MAYO CLINIC

Interventions to Reduce Physician Burnout and Promote Physician Well-Being

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Disclosure

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One of the mysteries of illness is that no one can be healed by anyone whose emptiness is greater than their own.

- Mark Nepo

Objectives

- **At the end of this talk, participants should be able to:**
  - Demonstrate knowledge of the scope of current literature on physician well-being interventions.
  - Recognize how this literature informs approaches to physician well-being moving forward.
  - Summarize general approaches to protect and promote physician well-being.

But first, a detour … Breaking News!

- A new illness runs rampant in our communities!
- Affects 54% of certain parts of the population, a risk 2x that of the rest of the population!
  - >400,000 people
  - Prevalence comparable to that of lung cancer
- Affects students and our most highly educated and trained individuals!

But first, a detour … Breaking News!

- Among those affected:
  - More professional errors, impaired professionalism, reduced client satisfaction, increased job turnover and reduced hours, higher rates of depression and suicidal ideation, more motor vehicle crashes and near-misses, lower standardized test scores, etc.
  - The group affected most is also more likely to complete suicides when affected.

What is this epidemic?

- An infectious disease?
  - Get the CDC involved ASAP!
  - Figure out the triggers and transmission patterns!
  - Develop effective prevention and treatment options!
- A chronic cardiovascular condition?
  - Rally the Surgeon General and the AMA!
  - Educate the public to prevent this problem!
  - Establish public health programs for support!
- A zombie apocalypse?

What is this epidemic?

BURNOUT

Brief Recap of Epidemiology

- Medical students matriculate with BETTER well-being than their age-group peers
- Early in medical school, this reverses
- Poor well-being persists through medical school and residency into practice:
  - National physician burnout rate exceeds 54%
  - Affects all specialties, perhaps worst in “front line” areas of medicine

Physician Distress: Key Drivers

- Excessive workload
- Inefficient work environment, inadequate support
- Problems with work-life integration and balance
- Loss autonomy/flexibility/control
- Loss of meaning in work

Recommendations in the Literature

Choices with regard to work-life balance

- Manage work-home conflicts

Stress management techniques

Spiritual nurturing

Positive life philosophy

Self-care (exercise, health, recognition of place on the "stress curve": reflection, mindfulness)

Strive for meaning in work

Almost all approach as individual responsibility.

Organizational Solutions

- Culture (is well-being valued?)
  - Formal policies on well-being for learners and faculty
    - Promote positive core values
    - Minimize work-home interference
- Curricula (is well-being taught?)
  - Training in stress management, well-being, recognition of distress

Organizational Solutions

Recognition of distress:

- Medical Student Well-Being Index (Dyrbye 2010, 2011)
- Physician Well-Being Index (Dyrbye 2013, 2014)
  - Simple online 7-item instruments evaluating multiple dimensions of distress, with strong validity evidence and national benchmarks from large samples of medical students, residents, and practicing physicians
  - Evidence that physicians do not reliably self-assess their own distress
  - Feedback from self-reported Index responses can prompt intention to respond to distress
- Suicide Prevention and Depression Awareness Program (Moutier 2012)
  - Anonymous confidential Web-based screening
- AMA STEPS Forward modules
  - Mini Z instrument (AMA, Linzer 2015): 10-item survey

Organizational Solutions

Practice/education environment (is well-being supported?)

- Workload, patient types, autonomy
  - “A physician only does what only a physician can do”
- Role models: support student/resident/faculty wellbeing
- Promote self-care

The Evidence

- Studies of interventions to reduce distress and promote well-being limited by:
  - Small samples
  - Uncontrolled studies
  - Focus on personal rather than shared responsibility with organization
  - Most interventions on personal time
  - Limited and poorly validated outcomes

The Evidence

- Prior systematic review results:
  - Fletcher 2011: Duty Hour Requirements (DHR) a/w modest reduction in EE among residents
  - Jamal 2011: DHR a/w improved QOL, perhaps reduced burnout among surgical residents
  - Ruotsalainen 2014: Interventions for physician occupational stress generally offer small degree of benefit, but evidence is limited and weak

The Evidence

- Systematic review on interventions for physician burnout, commissioned by Arnold P. Gold Foundation Research Institute (West 2015):
  - 15 RCT's, 36 non-RCT's
    - Results similar for RCT and non-RCT studies
  - 24 studies of residents (7 RCT's totaling 308 participants)
  - 19 studies of organizational/structural interventions (3 RCT's, only 1 in residents with total n=41)
    - 10 of Duty Hour Requirements (0 RCT's, 1 study of 2011 DHR's)

The Evidence

- Emotional exhaustion (EE):
  - -2.9 points, $p<0.001$
  - Rate of High EE: -14%, $p<0.001$
- Depersonalization (DP):
  - -0.7 points, $p=0.008$
  - Rate of High DP: -15% for staff, -3% for residents ($p=0.01$)
- All benefits more pronounced for staff than residents
- Benefits similar for individual-focused and structural interventions
  - DHR effects slightly less but consistent with overall results

The Evidence

- Individual-focused interventions:
  - Meditation techniques
  - Stress management training, including MBSR
  - Communication skills training
  - Self-care workshops, exercise program
  - Small group curricula, Balint groups
    - Community, connectedness, meaning

The Evidence

- Structural interventions:
  - DHR's
  - Shorter attending rotations
    - ?effect of alternate resident schedules
  - Shorter resident shifts in ICU
  - Locally-developed practice interventions

Physician Well-Being: Approach Summary

	Individual	Organizational
Workload	Part-time status	Productivity targets Duty Hour Requirements Integrated career development
Work Efficiency/ Support	Efficiency/Skills Training	EMR (+/-?) Staff support
Work-Life Integration/ Balance	Self-care Mindfulness	Meeting schedules Off-hours clinics Curricula during work hours Financial support/counseling
Autonomy/ Flexibility/ Control	Stress management/Resiliency Mindfulness Engagement	Physician engagement
Meaning	Positive psychology Reflection/self-awareness Mindfulness Small group approaches	Core values Protect time with patients Promote community Work/learning climate

Recommendations

- We have a professional obligation to act.
  - Physician distress is a threat to our profession
  - It is unprofessional to allow this to continue
    - Evolve definition of professionalism? (West 2007)
  - SHARED RESPONSIBILITY
- We must assess distress
  - Metric of training program/institutional performance
    - Part of the “dashboard”
  - Can be both anonymous/confidential and actionable

Recommendations

- We need more and better studies to guide best practices:
  - RCT's
  - Valid metrics
  - Multi-site
  - Individual-focused AND structural/organizational approaches
  - Evaluate novel factors: work intensity/compression, clinical block models, etc.
- Develop interventions targeted to address Five Drivers.

Recommendations

- The toolkit for these issues will contain many different tools.
- There is no one solution …
- … but many approaches offer benefit!

Thank You!

- Comments/questions

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