Evidence Based Approaches to Improve Physician Well-Being and Professional Fulfillment

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Disclosures

• I am employed by the American College of Physicians

• My spouse is employed by Merck and we own stock and stock options in the company
Imagine: Physician Well-being 2.0
What does it look like?

• Leaders, physicians, and hospital administrators work together using a QI framework to:
  • Improve the efficiency of the practice environment
  • Embrace human factors engineering and systems redesign
  • Focus on sustainable workloads, coverage for physicians when they are ill, appropriate and rest and breaks, offset intense periods of work with time off to recharge and optimization of team-based care
  • Role model caring about employees, cultivating relationships and inspiring change
  • Prevent burnout/occupational distress and promote thriving
Imagine: Elements of Wellness-Centered Leadership

![Diagram showing the 3 elements of the Wellness-Centered Leadership model.](image)
How are we going to achieve our vision?

1. Articulate the rationale for ongoing investment in physician well-being
2. Identify where you/your practice/organization are on the spectrum of addressing physician well being
3. Match strategies to advance physician well being to your current state
4. Lead from where you stand
Articulate the Rationale for Ongoing Investment in Physician Well-being
Physicians are the foundation of the US Healthcare System

• We are the system’s most valuable resource
• Recent national survey during the pandemic → 1 in 5 physicians plan to leave practice within 2 years
• In 2040 >20% of the US population will be over the age of 65 and they will need our care and expertise
• Both a challenge and an opportunity to radically transform the culture of medicine
• We need to join with other stakeholders to transform our system so that it better supports us personally and professionally

Physician Burnout is Associated with ↑ Medical Errors

Table 3. Association of a Self-Perceived Major Medical Error in the Previous 3 Months With Quality of Life, Burnout, Symptoms of Depression, and Empathy (N = 184)

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Metric (Scale)</th>
<th>Parameter Estimate (95% Confidence Interval)*</th>
<th>P Value†</th>
</tr>
</thead>
<tbody>
<tr>
<td>QOL</td>
<td>LASA overall QOL (0-10)</td>
<td>−0.39 (−0.72 to −0.06)</td>
<td>.02</td>
</tr>
<tr>
<td>Burnout‡</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depersonalization</td>
<td>MBI-DP (0-30)</td>
<td>2.45 (0.94 to 3.97)</td>
<td>.002</td>
</tr>
<tr>
<td>Emotional exhaustion</td>
<td>MBI-EE (0-54)</td>
<td>4.58 (1.71 to 7.46)</td>
<td>.002</td>
</tr>
<tr>
<td>Personal accomplishment</td>
<td>MBI-PA (0-48)</td>
<td>−2.59 (−4.22 to −0.97)</td>
<td>.002</td>
</tr>
<tr>
<td>Depression</td>
<td>Any positive 2-item depression screen</td>
<td>3.29 (1.90 to 5.64)§</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Empathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotive</td>
<td>IRI-EC (0-28)</td>
<td>−0.56 (−1.39 to 0.28)</td>
<td>.19</td>
</tr>
<tr>
<td>Cognitive</td>
<td>IRI-PT (0-28)</td>
<td>−0.72 (−1.59 to 0.15)</td>
<td>.10</td>
</tr>
</tbody>
</table>
Physician Burnout is Associated With ↑ Patient Complaints

- Retrospective cohort study of practicing physicians at Stanford
- Matched physician survey data with unsolicited patient complaints
- Calculated the Patient Advocacy Reporting System (PARS) score, a validated predictor of malpractice litigation risk and clinical outcomes
- Found a dose response association between occupational distress, sleep related impairment and unsolicited patient complaints
- Each 1-point increase in burnout and sleep-related impairment, on a 5-point scale, was associated with a 69% (odds ratio [OR], 1.69; 95% CI, 1.12-2.54) and 49% (OR, 1.49; 95% CI, 1.08-2.05) increased odds of being in the next higher PARS risk category
- Professional fulfillment was PROTECTIVE

