

***Physician Burnout:  
The Root of the Problem  
and the Path to Solutions***

A collection of original content  
from NEJM Catalyst



# NEJM Catalyst

November 2018


Dear Colleague,

Physician burnout is a growing problem with no easy solutions. Two-thirds of NEJM Catalyst Insights Council members — comprising clinicians, clinical leaders, and health care executives — say that more than a quarter of the physicians they know are burned out, and 96% of Council members agree that burnout has become a serious issue for health care today.

In this collection of original articles, conversations, and data previously published by NEJM Catalyst, we feature some of the nation's leading experts on physician burnout, as well as frontline clinicians, leaders, and residents, and members of the Insights Council.

We hope that this collection from NEJM Catalyst inspires you to find ways to address physician burnout productively, both in your own organizations and your own lives. Solutions are urgently needed.

The Editors,  
NEJM Catalyst



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The Root of the Problem  
and the Path to Solutions**

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# A Look in the Mirror: The Role of Medical Training in Physician Burnout

Article · January 9, 2018

Rich Joseph, MD, MBA

Brigham and Women's Hospital

I am now one and a half years in, about halfway through my postgraduate medical training. Admittedly, at times I wonder if I should soldier forth. I question my path not because I dislike patient care or relish self-pity. But any rational actor in today's medical industrial complex wonders, at times, whether the labor is sensible and the effort sustainable.

*What began as a proactive request for help soon morphed into feelings of guilt and shame for shirking my responsibility to prioritize patient care. I began to confuse preventive self-care for neglectful patient care, to mistake self-awareness for self-indulgence, and to suspect rest as a sign of weakness. I felt alone.”*

In fact, since graduating from medical school nearly 2 years ago, my five best friends have all elected to forgo further clinical training. Today's trainees have exposure to alternate career paths in tech, consulting, and policy. Contrast this with the bureaucratic, burdensome, and burned-out world of clinical practice, and this “MD drop out” trend makes sense. A recent article described the rise of online communities of dissatisfied and disaffected doctors, such as Drop Out Club and Physicians Nonclinical Career Hunters, looking to change careers. This is alarming, given an impending shortage of physicians in the United States.

Leaders of medical education and provider systems agree that this nationwide phenomenon of physician burnout is adversely impacting our already troubled health care system.

Many physician leaders blame bureaucrats and administrators for saddling us with more paperwork. Bob Wachter argues that endless quantification and comparison of the measurable aspects of care delivery are eroding physician autonomy and compromising the art of medicine. Abraham Verghese bemoans the time we spend treating the “iPatient” in the EMR at the expense of the real patient in the hospital bed. A group of leading hospital CEOs contend that “the spike in reported burnout is directly attributable

to loss of control over work, increased performance measurement (quality, cost, and patient experience), the increasing complexity of medical care, the implementation of electronic health records, and profound inefficiencies in the practice environment, all of which have altered work flows and patient interactions.”

These trends undoubtedly contribute to physician burnout. Yet the common thread here is pointing the finger outward — at administrators, policymakers, and “the system” — before examining our own complicity. As I navigate through training, it has become glaringly evident to me that the way we train primes us for burnout.

*As I navigate through training, it has become glaringly evident to me that the way we train primes us for burnout.”*

The literature cites six key ingredients of burnout: high job demands in conjunction with a lack of control; disconnect between individual values and that of the organization or system; insufficient rewards such that one feels taken for granted, undervalued, and/or undercompensated; work overload; unfairness; and breakdown of community. Medical training provides the perfect recipe. As soon as we enter the hospital, the floodgates open with minimal relief. Our ability

to advocate for patients’ safety is limited by our own emotional exhaustion and separation from administrators who set the institutional policies. We strive to serve patients, yet we spend most of our days cranking the hospital’s billing machinery.

Now saddled with debt from medical school, we are paid barely above minimum wage with limited flexibility to tend to other life responsibilities. Too much work, too few resources, too urgent: check, check, and check. And even though we are surrounded by our colleagues, a strong sense of community is diluted by ever changing schedules, rotating teams, night shifts, and hours lost in the vortex of Hyperspace.

This “system” we blame for physician burnout is in part a product of the system by which we train doctors. But because patient care is top priority, there is an unspoken tendency to consider changes to the work environment and training process as less important — even when these changes would clearly benefit patient care.

I am grateful to be a part of a supportive training program with leadership committed to helping me thrive. That said, internal research conducted by a colleague shows that nearly half of residents in our program experience burnout — no different than the national average. Recently, during my own bout of burnout, I sounded the alarm and asked for an extra day off (meaning my first 2-day weekend in nearly 3 months). Thankfully, my plea was granted. Yet the whole episode transpired behind closed doors to secure the necessary coverage and maintain parity in the program.



*“Because patient care is top priority, there is an unspoken tendency to consider changes to the work environment and training process as less important — even when these changes would clearly benefit patient care.”*

What could have been a catalyst to spark an open, program-wide conversation was confined to a covert operation. So instead, the conversation spiraled in my head. And what began as a proactive request for help soon morphed into feelings of guilt and shame for shirking my responsibility to prioritize patient care. I began to confuse preventive self-care for neglectful patient care, to mistake self-awareness for self-indulgence, and to suspect rest as a sign of weakness. I felt alone.

It is no wonder trainees often feel isolated, fearful of failure, and chained by perfectionism. Such an environment does not welcome questioning or self-doubt. It becomes easier to shut up, to accept the inevitable, and to internalize powerlessness in the system, rather than challenge the norms. When we repeatedly feel a loss of control in a situation, it is human nature to act in a powerless manner and overlook opportunities for relief and change. This so-called “learned helplessness” is strongly correlated with depression and is highly prevalent in hierarchical systems. Most disturbingly, learned helplessness is a self-fulfilling prophecy.

*“Such an environment does not welcome questioning or self-doubt. It becomes easier to shut up, to accept the inevitable, and to internalize powerlessness in the system, rather than challenge the norms.”*

Based on conversations that I have had with many colleagues, I am certain that many more would abandon clinical training if not hindered by learned helplessness, debt, or the expectations of mentors and family. Perhaps in days of old, the medical training process was indeed a rite of passage justified by the shining promise of professional independence and authority. However, learned helplessness, once limited to the rigorous years of residency, now spans the entire career of many clinicians. Effectively, the medical training system conditions us to a lack of agency, which now underlies many practicing physicians’ feelings of professional dissatisfaction and burnout.

Since we are complicit in creating this problem, we must be part of the solution.

How do we take an active role in unlearning learned helplessness? Start with the institutionalized norms that are contributing to trainee burnout. All residents should have representatives who have real negotiating power with hospital leadership, to protect our own well-being and to champion patient safety, both of which suffer when pitted against the pressure to rapidly turn hospital beds. (I am encouraged by the formation of the Brigham and Women’s Housestaff Council to cohere a collective resident voice across all training programs.) All residents should have the opportunity to innovate and drive change from within our own hospitals and clinics and out into the communities we serve.

To create an effective and equitable health care system, we need physicians who are not only patient advocates, but also social activists. To develop this skillset, residents should be offered formal training in effective communication and leadership of multidisciplinary teams. I am grateful that my co-residents are willing to use any spare time and even defer higher incomes for additional years to pursue management degrees, build advocacy campaigns, and spearhead quality improvement initiatives. Most important, all residents should have protected space and time to engage with the art of medicine by sitting alongside patients, rather than isolated behind a computer screen. I am relieved that even though we are often unable to realize this ideal, the desire persists among many.



*The key to looking inward, to strengthening our profession and institutions to better engage with the challenges around us, lies with residents, the link between what medicine is and what medicine can be.”*

The economics of health care and the traditions of medical training have made residents — this next generation of physicians who we desperately need to be leaders of health care reform — a standardized workforce shackled by tradition and dulled by inertia. A fellow intern said it best: “The key to looking inward, to strengthening our profession and institutions to better engage with the challenges around us, lies with residents, the link between what medicine is and what medicine can be.” Sadly, this friend is one of the five who left clinical training, each of whom would have been compassionate and competent clinicians. I feel sorrow

for all the patients who could have benefitted from their care. And I feel frustrated for my profession, which could have rediscovered more joy, fulfillment, and solidarity under their leadership. Yet here I am, halfway through and stubbornly hopeful because beneath frustration lies the raw energy to activate change.

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### **Rich Joseph, MD, MBA**

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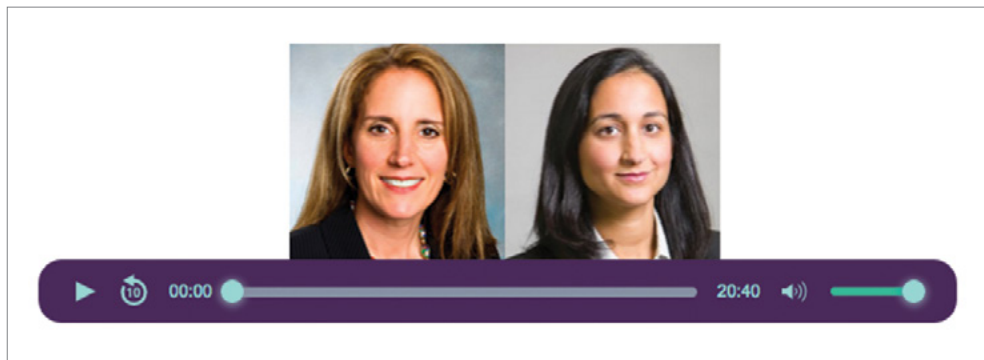


# Professional Fulfillment: Where We Want to Be


Interview · November 7, 2017

Jessica C. Dudley, MD & Namita Seth Mohta, MD

Brigham and Women's Hospital, NEJM Catalyst



*Namita Seth Mohta, MD, interviews Jessica Dudley, MD, Chief Medical Officer for Brigham and Women's Physicians Organization.*


 [Listen to audio interview.](#)

**Namita Seth Mohta:** This is Namita Seth Mohta for NEJM Catalyst. I'm speaking today with Dr. Jessica Dudley, Chief Medical Officer for the Brigham and Women's Physicians Organization, and Vice President for Care Redesign at Brigham and Women's HealthCare. Dr. Dudley has deep expertise and extensive experience leading teams to improve patient outcomes while also addressing the needs of providers.

Today we will be discussing the creative and innovative work Jessica is leading at the Brigham to realize three critically important objectives: addressing burnout, fostering innovation, and training physician leaders. Let's start, Jessica, with these three goals. How are they interdependent? Can we realize one without the others?



**Jessica Dudley:** First, thank you for having me. I'm excited to be participating in your program. To answer your question, I would say they are intricately interrelated. To be precise, yes, you could have one without the others, but in order to have what I think is the complete package we really need to have all three of them. The overarching umbrella under which all of the three fit is engaging physicians in leading the changes that we need in health care, and that's how they all fit together for me.



*If we rely on our physicians to be those closest to the patients, to understand where the opportunities are, to identify where we can improve outcomes, and also to try to help manage the challenges in rising costs in this country, ensuring that we are training our leaders, fostering innovation, and addressing challenges that they're facing is critical for us to achieve these goals."*


If we rely on our physicians to be those closest to the patients, to understand where the opportunities are, to identify where we can improve outcomes, and also to try to help manage the challenges in rising costs in this country, ensuring that we are training our leaders, fostering innovation, and addressing challenges that they're facing — one of which right now is burnout — these are critical for us to achieve these goals.

**Mohta:** When you talk about engaging physicians as the overarching theme and these three subgoals, if you will, being the tactics to realize that, what are some of the activities that you're leading at the Brigham to support these?

**Dudley:** A number of years ago, we recognized that while we have incredibly talented physicians as clinicians, researchers, and professors and teachers, they were not receiving as robust skill training in leadership as the changing health care

landscape was demanding, and it was a real opportunity for us to think about how could we better equip our physicians with the leadership skills that are being demanded by the rapidly changing environment. That has led us to make some pretty significant investments in identifying what skills our physicians need to develop their leadership, and then how to provide them with the opportunities to develop those skills.

We have developed, over the years, a number of what I would call formal leadership training programs, where we have docs who are interested in developing their leadership, or their department chairs are interested in having them develop as leaders, and they will apply for and in some cases be accepted (and others not) for a leadership development program. We have developed one that we've been running now for 10 years with Harvard Business School that we call our [Brigham Leadership Program](#). That's a general overarching leadership program. Then we have a number of additional programs, one for process improvement leadership, one for women's leadership. We even have a faculty mentoring leadership program, and then some additional, very targeted programs to develop specific skills like organizational change management.



*A number of years ago, we recognized that while we have incredibly talented physicians as clinicians, researchers, and professors and teachers, they were not receiving as robust skill training in leadership as the changing health care landscape was demanding.”*

We offer these formal training programs. Many of them are longitudinal, occurring over an extended period of time; a number of them involve a real hands-on project to advance the learning; and all of them have a component of a peer-engagement effort that ends up being of high value to them as they advance in their careers. So that’s a formal set of training programs that we have made investments in and offered.

In addition to those, we have what we call our Frontline Innovation Program. This was in response to recognizing that we had many physicians who had brilliant ideas on where we could redesign or innovate the clinical care we were delivering, but they were not able to frame them in a way that our administrators could embrace or access to then determine

whether or not they were worthy of making a real investment.

