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 first of a miniseries that will address the following topics: the problem of burnout, current state of the State (burnout survey), solutions at the individual and organizational level, and opportunities for collaboration and advocacy.

INTRODUCTION AND DEFINITION

Physicians and other healthcare professionals are the proximal reason for the quality of care provided to patients. What effect does increasing high-level and chronic occupational stress imposed from multiple uncoordinated sources have on them personally and ultimately the patients they serve? There is overwhelming evidence that the effect is devastating, but the level of awareness of this fact is slow to be recognized by the clinicians, the healthcare systems, and the sources of the stress. **Burnout is defined as a psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment** \(^1\). Each one of these definition criteria can have deleterious effects on the provider-patient interaction as shown in table 1.

The human condition of burnout is the same across many healthcare professions, but the specific stressors differ by profession. This article will focus upon physician burnout as a personal and public health issue, calling the question to reassess the best use of resources and better understanding the forces involved.

**AN INCREASINGLY RECOGNIZED EPIDEMIC FORGES A REFOCUS ON THE EXPERIENCE OF PROVIDING CARE**

The widespread problem of physician burnout has made it into many press outlets including the *New York Times*, *Time*, *US News and World Report*, and *Forbes* to name a few. Our patients know we are going through this dilemma as a group and now so do health care institutions.

From the period of 2011 to 2014, burnout in physicians rose from 46% to 54% while burnout in the general population remained about the same. Work/life balance went up in the general population and decreased in physicians during the same time \(^2\).

The forces involved in the creation of burnout are often considered nebulous, sometimes subterranean because they are an accumulation of a massive number of factors. Our own medical culture of endurance and somewhat super-human internal perceptions of ourselves and external perceptions others have of us have contributed to the delays...
burnout is equated with abuse and organizations are the main
culprit. Evidently, these polarized views are too simplistic. Six
rates of errors. We need to examine what we are doing to
higher the depression then general population. Two publications on The Quadruple Aim framework (5, 6) include
the fourth aim – improving the experience of providing care
such that the healthcare workforce of physicians, nurses and
employees find joy and meaning in their work. This frame-
work addresses the human factors in the delivery of care that
are essential to the success of the other three aims of patient
experience, cost, and quality of care.

PHYSICIANS IN TRAINING

College graduates who are enrolled into medical school have
lower burnout and depression ratings than the general pop-
ulation. Two years in medical school, this group has higher
burnout and higher depression then general population (7).
At the beginning of internship before it starts, the incidence
of depression is about 3.9%. Three months into internship it
becomes over 6 times higher at a rate of 27.1% and stays high
throughout internship (8). Suicidal ideation before internship is
at 2.5%, at 3 months becomes 4.0%, at 6 months becomes
over four times higher at 11.1% and stays high throughout the
rest of into internship (9). We also know that acute and chronic
depression can affect medical decision making increasing the
rates of errors. We need to examine what we are doing to this
humans in both the educational experience and early
work experience as a physician.

WHAT ARE THE WORK-RELATED STRESSORS THAT
CONTRIBUTE TO BURNOUT?

At the extremes, burnout can be viewed either as an inter-
personal/individual problem that can be solved by better selection
of physicians, mindfulness and yoga practice, and enhancing
resilience or as an external/organizational problem in which burnout is equated with abuse and organizations are the main
culprit. Evidently, these polarized views are too simplistic. Six
categories of work stress have been identified to contribute to burnout (10):

1. Excessive workload: physical, cognitive, or emotional.
2. Lack of control in being able to influence work environment.
3. Poor balance between effort and reward.
4. Lack of community: or of a culture of mutual appreciation
   and team work (This gets worse the busier the physician
   becomes).
5. Lack of fairness in resources distribution.
6. Value conflict: the stress of having to participate in sub-
   optimal unethical circumstances.

Of note, a denialist view of burnout that burnout can’t be a
major problem is superficially justified by the fact that plenty
of people still go to medical school and doctors still show up
for work. If physicians for a moment go back to their pre-med
experiences and the motivating factors to become a physician,
it becomes fairly clear that becoming a physician is a call-
ing and not a series of transactions that may be the focus of
the business of medicine. This dissonance needs to be better
acknowledged and reduced, but is beyond the scope of this
article.

