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/callousness, 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.

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

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 due to administrative obligations or mandates, technology challenges, or other logistical intrusions that actually unintendedly 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.

The external healthcare environment

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still may drive unrealistic expectations (see "fantasy" endpoint). 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.

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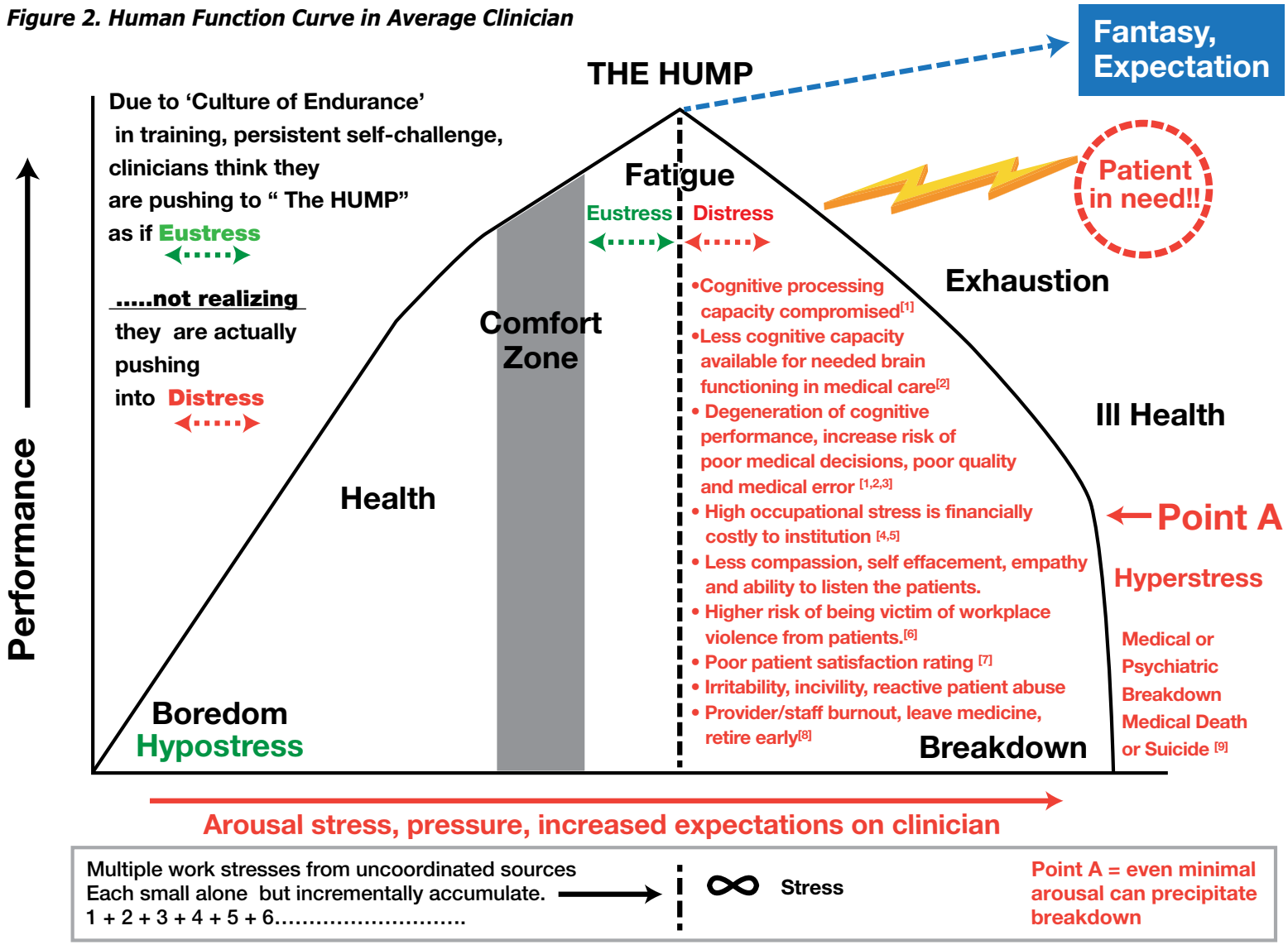
Figure 2. Human Function Curve in Average Clinician



Adapted from: Nixon PGF. The Practitioner. (217):765-770. 1976

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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 to a review article that explores gratitude at work further, and on this YouTube link 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.

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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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™ 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.

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**
2. **Ohio State University Center for Integrative Health and Wellness** (online)
3. **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.

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: re-think

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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 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 not 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

1. National Institute of Occupational Safety and Health (NIOSH): https://www.cdc.gov/niosh/docs/99-101/pdfs/99-101.pdf. Last accessed 09/14/2017.
2. Scudder L, Shanafelt T. Two sides to the physician coin: Burnout and Wellbeing. Medscape. February 09, 2015. Last accessed 09/14/2017.
3. Kabat-Zinn J. Full Catastrophe Living (Revised Edition) Bantam Books, New York. 2013.
4. Balch CM, Copeland E. Stress and burnout among surgical oncologists: a call for personal wellness and a supportive workplace environment. Ann Surg Oncol. 2007 Nov;14(11):3029-32
5. Hammond, K. R. Judgments under stress. Oxford University Press, New York. 2000.
6. Paas F, Renkl A, Sweller J. Cognitive Load Theory: instructional implications of the interaction between information structures and cognitive architecture. Instructional Science 2004;32:1–8,
7. Collie D. Workplace Stress: Expensive Stuff. http://www.emaxhealth.com/38/473.html (July 7, 2004). Last accessed 09/14/2017.
8. Cotton P, Hart PM. Occupational wellbeing and performance: a review of organisational health research. Australian Psychologist 2003;38(2):118-127.
9. Design Council. Reducing violence and aggression in A & E through a better experience http://www.designcouncil.org.uk/Documents/Documents/OurWork/AandE/ReducingViolenceAndAggressionInAandE.pdf. Last accessed 09/14/2017.
10. Tubbs SL, Husby B, Jensen L. Ten common misconceptions about implementing continuous improvement efforts in health care organizations. The Business Review, Cambridge (JAABC). Summer 2011;17(2):21-27.
11. Arnetz JE, Arnetz BB. Violence towards health care staff and possible effects on the quality of patient care. Soc Sci Med. 2001 Feb;52(3):417-27.
12. Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, West CP, Sloan J, Oreskovich MR. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med. 2012 Oct 8;172(18):1377-85.
13. Gold KJ, Sen A, Schwenk TL. Details on suicide among US physicians: data from the National Violent Death Reporting System. Gen Hosp Psychiatry. 2013Jan-Feb;35(1):45-9.
14. Gazelle G, Liebschutz JM, Riess H. Physician burnout: coaching a way out. J Gen Intern Med. 2015 Apr;30(4):508-13.