So we put a framework and a structure in place so that we can solicit ideas from our physicians — they are on the frontlines identifying where the opportunities are to make care better and improve efficiency — and then put them in a framework so that they can be managed more efficiently over time, and so that we can also require their reporting of a return on investment, and then measure their impact and determine whether or not to sustain them over time. We call that program BCRISP, which is our [Brigham Care Redesign Incubator and Startup Program](#), and we’ve been running that now for over 5 years.

Those are two different programs that we’ve put in place to put a framework around developing physicians as leaders and enabling them to help our institutional and physician organization leadership better identify those opportunities that could be ultimately integrated into operations, and we can leverage the expertise of our jobs to better transform how we’re delivering care overall.

**Mohta:** Jessica, the BCRISP program sounds fantastic and makes conceptual sense. Can you share an example of one of the earlier projects where the doc went through this process and then ultimately there was an idea that demonstrated enough of an ROI that then was integrated into operations?

**Dudley:** Sure. We had a couple of our intensivists in our medical Intensive Care Unit recognizing that there were a cohort of chronically critically ill patients who would get cared for very actively in our Intensive Care Unit, and then ultimately would be discharged to a longer-term acute care facility, never actually being discharged to home, and then that same cohort was getting readmitted at quite a high rate. They took a step back to try think about what could they do to better support the care for these patients, and that was a BCRISP that

was submitted, addressing the needs of this chronically critically ill cohort of patients, and their solution was to engage a much more robust team around the support of these patients that included a social worker, that included palliative care and goals of care discussions and resources, and then a much tighter relationship, much of which was virtual using technology, with the long-term acute care facility, so that when patients were discharged the receiving facility would know that there was a backup available at our hospital, so that if the patient started having challenges or was not doing as well as anticipated, they could easily reach out to a team here that knew the patient on a 24/7 type basis.

*“We put a framework and a structure in place so that we can solicit ideas from our physicians . . . and then put them in a framework so that they can be managed more efficiently over time, and so that we can also require their reporting of a return on investment, and then measure their impact and determine whether or not to sustain them over time.”*

It enabled that facility to be willing to accept those patients even earlier than they might have otherwise, knowing that this backup and this connectivity was there. It was certainly better for the patients and their families, who felt like they were being now managed in a much more cohesive way than previously, and then there was also value to the institution where patients could be cared for at the best and most appropriate site of care given the needs that they had at the time.

That’s an example of one of these programs that brought together resources from our institution and resources from an outside institution to package care better around a patient population that the system was previously failing.

We have other examples where the team recognized that there was another cohort of patients who again were falling through the cracks. These were patients who had abnormalities found on a chest X-ray or early on in an exam, and then they were getting lost to follow-up, and we recognized that these patients needed more close minding and much more rapid access to be evaluated for these findings.

Our pulmonary surgeons, our thoracic surgeons, our pulmonologists helped put together a specific program to better support these patients who had an early detection of a finding to ensure that they wouldn’t be lost to follow-up and that they could get shepherded through the process in a much more efficient fashion.

**Mohta: Taking it back up a level to these initiatives overall, some of the training leadership programs that you talked about, the BCRISP-specific program, what has been the impact to date in terms of any objective or subjective data that you’ve collected? I know I can speak for myself from a subjective standpoint as someone who’s an alum of the ELP program**

**that it was quite influential, and it really has given me a skill set and a network that I've leveraged heavily over the years. But I would be interested, as I'm sure our listeners would, about some of the metrics that you tracked to demonstrate the impact.**

**Dudley:** I wish that I had more current metrics on this. When we developed the program, we knew that the goal of the program was to do two things: develop our leaders and ideally have them develop and help advance work within our own institutions. But similarly, we had an objective that we would be developing leaders and enabling them to advance. And that would mean leading the institution and then moving to a higher-level position outside of the institution.

I don't have current data on that. Initially, we were successful in both of those. We were successful in growing our leaders internally — folks who were taking the course were then advancing locally within our institutions. And then we had quite a large cohort of leaders who were evolving, moving out onto more senior roles outside of the institutions. I have not tracked that more recently, so I don't have that data.

**Mohta:** **It sounds like there is enough momentum now around these programs, as evidenced by the number of applications that you get exceeding the number of docs you have, to suggest that it is definitely filling a need of the Brigham health care providers.**

**You also mentioned burnout earlier. We've talked about training physician leaders, we've talked about fostering innovation, and then the other area that you mentioned that's set into this overall theme of engaging physicians is around addressing burnout. Is your organization specifically addressing burnout, which we know is a very pervasive issue, or is it bundled into the fostering innovation piece and the training piece that you've mentioned?**

**Dudley:** It's actually an independent effort. It's something that we came to independent of those other two programs that we were just talking through. It's not unique to the Brigham. Physician burnout has become a very popular topic nationally, and in some cases globally, for a variety of reasons, but certainly at the national level there's been a rise even over the past few years, with one of the largest studies showing up to 54% of physicians reporting burnout. So we knew this wasn't a problem just for our own institution, it was something that has been [known] nationally.

I will say, locally here, after transitioning to a new electronic medical record and having some other more locally-based, state-based environment challenges with increased pressure on our physicians and our institutions as we shift into alternative types of care payment models, there certainly seem to be a rise in folks, a sense that our physicians are experiencing burnout — and that ultimately led us to complete a survey.

*We're a bigger institution, so in some instances we have the luxury of having a bigger platform with probably initially larger amounts of resources. I do think a lot of the efforts that we're putting in place can be done even in smaller institutions."*

We selected a survey that Stanford had designed, not because it just measures burnout but because it measures both burnout and professional fulfillment, and we were very focused not just on identifying that our docs were burned out — we know that's a national problem — we were looking for solutions to get us to where we want to be, which is professional fulfillment. And the survey they had designed enabled us to look at both burnout as well as professional fulfillment and not just quantify it but give us a little bit of a magnifying glass as to where to focus.

We surveyed our docs earlier this year. We had a terrific response rate, and that was largely driven by our hospital and physician leadership making it clear that this is a priority and something that they wanted to support. We had a 64% response rate on our survey — this is more than double what our normal survey response rate is — and we have begun looking at the data at an institution-wide level. We know that our burnout rate is around where we had expected. It's lower than the national average that I cited for you; although our tool is different than the one used in the national survey, it's validated against that survey. And then our professional fulfillment rates were not as high as we would like them to be. So we have opportunity both in reducing burnout and in improving professional fulfillment.

**Mohta:** And I have no doubt that you all will be aggressive in making sure to address those concerns.

**When you look back at the beginning years of these leadership programs, when you look back at the beginning years of the innovation programs, BCRISP for example, what were some of the biggest barriers to implementing these programs, and how did you overcome them? The reason I ask this is to help some organizations across the country and internationally who are interested in doing this anticipate some of the challenges as they grow their own innovation platforms and their own leadership platforms within their organizations.**

**Dudley:** It's a great question. We're a bigger institution, so in some instances we have the luxury of having a bigger platform with probably initially larger amounts of resources. I do think a lot of the efforts that we're putting in place can be done even in smaller institutions.

Part of the way I would think about prioritizing it would be first being very intentional about it. Intentionally acknowledging that some type of formal training is helpful, and that can certainly be done locally. Tapping into resources that are available — we connect with others even in our local market who have experience with what people call adult learning



or executive learning, — leveraging the skills to better communicate to adult learners, using group-based methods, case-based methods. These have all helped us to help transfer skill knowledge to our participants. Being intentional about designing programs where folks can access the learning in efficient ways is really important.

*“Now that we’ve been so focused on addressing the burnout and professional fulfillment issues, the role and importance of peer groups and peer programming I think is even that much more important.”*

All of our programs end up having a peer-cohorting component to them. I think that’s really helpful, and I’ll say now that we’ve been so focused on addressing the burnout and professional fulfillment issues, the role and importance of peer groups and peer programming I think is even that much more important. I would be designing a program that also focused on making sure there was a peer component to it. That’s important for the formal training programs.

Tapping into resources: I don’t think everybody needs to reinvent this. There are a couple core components that are helpful to have in a leadership development program, and

those are ones that you would want to include.

For the innovation program, doing something like that probably does require a little bit of resource upfront. It doesn’t have to be a large amount, but if the institution or the group of docs collectively are willing to pool some resources and then create more of a competition for applying and then being selected to receive those resources and being held accountable to delivering on it, that’s also really important.

We also do resource that program with some infrastructure, so a little bit of infrastructure like a project manager or data analyst can help hold people accountable and get the work moving forward. That that’s been very important for our frontline innovation program.

In the burnout area, I do think a survey is critical to opening up the dialogue and raising awareness, and I think that that’s the first step in this. We used a very robust survey — I don’t think you have to. There are now many different survey options out there. But picking a tool, having leadership commit to advancing it, getting folks to answer it, and then being willing to sit down and review the data and engage in discussion is pretty critical.

Those would be the components that I would suggest for advancing the work, even in a much lower-scale way than we’ve had the fortune of being able to do at our institution.

**Mohta:** Jessica, thank you so much for taking the time to speak with NEJM Catalyst today. We appreciate it. Thank you.

**Dudley:** Sure, my pleasure. Take care.

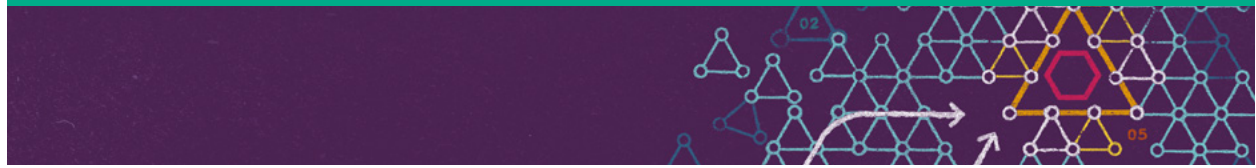
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# Combating Clinician Burnout with Community-Building

Article · July 31, 2018

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Beth Israel Deaconess Medical Center, Primary Care Progress, Harvard Medical School



Increasing evidence from medical studies and surveys has erased all doubt about the reality of what's happening in American medicine today: More than half of doctors are burning out.

The research is sobering. Burnout and isolation are leading to increased staff turnover, more clinical errors, unprecedented levels of depression, and some of the highest rates of suicide and suicidal ideation among any profession in the U.S. — and all this as we approach a shortage of health care professionals, a coming elder boom, and calls to expand the focus of our services to address social determinants of health.

It's clear we're facing an epidemic. For many of us in the trenches, our desperate need for relief is driving creative, effective interventions that show tremendous promise in turning the tide. And when we look at these interventions — from leadership models that underscore collaboration to peer-support networks — some of the most impactful solutions share one common feature: community-building.

## The Power of Peer Support

A primary care system within the Beth Israel Deaconess Medical Center in Boston provides a laudable example of the value of peer support. With morale at an all-time low among physicians in the network, a small group of providers — led by Nicolas Nguyen, MD — decided to invest in understanding and treating the problem.

When we look at these [burnout] interventions — from leadership models that underscore collaboration to peer-support networks — some of the most impactful solutions share one common feature: community-building.”

Beginning with a baseline evaluation of well-being, physicians in the network’s family medicine practices were surveyed, finding that 78% of providers intended to leave the organization within 5 years — attributed to a range of issues from professional dissatisfaction to feelings of isolation and work compression. Should those numbers play out, that would cost the average clinic, conservatively, over \$2.6 million in replacement costs based on internal estimates.

It was clear that the system’s *Resiliency Toolkit* — a resource guide containing exercises and interventions designed to stem physician exodus — while valuable, was insufficient. Taking lessons from outside the health care industry, and with a

\$10,000 budget from an administration eager to alter course, a new approach was developed. Through periodic dinners and retreats, and a group email list created to cultivate dialogue among area providers, clinicians soon discovered their colleagues felt just as overwhelmed, isolated, and helpless. In time, case consultations, socialization, and peer support transformed basic camaraderie into meaningful catharsis.


And it wasn’t just about connecting over coffee; it was about connecting over shared values. For the first time, many reported feeling like they had permission to feel — to see themselves and colleagues in the same way they’re taught to see patients: as whole.

When the initiative started, surveys revealed only 22% of respondents had an interest in staying in their practice for 5 or more years. One year and \$10,000 later, that number was up to 47%. The intentional construction of community had more than *doubled* the intended retention rate. Further, the actual attrition rate went from almost 12% annually to closer to 5%.

Even more important to note is that the real shift wasn’t just in behavior — people occasionally coming together. It was a shift in attitude. Once family medicine clinicians saw the value of forming a community, they sought out even more opportunities to engage, evidenced by the fact that attendance at these voluntary gatherings either became stable or increased with every subsequent event. And with the support, modeling, and full participation of leadership, clinicians felt increasingly comfortable being vulnerable and authentically connecting with peers through these gatherings.

### How Vulnerability Builds Teams

Inspired by the efforts, a second unofficial experiment began, this time to examine the well-being of the full care team.



*It wasn't just about connecting over coffee; it was about connecting over shared values. For the first time, many reported feeling like they had permission to feel — to see themselves and colleagues in the same way they're taught to see patients: as whole.”*

An effort was undertaken to assess practices with particularly high levels of staff turnover — some as high as 184% — to glean insight into causality. While a number of possible influencing factors played a role — from procedural requirements to personality dynamics — there was one consistent feature of each of the poorest performing practices: They lacked regular, all-staff meetings. And this absence of meetings is consistent with norms nationwide, the result of a relentless drive for productivity that demands clinics operate at full capacity with little protected time to nurture group dynamics through regular meetings.

