Capstone Project for the American College of Physicians:

Burnout Among Hospitalists- Time to "Walk the Talk"

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Project Overview

The focus of this research project is physician burnout. In reviewing the current medical literature, I did a systematic review of various medical databases including PubMed, Entrez, PsycINFO, Embase, Google Scholar among others. The scope of this project includes the following:

- Define physician burnout, and describe its signs and symptoms among physicians.
- Ascertain the scope of the problem.
- Describe the causes of burnout among internists and hospitalists
- Explain the consequences of burnout among hospitalists, given the complexity and multidimensional aspects of their jobs.
- Evaluate and recommend interventions to either prevent or address burnout in hospitalists, particularly at the local institutional level.
- Determine whether currently recommended interventions have had any impact on reducing burnout among Hospitalists.
- Asking the question- Does investing in physician wellbeing by healthcare organizations makes financial sense?
- Analyze interventions initiated at our institution.

What is the problem?

Physician burnout is a syndrome marked by emotional exhaustion, depersonalization, and a lack of sense of personal accomplishment primarily due to stressors in the workplace. It is one of the most pressing issues facing the medical community today and has reached epidemic levels. There is a plethora of research in the medical literature attesting to the increasing impact of stress and burnout on physician lives and performance.[1,2] National studies reveal that burnout is more common in physicians than American workers in other fields and this gap is worsening.[3,4] In a landmark Mayo Clinic-led study, the number of physicians who admitted to at least one symptom of burnout on the Maslach Burnout Inventory (MBI) increased almost ten percent over a three year period. The study investigators noted a rise from in just three years; from 45.5 percent in 2011 to 54.4 percent in 2014.[4] Clinical leaders and administrators have finally begun to realize the gravity of the problem. Ninety-six percent of healthcare leaders surveyed recently by the NEJM Catalyst acknowledged burnout as a moderate or serious threat to the health care system.[5]

Being at the front lines of medical care, internists and hospitalists are prone to burnout. Physician burnout among physicians is not new; in fact, it has been recognized as a constant problem in hospitalist medicine since its inception. A 1999 study by the National Association of Inpatients revealed a 13 percent burnout rate among hospitalists, while an additional 25 percent were felt to be at risk for burnout.[6,7]In 2013 the overall "burnout rate" was 42 percent.[8]

While physicians of all specialties may express job dissatisfaction, hospitalists are at a higher risk of experiencing burnout because they are much closer to the corporate practice of medicine and face additional stresses unique to their specialty. Only Emergency Physicians and Ob/Gyn physicians reported a higher rate of burnout at 59 percent and 56 percent respectively.[9]

The burnout rates are almost equivalent among hospitalists and outpatient general internists. A 2014 Journal of Hospital Medicine noted more than 52 percent of hospitalists and nearly 55 percent of outpatient internists were affected by burnout.[10] Hospitalists differed from internists in some ways. For example, hospitalists were more likely to have low scores on one key symptom of burnout: personal accomplishment. However, both scored similarly in other areas including emotional exhaustion, and depersonalization. Forty percent of hospitalists reported symptoms of depression and 9 percent reported noted recent suicidal thoughts.[10]

The 2017 Medscape Lifestyle Report revealed a higher percentage of burnout by female physicians (58 percent) compared with their male peers (52 percent). The percentages have trended upwards for both men and women since this question was first asked by Medscape in 2013.[9]

Data reveals that is a national phenomenon. Internist burnout rates were highest in the Northeast (60 percent), Mid-Atlantic (58 percent), and Northwest regions (57 percent) and lowest in the Southeast (48 percent) and North Central (49 percent) region according to the 2017 Medscape survey.[9]

What is physician burnout?

Burnout is defined in this paper and other major studies as a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment. The Maslach Burnout Inventory(MBI), a validated 22-item survey designed to measure the 3 aspects of burnout, emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA), is the instrument used in most studies of physician burnout.[11]. A simpler, non-proprietary, validated, version, using a single-item measure of burnout is also available and has been used widely.[12] The General Health Questionnaire, Nursing Stress Inventory, The Copenhagen Burnout Inventory and the Shirom-Melamed Burnout Questionnaire (SMBQ, among others, are alternative validated measures.[13-16]

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What causes burnout?