Physician Burnout is Associated With ↑ Physician Turnover

<table>
<thead>
<tr>
<th>Table 2. Correlates and Outcomes of Burnout, Multivariable Regression Models Using Backward Variable Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parameter</strong></td>
</tr>
<tr>
<td><strong>Correlates of Burnout</strong></td>
</tr>
<tr>
<td>Overall Burnout, OR (95% CI)</td>
</tr>
<tr>
<td>Nonwhite (vs white)</td>
</tr>
<tr>
<td>Clinical FTE, %</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Emotional Exhaustion subscale, OR (95% CI)</td>
</tr>
<tr>
<td>Nonwhite (vs white)</td>
</tr>
<tr>
<td>Clinical FTE, %</td>
</tr>
<tr>
<td>&gt;20 y in practice (vs &lt;10 y)</td>
</tr>
<tr>
<td>Depersonalization subscale, OR (95% CI)</td>
</tr>
<tr>
<td>Male sex (vs female sex)</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td><strong>Outcomes of Burnout</strong></td>
</tr>
<tr>
<td>Emotional Exhaustion subscale</td>
</tr>
<tr>
<td>Leaving the organization, OR (95% CI)</td>
</tr>
<tr>
<td>Satisfaction with primary care physician communication, β (95% CI)</td>
</tr>
<tr>
<td>Depersonalization subscale</td>
</tr>
<tr>
<td>Ombudsman complaints, OR (95% CI)</td>
</tr>
</tbody>
</table>

**Abbreviations:** FTE, full time equivalent; OR, odds ratio.

Physician Burnout is Associated With ↑ Cost from Turnover

Table 2. Annual Cost Attributable to Physician Burnout in a Hypothetical Organization With 1000 Physicians

<table>
<thead>
<tr>
<th>Parameter/Model Output</th>
<th>Primary Care Physicians</th>
<th>Surgical Specialties</th>
<th>Other Specialties</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age &lt;55 y</td>
<td>Age ≥55 y</td>
<td>Age &lt;55 y</td>
<td>Age ≥55 y</td>
</tr>
<tr>
<td>U.S. physicians, %</td>
<td>28.1</td>
<td>14.2</td>
<td>12.6</td>
<td>7.5</td>
</tr>
<tr>
<td>Physicians in hypothetical organization, n*</td>
<td>281</td>
<td>142</td>
<td>126</td>
<td>75</td>
</tr>
<tr>
<td>Estimated average cost per employed physician, 2015 USD</td>
<td>7100</td>
<td>5900</td>
<td>10 800</td>
<td>9100</td>
</tr>
<tr>
<td>Total cost, 2015 USD</td>
<td>2 000 000</td>
<td>840 000</td>
<td>1 400 000</td>
<td>690 000</td>
</tr>
</tbody>
</table>

* Assuming physicians are distributed across segments according to national averages.

Physician Burnout is Associated with ↓ Quality

Table 4 | Results of regression analyses of standardized mortality ratios, length of stay, on burnout and unit characteristics ($N = 54$).

<table>
<thead>
<tr>
<th>Step and variables</th>
<th>Standardized mortality ratios</th>
<th>Length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Step 1</td>
<td>Step 2</td>
</tr>
<tr>
<td>1 Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>−0.17</td>
<td>0.08</td>
</tr>
<tr>
<td>2 Professional role</td>
<td>−0.35</td>
<td>−0.19</td>
</tr>
<tr>
<td>Trainee status</td>
<td>0.14</td>
<td>0.06</td>
</tr>
<tr>
<td>Leadership status</td>
<td>0.10</td>
<td>0.03</td>
</tr>
<tr>
<td>Team professional experience</td>
<td>−0.75</td>
<td>−0.77</td>
</tr>
<tr>
<td>Workload</td>
<td>−0.03</td>
<td>−0.10</td>
</tr>
<tr>
<td>Predicatability</td>
<td>−0.05</td>
<td>−0.12</td>
</tr>
<tr>
<td>3 Emotional exhaustion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depersonalization</td>
<td>−0.24</td>
<td></td>
</tr>
<tr>
<td>Personal accomplishment</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>$\Delta R^2$</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Adjusted $R^2$</td>
<td>0.07</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Standardized regression coefficients are reported for the respective regression steps.
Step 1 including control variables age and gender, step 2 including organizational characteristics, and step 3 including respective burnout dimensions.

*p < 0.05 (two-tailed test); **p < 0.01 (two-tailed test); ***p < 0.001 (two-tailed test).