Analysis of the turnover data showed that team meetings closely correlated to retention. The more frequent the meeting *and more equitable the participation of team members at the meeting*, the lower the turnover.

From there, a new intervention was born.

The first Friday of the month, for 1 hour over lunch, the clinic closes its doors and convenes inside a small office, where each member of the team sits in a circle as *equals*. Following a brief moment of stillness, the dialogue begins with housekeeping items, moving on to acknowledgements, concerns, and shared decision-making among staff and leadership.

And while at any given meeting a receptionist may ask for support managing patient flows or a pharmacist may talk about a new shingles vaccine, there is an expectation of staff and a modeling from leadership that — during that one precious hour of time — each person shows up fully. Conversational equity, eye contact, and other key belonging cues are as present among the team as scrubs and stethoscopes — the subtle indicators that signal to everyone that their ideas, ideals, and contributions matter.

The meetings close with an activity that has yielded perhaps the most profound shift in organizational culture. In an exercise called the *Failure Bow*, popularized in Schwartz Rounds<sup>®</sup>, each person stands, shares an error, omission, or challenge from the previous weeks, then leans in and takes a bow. And as team member after team member steps into a space of vulnerability, their colleagues meet them with empathy and compassion — a virtual trust fall.

This single practice site — after 2 years of peer support, connection, trial, and error — has succeeded in bringing the actual retention rate of the full team to more than 93% over the course of the initiative.



*“Conversational equity, eye contact, and other key belonging cues are as present among the team as scrubs and stethoscopes — the subtle indicators that signal to everyone that their ideas, ideals, and contributions matter.”*

These monthly huddles have now evolved into team meetings every 3 weeks, 30–60 minutes in duration. And although other practice sites in the system have implemented slightly differing schedules, all sites maintain a regular cadence and structure, all sites engage leadership as an essential part of the effort, and all sites have been able to sustain the practice with little cost beyond the occasional refreshments. Ongoing evaluation will soon shed light on the retention results of these additional practices, as well.

Much like the previous example of clinician gatherings, the impact of practice meetings has also lasted — not just because of the intervention itself, but because of the culture change it provoked.

### The Power of Connection

It’s easy to wonder what’s at work in these examples: What underlying factors are driving the shift in culture? Is it the simple practice of meeting? Is there something in the design and execution of the meeting? What’s the *right amount* of meeting time? We know that this profound impact cannot be a result of the meetings alone; leaders in primary care practice sites also receive support and training to effectively run those meetings, as well as the leadership development necessary to build better teams. So there’s certainly a trickle-down effect achieved by engaging leadership.

That said, what seems clear, from that original experiment developing networking opportunities to the act of convening the staff, is that community-building is likely playing a role in the solution.

Indeed, we see similar examples of the promise of community-building throughout health care. The Mayo Clinic used peer support groups to help address burnout among thousands of clinicians in their network. They also credit a year-long, institution-wide, community-building effort as the foundation of their system charter, leading to improved staff morale and quality of care.

*“Much like the previous example of clinician gatherings, the impact of practice meetings has also lasted — not just because of the intervention itself, but because of the culture change it provoked.”*

What’s finally being tapped into — and what there is already extensive data to support — is our evolutionary craving for connection. We’re social creatures, with language, kinship, and tribalism. Recent data makes abundantly clear how needed connection is in our everyday existence and the devastating impact of the lack of community on personal health and wellness, with isolation and loneliness leading to morbidity at rates higher than that of smoking and obesity.

Heretofore, however, solutions to address clinician burnout have been twofold: focused on the system and its untenable pressures, and aimed at the individual and their unique characteristics. In fact, a favorite focus of late is the role that relatively internally focused interventions like mindfulness and meditation can play.

Unfortunately, these approaches fail to get at our core wiring: our biological drive for connection.

As the field of clinician wellness evolves, it's imperative to focus on the formal and informal ways that human connections can be created and sustained. As evidenced by examples from large health systems like Mayo to a network of primary care sites in Boston, practices as simple as meetings and peer groups can make an immense difference in the daily experience of health professionals. Surely, other interventions aimed at tapping into this underlying phenomenon have yet to be discovered.

At a time of growing commitment to serve the communities that exist *outside* our system walls, we must concurrently work to develop community *within* our walls to fashion a real *we* in order to sustain an amazing army of *me's*.

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### **Nicolas S. Nguyen, MD**

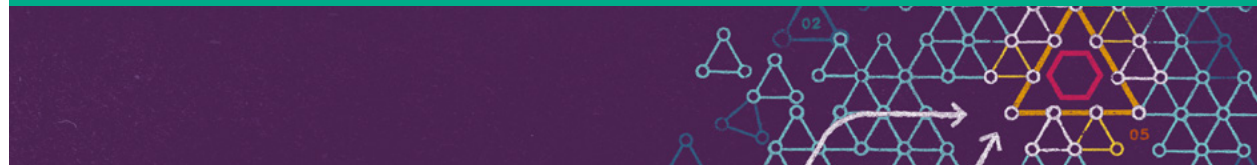
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# Applying Community Organizing Principles to Restore Joy in Work

Article · May 31, 2018

Jessica Perlo, MPH & Derek Feeley, DBA

Institute for Healthcare Improvement



Health care leaders know that for their organizations to successfully adapt to the rapidly changing payment and service landscape, they need a motivated, engaged, and productive workforce — a workforce that finds joy in work. Caring and healing should be joyful activities, not sources of stress.

However, burnout is reaching epidemic proportions across health care. For example, burnout is now estimated to affect more than 50% of physicians, and one-third of new registered nurses seek another profession within a year. Burnout is a measurable syndrome that lessens staff engagement and can, in turn, lower the quality and safety of patient care. Increasing joy in work can help mitigate burnout and turnover.



*By applying community organizing principles to improve joy in the workplace, and then testing our approaches to make sure they're effective, we have the potential to empower our health care workforce to drive changes that it seeks and to deliver the quality care our patients deserve."*

Since its inception, the Institute for Healthcare Improvement (IHI) has been advocating for creating a joyful and productive health care workforce. Because caring for patients is a team effort, we need to optimize the experience of all health care workers. There is ample evidence that having a joyful, engaged workforce translates into fewer medical errors, better patient experience, higher productivity, reduced turnover, less waste, and better financial performance.

Fostering joy in work is about creating systems that promote staff engagement, satisfaction, and resilience. This should be a shared responsibility of caregivers, leaders, and organizations. To that end, IHI designed and tested a Framework for Improving Joy in Work that was based on published literature, expert

interviews, site visits, and results from a prototype testing program developed by IHI and conducted in 11 health systems nationally.

Through the process of delving more deeply into this topic, we've discovered that lessons from the field of community organizing are readily applicable in health care. Community organizing is a set of collaborative leadership practices designed to enable a community of diverse actors to mobilize toward a common goal, according to longtime organizer and Harvard Kennedy School faculty member Marshall Ganz. In this view, community organizing is a tool for building the capacity of people to work together to create change.

Here are four lessons we've learned from community organizing to nurture joy in the health care workforce.

### Know Why You Care

Motivating others to join in action requires answering (1) What will we do? and (2) Why should we do it? What we do is a matter of tactics; why we do it is a matter of heart. Together, they make for a successful strategy. As Marshall Ganz teaches, we need to convey our motivations to elicit them in others. Communicating why we care in the form of stories provides staying power that no strategy alone can achieve.



*Motivating others to join in action requires answering (1) What will we do? and (2) Why should we do it?"*

For example, staff from the Frankel Cardiovascular Center at Michigan Medicine who were involved in IHI's prototype program aimed to engage colleagues in a discussion about joy in work to discover what matters to the team. To do this, they shared stories of what called them to this profession and what was getting in the way of experiencing joy. Small groups of nursing staff, cardiology fellows, and "scribes" then checked off

echoed comments to identify top priorities for testing small changes. This process gave everyone a chance to explore shared values and concerns and to weigh in on what to tackle first.

### Start with Your People, not Your Problem

Too often, we begin our efforts to enhance staff joy by looking at staff satisfaction survey results. The data is helpful, and we'll need it for improvement, but it's better to start with the same question we've been urging our care teams to ask patients: "What matters to you?" Only by understanding what truly matters to staff will leaders be able to identify and remove barriers to joy in the workplace. When we begin with asking "What matters?" we demonstrate that we value staff members' feedback and ideas for improvement. We also tap into strengths or bright spots — what's already working in the organization — that offer

energy for change. As an example in the food industry, Starbucks encouraged employees to use a special postcard to report decisions that they feel don't support the company's mission.

### Do “With” and not “For”

The biggest barrier for many in asking staff “What matters to you?” is what to do with the responses. There is a very real fear that the challenges that come up will feel more like boulders than pebbles in our shoes — such as cumbersome electronic health records or perceived inadequate staffing levels. We can't ignore these issues, but we can also empower local teams to identify and address impediments they can change without having to wait for external resources. This process converts the conversation from “If only they would . . .” to “What can we do today?” It helps everyone see the organization as “us” and not “them.”

### Share Power

The *IHI Framework for Improving Joy in Work* asks leaders to make joy in work a shared responsibility at all levels of the organization. Shepherding this work and moving to what IHI President Emeritus and Senior Fellow Donald M. Berwick envisions as a new era in medicine means we need to support leaders at all levels of the system, from frontline workers to the C-suite. This concept, called “distributed leadership” in organizing, is a social process by which many people across group boundaries and levels within a social system create the conditions for collaboration. In this definition, leadership is a set of social functions, not a position. It is shared among many people in a system and is exercised by sharing resources, expertise, and authority. When guiding change at the unit level in health care, creating a distributed leadership team means we can sustain the effort, even when our energy for the work wanes.



*Only by understanding what truly matters to staff will leaders be able to identify and remove barriers to joy in the workplace.”*

At IHI, the responsibility for nurturing staff joy in work is shared, not just with our executive team, but with supervisors and project teams collectively aimed at improving the staff experience. By moving from the traditional top-down approach of responding to staff satisfaction data, we were able to increase the percentage of staff who believe IHI is an excellent place to work from 87% to 92% in one year — with an added equity aim of closing the gap in satisfaction between white staff and staff of color.

By applying community organizing principles to improve joy in the workplace, and then testing our approaches to make sure they're effective, we have the potential to empower our health care workforce to drive changes that it seeks and to deliver the quality care our



patients deserve. What's more, we might be able to start moving the needle to combat burnout and restore the joy that is at the core of our profession.

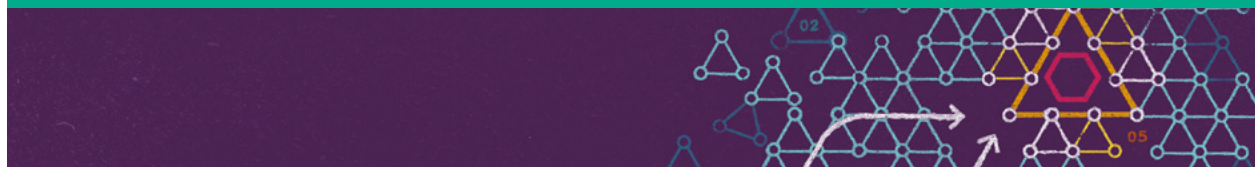
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**Jessica Perlo, MPH**

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# Physician Resiliency and Wellness for Transforming a Health System

Article · May 2, 2018

Carl S. Armato, MBA, CPA & Tom E. Jenike, MD

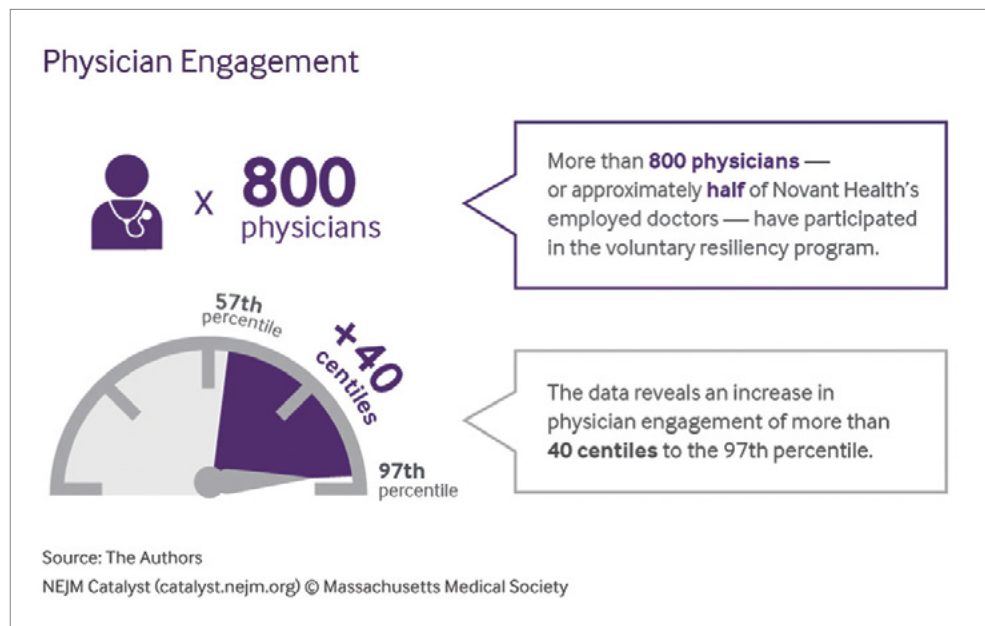
Novant Health



Since it was launched in 2013 at [Novant Health](#), a unique physician resiliency program has had a positive impact on physician engagement and alignment, helping them to better understand their thoughts, feelings, behaviors, and fundamental commitments to medicine. To date, more than 800 physicians — or approximately half of our employed doctors — have participated in the voluntary resiliency program. In addition to a wealth of anecdotal feedback from participants, data reveal an increase in physician engagement of more than 40 centiles to the 97th percentile, according to Press Ganey. Similar improvements are occurring in nearly every aspect of an internal organization-wide engagement assessment about the physician experience.