Most physicians are altruistic and passionate about their field of training. They tend to view the medical profession as a vocation and not just as a job. Their training is arduous with years of long work hours. They often end up making personal and financial sacrifices to obtain training. They are taught to address various types of complex problems and to deal with challenging case scenarios all with the aim of providing quality, compassionate healthcare. Obstacles that prevent them from providing quality health care remain the leading cause of burnout.[17,18]

Recent years has witnessed tremendous changes in the healthcare industry that have affected clinical practice. At one time, most physicians ran their own clinics and could control the parameters of care. This is no longer the case. A survey conducted by the Physicians Advocacy Institute, a not-for-profit organization, and the healthcare consulting firm Avalere Health found that one-in-four medical practices are now owned by a hospital or health system.[19] Most physicians are now employees of health care systems, and have lost control of these parameters or "care metrics." Many feel that it is this loss of autonomy that is a major risk factor for burnout as an increasing number of doctors are becoming overworked employees rather than care providers.[20,21]

Other causes of burnout include increased performance measurement reporting, the increasing complexity of medical care associated with an aging population and the introduction of computerized physician order entry aka electronic health records (EHRs). These have altered workflows and physician-patient interactions. The consequences are that many previously well-

adjusted and engaged physicians are stressed to the point of burnout, prompting them to go part-time, retire early, or leave the profession altogether for other avenues.[22-26]

Other contributing factors to burnout including increases in regulatory and payer demands and pressures to increase productivity have left many physicians feeling unable to provide the quality of care they would like. One unintended casualty of the requirements for this increased documentation is an impaired physician-patient relationship. A study of ambulatory care physicians revealed that they spend almost twice the time on nondirect patient care EHR and clerical and administrative tasks (49.2 percent) compared to direct face time with the patient (27 percent).[27] Many physicians report spending another one to two hours each evening finishing documentation and administrative tasks at home, dubbed "pajama time."[27] All this takes away from a physician's primary purpose -practicing medicine and helping people.

Why does burnout especially affect the hospitalist profession?

The answer lies in in their role as the "Primary care physicians in the hospital." Once a patient is admitted to the hospital, either through the ER or as a direct admission, the hospitalist is the one who is primarily "running the show," as their attending physician or as a consultant with other specialists.

One significant burnout factor is the constant rounding with its relentless pace. The hospitalist travels many places; from the emergency room to the medical floors, from the surgical floors to the intensive care unit and even the inpatient psychiatry unit. Hospitalists are under pressure from the administration to discharge patients before noon to allow faster and more efficient patient throughput. Hospitalists are also "graded" on the rapidity of their responsiveness, including ED response time. The constant pressure of performing at "full steam" all day long for up to seven days at a time is a key factor in physician burnout.[28-30]

Other factors contributing to burnout include:

-**The many physician "jobs**:"-Frequent interruptions by being continually being paged by nursing/lab/radiology/ER/pharmacy. Throughout the day, nurses page with questions, pharmacists request clarification of medication orders, case managers call in with discharge queries, coders call in their specific queries – all of which constantly interrupt physician workflow. It becomes quite difficult to multitask and focus on patient care. A small study done in 2006 evaluating the time hospitalists spent on different aspects of patient care revealed that they spent 18 percent of their time on direct patient care, 69 percent on indirect patient care and received an average of 3.4 ± 1.5 pages per hour.[31]

-The7-on, 7-off shift structure: This is the typical shift structure utilized in many hospitalist programs. While the idea of having 26 weeks off per year is enticing, the degree of burnout working those seven days in a row is grossly unrecognized. At the time this schedule was designed nearly 20 years ago, almost every hospitalist was young, between the ages of 28 to 35.

But the demographics have now changed. Now, most hospitalists are older with only 12 percent aged 34 years or younger. Seventy-five percent of hospitalists are aged 45 or older[32]. The 7-day-on, 7-day-off schedule is suitable for a 30-year-old finishing residency taking his or her first job and not viable for an older hospitalist.

