Interventions to Reduce Physician Burnout and Promote Physician Well-Being

November 17, 2015

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Disclosure

• No conflicts of interest to report.
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
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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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