## Physicians Are Not Invincible

Physicians throughout the nation are faced with the challenge of delivering high-quality care that is increasingly patient-centered, while also keeping pace with the rapid shifts in the economy, technology, and regulatory areas. Changing reimbursement models, market consolidation, new competition (e.g., urgent care, walk-in clinics, and open/online scheduling) and a rise in [consumer preference](#) are creating new sources of pressure on physicians and their well-being. Physicians are often physically and emotionally exhausted, which threatens their overall performance and effectiveness.



This phenomenon, labeled physician *burnout*, is a growing epidemic that poses serious consequences to hospitals, health systems, and the larger medical enterprise. Moreover, burnout will exacerbate the challenges associated with inadequate physician supply, which is projected to get worse; by 2025, demand for doctors will exceed supply by as many as 61,700 to 94,700 (25th percentile to 75th percentile) — roughly doubling the projected 2018 gap between supply and demand, according to the Association of American Medical Colleges.

*Perhaps because of the stigma associated with depression among medical professionals, many doctors do not talk about the toll their demanding job is taking on their health, their relationships, and their career. As health care leaders, we need to take steps to address the problem, and provide a 'safe place' for the conversation to happen."*

It is well documented that physicians have a higher rate of depressive symptoms and suicide than the general population. According to the National Academy of Medicine, an estimated 400 U.S. physicians take their lives every year. We, too, have lost colleagues to suicide, and we have seen others walk away from their profession due to dissatisfaction, omnipresent stressors, or full-blown burnout.

Perhaps because of the stigma associated with depression among medical professionals, many doctors do not talk about the toll their demanding job is taking on their health, their relationships, and their career. As health care leaders, we need to take steps to address the problem, and provide a "safe place" for the conversation to happen.

## Changing the Conversation

In recent years, it became evident that the increasing demand for doctors, combined with rising rates of physician burnout, threatened our organization's ability to consistently deliver quality care and maintain a healthy physician workforce. Recognizing this complex threat, we organized a systematic effort to address physician burnout.

We started by partnering with executive coach Nicholas Beamon, now of [OneTeam Leadership](#), to create a [resiliency, wellness, and leadership](#) program, the Novant Health Leadership Development Program. This initiative — which includes a multiday wellness retreat, one-on-one coaching and mentoring program, and single-session intimate conversations — is designed to help our physicians rediscover their core as a basis for developing stronger leadership skills, effectively engage with their peers and patients, and help them achieve better work-life balance.

The premise is rather simple: lead the self, lead the team, and lead the organization. While the work requires deep reflection and a strong commitment to the process, it has increased physician collaboration and created an environment that encourages new ideas and innovation.

The Novant Health Leadership Development Program includes nine critical elements:

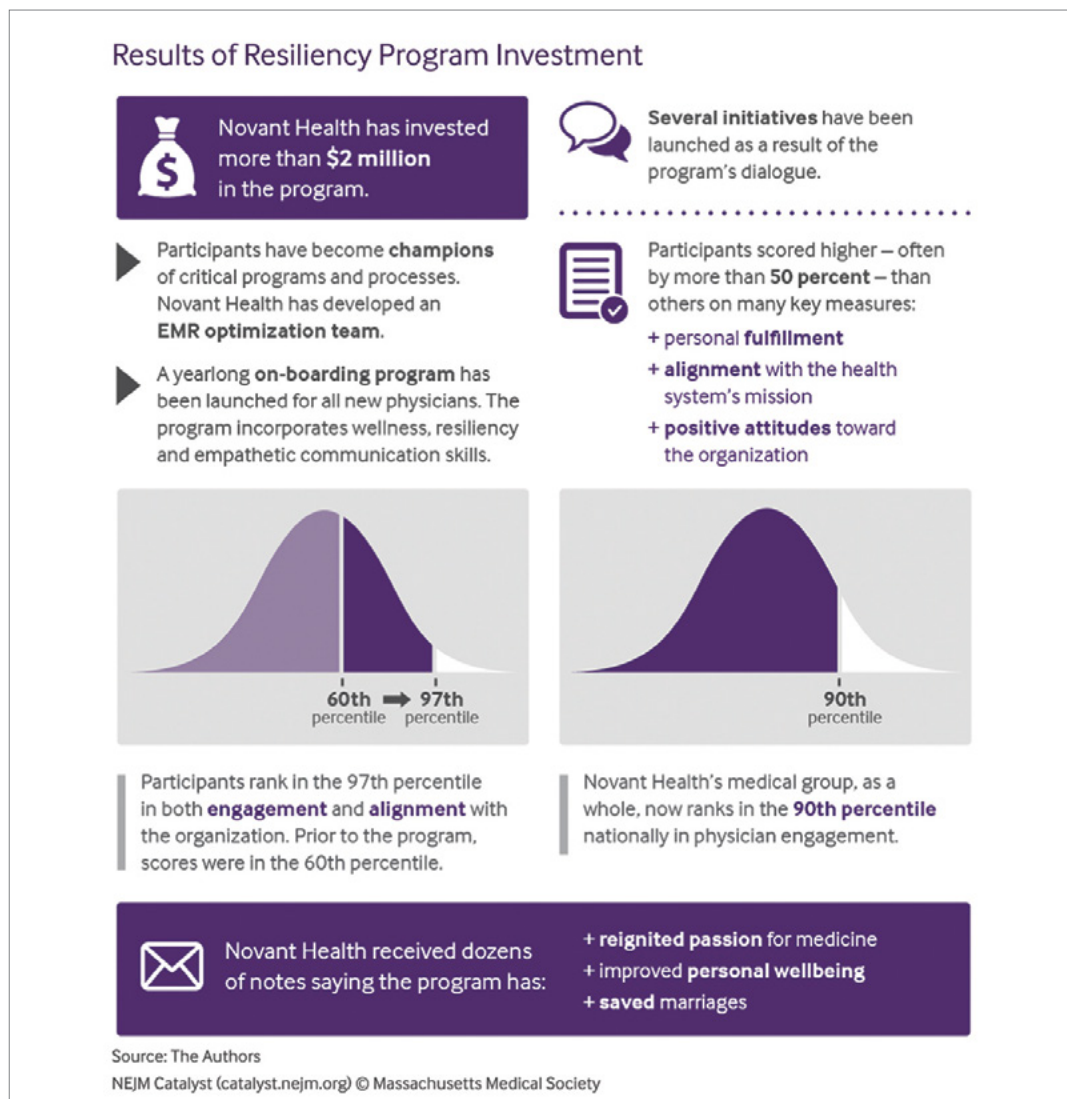
1. Learn how to operate from a deeper personal understanding of purpose.
2. Develop a keen sense of personal awareness and understanding of how nonconscious patterns of bias, behaviors, and thinking contribute to burnout.
3. Focus on creating an “attraction to wellness” rather than a solution for burnout.
4. Develop a new mind-set, new habits, and a commitment to living like “health care athletes,” which includes the concepts of work, rest, recovery, and rejuvenation.
5. Focus on training to be fully present and aware, or operating from one's personal core.
6. Develop a deep understanding of “influential leadership” as a critical skill and learned ability.
7. Become a more effective person, through intentional daily living.
8. Redefine the medical group culture by establishing a strong community of physician support, communication, and [camaraderie](#).
9. Mobilize past participants as champions to address organizational forces that drive burnout, impacting the electronic medical record (EMR), team-based care, mentoring, and even reimbursement models.

## Transforming Health Care

As more and more providers participate in the program, word has spread of its personal and professional benefits. Many physicians have reached out directly to Novant Health leaders to express a desire to participate, while others have been referred to the program by a concerned colleague.

*“The premise is rather simple: lead the self, lead the team, and lead the organization.”*

Currently, there is waiting list of providers who are willing to give up a weekend — or block out a full day of appointments — to attend either the 3-day retreat or the condensed 1-day version held at an off-site local location. Since its inception, Novant Health has invested more than \$2 million to develop, implement, and promote the resiliency program throughout the system for physicians, nurses, and administrative leaders.





Among the results from these investments:

- ▶ Our research shows that those who participated in the resiliency program scored higher than nonparticipants — sometimes more than 50% higher — on several key measures, including personal fulfillment, alignment with the health system’s mission, and positive attitudes toward the organization. Further, over the past few years, we have seen nonparticipant scores rise as well — reaching the 90th percentile in some measures — which we attribute in part to a ripple effect of the resiliency program.
- ▶ According to scores from Press Ganey, a provider of patient experience solutions, Novant Health Medical Group participants rank in the 97th percentile in both engagement and alignment with the organization. Prior to the program, engagement scores had been in the 60th percentile.
- ▶ Novant Health’s medical group, as a whole, now ranks in the 90th percentile nationally in physician engagement.
- ▶ Several initiatives have been launched as a result of dialogue that took place during the program. For example, participants have become champions of critical programs and processes. We have developed an EMR optimization team that proactively supports our physicians and enhances their ability to utilize the tool and save them time. Additionally, a yearlong on-boarding program has been launched for all new physicians; the program incorporates wellness, resiliency, and empathic communication skills. Both these services are led by graduates of the Leadership Development Program.

Beyond the metrics, we have received dozens of anecdotal notes of appreciation from medical staff who say the resiliency program has reignited their passion for medicine; made a positive difference in their health and well-being; improved relationships with patients, staff, friends, and family; and even saved marriages. Here are just a few of highlights:

#### ANECDOTAL NOTES FROM MEDICAL STAFF

“The program made me realize that I wasn’t truly getting to know my patients. I was also not mentally available to my wife and children, even if I was physically present with them. Today, my patient satisfaction has improved and even the mood in the office has become less stressful. I’ve regained my love of seeing patients.”

(CONTINUED ON NEXT PAGE)

**ANECDOTAL NOTES FROM MEDICAL STAFF (CONTINUED)**

“The downstream impact of a program — one that focuses on enhancing the lives and relationships of a truly suffering physician population — is immeasurable, especially when you consider the gravity of the decisions we make on a daily basis and the consequences that those decisions have for our patients.”

“My life changed significantly since participating in the physician wellness program. Like many, I was frustrated and overwhelmed, both personally and professionally. By sharing experiences in a nonjudgmental and supportive atmosphere, I was able to gain insight, rejuvenate, and begin to improve my future. Because of this program’s tools and guidance, I have learned how to take control of my happiness and I have a much brighter outlook overall.”

**Implementation Tips**

For hospital and health system leaders considering developing their own physician resiliency and wellness programs, we suggest you consider the following:

- ▶ *Who on your staff will “own” the program? Can you assign this to one individual?* At Novant Health, our program is facilitated by our chief human experience officer with support from leadership within our employed medical group.
- ▶ *What is the right amount to budget for this type of program for your organization?* Novant Health has budgeted approximately \$3,500 per physician participant. For other health care providers, such as nurses, the health system has budgeted approximately \$400 per participant. We are accredited for 36 hours of Category 1 AMA CME for physicians, and 9 hours of CNU for nurses.
- ▶ *What metrics will you use to assess the financial and nonfinancial return on investment?* For example, at Novant Health we are looking at the impact of the resiliency and wellness program on recruitment and retention. We have seen a 300% growth in our employed medical group since program inception. Replacing a physician can cost an organization

two to three times the annual salary of a physician who left, according to a December 2017 report in *JAMA*. Therefore, retention is of paramount importance to us. Also, our program has impacted the patient experience positively, which is reflected in many reimbursement models.

*Medical staff say the resiliency program has reignited their passion for medicine; made a positive difference in their health and well-being; improved relationships with patients, staff, friends, and family; and even saved marriages.”*

## A Leadership Imperative

As health care systems across the country face unprecedented change and a variety of challenges that are turning business-as-usual practices on their head, physician burnout is an issue that cannot be ignored. Acknowledging that numerous external forces are real — and clinical and executive leaders are not just imagining that their work is getting more challenging — must be an important part of the conversation. While we can encourage physicians to confront and control external forces as much as possible, the focus must be on what they can impact the most, which is their “internal condition.”

At Novant Health, we have learned that an intentional and deliberate focus on physician wellness is critical to operating a high-performing and change-ready health care organization. And we have learned that is the responsibility of the executive leadership team to encourage and enable staff to engage in their own wellness and resiliency. We need to demonstrate that it is possible — and OK — to behave differently in our personal and professional lives by:

- ▶ Slowing down, pressing pause, and being present. Being “all in” for the moments of life — not just for work.
- ▶ Recharging and maintaining our batteries by building in intentional time to recover and rejuvenate.
- ▶ Acknowledging that improving oneself is the access point to improving our life and the lives of those around us.
- ▶ Being realistic about expectations for ourselves and others — you cannot help everyone. Start by being kind to yourself.