-**The lack of respect**: Some hospitalists feel they are treated as glorified residents.[33] Far from treating hospitalists as the team lead in a hospital setting, other professionals and patients treat them as interns, Hospitalists also perceive themselves as a "dumping ground" for difficult patients and inconvenient admissions, such as those that come in on a Friday evening when their specialist colleagues are eager to head home. Becker's Hospital Review assessed feedback from hospitalists at three hospitals in different parts of the country. In those conversations, hospitalists complained about their specialist colleagues for failing to return calls, ignoring consults, or providing patients with information without first conferring with the hospitalist in charge of their care.[34]

-**The electronic health record (EHR**): They cause stress for hospitalists only in part because they are cumbersome and not user-friendly. EHRs are programmed primarily for billing purposes and data storage, rather than as tools to improve the physician's clinical workflow.[27] The bigger issue is that the complexity of using the EHR often leads doctors in most other specialties to back off from direct in-hospital patient care. This forces the hospitalists to manage much of the medication management and documentation that should have been done by the specialists.[35]

-**The patient status determination**: Hospitalists also bear a huge burden regarding observation status. Doctors in most other specialties rarely face complex decisions regarding whether observation or inpatient is the right choice and are often the target of patient/family frustration and anger related to admission status.[35]

-**The jack of all trades phenomenon**: Another huge burnout factor is having to multitask. Hospitalists are constantly multitasking and functioning as a "jack-of-all-trades." A 2006 study published in the Society of Hospital Medicine revealed that multitasking by hospitalists was done 21 percent of the time. The inherent distraction caused by frequent interruptions and multitasking is a potential contributor to medical errors.[31]

-**The unpredictability of the day**: Having to round on 15 to 20 patients while dealing with constant pages from nursing, pharmacist, documentation specialists, meeting with case managers, calling insurance for peer to peer reviews, admissions from the ED, rushing to a rapid response or code blue becomes very stressful.

-**The lack of leadership skills training**: A leadership role one is not trained for- Hospitalists often complain about how they are thrust into the position as the leader of a healthcare delivery team without receiving any formal leadership skills training.[36]

What is the fallout from burnout?

Among physicians (applicable for both Internists and Hospitalists) burnout has been linked to:

- Decreased work satisfaction
- Disrupted personal relationships
- Increased substance abuse
- Decreased productivity,
- Higher job turnover,
- Early retirement
- Increased depression rates
- Increased abuse of alcohol
- Suicide-Every year, 300-400 physicians in the United States commit suicide. Female physicians are 2.3 times more likely to commit suicide than are female nonphysicians; for males, the risk is 1.4 times higher among physicians compared to the general population. [37-48]

From a quality and safety perspective, burnout is associated with

- Higher medical errors
- Reduced quality of patient care
- Lower patient satisfaction
- Increased risks of medical malpractice suits
- Impaired interpersonal teamwork [36,49,50-53]

Public Health Impact: Manpower Issues

Burnout is also contributing to a growing shortage of physicians as they leave the practice of medicine or decrease hours worked due to burnout. In March 2015 the Association of American Medical Colleges published their projections for physician supply and demand during the next ten years. The chilling fact- demand is growing faster than supply, leading to a projected shortfall of 46,100 to 90,400 physicians by 2025**.**[54]

A study in 2012 indicated that 6 out of 10 physicians would quit medicine if they were financially able to do so. They were more likely to recommend others against pursuing a medical career exacerbating the already severe physician shortages in some areas**.**[55,56]

Cynicism about a career in medicine

A recent survey by the Physicians Foundation revealed that 63 percent of respondents had negative feelings about the course of medical profession in the future and that 49 percent would not recommend a career in medicine to their children.[57]

What are the current recommendations to mitigate this epidemic? Are we just "Talking the Talk"?.

Although awareness and recognition of burnout have grown substantially over time, successful interventions to prevent or mitigate burnout have not. Many potential interventions and ideas have been suggested, but none have had a substantial impact or have been adopted within or across institutions. As of this writing, no government body has publicly addressed the issue of physician burnout in the U.S. or its toll on health care.[58]

According to a Modern Healthcare survey of approximately 100 healthcare CEOs, only about one-third reported that their organization had programs to address physician burnout, and another one-third were in the process of developing such programs.[59]

There have been some positive developments recently.