THE IMPACT OF CLINICIAN BURNOUT IS COSTLY

There are multiple dose-related relationships such that the
higher the burnout the higher the incidence.

Institutional and patient toll:

- Increased medical errors and malpractice claims.
- Disruptive behavior.
- Reduced empathy for patients, patient satisfaction.
- Reduced patient adherence to treatment regimens.

Financial Toll:

- Reduced in-patient satisfaction scores.
- Major contributor to turnover costs.
- Increased medical claims by employees.
- Major contributor to short-term and long-term disability
  costs.

Personal Toll:

- Reduced career satisfaction.
- Higher Suicide Rate among physicians (about 400/year).
- Substance abuse.
- Divorce.
- Coronary Heart Disease.
- Depression.

MECHANISMS OF IMPACT, THE CASE FOR BIOLOGICAL
PLAUSIBILITY

Physicians are trained to use what they have learned for
medical decision making (MDM). The prefrontal cortex (PFC) is
the part of the physician’s brain that (together with widespread
neuronal networks) is responsible for executive function (EF).
EF weighs the multiple factors at hand to make the best diag-
nosis and treatment plan and is a limited resource. EF includes
the ability to manage time, attention, switch focus, plan and
organize, remember details, curb inappropriate behavior and
speech, and integrates past experience (e.g. medical training)
and experiences with present needed action to practice medi-
cine of the highest competence. PFC is the most evolved brain
region and subserves our highest-order cognitive abilities.
Unfortunately, it is also the brain region that is most sensi-
tive to the detrimental effects of stress exposure. Even quite
mild acute uncontrollable stress can cause a rapid and dra-
matic loss of prefrontal cognitive abilities, and more prolonged
stress exposure causes architectural changes in prefrontal and
amygdala nerve cells. This constant prioritization processing
induced by uncoordinated mandates and subsequent dimin-
ished attentional resources available then increases “goal
shielding” that attempts to help the doctor filter out other
factors and get overly narrow in focus. Over-focus on specifi-
cally allocated task-relevant processing (for example, making
sure all the Meaningful Use in the electronic record are noted as
“marked as reviewed” by properly clicking the appropri-
ate buttons), then detract from cognitive flexible memory
(CFM) needed in the clinical moment with the patient needed
to weigh factors at hand. Habit memory (HM) then predomi-
nates over CFM that would have been used to examine factors
in more accurate diagnosis, more comprehensive and effec-
tive care planning, as well as the emotional availability to the
patient and family.

Cognitive processing capacity of the human mind is lim-

in awareness of how stressful and toxic the healthcare work
environment has become. As author Dike Drummond MD states: “It’s not a fair fight” as a final acknowledgement that
in total, the job description has become actually impossible
to achieve. He also describes the multiple factors as “death
by a thousand paper cuts” as an imagery to try to under-
stand this accumulation effect (3).

The emerging evidence of how clearly burnout affects the
healthcare system and the quality and safety of the care
provided to our patients now squarely promotes the needed
opportunity for collaboration among educators, administrators,
quality and safety advocates, patient experience advocates
and the healthcare industry. It has become clear that The Triple
Aim (4) framework of a better quality of care, and enhanced
patient experience at a reduced cost is an incomplete view of
what needed to occur for sustainability of practice and safety
in patient care. Since many decision-makers in healthcare and
the support industry to healthcare are non-clinicians, a “perfect
storm” occurred 1) externally: over-expectation of demands
of healthcare workers and 2) internally: over-expectation of
human capabilities by the healthcare workers themselves.

Two publications on The Quadruple Aim framework (5, 6) include
the fourth aim – improving the experience of providing care-
such that the healthcare workforce of physicians, nurses and
employees find joy and meaning in their work. This frame-
work addresses the human factors in the delivery of care that
are essential to the success of the other three aims of patient
experience, cost, and quality of care.

A SPECIFICALLY VULNERABLE POPULATION:

Aphasias in Training

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- Higher Suicide Rate among physicians (about 400/year).
- Substance abuse.
- Divorce.
- Coronary Heart Disease.
- Depression.
Intrinsic vs. extraneous vs. germane cognitive load are the factors involved in best decision making. Intrinsic load refers to the inherent difficulty of the mental task. Excessive extraneous load will deplete EF away from the ability to make good medical decisions (see reference 11 for multiple supporting references).