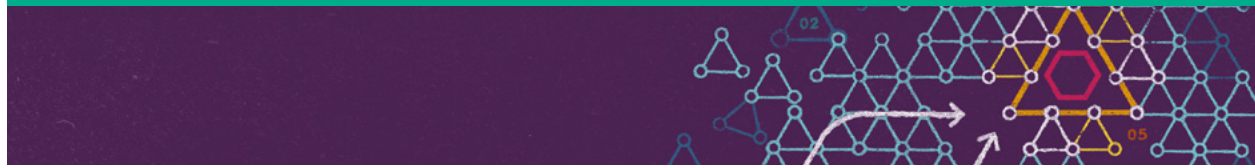
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# Leadership Survey: Immunization Against Burnout

Insights Report · April 12, 2018

Stephen Swensen, MD, MMM, FACR, Steven Strongwater, MD & Namita Seth Mohta, MD

Intermountain Healthcare, Atrius Health, NEJM Catalyst

*Analysis of the NEJM Catalyst Insights Council Survey on Leadership: Immunization Against Burnout. Qualified executives, clinical leaders, and clinicians may [join the Insights Council](#) and share their perspectives on health care delivery transformation.*

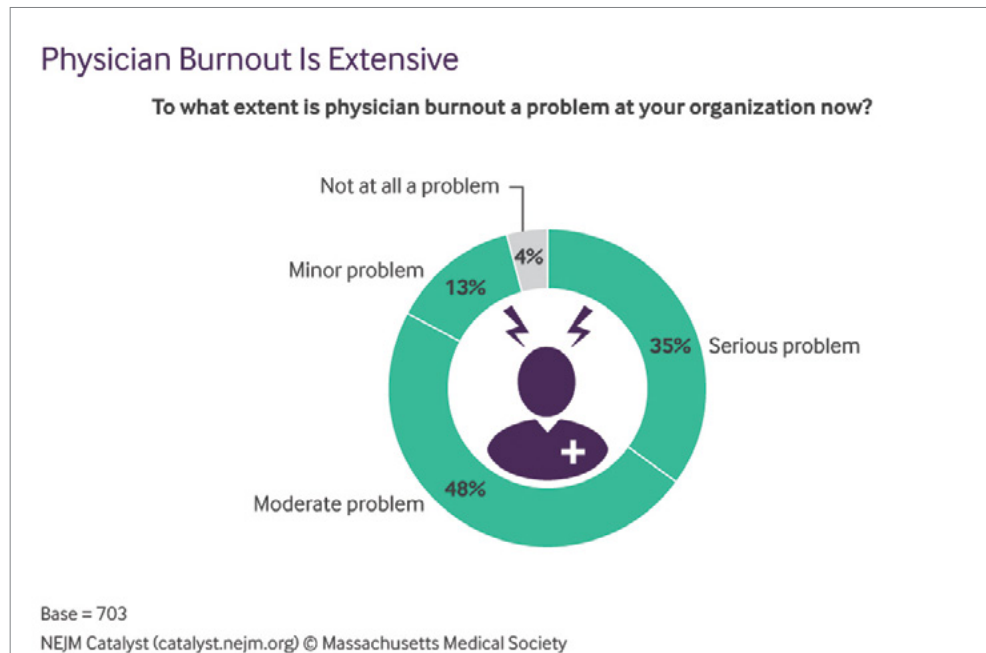
## Advisor Analysis

By Stephen Swensen, Steven Strongwater, and Namita Seth Mohta

We were not surprised that 83% of respondents — who are clinicians, clinical leaders, and health care executives — call clinician burnout a “serious” or “moderate” problem in their organizations. That could be considered a slight improvement from the findings of our fall 2016 [survey on burnout](#), when 96% of Insights Council members said physician burnout was a serious or moderate issue. It is clear, however, that the problem remains prevalent.

This most recent survey also finds burnout a major concern for registered nurses (78% say it is a serious or moderate problem), advanced practice nurses (64%), clinical leaders (56%), and health care executives (42%).

With such a large swath of health care organizations affected, leaders and frontline clinicians have become thirsty for solutions. After all, the damage to their business and culture can be quite severe — from straightforward pocketbook issues (at Steven Strongwater’s employer, Atrius Health, it costs between \$500,000 and \$1 million to [replace a physician](#)) to a well-studied breakdown in [patient satisfaction](#) and the [quality of care](#). Clinicians feel the impact of burnout by reducing their hours, switching to administrative roles, or leaving health care altogether, [taking them away](#) from why they chose medicine in the first place: to treat patients.



While it might seem a trivial place to start, many organizations have stopped referring to the condition as “burnout,” realizing the word has something of a contagious effect. Instead, they are using more positive and aspirational nomenclature such as “esprit de corps” and “joyfulness in work.”

No one is under the illusion, though, that simply swapping to more optimistic language will solve this predicament. Instead, interventions must be targeted at multiple levels: provider organizations, regulators (specifically around payer/documentation requirements), the work unit leader, and individual clinicians. In the survey, 82% of respondents place the onus on organizations, through system and infrastructure improvements, but we believe interventions should be a shared responsibility with the individual (chosen by 47% of respondents).

*This most recent survey also finds burnout a major concern for registered nurses (78% say it is a serious or moderate problem), advanced practice nurses (64%), clinical leaders (56%), and health care executives (42%).”*

What complicates the organizational approach to burnout is that physicians and nurses experience burnout in very different ways. We have found the drivers of physician burnout to be workload, work/life balance, cognitive dissonance, and clerical work, while nurses more often suffer burnout due to compassion fatigue, moral distress, and work environment issues such as psychological safety and hostility. There is also variation between specialties and practice locations.

There is broad agreement on the need for more face-to-face time between clinicians and patients and less time spent on the electronic medical record and documentation. A little over half of survey respondents recommend offloading clerical tasks


to scribes, pharmacy technicians, or population health facilitators. That way, physicians and nurses (and all clinical team members) can work appropriately at the top of their licensure. The next most popular solution, chosen by 46% of respondents, is improving the functionality and interactivity of EMRs and other IT systems.

That theme came up consistently in verbatim responses to the survey, with one respondent hoping to “treat patients rather than treat the chart.” At Atrius, efforts are under way to improve clinician workflow in the EMR, ranging from reducing inbox messages to changing staffing patterns, but deployment of those processes is two years out. Some organizations have shared with us that they don’t have the resources to invest in better systems, workflow, and people to alleviate burnout, so it has fallen on clinicians to be more resilient.

In addition to improving IT systems, we believe organizations should focus on improving the communication and management skills of their point-of-care leaders. After all, employees don’t tend to leave organizations, they leave their managers.

Self-care is another important part of the solution to burnout. Clinicians cannot resolve these complex issues on their own, but neither are they helpless victims. Until structural changes are deployed, individual mitigation strategies can be effective. Just over half of survey respondents rate self-care as the top tool to reduce individual clinician burnout, which can include meditation, yoga, and engaging in a hobby.

Where organizations and individuals can work together is in creating incentive models and positive role models that encourage wellness. Together they can strengthen camaraderie, time for creativity, purposefulness, and personal resilience. Leaders can encourage self-care by setting up protected, guilt-free personal time for clinicians.



*We are not a corporate culture. Medicine is a practice and tying a physician to a corporate model is the one driving force that leads to burnout.”*

Leaders should get in the habit of measuring clinician joy, camaraderie, engagement, and satisfaction, just as you would a patient’s vital signs. You can use regular unit-based voluntary surveys to measure these characteristics. Only measure them, however, if you are committed to improving them. It may also be helpful to collect and manage metrics on the efficiency of EMR use, such as how many clicks are required for certain conditions and unit workflows. When there is substantial variation, super users can help colleagues improve their efficiency and reduce their work hours. Unless you measure it, it won’t get better.



While a majority (60%) of Insights Council members believe clinician burnout will worsen over the next two to three years, 15% of respondents believe the situation will improve over the next two to three years. Count us in the optimistic camp, as we already see EMR vendors trying to make improvements to their technology and organizations trying to return meaningfulness to clinician work.

### VERBATIM COMMENTS FROM SURVEY RESPONDENTS

**What is the one thing you would do to reduce clinician burnout at your organization?**

“It has to be more than one thing: 1) Does the organization have a robust improvement department and have all administrators, physicians, and clinicians agreed to actively pursue and participate in improvement, this is critical. 2) EMR optimization. 3) All clerical and documentation work (see #1 for how to fix). 4) Culture & camaraderie.”

— *Director of a midsized community hospital in the Midwest*

“Engage clinicians in decision making and innovation activities.”

— *VP of a small university hospital in New England*

“Develop a more team-based approach to care instead of our current model which places the burden of documenting and education on the physician. Reducing the clerical tasks currently burdening physicians will help considerably as will revamping physician compensation as the drive to see more patients to rack up RVUs is a contributing factor to physician satisfaction.”

— *Chief Medical Officer of a large physician organization in the South*

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**VERBATIM COMMENTS FROM SURVEY RESPONDENTS (CONTINUED)**

“Improve efficiency of busy work so they can focus on the real purpose.”

— *Executive of a large nonprofit health system in the Midwest*

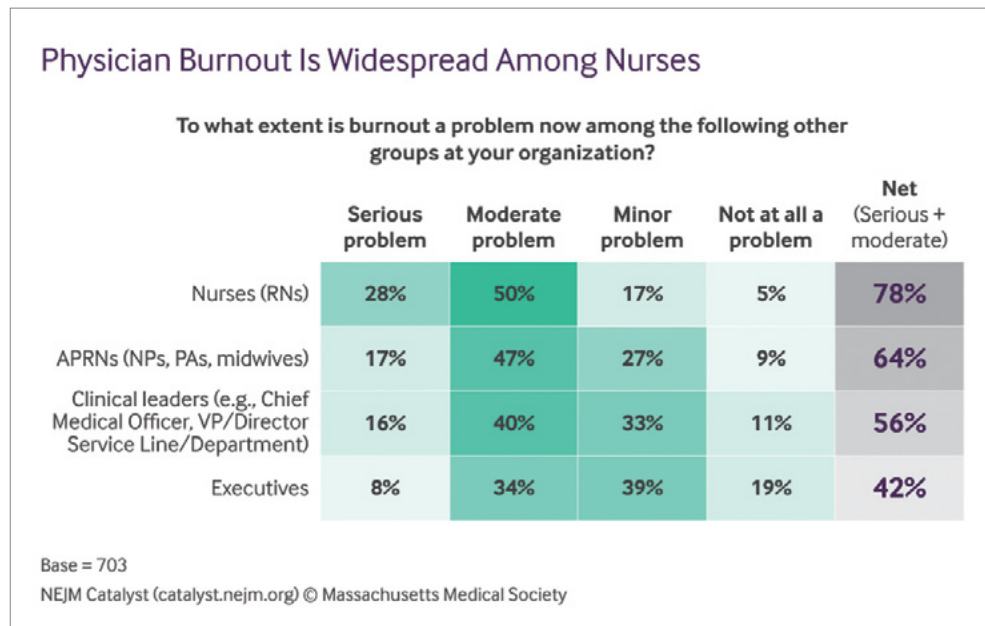
“Improve ability to care for self.”

— *Clinician at a for-profit organization in the mid-Atlantic*

**Charts and Commentary**

by **NEJM Catalyst**

We surveyed members of the NEJM Catalyst Insights Council, who comprise health care executives, clinical leaders, and clinicians, about clinician burnout. The survey covers the extent of clinician burnout at their organizations, the extent of burnout among other groups at their organizations, the level of clinician burnout over the past 2–3 years and expected during the next 2–3 years, where interventions to reduce burnout should be targeted, and tools that individuals and organizations are using to reduce burnout. Completed surveys from 703 respondents are included in the analysis.



Nearly all respondents (96%) say physician burnout is a problem in their organizations to some degree. Just over a third consider it a serious problem, while nearly half say the problem is moderate. Respondents at health systems (44%) are more likely to say it's a serious problem than those at hospitals (36%). Executives, clinical leaders, and clinicians agree about the extent of the problem. In a written comment, one Insights Council member attributes burnout to the change in the business of medicine. "We are not a corporate culture. Medicine is a practice and tying a physician to a corporate model is the one driving force that leads to burnout," the respondent says.

### Stephen Swensen, MD, MMM, FACR

Intermountain Healthcare

Stephen Swensen is the Medical Director for Professionalism and Peer Support at Intermountain Healthcare. He is also a Senior Fellow of the Institute for Healthcare Improvement, where he co-leads their Joy in Work Initiative.

### Steven Strongwater, MD

Atrius Health

As President and CEO of Atrius Health, Dr. Steven Strongwater, MD, leads 6,800 employees serving 675,000 patients across eastern Massachusetts with coordinated medical care, home health, and hospice.

### Namita Seth Mohta, MD

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# Physicians Are Facing a Crisis

Talk · July 12, 2017

**Steven Strongwater, MD**

Atrius Health



[View video.](#)

“I’m 45 years old, and I can’t do this anymore. I am just exhausted.”