Rationale

- Physicians are foundational to the healthcare system- there is no healthcare system without us

- Physician burnout has been associated with increased turnover, loss of productivity, medical errors, patient complaints and decreased quality of care

- It makes financial, moral and ethical sense to make ongoing investments in prevention of physician burnout and to create practice environments designed to support physician well-being and promote thriving
Identify Where You Are on the Spectrum of Addressing Physician Well-being
Era of distress
- Deity-like qualities
- Perfection
- No limits on work
- Self-care
- Isolation
- Performance

Well-being 1.0
- Hero-like qualities
- Wellness
- Work-life balance
- Resilience
- Connection
- Frustration

Well-being 2.0
- Human qualities
- Vulnerability & growth mindset
- Work-life integration
- Self-compassion
- Community
- Meaning and purpose

Use a QI Framework/ACP Resources to Improve Physician Well-being

- Step 1: Establish the What and Why for Change
- Step 2: Identify How to Measure Change
- Step 3: Plan for Change and Identify Solutions
- Step 4: Implement and Sustain Change
Match Strategies to Advance Physician Well-being to Your Current State
Interventions Improve Physician Well-being

• Systematic review of interventions published in 2016 by Colin West et al. showed that both individual-focused and structural or organizational strategies can result in clinically meaningful reductions in burnout among physicians.

• Overall improvement was 10%

• Organizational interventions were more effective than individually focused ones

Impact of Workplace Interventions on Physician Burnout

**SYSTEMATIC REVIEW ON PHYSICIAN BURNOUT**

**FIGURE 2.** Number of studies by intervention type. EHR = electronic health record.

NAM Organizational Evidence-Based and Promising Practices for Improving Clinician Well-Being: Seven Steps

1. Solicit ideas from all levels of stakeholders, including front-line clinical staff
2. Identify interventions that align with other organizational priorities
3. Look for interventions that simultaneously improve clinician well-being and patient experience
4. Identify metrics to assess the impact of implementing the intervention
5. Engage front-line clinicians in the planning, implementation, and assessment of the pilot
6. Pilot interventions with small groups of clinicians and patients before rolling out more broadly
7. Transparently share learnings from the pilot with staff and iterate to improve the effectiveness of the intervention.

https://doi.org/10.31478/202011a
Measurement

Shared accountability for clinician well-being is dependent on measurement of burnout, its potential drivers, and its consequences. Organizations should perform periodic assessments of the following:

1. **Clinician well-being**, using one of several **validated instruments** (i.e., Maslach Burnout Inventory [55], Mayo Well-Being Index [56], Stanford Professional Fulfillment Index [57], or the Mini-Z burnout assessment [58,59]);
2. **Departmental or business unit-level leadership qualities** [16] (i.e., a survey of leaders’ direct reports);
3. **The efficiency of the practice environment** [60] (i.e., by EHR-use metrics [11] and assessing team structure and function [20]);
4. **Culture and trust in the organization** (i.e., Agency for Healthcare Research and Quality Patient Safety Culture Surveys [61]; Mini-Z [62]);
5. **Organizational cost of clinician burnout** [15]; and
6. **Workforce recruitment and retention** [63] (i.e., through measures of intention to cut back clinical effort or leave the organization).
Box 1 | Resources for Health Care Leaders to Drive Transformative Change

1. Brigham Health Clinical Care Redesign pilot programs: Brigham and Women’s Hospital is seeking to redesign delivery of care for their patients through efforts that improve innovation in care delivery, technology, physician and patient engagement, and care transitions [31].

2. Stanford Medicine Chief Wellness Officer Course: Stanford Medicine offers a short workshop to train senior health care leaders in the principles of well-being and help them develop a strategic plan for their organization [32].

3. Vanderbilt Center for Professional Health: Vanderbilt University provides courses and tracks research and resources to promote professional health and wellness for physicians and other clinicians [33].

4. American Medical Association STEPS Forward modules: The American Medical Association compiles resources, including toolkits for “Creating the Organizational Foundation for Joy in Medicine” [34], “Establishing a Chief Wellness Officer Position” [10], “Chief Wellness Officer Roadmap” [9], and “Creating a Resilient Organization: Caring for the Healthcare Workforce during Crisis” [4].

5. Action Collaborative on Clinician Well-Being and Resilience case study series: The case study series examines features contributing to success of well-being initiatives at The Ohio State University [35] and Virginia Mason Kirkland Medical Center [36].
Responding to a Constantly Changing Landscape

ACP Well-being Champions and Chapter Support

ACP COVID-19 Physician’s Guide

ACP & Project N95 Partner to Provide PPE for Frontline Internists

ACP I. M. Emotional Support Hub

We See You. We Hear You. We Support You.

ACP’s IM Emotional Support Hub

Connect With ACP for Emotional Well-Being Support

Let's weather the storm together. With ongoing COVID-19 burdens and other challenges to physician mental health, it is crucial to take care of your own well-being and support colleagues who may be feeling overwhelmed. Connect with a large peer community and explore other resources at ACP's Emotional Support Hub.