**OUR CURRENT HEALTH ECOSYSTEM**

Figure 1 displays the current health care system ecosystems of interacting factors.

- **Macro level** describes national state industry and regulatory factors.
- **Meso level** is at the hospital or healthcare system factors.
- **Micro level** describes individual clinicians with other staff and with patients and their families.
- **Exo level** describes the individual physician and their family in daily life outside of medicine.

The individual physician is surrounded by an environment that promotes the medical culture of endurance and self-effacement such that how you feel does not matter, and you have to remain professional at all times (as opposed to acknowledging your feelings but choosing your behaviors). Internally, there is a sense of altruism, workaholism, perfectionism, and obedience to authority. There is also the well-known fact that everyone is evaluating their competence around them and they don’t want to be seen as ‘weak’ with so much at stake: all the personal sacrifice, debt, and a family that is depending upon them.

Some factors are well intended for patient care but are not coordinated, harmonized, but these mechanisms are paradoxically making patient care less safe. With the rapid roll out of healthcare reform, and many non-clinicians involved in making the decisions, a ‘halo bias’ led to the adoption of too many measures that are attempting to quantify quality. Just because someone calls it “quality” it must be good (since the word ‘quality’ has a halo over it). The tsunami of these measures slipped by sufficient scientific scrutiny. Too numerous chaotic and unproven quality metrics are not good and in fact harmful (12).

Some factors are not well intended, and are actually devised to wear down the physician as a means of cost control, by hassle factors that physicians experience while trying to achieve care for their patients. There really is no justifiable room for the continuance of these wear-down methods by the healthcare business industry given the seriousness consequences of burnout.

Table 2 outlines a number of strategies to be considered to reduce burnout in physicians. The combination of individual and organizational interventions is required to be effective and... (Continued on page 17)
CONCLUSIONS

1. Burnout can no longer be ignored among physicians as it can take a toll on both the physicians and their patients.
2. Attention to the fourth aim (experience of providing care) of the Quadruple Aim framework is critical to the success of the other 3 aims of cost quality and patient experience.
3. There are complex factors that can contribute to burnout and its impact is very costly.
4. “Meaningful progress will require collaborative efforts by national bodies healthcare organizations, leaders, and individual physicians as each is responsible for factors that contribute to the problem and must own their part of the solution.”

In the next article, we will review how you can measure burnout, and what the current state of the State is in terms of burnout, its causes, and its consequences. We will also address how we can cope with it, as well as strategies for organizational intervention based on literature and the results of the recent MSSNY survey.

RECOMMENDED READING:
- Shanafelt TD. Noseworthy J. Executive Leadership and Physician Well-being:
  • The AMA’s Steps Forward program is an excellent source of helping the individual and the organization. https://www.stepsforward.org/

REFERENCES

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 second 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.

**INTRODUCTION AND METHODOLOGY**

In the fall of 2016, the MSSNY Task Force on Physician Stress and Burnout sent out to the membership via email a survey with the purpose of identifying the prevalence of burnout among NYS physicians, as well as to get more insight into the potential factors associated with it, and the ways in which they cope with it.

While it is understandable that doing something about burnout is overdue [1], the task force members acknowledged that, prior to embarking on any further action, measurement was necessary as a first step to gauge the magnitude of the problem and to probe the ways in which help can be provided based on the voice of the customer.

In the survey, the Mini Z was the validated tool used to measure burnout [2]. In addition, demographic and pertinent questions were added based on the known stressors of burnout from the literature, prior surveys, as well as expertise from task force members.

**INITIAL FINDINGS**

Of the 8,109 physicians who opened their email to the survey, 1,191 responded for a response rate of 14.68 %. It was noted that the data was very rich and bared some in-depth analysis of both quantitative and qualitative nature (of the free text answers). In the following figures, we share with you some of the major findings of the survey that would hopefully reflect the bigger picture of burnout in NYS. So let us see what we found without delay.