Over the past few years, clinical leaders and administrators have started to recognize that burnout is a problem: The CEO of the American Medical Association and leaders from 10 prestigious health systems wrote a March 2017 post on the Health Affairs Blog titled "Physician Burnout is a Public Health Crisis: A Message to Our Fellow Health Care CEOs." They acknowledged that physician burnout is public health crisis, committed themselves to mitigating it and invited other healthcare administrators to join them in their efforts.[60]

There is, however, still a long way to go with physicians voicing increasing frustration over the slow pace of reforms. The encouraging news is that at least there is a lot of activity and discussion around trying new interventions to reduce burnout, in both medical schools and graduate training programs. The thought is that if one starts employing healthy resilience strategies during training, these can be carried throughout a career to diminish the risk and severity of burnout.

What are interventions to address physician burnout?

Most studies focusing on physician burnout have identified two broad categories of interventions that seem to have some impact: individual-focused approaches and organizational solutions**.**[61] These interventions focus either on developing physician resiliency or on making organizational changes that reduce the precipitants of burnout. Although both types of initiatives come highly recommended, studies indicate that physician-directed interventions aimed at individuals aiming to enhance personal resilience and coping skills are associated with small but significant reductions in burnout. Organization directed interventions aimed at reducing workload and enhancing teamwork and leadership were felt to have a greater impact.[1,62,63.] In May 2017, the Physician Burnout Workgroup of the American Psychiatric Association began a meta-analysis of 26 RCTs of burnout interventions. Preliminary findings show that 71 percent of institution-

targeted interventions successfully reduced burnout, while only 42 percent of physician-directed efforts achieved this, supporting the prevailing notion that real changes in dealing with burnout have to come at the organizational level.

A meta-analysis of 19 randomized controlled trials of burnout interventions revealed that organization-directed interventions reduced burnout measures of emotional exhaustion significantly more than physician-directed ones .[63,64]

Physician-directed interventions

Most Physician-centered interventions attempt to improve physicians' resiliency by teaching them communication and coping skills through cognitive behavioral therapy (CBT) and stress reduction techniques.

Self-awareness and mindfulness training- This form of meditation is the practice of learning how to slow down and nurture calmness and self-acceptance. Hospitalists who attended an average of two mindfulness sessions over five weeks demonstrated a statistically significant increase in mindfulness and decrease in perceived stress.[65,66] Other practices that have been found to be effective include exercise, tai chi, yoga, and laughter therapy.[67-72]

Various online resources are available and are an excellent resource to tackle stress. The AMA has four excellent modules on physician wellness developed by the AMA Steps Forward program (https://www.stepsforward.org/). The Stanford Medicine' WellMD site is another informative site for mindfulness and other wellness tools (https://wellmd.stanford.edu)

Small group discussions have been shown to help physicians feel less isolated, and provide a release valve for stress. Small group discussions aim to build camaraderie among physicians. Discussions about challenging /exciting/interesting cases, ethical dilemmas, and unique experiences with patients or their families enable physicians to express themselves and to reconnect with and draw support from colleagues.[73,74]

Trying to implement a work-life balance and maintain healthy boundaries between work and non-work life. A work/life balance can mean going to a flexible schedule to spend more time with family. It can also be about pursuing passions, such as volunteer work, hobbies, travel, sports and recreational activities or the outdoors. Anything that helps one unwind physically and mentally.[73-75]

Organization directed interventions

To date, small reductions in burnout have been achieved with a variety of interventions, but organizational efforts are showing the most promise. More and more institutions are

demonstrating their commitment to addressing burnout by making physician wellness and satisfaction one of their quality indicators. They have begun to realize that the negative consequences of physician burnout have a detrimental impact on the bottom line for their organizations. Any decrease in physician burnout should produce measurable improvements in patient satisfaction, quality of care as well as physician and staff retention.

-A few institutions have jumpstarted the process by starting a **physician wellness committee/**physician burnout prevention committee (including my organization). Their mission is to assess the degree of burnout in their institution and identify drivers of burnout. Develop performance improvement initiatives with input from front-line physicians and resurveying those interventions periodically to measure success and modify them if not meeting goals.[76-78]

-Flexible scheduling/ adjusting workloads can increase hospitalist's satisfaction and decrease stress. The widely used 7-on, 7-off shift structure leads to more stress and burnout, especially among older hospitalists. They prefer a shift based or hybrid schedule. The number of programs using hybrid schedules that mix call-only and shift-based scheduling is increasing. Other options include staggering shift lengths and giving physicians the flexibility to leave early on slow days. Ali NA et al. found lower degrees of burnout, better work-life balance and lower levels of physician distress with cross-coverage on the weekends than with continuous scheduling in an ICU setting.[79] There is, however, no consensus, on the best way to manage these scheduling issues and will ultimately depend on the individual organization, the age mix, and culture of the hospitalist group.

