The True Cost of the Burnt Out Physician

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DISCLOSURES/DISCLAIMERS

I have no conflicts of interest
The True Cost a Burnt Out Physician

Objectives:
1. Review the scope of Physician Burn Out
2. Define differences between Wellness, Resiliency and Burn Out
3. Discuss Causative factors
4. Review Implications
5. Briefly Outline Mitigating Organizational Strategies
WHAT ARE WE REALLY TALKING ABOUT?
1. Burnout-Wellness-Resiliency-Professional Satisfaction
Wellness:
Sleeping well
Eating well
Exercise
Stress reduction
Spirituality

Taking care of ourselves!

Burnout:
Syndrome characterized by exhaustion, cynicism and reduced effectiveness.

Resiliency:
The ability to adjust to difficulty, negativity, or hardships.
Capacity to respond to stress in a way such that goals are achieved at minimal psychological and physical cost

Why we need to be cautious with “Resiliency”...

If stretched for a long time and held under constant stress though, - lose elastic properties AND SNAP!
Nearly a third of new doctors at high risk for depression

Why Do Doctors Commit Suicide?

By PRANAY SINHA  SEPTE 4, 2014

Doctors Unionize to Resist the Medical Machine

An Oregon medical center’s plan to increase efficiency by outsourcing doctors drove a group of its hospitalists to fight back by banding together.

By NOAM SCHEIBER  JAN. 3, 2016

THE SILENT ANGUISH OF THE HEALERS

BY NEWSWEEK STAFF ON 9/12/99 AT 8:00 PM
Medical Research in this area has exploded!

Published online 2013 Sep 4. doi: 10.1007/s11606-013-2597-8
PMCID: 10 Bold Steps to Prevent Burnout in General Internal Medicine
Mark Linzer, MD, Rachel Levine, MD, MPH, David Meltzer, MD, PhD, Sara Poplau, BA, Carole Ward

Medscape Family Medicine
Physician Burnout: It Just Keeps Getting Worse
Carol Peckham
Disclosures January 26, 2015

Is Your Doctor Burned Out? Nearly Half of U.S. Physicians Say They’re Exhausted
Burnout and poor work-life balance are a bigger problem for doctors than other professions
By Alexandra Sifferlin @acsifferlin Aug. 21, 2012 24 Comments
## Burnout- The Stats

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Turnover related to Burn out:</strong> $250,000/departing physician</td>
<td>Buchbinder et al. <em>Am J Manag Care</em> 1999;5:1431-8</td>
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<td>Of 17,000 Physicians 48% cutting back, retiring early, trying to find ways to limit patient care <strong>secondary to burnout</strong></td>
<td>2016 American Physicians Foundation Survey</td>
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<td><strong>Relative to physician burn out:</strong> 1) reduced patient access to care, 2) reduced patient satisfaction, 3) reduced patient medication adherence</td>
<td>Linn et al. <em>Med Care</em> 1985;23:1171-78; DiMatteo. <em>Health Psychol</em> 1993;12:93-102</td>
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<td>Female physicians are 2.3 X’s more likely to commit suicide than women in the general public</td>
<td>Typical Dr has 2300 in a panel= 1 million patient per year lose their physician to suicide</td>
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“Burnout- Heading In the Wrong Direction”

Shanafelt et al, 2015
Mayo Clinic Proceedings

Highest rates in front-line specialties:
Family Medicine, General IM and Emergency Medicine

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<tr>
<th>Specialty</th>
<th>2011</th>
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<td>Mean burnout among all physicians</td>
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<td>General surgery subspecialty</td>
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<td>Radiation oncology</td>
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<tr>
<td>Other</td>
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<td>Preventive medicine/occupational medicine</td>
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% Reporting burnout
HOW DID WE GET HERE?

1. **Electronic Medical Record**
   more than 50% of our time on EHR and desk work-27% of time with patients-

2. **Workplace demands** (do the same amount of work in less time)

3. **Culture of Medicine has changed but the stressors have not gone away** -(More about Regulatory aspects, Billing, Documentation, Metrics, Tracking, Satisfaction scores, Incentives-
   Less about the patient, the connection, the diagnosis, the colleagues and team structure)

4. **Inefficient Chaotic work environments**

5. Limited or no control over workload or schedule

6. Less resources available to complete the work

7. Less ability to shape career to focus on interests

8. Work load is commonly part of the home environment

9. Insufficient time to document adequately

10. Medical decision-making completed more by outside guidelines
Annals of Internal Medicine

Original Research

Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties

Christine Sinsky, MD; Lacey Colligan, MD; Ling Li, PhD; Mirela Prgomet, PhD; Sam Reynolds, MBA; Lindsey Goeders, MBA; Johanna Westbrook, PhD; Michael Tutty, PhD; and George Bliek, MD

Background: Little is known about how physician time is allocated in ambulatory care.