**DEMOGRAPHICS AND SPECIALTY: HARD FACTS**

The following 3 figures show the rate of burnout by age, gender and specialty. They show a higher prevalence of burnout among female physicians, and across a wide interval of age [25-64 years], and across many specialties. These are considered to be factors that are hard to modify in general. These findings are consistent with the published literature on burnout [3].

**CORRELATIONS: WORKLOAD, CONTROL, TIME**

The next figures show the rate of burnout by workload reflected in hours worked per week, sense of control over the workload, and the time available for documentation.

The sources of these burdens have been understood to come from national, state and industry decisions that heavily affected physicians. These are factors associated with burnout. Research has illuminated that for every hour with a patient, 2 hours is now either EMR or desk work [4]. While MSSNY continues to work on the sources of these burdens, these factors may be amenable to modification partly through improving efficiency, scribes, time management, office efficiencies, creating or recruiting extenders that alleviate some of the following burden factors.
WORKPLACE CONDITIONS, LEADERSHIP ROLE AND WORK-LIFE BALANCE: THE DIFFICULTY IN MAINTAINING AN UNSTABLE EQUILIBRIUM

The following 3 slides demonstrate the relationship between workplace conditions, (mal)alignment with professional values as reflected by departmental leadership, and the overflow of work to home “thanks to” the technological capabilities of Electronic Medical Records. Regardless of Proficiency with EMR, burnout rate is 53-62% (Not clearly differentiate or trend by proficiency)

While these are also modifiable, they differ from the previous factors in that they often require external environmental modifications. While learning time management and improving efficiency may help, they likely will require a higher level intervention aimed at improving work conditions. This would include leadership style, and a reduction in the “intrusion” of the EMR into private life in the name of accessibility by appropriate policy, work environment culture change and the personal decision to finish charting at work. The latter resolution may mean trimming down documentation to essentials clinically, for billing and for medical-legal reasons.

WORK RELATED STRESSORS: THE HEAVY HAND OF REQUIREMENTS

When asked about the top work-related stressors, the top 10 winners reflect the requirements at the individual level (e.g., CMEs), hospital or departmental level (e.g., Quality metrics, pre-authorizations), and regulatory level (e.g., documentation requirements).

Of these Top 10 Work Stressors of NYS Docs, 80% are organizational/systemic. This list raises the need for local and state-wide advocacy and for a national awareness and action.

The percent of respondents who answered “Definite Barrier” to the question: “How important a barrier would it be for physicians to receive mental health care if they would have to report this on:
License Applications and Renewals……………....67%
Malpractice Carrier Applications and Renewals…..62%
Hospital Privileging Applications and Renewals …64%

SUMMARY AND CONCLUSIONS

In summary, 70% of New York physicians feel a great deal of stress because of their job and 57% are burned out. Half of them are not satisfied with their jobs
And only 58% would choose to be a physician if they could revisit their career choice. On average, 2/3 of doctors believe that having to report mental healthcare on license applications and renewals, malpractice carrier applications and renewals...
and hospital privileging applications and renewals would be a definite barrier to receiving mental health care. We must figure out a way to protect the public, while still promoting the mental health of those taking care of the public in currently highly stressful healthcare environment.

These numbers reflect the need to act, and to act with traction, and soon, before the implications of this epidemic affect the physicians and the patients any further. While research agendas have been proposed and they are laudable efforts for a better understanding and for a better “case”, there are many interventions that can be useful now in the fight against burnout, at the individual, organizational and national level. We will explore them in the next few articles. Stay tuned.

**REFERENCES**


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

Privitera, Michael Chair
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Bertin, Mark
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Skelly, Eunice
Bedient, Terrance
Burnout Reduction for the Individual Clinician

In May of 2016, the MSSNY created a Stress and Burnout Task Force. This Task Force was charged with formulating a strategy and plan of action to fight burnout and reduce stress among the constituents of the MSSNY. The following article is the third 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.

Many professions experience burnout from occupational stress, especially in healthcare. Specific sources of occupational stress differ by profession. Our focus in this article is on clinician burnout. Burnout is defined on several realms: 1) Exhaustion, physical and/or emotional, 2) Depersonalization/calculousness, which is a dysfunctional coping mechanism that distances you from patients and others, and 3) Lack of efficacy, which can be imagined or real, and as it progresses, it contributes to a loss of self-confidence and sense of purpose.