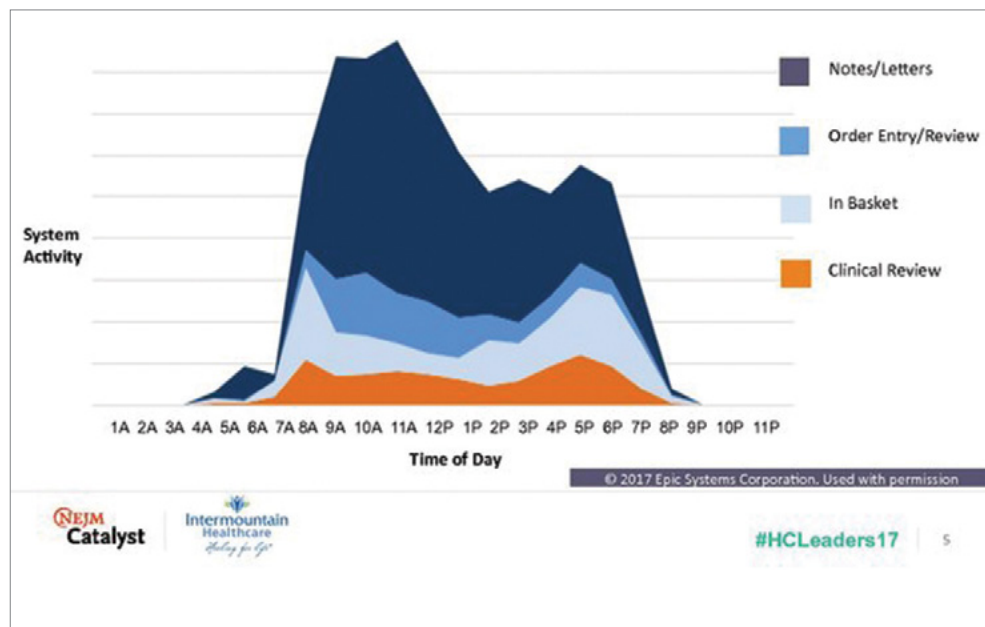
It was the beginning of [Steven Strongwater’s](#) tenure as President and CEO of Atrius Health, and a group of physicians were taking turns introducing themselves. One of the physicians told the group that her father was a general practitioner well into his late 70s — but she did not see herself following in his footsteps.

“As I looked around the room, what was so frightening to me was that every other head, every other primary care doc in that room, was nodding their head in agreement,” says Strongwater. “That’s the story that we are facing, and the problem that’s facing our country, and it is increasingly getting worse.”

*As I looked around the room, what was so frightening to me was that every other head, every other primary care doc in that room, was nodding their head in agreement.”*

Strongwater was thrilled to learn of a burnout prevention model now being more broadly adopted that emphasizes a culture of wellness, efficiency of practice, and the need for personal resilience. But, while the components of the model are good, Strongwater argues that the pie shape is off. “What’s principally driving burnout in our country is the efficiency of practice — it’s the work, it’s the workflow, it’s the demands we’ve put on the plates of so many clinicians,” he says.

In a graph displaying different types of clinician work on the electronic medical record (EMR), the baseline, time, shows that the clinician’s workday starts at 4 a.m. — and ends at 9 p.m.



Imagine doing that every single day for 10 years, 15 years, 20 years. I would argue that our primary care docs are incredibly resilient,” says Strongwater.

*What’s principally driving burnout in our country is the efficiency of practice — it’s the work, it’s the workflow, it’s the demands we’ve put on the plates of so many clinicians.”*

Employment status has changed, Strongwater adds. In Massachusetts, 85% of physicians are employed by large organizations, according to Strongwater. Across the U.S., more than half of physicians are employees, and some work for nontraditional medical employers such as insurers and payers. One might assume that more

deeply financed organizations could improve the practice environment, but that's not true. The Massachusetts Medical Society tracks a Physician Practice Environment Index. In the 1990s, that score was about 100; today, it's about 70. "Things have not gotten better," says Strongwater. "Indeed, they have gotten worse."

In his book *Drive*, Daniel Pink says that professional satisfaction is driven by three things: purpose, autonomy, and mastery. Primary care doctors are certainly purposeful, notes Strongwater. "But we have forced them to make a trade: clicks before care. We have forced them to stare at computer screens and not into the eyes of their patients. We have disrupted that patient-physician bond." With the majority of U.S. physicians as employees, they give up some autonomy in decision-making. As for mastery, physicians are facing a crisis, argues Strongwater. "We look on our cell phones and have such incredible ease of use, and then we look at our electronic medical record screen and we are searching and clicking, and the tools are not quite as sharp, yet, as they need to be."

*We have forced them to make a trade: clicks before care. We have forced them to stare at computer screens and not into the eyes of their patients. We have disrupted that patient-physician bond."*

Few individual physicians can actually impact the current state, because they are employees. But they can go to their leadership. "This is a leadership demand," says Strongwater. "There's a leadership opportunity to step in and recognize that burnout is an issue, an important issue, and to help make investments that are appropriate in order to make change happen." Having conversations on burnout is a step in the right direction, but to make any progress, leadership needs to walk away from those conversations committed to finding solutions and report regularly on burnout to their boards.

What can leaders do to reduce EMR time? Strongwater describes several approaches:

- ▶ **IT bundle.** To help physicians reduce their after-hours EMR time, the Atrius IT team created a five-component bundle that they anticipate will reduce between 1 million and 1.5 million clicks.
- ▶ **PAYGO.** In PAYGO, if you want something that costs money, you must offset it with something else. So if you want more EMR clicks, you have to take something else away.
- ▶ **Streamlined forms.** Leaders, at the negotiation table, can weed away unnecessary utilization requirements and pre-approval forms that are a waste of time.
- ▶ **Scribes.** "There are some things that are, quite honestly, below the top of the physician's license, and we should fix that," says Strongwater, by hiring scribes.



- ▶ **Empathy training.** “After 2 hours of interdisciplinary empathy training, our patient satisfaction scores went up dramatically,” Strongwater says.

*This is a leadership demand. There’s a leadership opportunity to step in and recognize that burnout is an issue, an important issue, and to help make investments that are appropriate in order to make change happen.”*

On the harder side, Strongwater encourages all of us to demand that EMR user interfaces become as good and facile to use as smartphones and tablets.

“Our primary care physicians are not whining millennials; they really are working very, very hard. And we should thank them, because we’re going to need them, especially as all of us get older,” says Strongwater. “We need to ask our leaders and help the leaders see that this is an important opportunity for them. And I know they can make a difference. We have solved so many complex problems. This just has to become a priority.”

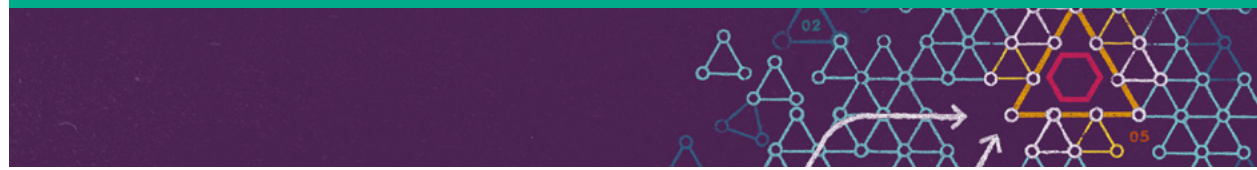
*From the NEJM Catalyst event [Physicians Leading | Leading Physicians at Intermountain Healthcare](#), July 12, 2017.*

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## Steven Strongwater, MD

Atrius Health

As President and CEO of Atrius Health, Dr. Steven Strongwater, MD, leads 6,800 employees serving 675,000 patients across eastern Massachusetts with coordinated medical care, home health, and hospice.



# Coaching to Enhance Individual Well-Being, Foster Teamwork, and Improve the Health Care System

Article · August 7, 2017

Steven A. Adelman, MD & Jane M. Liebschutz, MD, MPH

UMASS Medical School, Boston University Schools of Medicine and Public Health

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The emerging profession of coaching has three primary applications in the health care industry: (1) leadership coaching, (2) health care provider coaching, and (3) patient coaching. As explained by Wolever et al. in chapter 29 of the *Sage Handbook of Coaching*, the goals of all three applications are to promote health and wellness, to improve outcomes, and to decrease the individual and societal burdens of chronic disease. While all three applications are important, this article will focus on the use of health care provider coaching as a way to address the increasing problem of physician burnout.

## The Burnout Epidemic

Health care provider coaching focuses on provider well-being and performance challenges in the current pressurized environment, in which mounting rates of physician burnout represent what medical ethicist Arthur Caplan has characterized as a public health crisis. Burnout has taken center stage in the world of physician health, with an April 2017 joint session of the Federation of State Physician Health Programs (FSPHP) and the Federation of State Medical Boards (FSMB) focusing on burnout prevention.

To understand how coaching may play a role in alleviating burnout, we need to understand the change process involving the corporatization and commodification of the medical profession. Roughly 30 years ago (circa 1985), the physician was a knowledgeable, highly-revered healer who alleviated human suffering and cured disease on his or her terms, one patient at a time. The doctor-patient relationship was central to the art and craft of medical practice. Record-keeping, regulatory compliance, medical billing, and adherence to standardized practice guidelines remained in the background, rarely overshadowing the

*In today's corporate health care environment, screen time and the ever-mounting stream of bureaucratic tasks have crowded out the main event: quality face time with patients."*

healing relationship with the patient or the autonomy of the physician. In today's corporate health care environment, screen time and the ever-mounting stream of bureaucratic tasks have crowded out the main event: quality face time with patients. Frustration and pressure have supplanted the pride and satisfaction derived from alleviating the pain and suffering of a fellow human being.

### **Coaching Individual Health Care Professionals: Theory and Practice**

How might coaching play a role in helping physicians and other health care professionals recapture meaning, joy, and satisfaction in their work and enable them to increase their internal locus of control? From a theoretical perspective, coaching enhances self-awareness, draws on an individual's strengths, fosters creative problem-solving, questions self-defeating thoughts and beliefs, examines new perspectives, aligns personal values with professional duties, and helps clients maximize their inner knowledge and skills to enable them to handle the challenges before them.

*Preliminary data have suggested that this type of intervention, in which coaches partner with distressed primary care physicians to identify and address their goals, can result in measurable improvements in job satisfaction, engagement, compassion, and other related variables."*

From a more practical standpoint, coaching sessions can be held either in person or remotely. Although face-to-face coaching is preferable, coaching sessions are often conducted by telephone or Skype for 30 to 60 minutes to accommodate busy physician schedules. During the initial coaching sessions, coaches collaborate with their clients to identify and implement (1) actionable short-term and long-term goals that are consistent with clients' strengths and values and (2) small and large actions that the clients themselves can take to achieve those goals. During subsequent sessions, coaches and their clients maintain focus on the goals, make necessary modifications, and may establish new goals in what can be thought of as an accountability partnership.

Coaches also may employ mindfulness training, resilience training, and stress management to assist their physician clients. These techniques are known to have efficacy in counteracting burnout, and they have been cited in a handful of studies suggesting that coaching helps practicing physicians. A February 2017 presentation on Physician Well-Being at the Society of Consulting Psychology focused on coaching as a strategy for enhancing the performance of teams and for promoting "healthcare industry culture change." Figure 1 illustrates how different coaching interventions fit into the health care ecosystem and facilitate interactions between individual patients, professionals, and health care leaders.

## Controlled Study of Physician Coaching: Encouraging Preliminary Results

In a current study funded by a grant administered through the [Institute of Coaching](#) at McLean Hospital (an affiliate of Harvard Medical School), a team of coaches and researchers is evaluating a group of 60 primary care physicians at four large Boston-area health care organizations (Atrius Health, Beth Israel Deaconess Medical Center, Mt. Auburn Hospital, and Boston Medical Center). The investigators are examining the extent to which a six-session, 3.5-hour positive psychology coaching intervention improves well-being, reduces burnout, and attenuates the intention to leave medical practice. To our knowledge, this investigation represents the first controlled study of a physician coaching intervention at this scale and is the first to focus on the development of client-centered goals.

*To optimize the performance of a system, individuals who direct the entities that comprise the system should interact and interface with one another harmoniously and with minimal friction.”*

Preliminary data have suggested that this type of intervention, in which coaches partner with distressed primary care physicians to identify and address their goals, can result in measurable improvements in job satisfaction, engagement, compassion, and other related variables. In addition, several study subjects have reported that working with a coach helped them initiate concrete changes that enabled them to improve their self-care and become more satisfied and engaged in their current position.

### Deployment of Coaches to Different Settings

Increasingly, experienced coaches are being deployed to assist physicians in a variety of settings. At Physician Health Services in Massachusetts, an organization that assists physicians and physicians-in-training with health challenges that may impede their professional abilities, [the number of physician self-referrals](#) has nearly tripled in 4 years. Many of these self-referred physicians identify themselves as “burning out” and welcome referrals to coaches who can assist them with goals related to self-care and work-life balance. Many of our Massachusetts-based coaches are themselves physicians who have received training and certification in coaching. Some coaching engagements are completed in two to four sessions, whereas others may involve 20 or more meetings over a year or more, depending on the agreed-upon coaching goals.