-Reduce the clerical burden on physicians. Institutional interventions should seek to decrease workplace stressors by delegating data entry to support staff. The goal is to give hospitalists more patient face time as well as restore physician autonomy. The thought process here is to permit physicians to focus on doing the work that only they are trained to do. It also makes financial sense. Would one have a physician being paid to perform data entry (not being done very efficiently) or prefer the same job being done faster, cheaper and more efficiently by ancillary staff? Medical scribes, who accompany the hospitalist during the patient visit and document the care plan in the EHR, can also help relieve the administrative burden and are allowed per MUSC Health policy. Adding advanced care providers to the care team, who could help round, aid with documentation, and update salient features with the physician before the patient visit, could be one way of optimizing workflow.[73-75]

-Tap and go devices enable physicians to instantaneously log into the EHR with the tap of a badge, saving the physician, time as well the frustration of logging in multiple times each day.

-The cumbersome EHR- Ever since the government mandated Electronic Health Records (EHR) and tied payment reimbursements to them, EHR's have become a significant source of stress and frustration for physicians. Multiple studies point to some of the fundamental problems physicians have with their EHRs and how they often block productivity and decrease the

physicians' ability to deliver quality patient care. In its 2016 EHR Report, Medscape found that most providers saw a slowdown in clinical workflow following EHR implementation because these technologies are neither intuitive nor navigable. Providers must attest to federal reporting programs; they must navigate through difficult-to-use screens, and through numerous alerts and reminders. Given the abovementioned difficulties of the HER, it is often difficult for providers to keep the focus on the patient.[27, 80-82]

-Provide leadership skills training- to overcome the paucity of effective leadership that exists in hospitalist management, hospitals need to work closely with their hospitalist teams to identify and develop future physician leaders.[83-87]

-Meeting socially/informally - in a non- clinical setting fosters camaraderie and teamwork among the members of the hospitalist group.

-**Artificial intelligence** Exciting new evidence is emerging that AI has the potential to assist physicians in extracting information from the different information systems (electronic notes, imaging, laboratory, and pharmacy systems). AI is able to assemble this information into the proper places in the note and to develop a data-driven plan of action.[88] However this is still a few years from actual use-Physicians need help now.

To make real headway with burnout, however, more research is needed to determine which of the institution-directed interventions are most effective or whether a combination of institution-directed and physician-directed interventions works better than either one alone.

What are some measures specific to hospitalists?

Most of the points discussed above are relevant to hospitalists as well.

Leslie Flores, MBA, recently wrote about burnout at The Hospital Leader blog. Her list included several specific examples of reducing the top causes of burnout among busy hospitalists:[89]

-Modifying the skill mix in hospital medicine groups so that less costly support staff are doing much of the work not requiring a physician's expertise, freeing up hospitalists to provide better care to more patients.

-Reducing unnecessary interruptions and the stress they cause, via both technology and process improvement

-Paying particular attention to hospitalist personal and **professional well-being**.

-**Adjusting hospitalist schedules and workflow** so that hospitalists can be more efficient (that is, do less low-value work and re-work) and have better work-life balance.

-Ensuring that hospitalists have the **training, clinical competencies**, and support to comfortably perform in expanded clinical roles.

Other measures include:

-**Using Nurse Practitioners**- the use of NPs in hospitalist programs has been increasing for the last decade. Nearly 65 percent of all adult hospital programs and 33 percent of pediatric programs employ either physician assistants (PA) or NPs, according to the 2016 State of Hospital Medicine Report from Society of Hospital Medicine. Literature supports equivalent outcomes in both primary care and inpatient settings when PAs and NPs are used to handle responsibilities within their scope of practice.[90,91]

-**Starting a wellness committee** and choosing a wellness champion- The wellness committee is formed from various disciplines and administrators that work with organizational leaders to periodically measure burnout and brainstorm solutions to obstacles that increase burnout risk. The committee should meet quarterly to review current projects, plan new initiatives, and respond to new opportunities.