Occupational stress is defined as the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker. Job stress is a workplace hazard that can lead to poor health and even injury.

**MOST DEDICATED AT RISK**

It has been noted by researchers that those clinicians at greatest risk for burnout are those most dedicated and committed to their work, who may get consumed by their job, and have difficulties drawing healthy boundaries between work and home. Society would consider these individuals our "ideal doctors." However, in today's culture of medicine with overexpectations becoming an unsustainable norm (roll out of numerous compliance and quality initiatives), no central agency or office looks after the wellbeing of the individual clinician. Therefore, being able to recognize how occupational stress is affecting you as a clinician is critical for your wellbeing.

Numerous and complicated factors discourage clinician wellness. Some are internal and many are external (Figure 1). Caring for yourself was challenging enough in our old culture of medicine where we had more autonomy in decisions and intrinsic motivation was the driver of our workload. "Working hard" and choosing to stay late to take care of patients felt much different in the old culture than our current culture of medicine where it is considered an expectation from any clinician. Currently, major drivers of overwork are imposed extrinsically. Clinicians find themselves staying late at the interface and often, are not clinicians. The clinician who looks OK to his or her staff at the start of a procedure, then can't impairments in human function. A), and continue to progress to significant impairments in human function. Hyperstress helps peak our functionality. Distress is a state of abnormally low stress. Then boredom and restlessness occur. Eustress is a state of being energetic, inspired, or motivated and helps peak our functionality. Distress is a state of either acute intense severe stress, or chronic intense severe stress, and it begins to demonstrate breakdown in human functionality. Hyperstress occurs when this intense severe distress becomes chronic and actually starts to deplete coping mechanisms. At this point, small triggers may send you "over the edge" to mini breakdowns (see "Point A"), and continue to progress to significant impairments in human function. The clinician who looks OK to his or her staff at the start of a procedure, then with some stress "loses it", is likely living at this "Point A" and may not realize it. This is dangerous to the clinician and his patient.

The external healthcare environment still may drive unrealistic expectations due to administrative obligations or mandates, technology challenges, or other logistical intrusions that actually unintentionally interfere with our care of and relationship with the patient.

**RULES MADE BY NON-CLINICIANS**

Over 75% of physicians in the United States are now employed. Many decisions about compliance with the tsunami of regulations are made by people who are far removed from the clinician-patient interface and often, are not clinicians. Each law, regulation, or mandate may individually be well-meaning and sold as "quality-" or "safety-" related. Hence, enforcement can make sense to those whose job it is to do so. What is not included in the current calculations is the human effort required to achieve compliance when coming from disparate authorities in healthcare. The airlines industry has to report to one authoritative agency, the FAA (Federal Aviation Administration). Healthcare has to report numerous siloed authorities, each with their own set of regulations, laws, or mandates, without one authority that oversees it all. Full additive compliance is neither humanly possible to do, nor safe for clinicians or patients. More national awareness about this paradoxical backfire from over regulation has occurred.

**REWARD AND PUNISHMENT**

Rapid roll out of numerous federal, state, certification and industry initiatives tended to focus upon ‘carrot and stick’ methods of reward and punishment for desired behaviors in healthcare practice. Hence decision-makers concerned about the bottom line of the institution or practice naturally insist upon compliance to different agencies. More big-picture thinking healthcare administrators are picking up on this human factor gap. However, until your institution begins to recognize this fact, or even while they are in the process of addressing these human factor issues, this article is for your self-care.

Different forms of stress need to be differentiated (Figure 2). Hypostress is a state of abnormally low stress. Then boredom and restlessness occur. Eustress is a state of being energetic, inspired, or motivated and helps peak our functionality. Distress is a state of either acute intense severe stress, or chronic intense severe stress, and it begins to demonstrate breakdown in human functionality. Hyperstress occurs when this intense severe distress becomes chronic and actually starts to deplete coping mechanisms. At this point, small triggers may send you "over the edge" to mini breakdowns (see "Point A"), and continue to progress to significant impairments in human function. The clinician who looks OK to his or her staff at the start of a procedure, then with some stress "loses it", is likely living at this "Point A" and may not realize it. This is dangerous to the clinician and his patient.