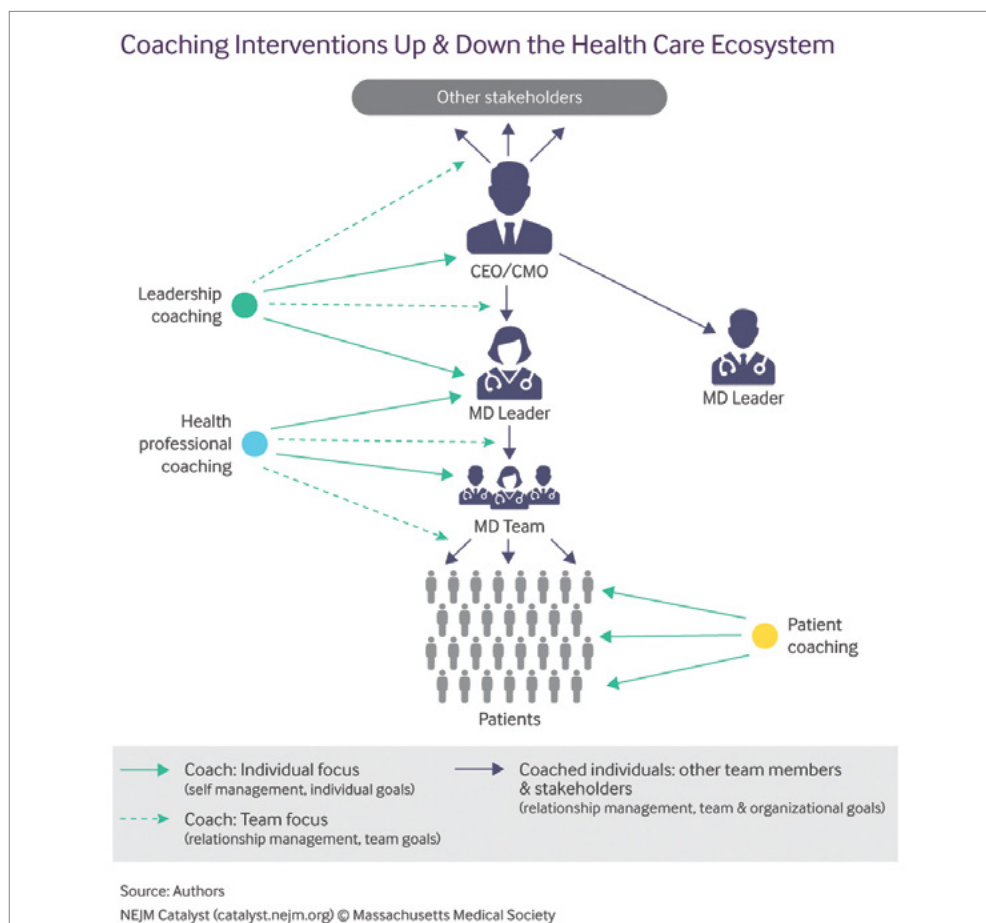
We have observed that some physicians who are reluctant to receive services from mental health professionals are amenable to coaching interventions. [The Brigham and Women’s Hospital Professionalism Program](#) utilizes coaches to assist physicians with challenges in a wide variety of domains, such as professionalism, anger management, stress management, social and emotional intelligence, communication skills, and organizational skills. From our vantage point in Massachusetts, it appears that coaching physicians and other health

“Coaching’s emphasis on self-management and self-awareness is fundamental to the improved functioning of individuals such as practice and health system leaders as well as frontline clinicians.”

professionals in how to deal with burnout and a variety of other problematic workplace behaviors is just beginning to enter the mainstream. Word of mouth, experience with health professional coaching, and the [International Coach Federation’s FAQs](#) all may guide the selection of an appropriate coach.

### Toward a Culture of Coaching: Individuals, Teams, Organizations, and the Health Care System

Meta-analyses of the literature on remediating physician burnout that have been published in [The Lancet](#) and [JAMA Internal Medicine](#) have indicated that system-level interventions are more important than individual-level interventions. However, individual physicians, health care professionals, medical leaders, managers, and executives are the effector arms of the practice teams, groups, organizations, and corporate entities that together comprise the entirety of the health care delivery system. In order to optimize the performance of a system, individuals who direct the entities that comprise the system should interact and interface with one another harmoniously and with minimal friction.



Coaching's emphasis on self-management and self-awareness is fundamental to the improved functioning of individuals such as practice and health system leaders as well as frontline clinicians. In addition, the focus on strengths-based solutions can enhance both individual and group performance. We would like to see coaching skills become a core competency of team leaders and medical managers at the practice level and are encouraged by initiatives such as the [Resident Coaching Program at Massachusetts General Hospital](#).

*In the past decade, the business world has become increasingly aware of the value of coaching. As the largest and one of the most important sectors of the entire U.S. economy, the health care industry is now discovering this important resource.”*

This program pairs faculty members who are trained in positive psychology and coaching with residents and fellows. The purpose of these dyads is to help trainees overcome challenges and achieve goals early in training, thereby improving the self-management and teamwork skills that will become the foundation for a successful long-term career. We remain hopeful that a “culture of coaching in health care” is just now beginning to take root and that it will ultimately spread across the teams, organizations, and institutions that comprise the larger system. This culture may help stakeholders at every level embrace the dizzying change process that is one of the root causes of the burnout crisis.

In the past decade, the [business world](#) has become increasingly aware of the value of coaching. As the largest and one of the most important sectors of the entire U.S. economy, the health care industry is now discovering this important resource. Sadly, the overwhelming majority of physicians have not been adequately prepared to manage the personal and interpersonal stresses and strains of the rapid and choppy change process of health care in the 21st century. In addition to investing in technology and technical advances, health care innovators should invest in the development of scalable, evidence-based coaching programs with the potential to alleviate burnout by improving the functioning of the system's human assets at every level.

**Note:** *This article is an outgrowth of an [interview with Dr. Adelman](#) that took place in February 2017.*

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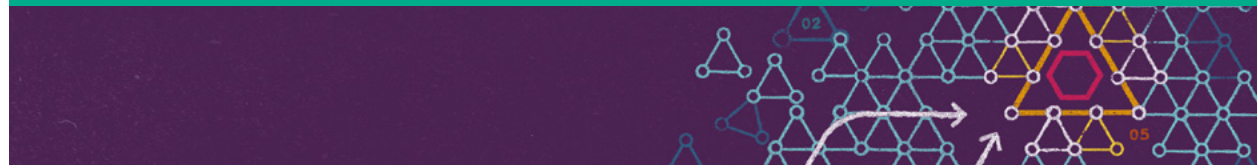
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# Physician Well-Being: The Reciprocity of Practice Efficiency, Culture of Wellness, and Personal Resilience

Article · August 7, 2017

**Bryan Bohman, MD, Liselotte Dyrbye, MD, MHPE, Christine A. Sinsky, MD, Mark Linzer, MD, FACP, Kristine Olson, MD, MSc, Stewart Babbott, MD, Mary Lou Murphy, MS, Patty Purpur deVries, MS, Maryam S. Hamidi, PhD & Mickey Trockel, MD, PhD**

Stanford University School of Medicine, Mayo Clinic, American Medical Association, Hennepin County Medical Center, Yale University School of Medicine, University of Virginia School of Medicine



The quality and safety of patient care, and indeed the very vitality of our health care systems, depend heavily on high-functioning physicians. Yet recent data have revealed an extraordinarily high — and increasing — prevalence of physician burnout, defined as emotional exhaustion, interpersonal disengagement, and a low sense of personal accomplishment. In light of compelling evidence that burnout negatively affects patient care, health care leaders are rightly alarmed and are searching for answers.



*These efforts will be most effective when they address drivers of physician well-being from each of the three reciprocally related domains of practice efficiency, a culture of wellness, and personal resilience.”*

The resulting national dialogue on physician burnout presents an opportunity to address physician well-being more broadly, in that physician well-being should be viewed — to paraphrase the World Health Organization’s well-known definition of health — as an optimal state of physical, mental, and social well-being, and not merely the absence of burnout. Professionally fulfilled physicians (defined as those who experience happiness or meaningfulness, self-worth, self-efficacy, and satisfaction at work) are better equipped not only to practice the art and science of clinical care, but also to lead the effort to identify and implement much-needed improvements to our systems of care.

The many drivers of both burnout and high professional fulfillment fall into three major domains: efficiency of practice, a culture of wellness, and personal resilience. Efficiency of practice and a culture of wellness are primarily organizational responsibilities, whereas maintaining personal resilience is primarily the obligation of the individual physician. Each domain reciprocally influences the others; thus, a balanced approach is necessary to build a stable platform that will drive sustained improvements in physician well-being and the performance of our health care systems.



While it is important to promote the well-being of all members of the health care team, we focus here on physician well-being for two reasons. First, physicians have been hard-hit by the organizational transformation of the health care system, resulting in an epidemic of burnout and declining professional fulfillment. They have suffered a reduction in their sense of professional autonomy, have experienced a significant increase in clerical duties, and are beholden to a growing array of imperfect and inconsistent quality and productivity metrics. Second, medical training has historically acculturated physicians to deny their own self-care in the service of others.

*It is counterproductive to ask physicians to ‘heal themselves’ through superhuman levels of resilience even as the practice environment continues to deteriorate.”*

In this context, it is counterproductive to ask physicians to “heal themselves” through superhuman levels of resilience even as the practice environment continues to deteriorate. Yet the majority of interventions and research related to physician wellness have focused on personal resilience (e.g., mindfulness), while organizational interventions are more difficult and are only beginning to emerge.

Health care organizations must embrace their responsibility to build an efficient practice environment and to foster a culture of wellness while also supporting physicians’ efforts to improve their own resilience. This model in no way relieves physicians of their own professional obligation to build and nourish their personal resilience while simultaneously playing key roles in helping their organizations to build a culture of wellness and to improve the efficiency of practice. While this model is broadly applicable to any professional calling, many of the specific drivers within each domain are unique to physicians and demand tailored interventions.

### Efficiency of Practice

*Efficiency of practice* is defined as the value-added clinical work accomplished divided by time and energy spent. Factors that contribute to physicians’ efficiency of practice include workplace systems, processes, and practices that help physicians and their teams to provide compassionate, evidence-based care for their patients.

*Health care organizations must embrace their responsibility to build an efficient practice environment and to foster a culture of wellness while also supporting physicians’ efforts to improve their own resilience. This model in no way relieves physicians of their own professional obligation.”*

Physicians have a deep intrinsic desire to provide optimal care for their patients. Excessive time pressures and chaotic work environments that impair patient care are thus associated with burnout. It follows that strategies that help clinicians to efficiently deliver high-quality care by re-engineering and continuously improving care processes and clinical workflows will improve physician well-being. Key targets for improvement include the usability of electronic medical records, adequate staffing (allowing physicians to spend more time doing work for which they are uniquely trained), mitigating regulatory and documentation burdens, maximizing user-friendly decision support, and facilitating reliable care coordination.

Efficiency of practice reciprocally affects the other two domains in that those who practice in an efficient clinical setting will have more capacity to improve their personal resilience by engaging in positive health behaviors. As their well-being improves, they can also better contribute to their organization's culture of wellness through healthier interpersonal interactions and by encouraging others to care for their own wellness. This virtuous cycle of reciprocity is complete when a more resilient medical staff, embedded in a culture of wellness, is better able to partner with administrative leaders to drive further improvements in efficiency of practice.

## Culture of Wellness

*Culture of wellness* is defined as a set of normative values, attitudes, and behaviors that promote self-care, personal and professional growth, and compassion for colleagues, patients, and self. Health care organizations that recognize physician well-being as a vital quality indicator will monitor and attend to it with sustained resourcing and an accountability structure that includes both clinical and administrative leadership. They will select leaders who exhibit characteristics and skills associated with the promotion of well-being and professional fulfillment and will support the development of those skills when there are gaps.



*Clinical leaders are particularly well-positioned to lead a paradigm shift in rejecting the historic 'iron doc' culture by encouraging physicians to extend to themselves and their colleagues the same natural compassion that they show to their patients."*

Clinical leaders are particularly well-positioned to lead a paradigm shift in rejecting the historic "iron doc" culture by encouraging physicians to extend to themselves and their colleagues the same natural compassion that they show to their patients. Leaders should *expect* physicians to attend to their own well-being and should view self-care as a professional core competency, abandoning the antiquated and dangerous misconception that self-care and patient care are competing interests.

It is essential to build a culture of appreciation, support, and compassion along with a deep sense of community.

For example, peer support programs that train clinicians to provide emotional support to colleagues may be effective ways to prevent harmful stress while contributing to a culture of compassion and a sense of community. Medical teams also can reduce harmful stress by ensuring that all team members feel safe when pointing out problems, rather than fearing retaliation or other negative reactions from colleagues or superiors.

A culture of wellness also exerts a reciprocal effect on the other two domains, as physicians who feel supported by their organizations tend to contribute more to improvement efforts that increase the efficiency of their practices. They are also more likely to attend to their own personal resilience when they are embedded in a culture that values and encourages this behavior.

## Personal Resilience

*Personal resilience* is defined as the set of individual skills, behaviors, and attitudes that contribute to personal physical, emotional, and social well-being — including the prevention of burnout. It is vitally important, in our inherently stressful profession, that physicians internalize a professional duty to pursue these healthy personal behaviors. Messages linking physician wellness to clinical care outcomes may be critically important to attenuate medical culture norms that characterize self-care as selfish. When cultural norms support self-care and clinical practice efficiency allows sufficient time margins for self-care, physicians are likely to strengthen their own personal resilience.

*When cultural norms support self-care and clinical practice efficiency allows sufficient time margins for self-care, physicians are likely to strengthen their own personal resilience.”*

There are numerous strategies that physicians can use to improve their resilience. For example, optimal nutrition, exercise, and sleep not only reduce the risk of burnout and improve general well-being but also have the potential to improve cognitive performance. Engaging in mindfulness-based stress reduction and compassion cultivation are also promising approaches to enhance personal resilience. Organizational strategies to promote personal resilience-enhancing behaviors include limiting work hours (for physician trainees and other busy clinicians), providing

convenient access to low-cost or free healthy food, providing on-site exercise facilities, and providing convenient places to take a nap (or relax or meditate) during on-call, overnight, or long-shift responsibilities.