The Hospitalist Wishlist

There are things that hospitalists would like to have in place that would not only reduce burnout but foster improved clinical care as well as physician-administration communication. These include:

- **Have decision-making autonomy**- Hospitalists often find it frustrating that decisions about almost everything that they do from their schedule to daily workflow and operating procedures are dictated by others, especially when these decisions are made by nonclinical staff. The hospitalist should be in charge of the day to day working of the group and delegate operational decisions to the team, with the proviso that they must perform well and meet all the required benchmarks. This would improve teamwork and productivity – the group would feel supported and emboldened to ensure the team succeeds collectively.

-**Appreciate the hospitalists' contributions**. A little bit of appreciation goes a long way in making a hospitalist feel valued. Hospitalists often complain that they only hear from the senior staff when they have bad news, need a favor or when the hospitalist has done something wrong. Mistakes certainly need to be pointed out, but it's also important to acknowledge them when they have done something exceptional and to let them know that their efforts are appreciated.

-Ensure that they are respected. Hospitalists often complain that they are often treated as Interns by specialists and patients. In 2012, Today's Hospitalist surveyed hospitalist's feelings about their professional standing. Less than 70% said they felt respected by non-hospitalists in their facilities, and only 55% thought that hospital administrators considered their group's input in making decisions.[94] They feel like the "secretaries of other services." Some hospitalist shared their experience about sitting next to two specialists busy discussing a patient's plan of care and entirely ignoring the hospitalist who was the one who consulted them in the first place. At times requests are forced on them in a way that is disrespectful and demeaning.[95] Hospitalists want their leaders and administrators to support them when they are being taken advantage of and expect them to engage medical staff leaders to ensure the hospitalists are treated with professional respect by other medical staff members.

-Meet with the hospitalists (or at least the leaders) on a regular basis either in the office or an informal surrounding by inviting them out to lunch/ dinner. Hospitalists are in the hospital for 12 hours/7 days at a time (assuming a 7on/7 off schedule) and have an inside knowledge of the good and not so good aspects of how their hospital functions. They are also in a unique position to offer suggestions on how to streamline the functioning of their group/hospital. It's worth getting to know them and letting them know that their input is appreciated and that they are valuable members of the group.

-Give them leadership opportunities. One of the best ways to retain and ensure long-term career sustainability is to groom hospitalists for leadership opportunities. Ensure that systems are in place to identify hospitalists' interests and talents, and match them with opportunities to do pursue their area of interest and support them by funding the necessary training.

What can national level /professional organizations do?

Significant changes have to come from within each organization, and there is a need for guidance from national and professional organizations. Organizations such as Society of Hospital Medicine, American Medical Association, the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education and the American College of Physicians could better represent its members by seeking relief from the regulatory burden borne by doctors. To be fair to them, they have been attempting to evaluate the problem and suggesting ways to mitigate physician burnout for quite some time.

Other national efforts are also currently taking place. For example, the National Academy of Medicine launched an "action collaborative" in December to promote clinician well-being and resilience. More than 35 professional organizations, including the American Hospital Association, health systems, and payers have signed on as sponsors.[94]

In the summer of 2017, the AHA joined with the AMA, the American Nurses Association, the Association of American Medical Colleges, the Mayo Clinic and the Agency for Healthcare Research and Quality to develop a discussion paper on burnout among healthcare professionals.

However, these efforts can be compared to a "whisper in a crowd." What is needed is for them to "shout from the rooftops" to garner public attention as well as to make their elected representatives aware of this tragic problem of physician burnout.

Having the government declare physician burnout a national emergency may be one way of escalating this to the next level. Convening a task force, setting specific targets to reduce physician burnout in a timeframe that aligns with other national health care goals and grading hospitals on how well they are able to reduce burnout might just about be the spark needed to convert talk to real action. No healthcare administrator would want to see their hospital get a low rating ensuring some form of remedial action.

How is my Institution dealing with the problem of Physician Burnout?

My institution has been over the past year taken multiple proactive measures to address Physician burnout. These include

-Tap and Badge-. Tap and go devices enable physicians to instantaneously log into the EHR with the swipe of a badge, saving time and avoiding the frustration of logging in multiple times.