**Figure 1. Strong Forces that Discourage Physician Self-Care in the Culture of Medicine Physician External and Internal Scripts**

- External world environment
  - Hidden curriculum in training
  - Medical Culture of Endurance and Silence

- Internal world:
  - Altruism, workaholism, perfectionism, obedience to authority.
  - These numerous regulations are impossible and aren’t good care
  - Ultimately, it is my fault if there is a bad outcome
  - I don’t want them to think I can’t handle this
  - Everybody else keeps showing up for work, is it just me?
  - I wonder if anyone else feels this way?
  - My family is depending upon me

- Everybody has to do it.
  - New regulations say this is ‘good care’, but they don’t see the unique situations of the patient in front of me
  - Group Think Bias. ‘Everyone’ is following these authorities.
  - Significant penalties if I don’t follow
  - You are a ‘professional’ and supposed to suppress how you feel (instead of acknowledging feelings but choosing behaviors).
  - You are lucky to be working/training here.
  - Don’t be ‘weak’. Don’t be a ‘fanatic’.

- Figure 2

- External world environment
  - ‘Hidden curriculum’ in training
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- Figure 2
We, individual clinicians, have the responsibility to take care of ourselves. Healthcare institutions are slowly coming to understand that the fourth aim (the experience of providing care) is critical to patient care and safety, to the health of individual practitioners and to the healthcare system as a whole. The fourth aim is essential to the success of the usual Triple Aim of reducing costs, improving quality of care and patient experience of receiving care.

**MEDICAL STUDENTS TOO**

Physicians start off more resilient than the general population. Two years into medical school this relative relationship reverses with more burnout and depression in medical students than in the general population of same age and education.

Yet the “hidden culture” in training programs dictates that clinicians maintain a ‘stiff upper lip.’ Therefore, it is imperative to recognize signs of stress and burnout in self and others (such as feeling drained, or easily frustrated with people, or becoming careless) as well as unhealthy strategies (like self-medicating with alcohol, drugs, or stress eating).

Hence, individual interventions must be paired with organizational interventions. Reduce the stress organizationally while working on individual interventions. In this paper, we will focus on individual interventions. Our subsequent article will focus on organizational interventions.

**INDIVIDUAL INTERVENTIONS**

The following have been accumulated from many sources, several of which are listed in websites or references below. In our experience, there is no one size that fits all. Clinicians need to determine which best fit their needs, their personality, and their time.

### I General steps

Many overall steps to promote personal well-being have been suggested:

1. **Identify personal and professional values and priorities.**
   - Consider ranking each group in order. This may help to determine where to focus when managing conflicts of time or other priorities.

2. **Enhance areas of work that are most meaningful.**
   - a. What is your ideal practice, the Blue-sky version?
   - b. How can you maximize the overlap between your current job and your blue-sky version?

3. **Identify and nurture personal wellness strategies of importance to you.**
   - a. Protect and nurture your relationships, and spirituality practices.
   - b. Respect basic human needs such as sleep, nutrition or exercise.
   - c. Develop hobbies and interests outside of medicine.

### II Resources from State and National Organizations:

1. **American Medical Association (AMA)**
   - The AMA has set up the resource website called STEPS Forward that helps with individual and organizational/practice methods that can reduce burnout. STEPS Forward™

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**Figure 2. Human Function Curve in Average Clinician**

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Adapted from N. POSIX. The Practitioner. (217):788-770, 1978

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Point A = even minimal arousal can precipitate breakdown
Other Personal Tools or Pearls

**Gratefulness/3 Good Things Journaling:**
Gratitude has been defined as a warmly or deeply appreciative attitude for kindnesses or benefits received. It may be helpful in reducing duress and reframing a personal situation. Check [this link](https://mssny.org) to a review article that explores gratitude at work further, and on this [YouTube link](https://www.youtube.com) to learn more about the Three Good Things Intervention at Duke University.

**The Happy MD:**
Dike Drummond, MD provides a rich resource of short helpful videos, book available, free personal discovery hour to set up your plan to address burnout. He has been a consultant to physicians for many years and has gone through burnout himself twice. He gives an individual and organizational model of reducing stress and improving recharge. Click [here](https://mssny.org).