Personal resilience exerts a reciprocal effect on the other two domains because healthy physicians are better contributors to their organization’s culture of wellness. They tend to “preach what they practice,” meaning that they are more likely to encourage positive health behaviors in colleagues (as well as patients) when they are engaged in these behaviors themselves. They are also more capable of embracing their vital role in improving their care processes to enhance efficiency of practice for themselves and their colleagues.

## A Balanced Approach to Physician Well-Being

It is increasingly clear that the growing threat to physicians' well-being directly threatens the quality of the care that they deliver as well as the health and effectiveness of the organizations in which they practice. Thus, it is highly appropriate that health care organizations are beginning to take responsibility for developing programs to address the crisis of physician burnout, and this research is rapidly expanding. We need comprehensive, systematic, and sustained efforts to improve physician well-being. These efforts will be most effective when they address drivers of physician well-being from each of the three reciprocally related domains of practice efficiency, a culture of wellness, and personal resilience. A balanced approach is necessary to build a stable platform that will drive sustained improvements in physician well-being and the performance of our health care systems. All of us who work in health care owe it to ourselves, to our patients, and to the next generation to work together to improve our practices, our culture, and ourselves.

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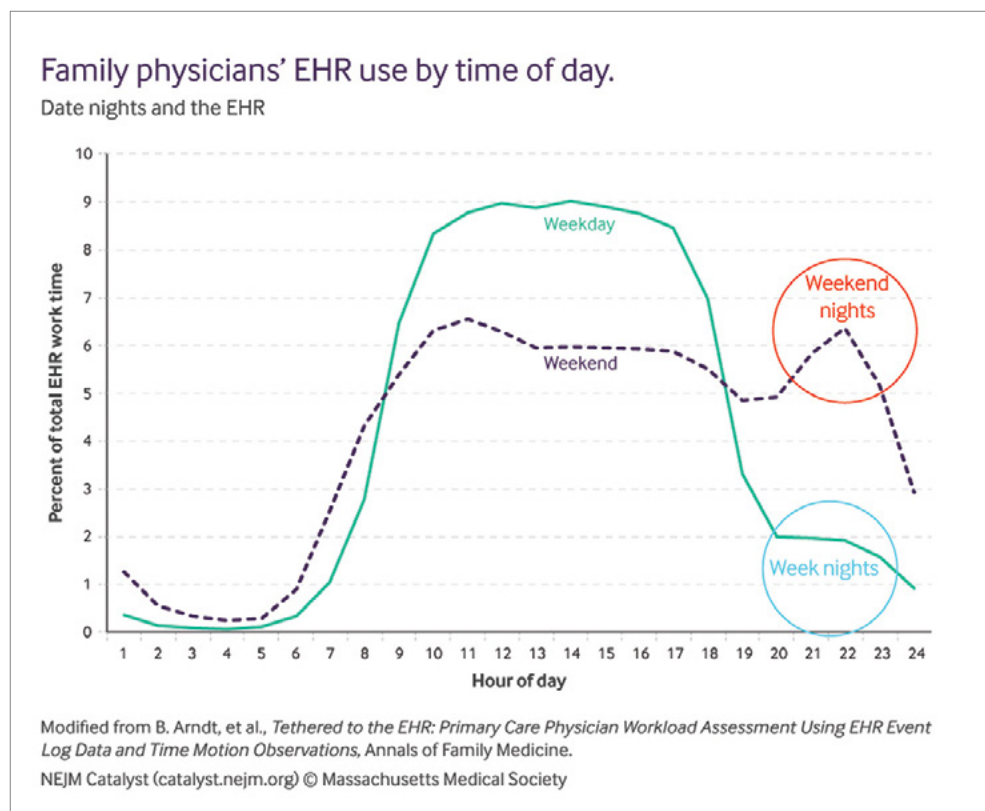


# Infographic: Date Night with the EHR

Infographic · December 12, 2017

Christine A. Sinsky, MD, FACP

American Medical Association



It is Saturday night. Do you know what your doctor is doing? Is she sitting on the deck with her husband watching the moon rise over the horizon? Enjoying conversation around the fire with her children? Returning home from a cultural night out? Heading to bed for a good night's rest?

Maybe. But there is also a good chance she is doing none of these restorative or healing activities, but rather is sitting in the glow of her computer screen, working down the inbox in her electronic health record (EHR), manually entering visit notes from patients seen during the week or providing perfunctory signatures for hearing aid batteries, diabetic shoes, and the like — none of which requires a medical education and little of which adds true value to patient care.

*It is Saturday night. Do you know what your doctor is doing?"*

An AMA-supported study we did of physicians in four specialties (family medicine, internal medicine, cardiology, and orthopedics) found that despite spending nearly 2 hours on EHR and deskwork for every hour of direct patient care during the workday, physicians routinely take 1–2 hours of EHR/paperwork home each night, an activity that has been called “pajama time.” Other studies have found similar data. Researchers at the University of Wisconsin tracked physician time in the EHR and found that their family physicians on average spend nearly 30 hours per month working after work on the EHR. Weekend activity peaks around 10 a.m., and again around 10 p.m.

For many physicians, weekends that should belong to romance, children, culture, healing, or sleep are intruded upon by the ever-present Epic, Cerner, Athena, or whichever EHR their organization uses. How can we address this?

To be sure, the solution to this is a shared responsibility. Here’s what we can do. Vendors can decrease the clicks and increase the ability to share tasks with team members. Regulators and payers can reduce non-evidenced-based requirements for signatures. Institutional leaders can support advanced models of team-based care with in-room documentation support by clinically trained assistants. And physicians can draw a line and say, for the sake of our patients and our families, we can no longer spend the majority of our days doing work that does not require the training society has invested in us. I want my doctor to love her job, and enjoy her weekends. Together, we can fix this problem.

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## Christine A. Sinsky, MD, FACP

American Medical Association

Dr. Sinsky is the Vice President of Professional Satisfaction at the American Medical Association. A board certified internist, she also practices at Medical Associates Clinic and Health Plans in Dubuque, IA.



# Survey Snapshot: Admitting We Can't Do This — Interventions and Tools to Reduce Clinician Burnout

Insights Report · April 27, 2018

Sandra Gittlen

NEJM Catalyst

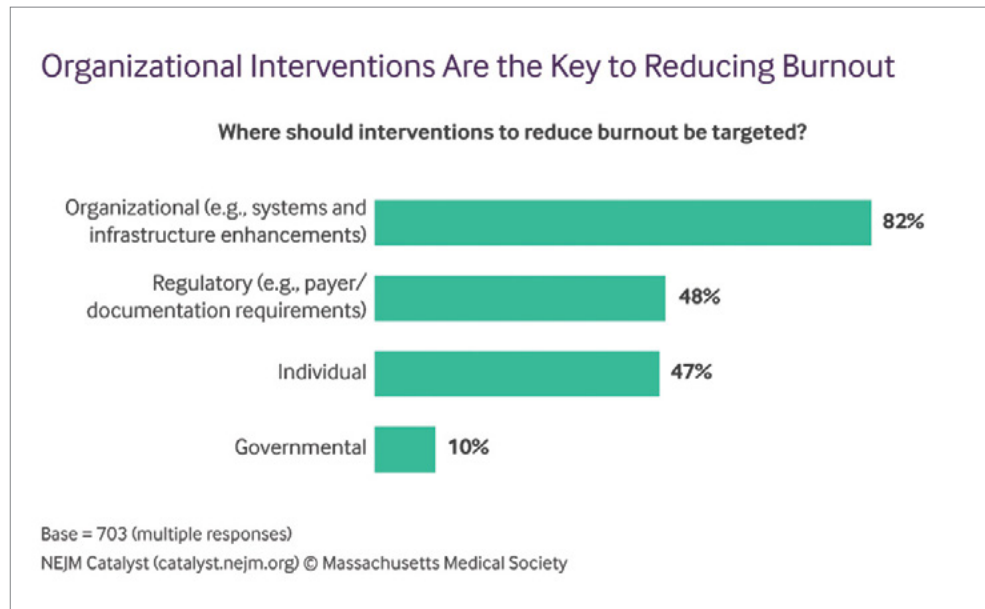
Lia Logio, MD, FACP, in a new role as Chair of Medicine at Drexel University College of Medicine, believes helping clinicians realize the importance of self-care can help mitigate burnout at the institution level.

“Part of the challenge in today’s health care environment is carving out time — time to connect with colleagues and pursue hobbies,” Logio says. “There is so much erosion of personal time for clinicians that their own time to connect and feel part of a community gets put on the back burner.”

*Do you realize how hard it is for me to admit to myself that I can't do this?”*

In a recent NEJM Catalyst Leadership survey, Immunizing Against Burnout, the great majority (83%) of respondents consider burnout within their organizations a serious to moderate problem. Logio, who has served as a program director for residency and internal medicine programs at multiple institutions over more than 2 decades, finds this “unsurprising”; she deals with burnout every day. She believes the solution lies in a partnership between the organization and the individual. Our survey results show that 82% of respondents believe interventions should be targeted at the organization, while nearly half say the individual.

Although burnout has been “elevated to commonplace,” Logio says, it is still difficult to get people to assess their own burnout status, which, in turn, makes it difficult for the organization to help. “There is this very strong self-efficacy sentiment for physicians,” she says, sharing the story of a physician who, after hearing her speak about burnout, came to her office and broke down in tears. “He said to me, ‘Do you realize how hard it is for me to admit to myself that I can’t do this?’” Logio says. In our survey, practicing self-care ranks as the top tool that individuals can use to reduce burnout, indicated by half (51%) of respondents.



Elizabeth Harry, MD, Assistant Program Director of the Internal Medicine Residency Program at Brigham and Women’s Hospital in Boston, studies cognitive load and believes burnout is intricately related to an increase in the complexity of things that clinicians deal with on a daily basis, including EMRs. Although she appreciates the flexibility of being able to chart from home so she can spend more time with her family, there is a clear downside to technology.



*They give short visits to folks who should have long visits and vice versa, which blows up [my] day.”*

She points to alert fatigue as an example. “The amount of data received is increasing logarithmically to where it’s not unusual for frontline clinicians to get multiple alerts while trying to admit a patient,” she says. This problem can’t be solved simply. “Everything introduced or taken away has a web of complexity so thick that when you change one node, you don’t know what else it changes and what consequences will occur down the

way. It’s known as a wicked problem.”

Like Logio, she considers burnout a shared responsibility between organizations and individuals. She likens the condition to the various stages of heart failure, saying it's important to identify and treat the problem early on. "With heart failure, we treat patients who are at risk before they have heart failure. We should do the same with burnout," she says. "You don't want to get to Stage B, where the clinician starts compensating for burnout symptoms; Stage C, where they start to suffer anxiety and depression; or Stage D, where they have suicidal ideation. You must create a culture where you make it easy for physicians to do the right thing and get help."

Logio sounds a similar note. "Most people who commit suicide have mental health problems, and those problems can either be mitigated by the culture of the organization or they can be exacerbated by sleep deprivation and other clinician demands," she says.

In Moriarity, New Mexico, Roger Felix, MD, is a staff physician at the three-clinic New Mexico Medical, a family practice and urgent care group that mostly serves an underserved population. He says the problems that lead to clinician burnout in his region are threefold: poor reimbursement, the nature of rural medicine, and the lack of medical expertise among schedulers.

"Everything in New Mexico is spread out and it's hard to get care to the people, so physicians wind up doing more than we would normally do," he says. He fits patients in, making sure to give them all the treatments they need while they are in the office and spending as much time as necessary with them. "We still don't get reimbursed enough for primary care," he says, which strains his group when patients need a little more care during their visits.



*With heart failure, we treat patients who are at risk before they have heart failure. We should do the same with burnout. ... You must create a culture where you make it easy for physicians to do the right thing and get help."*

Some of that could be overcome with better scheduling, he says. "They give short visits to folks who should have long visits and vice versa," which, he says, "blows up his day."

Offloading clerical tasks, as 54% of respondents suggest as a tool to reduce burnout, wouldn't help him, because he uses his documentation time as an opportunity to review the care he provided and think of other ways to help each patient.

A primary care physician herself, Logio also has felt the internal pressure of changing requirements. She says the things that motivate physicians — autonomy, mastery, and purpose — are being chipped away at in the new world of medicine.

Overscheduling is a widespread and growing problem, she says. "Some docs say to me, 'I can't go to grand rounds because I'm expected to see 12 patients and I'm behind on my patient visits.' It's become about numbers and efficiency and how fast you can do things — not about how well you do them."





Innovative programs like cross-training could help, where people are taken out of their day-to-day work and exposed to something new, Logio says. For instance, at a pharmaceutical company she visited, the management team encouraged workers to spend a portion of their work day in other divisions.

Aside from human welfare, there is also a business case for tackling burnout, Harry says. Brigham and Women's is a self-insured institution, so paying for preventative care makes sense to avoid employees taking sick days or experiencing at-risk behavior. Burnout causes high turnover, she adds, which is even more expensive considering that "the cost of replacing a physician is so high."

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## Sandra Gittlen

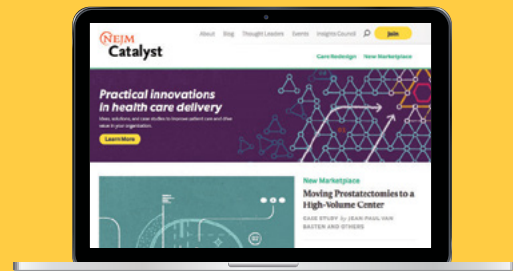
Contributing Writer, NEJM Catalyst



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