Member of MSSNY Physician Stress and Burnout Task Force
Medical Director, Committee for Physician Health