**Yoga**

**Better nutrition**

**Sustainable amount of exercise:**
Start small and simple, frequent and fun

**Narrative medicine:**
To vent past traumas in training and practice

**Personal trainer/coach (fitness, communication, performance, lifestyle)**

**Honoring Self:**
You are the only one that can take care of yourself, and it is not only OK to do so, but necessary for being the best physician, colleague, spouse, friend, parent, you can be.

**Set a boundary ritual between work and home:**
As an example, listening to relaxing music or doing mindful breathing during the car ride home, or doing a Mr. Rogers routine (yeah, the sweater, the sneakers!)

**Bucket list activities:**
Write them down and start doing the list.

**Regular vacation:**
Don’t run yourself ragged before you decide to take off.

**Important relationships:**
Prioritize and invest adequate time to strengthen emotionally important relationships

**Advocacy or volunteerism for something that you are passionate about**

**Spirituality:**
Put work within the larger context. Try to get back in touch with the original reasons that motivated you along this road to become a clinician.

**Check your institution or community resources on stress reduction or wellness offerings**

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offers innovative strategies that will allow physicians and their staff to thrive in the new health care environment. It includes modules on physician burnout and resilience.

**2. Medical Society of the State of New York (MSSNY)**
The MSSNY Task Force for Physician Stress and Burnout has developed a resource library geared for individuals, those that help individuals, and those who are administrators hoping to improve the situation at their institution. Visit the [MSSNY Physician Burnout Library](https://mssny.org).

**III Peer Support Programs**
Peer support is the existence of positive psychosocial interactions with others with whom there is mutual experience, trust, concern and empathy. These relationships contribute to positive adjustment and may buffer against stressors and adversities. Peers, because they have undergone and survived relevant experiences, are credible supports for others. Interactions with peers who are successfully coping with similar situations are more likely to result in the development of resilience. MSSNY Burnout Task Force is currently working on ways to help make this means of support more available in our state.

Becoming burned out can be an isolating experience. Social support and community can mitigate stressors that contribute to burnout. Consider community building activities such as meet and greets, journal clubs, book clubs, etc.

**IV Institution-based efforts to help individuals.**
Some institutions are offering a series of wellness seminars that would qualify for CME and if attend enough seminars would qualify for malpractice reduction.

Wellness seminars, when offered at an institution, can be a safe place to start to address self-care. Volunteer faculty may not be experts in certain areas but may be able to have an interest to learn more and be able to teach others on various topics for seminars and be the new local expert. The discussions that come from the assembly around the topic itself can be therapeutic and the beginning of a safe space to begin to deconstruct the culture of endurance and silence. Many suggestions can begin to give form to organizational interventions that need to be done. These seminars became an invaluable intervention by creating a safe space to open up the topic of occupational stress and the toll that it takes. Even the process of advertising the seminars is a powerful supportive intervention by means of their stress-validating topic titles promoted from a ‘mainstream’ institution-based entity like a Faculty Development Office. Examples of seminar titles: Overview of Burnout: Causes, Mechanisms and Reduction; Put Your Oxygen On First as You Take Care of Others; The Emotional Life of the Clinician; Finding Meaning in Medicine and Healthy Approaches to Clinician Stress.

**V Mindfulness Based Stress Reduction (MBSR)**
MBSR training can occur in person, if arrangeable in your schedule, or some are online. Here are some resources:
1. [URMC Mindful Practice](https://www.urmc.rochester.edu/mindful-practice)
2. [Ohio State University Center for Integrative Health and Wellness](https://wellness.osu.edu) (online)
3. [Mindful.org](https://www.mindful.org) (online)

**VI Web-based Cognitive Behavioral Therapy**
For busy practitioners or those in training who find it difficult to make it to outside appointments, a web-based program of Cognitive Behavioral Therapy was studied in interns to help reduce depression and suicidal ideation. Click [here](https://www.mindful.org).

**VII Time Management**
Example of time management would be:

1. E-mail grouping in batches during the day (e.g.11:30 and 4:30 PM). This reduces the unnecessary expenditure of your brain’s neural resource that gets used up, just in the process of starting and stopping one activity, recovery after interruptions, etc.