Objective: To describe how physician time is spent in ambulatory practice.

Design: Quantitative direct observational time and motion study (during office hours) and self-reported diary (after hours).


Participants: 57 U.S. physicians in family medicine, internal medicine, cardiology, and orthopedics who were observed for 430 hours, 21 of whom also completed after-hours diaries.

Measurements: Proportions of time spent on 4 activities (direct clinical face time, electronic health record [EHR] and desk work, administrative tasks, and other tasks) and self-reported after-hours work.

Results: During the office day, physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work. While in the examination room with patients, physicians spent 52.9% of the time on direct clinical face time and 37.0% on EHR and desk work. The 21 physicians who completed after-hours diaries reported 1 to 2 hours of after-hours work each night, devoted mostly to EHR tasks.

Limitations: Data were gathered in self-selected, high-performing practices and may not be generalizable to other settings. The descriptive study design did not support formal statistical comparisons by physician and practice characteristics.

Conclusion: For every hour physicians provide direct clinical face time to patients, nearly 2 additional hours is spent on EHR and desk work within the clinic day. Outside office hours, physicians spend another 1 to 2 hours of personal time each night doing additional computer and other clerical work.

Primary Funding Source: American Medical Association.
Example of “the perfect storm”

EHR/Portal Messaging: Allows patients to get their results in “real time”.

Patients See their medication lists after visits; better adherence and compliance

Send messages when unclear of how to proceed with their health care

Get their refills faster!

Notes readily available for their other healthcare providers or in urgent situations.

Labs and tests and notes come to the provider all day to see results as quickly as possible

Organization gets incentives if providers use the portal and sign their patients up for using the portal in a meaningful manner
Primary care- average of 77-107 electronic message/notifications per day (test results, values, questions which required 1-7 minutes of work at the minimum

48% of the messages required a greater cognitive burden.

Extrapolated: One hour and 7 minutes per day processing messages (then documentation of the encounter on top)

Documentation in general: many of the physicians consider their documentation in the electronic medical record to be equal to the job of a data entry person

Health systems pay their highest paid employees and their most well trained professionals to complete data entry!

Less cognitive time for innovative, diagnostic, medical maintenance, skill development.
WHY CARE?
Organizational Climate, Stress and Error in Primary care: The Memo Study  
30% more likely to leave job in 2 years

Patient care outcomes linked to work conditions

Strong relationships between work conditions (time pressure, work control, chaos, organizational culture) and physician satisfaction, stress, burnout, intent to leave earlier than expected.
Job satisfaction: Business Case

Harvard Business School: stocks rose 147% when employee satisfaction rose

In 7900 businesses: productivity and income tied to employee satisfaction

Sears: when employee satisfaction rose 4%, sales increased by $200 million, with a rise in customer satisfaction
Burnout: Syndrome of exhaustion, cynicism, and reduced effectiveness

1. Less committed and less **productive** physicians

2. Statistics show us poor **quality of care** with higher burn out scores

3. Less desire for **patient and team engagement**

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Burnout: Syndrome of exhaustion, cynicism, and reduced effectiveness

4. Statistics show an increased rate of patient **safety errors** with higher burn out scores (Increasing stress and burnout)

5. Lower **patient satisfaction** scores with higher burn out scores

   Repetition, medical malpractice, health system or practice reporting to regulatory agencies. **COSTLY**

   Loss of patients
Burnout: Syndrome of exhaustion, cynicism, and reduced effectiveness

Physician turnover and retention problems with higher burn out scores

Decreased professional effort

Poor test ordering, errors with scripts, increased risk of malpractice

At the least is 295,000
Usually 2 times the salary in recruitment, loss of patients, relocation

$$$$

Malpractice and errors
1. Overall, I am satisfied with my current job:
   - Strongly disagree
   - Disagree
   - Neither agree nor disagree
   - Agree
   - Agree strongly

2. I feel a great deal of stress because of my job:
   - Strongly disagree
   - Disagree
   - Neither agree nor disagree
   - Agree
   - Agree strongly

3. Using your own definition of “burnout”, please circle one of the answers below:
   1. I enjoy my work. I have no symptoms of burnout.
   2. I am under stress, and don’t always have as much energy as I did, but I don’t feel burned out.
   3. I am definitely burning out and have one or more symptoms of burnout, ex. emotional exhaustion.
   4. The symptoms of burnout that I’m experiencing won’t go away. I think about frustrations at work a lot.
   5. I feel completely burned out and often wonder if I can go on. I am at the point where I may need to seek help.