Curated resources include:

- Free peer support through the Physician Support Line
- Confidential counseling through The Emotional PPE Project and The Therapy Aid Coalition
- Self-compassion guided practices
- Well-being interventions designed for busy healthcare workers

Visit the Hub

SCAN ME
Strategies to Support Organizational Posttraumatic Growth

• Debrief unit by unit as well as by profession

• Catalogue what was learned and update the crisis plan for next

• Deploy an organization-wide approach for supporting the workforce after the crisis;

• Identify new needs to facilitate recovery and restoration.

• Honor the dedication, commitment and sacrifice of healthcare professionals

• Memorialize health care professionals that have been lost

• Resume efforts to attend to organizational and system factors that promote well-being and create a resilient organization

Clinician WBPF Resources in the Intersection of Advocacy and Quality Video Series

• In Partnership With YouTube, ACP Addresses Vaccines, COVID-19 Misinformation

• Self-Advocacy Resources for Residents and Fellows
Resident Well-being Learning Hub

- Aligned with the new ACGME requirements for resident training in well-being
- This learning hub is designed to foster conversations between residents, faculty and leadership
Creating and Sustaining Change Efforts
Curated Resources

- ACP Advance Quality Improvement (QI) Curriculum
- Appreciative Inquiry: Mini But Mighty Skills for Well-being
- A Call to Action: Align Well-being and Antiracism Strategies
- Five Evidence-Based Actions Leaders Can Take Now to Support the Healthcare Workforce
- Team-Based Care Toolkit
- Library of Well-being Interventions

Improving the Practice and Organizational Environment

ACP provides clinicians with high quality information, resources, tools, and support to help your practices thrive.

SCAN ME
Lead from Where You Stand
Take Time to Support and Nurture One Another
#Don’tworryalone
Stop Expecting Yourself to Be Perfect
Clinician Well-being Resources

Advocacy

Toolkit: Revising License and Credentialing Applications to Not Ask About Mental Health
Examples of Organizational Strategies to Support Physicians

Encourage/role model for colleagues:

• Acknowledge the need to shift away from the 24/7 “always on” culture
• Reduce administrative burdens: frequency of meetings, e-mails, townhalls, online modules
• Take breaks during work
• Take unplugged vacation time
Honor The Dedication, Commitment and Sacrifice of Physicians

• Memorialize physicians that have been lost

• Create safe spaces for conversations about
  • What has happened
  • What do you imagine will happen next

• How can you find meaning in the events that have occurred?

• Work that benefits others – often those with similar experiences, those in your community

• Includes advocacy work - ACP Advocacy

• Includes mentoring and teaching
In Summary

1. There is a compelling rationale for ongoing investment in physician well-being
2. Organizational/systems interventions are more impactful than individual ones
3. Use simple QI methodology to test interventions
4. Lead from where you stand and build on what is working
Thank you to Drs. Liz Lawrence and Eileen Barrett, ACP WB Champions, from NM and Crissy Walter who runs our national program at ACP.

Questions?

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References

References


Consider an Organization-wide Approach For Supporting Physicians After the Pandemic

• Encourage colleagues to seek help
  • Leaders share personal stories and their own vulnerabilities
  • Work on licensing laws around best-practice wording: use the ACP toolkit to help
  • Continue to provide It is important to continue to provide confidential and readily accessible emotional, psychological, mental health support for 6-12 months after the crisis has passed.

• Build a peer support program
  • AMA Steps Forward module on peer support
  • Check out PeerRx for building a buddy program – or just signing up with a partner - https://www.peerrxmed.com/
Identify New Needs To Facilitate Recovery And Restoration

• Emotional regulation: anger, guilt, exhaustion, fear

• Use ACP resources to help identify these needs, support colleagues, and process emotions
Physician burnout is associated with

- **Increased self-reported medical errors**

- **Increased patient complaints**
Physician burnout is associated with

• **Increased physician turnover**

• **Decreased productivity**
Physician burnout is associated with

- **Decreased quality of care**
Physician Well-Being 2.0: Individual

- Hero → human
- Wellness → vulnerability and growth
- Work-life balance → work-life integration
- Resilience → Self-compassion
- Connection → Community
- Frustration → Meaning and purpose
Physician Well-being 2.0: Organizations

- Awareness → action
- Focus on needs of patients → Focus on needs of people
- Choice → flexibility
- Team → system solutions
- Treat distress → prevent distress, cultivate fulfillment
- Carrots and sticks → aligned autonomy
- Blame individuals → shared responsibility
- Return on investment → value on investment
- Adversarial relationship between physicians & administrators → physician-administrator collaboration