2. Documentation in charts: rethink how much you need to document. Write smart, not write long. The EMR templates promotes obsessiveness and over-documentation. Use the clock to limit the time you will spend on each note.

3. Schedule the things you are going to do outside of work. Get them on your calendar that you can see at work.

Consult [this link](https://mssny.org) for further information on time management.
VIII Learning ways of dealing with upset patients and upsetting situations

See if local mental health colleagues can pull together a seminar on de-escalation, dealing with angry, demanding patients and families. These skills are not taught in medical school yet are dealt with on an almost daily basis. It does not help to talk over them, recite rules, etc. Learn when listening, understanding words and empathy can help, and when situations go beyond empathy and words no longer can help, and you have to think of your own well-being. People can also advocate for discussion programs within their own institutions such as psychological first aid, multi-perspective programs like Schwartz Center Rounds.

IX Employee Assistance Program (EAP) or private therapist, psychotherapy and/or medication

Psychotherapy and or medication can be life-saving when burnout gets to the level of depression and having someone else to help you find strategies to take back the life and self-care needed to sustain the practice of medicine.

CONCLUSION

No matter what method(s) you choose that best appeal to you, try to follow through. Persistence in the resolve to take better care of yourself in this very chaotic healthcare work environment is the first step. Just keep moving in a better direction, no matter how slow the progress. It is not part of our DNA to take care of ourselves, so this requires practice until our work environment starts catching on to how important this is, and just maybe the environment will become less stressful. As we tell our patient, you need to care for yourself to be able to care for another. Self-care requires practice and maintenance.

Stay tuned for the next MSSNY article which will focus upon organizational/Systemic interventions to reduce clinician burnout.

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The following Q&As – prepared by Terrance Bedient, FACHE, Vice President/Director of Committee for Physician Health of MSSNY—relate to attending physicians, residents, medical students and physician assistants in New York State:

Q1. Does it affect my license to have seen a mental health provider?

A1. No. When an attending physician, resident, medical student or physician assistant (physician) is applying for initial licensure or biennial re-registration, the forms include NO question about having been seen by a mental health provider. Further, any information learned by a physician while providing treatment to another physician is considered absolutely confidential. NYS Public Health Law §230-11e.

Q2. Does it affect my malpractice to have seen a mental health provider?

A2. Applications to the state’s major medical malpractice carriers typically do not query if an applicant has seen a mental health professional. CPH’s experience with all the medical malpractice carriers have been very physician-friendly.

Q3. Do I need to declare this on my license renewal application?

A3. No. When a physician applies for biennial re-registration, the forms include NO question about having been seen by a mental health provider.

Q4. Does it make a difference for any of the above, whether I see a Lifestyle professional (EAP) compared to a Disease management specialist (Behavioral Health Partners, private therapist, or psychiatrist, etc.).

A4. No. The confidentiality provisions apply equally to employee assistance, Behavioral Health Partners, private therapist or psychiatrist.

Q5. Does it make a difference as to whether I had psychotherapy or whether medications were needed?

A5. The confidentiality of treatment remains for all diagnoses and treatments.

Q6. Can it be considered misconduct by having the diagnosis of a mental disorder, even though it is stable?

A6. It is misconduct to be maintained on an approved therapeutic regimen that does not impair the ability to practice. NYS Education Law §6530-8. It would be misconduct if practicing the profession while impaired by alcohol, drugs, physical or mental disability. NYS Education Law §6530-7.

REFERENCES


### 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](image1.png)

<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.
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. 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.”

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 for emotional and cognitive rejuvenation. Regardless of the cost or complexity of the intervention, it should be targeted and well-implemented.

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**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>
FIFTH: SUPPORT AND DEVELOP YOUR LEADERS

Strong leadership is undoubtedly one of the essential elements of reducing burnout in the workplace\(^\text{10}\). 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\(^\text{10}\), 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.”\(^\text{11}\).

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

Linzer and associates\(^\text{12}\) 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.\(^\text{13}\) 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.\(^\text{14}\)

More recently, Shanafelt and associates\(^\text{15}\) 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 considering 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 fac-
tors 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 (18). 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 (10). 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.

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