4. My control over my workload is:
   - 1 – Poor
   - 2 – Marginal
   - 3 – Satisfactory
   - 4 – Good
   - 5 – Optimal

5. Sufficiency of time for documentation is:
   - 1 – Poor
   - 2 – Marginal
   - 3 – Satisfactory
   - 4 – Good
   - 5 – Optimal

6. Which number best describes the atmosphere in your primary work area?
   - Calm
   - Busy, but reasonable
   - Hectic, chaotic
   - 1
   - 2
   - 3
   - 4
   - 5

7. My professional values are well aligned with those of my department leaders:
   - Strongly disagree
   - Disagree
   - Neither agree nor disagree
   - Agree
   - Agree strongly

8. My professional values are well aligned with those of our organizational leaders:
WHY CARE IN HEALTH CARE

• Clinical Performance
• Re-admissions, and length of stay
• Patient safety errors,
• Recruitment and Retention
• Access to Care
REFLECTION

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD¹
Christine Sinsky, MD²,³

¹Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California San Francisco, San Francisco, California
²Medical Associates Clinic and Health Plan, Dubuque, Iowa
³American Medical Association, Chicago, Illinois

ABSTRACT

The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely accepted as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.

“Don’t avoid the burned-out physician, avoid the organization who burned them out”

PHYSICIAN BURN OUT SCORES:

The quality indicator now available on all web sites!
Common sense “take aways”:

….eat well, sleep well, spend time w families and friends, we have more satisfaction in our life

- If an accountant had one hour to do a financial plan perfectly but was told he/she now needed to get 3 done per hour. They might worry if it was accurate. They might have more errors. They might not feel so good about their job. They might decide their job is not as good as it used to be. It might not feel safe. BUT they will never have to worry that their direct error or decision might cost someone their life or health.

We can certainly figure out how to do the electronic medical record well enough- maybe even meaningfully, we are smart people- however it makes common sense that we are living with piles of paperwork of which our counterparts(lawyers) get paid to complete that we will never begin to see reimbursement for in our lifetime.
Common sense take aways:

That it feels punitive to have no schedule flexibility when we know we might need a 15 min break in the middle of the morning to call patients, ask colleagues for advice, answer a patient complaint, finish a thought on my note, finish my cold coffee, refill a medication and decide all on my own THIS PATIENT MEEDS MORE TIME!
Common sense take always: It is common sense that

That we WANT to be a part of the decision making and brainstorming of how to have us best work in this environment and how we can do everything we can to improve the outcomes of our patients.

If we are given the opportunity to actively participate in how our work is completed, and then when we are less burnt out, we have more productivity and are more enthused about being a part of the important initiatives all around us.

We benefit, the organization benefits and the patients benefit!
WHAT’S NEXT:

Define it, Know the scope
Acknowledge and Assess the problem (i.e. AMA survey)
Senior Leadership and Physician Leaders need to be involved together
ALWAYS KEEP THE PATIENT IN THE CENTER!

Don’t make a narrow list of solutions
Acknowledge and Assess
Make deliberate organizational changes
Determine exactly what are the incentives desired

Align values and strengths
Promote Flexibility and work-life integration
Promote healthy resiliency
Facilitate and fund career efforts
So why do we care about “what is the true cost of a burnt out physician”? 

First and foremost: Because it is about human decency
Burnt out Physicians at VCU
Recovery and Organizational Change

1. Our VCU AMA Burn Out Survey Results
2. Mitigating Burn Out
3. Strategies across the continuum
4. Promoting professional satisfaction

a. Negotiate scribes
b. Discuss better work schedules with flexibility
c. Physicians should be at the forefront of making decisions
d. Allow others to do what is not Physician work
e. Develop floater pools when someone needs to catch up or needs respite
f. Buy pizza now and then!!