-**A Dedicated Admitting PA/NP**-freeing up the hospitalist to spend more time with patients.

-**A 10 AM-10 PM fixed scheduled advanced practitioner** to help with rounding/admissions as well as be a bridge between the day and night provider

-Internal Messenger/TigerText-ensures that nursing can contact the hospitalist with queries minimizing the use of pagers. Rather than be frequently interrupted in the middle of charting or the midst of a face to face patient interaction, the hospitalist can check his messages every 10 to 15 minutes or in between seeing patients and deal with the queries.

-**Formation of a physician burnout committee**-with the functions described previously.

- **Wellness Program** - encouraging healthy eating and partners with local farmers to offer employees 20 weeks of locally grown produce delivered to their job site between June and October.

- **The network-wide "Caring Starts with You**" program is open to hospital employees and spouses. The program offers biometric screenings and an online health assessment. It also provides a personal health report and recommendations to manage one's own health risk and improve overall health and well-being. Employees and spouses participating in the program

receive a significant discount on their medical insurance deductible the following plan year and have lower co-pays when they see their doctor or primary care provider.

-**SilverCloud -an online app**- offers secure, immediate access to online supported CBT. It's flexible, and employees can access it anywhere on a computer, tablet or mobile phone.

-Gives incentives and **reduced-price memberships** to employees and their spouses as members of Fitness & Sports Performance. Four locations are available in the network.

- **Free Health Coaching** for eligible employees and spouses. The sessions offer a range of tailored health education programs geared toward increasing awareness, skill development, lifestyle/behavior changes, improving access to services and improving individual health status.

-**Dinner with our CEO**- Our CEO holds regular meetings to ascertain the problems/barriers to delivering exceptional patient care and ways to tackle it. The meetings are usually held in an informal setting. A few days later he sends out an email to everyone involved detailing the points raised and what the management proposes to do about it. Another meeting is held six months later to assess the progress of these interventions and flesh out the problems.

Is tackling physician burnout is financially viable?

Investing in physician well-being makes fiscal sense. In an article in the September 2017 JAMA Internal Medicine, Tait Shanafelt, MD, with Stanford University, and colleagues, made a convincing case for why organizations should address physician burnout. They argued that a healthcare organization which employs 450 physicians could realize a 12.5 percent return on a $1 million investment to tackle physician burnout from 50% to 40%. This intervention could yield organizational cost savings of $1.125 million per year, with a 12.5% return on investment, as well as the potential financial benefits of improved patient satisfaction and quality of care. This hypothetical intervention has more impact than that of multiple actual measures that have been shown to reduce burnout.[95]

What can we conclude?

Physicians/Hospitalists are a precious resource that may soon be in short supply. Burnout is a national catastrophe which is getting worse every year.Not only is physician burnout linked to decreased patient satisfaction and worse patient and physician outcomes. Also, burned out physicians are also more likely to change jobs or leave the practice of medicine. Unless more radicle measures are implemented to tackle this urgently, all that will be left will be an aging population with complicated medical issues and a tremendous shortage of physicians/hospitalists. Projections from the Department of Health and Human Services are grim

and suggest that the U.S. will face a shortage of 50,000 physicians by 2020 and a projected shortfall of 46,100 to 90,400 physicians by 2025.[57,96]

As discussed above, although awareness and recognition of burnout have grown substantially over time, successful interventions to prevent or mitigate burnout have not. Many potential interventions and ideas have surfaced and have been published, but none have had profound impacts or have been adopted widely within or across institutions. Only bandages have been applied to address the problem thus far, involving stress management, resiliency workshops, and mindfulness training to individual physicians.

Providing resources to help physicians adjust to the stresses in their environment will go a long way towards improving over-all satisfaction, engagement, productivity, and care efficiency. Health care should focus on giving meaning to its practitioners. Health care leaders have recommended amending the "Triple Aim" which involves- enhancing patients' experience, improving population health, and reducing costs, and adding a fourth goal: improving the work life of the people who deliver care.[97] Health care needs to change its focus on giving meaning to its practitioners so that they do not feel like "cash cows" or "revenue-generators".

Using nurse practitioners/physician assistants and administrative support staffers can help decrease the burden of nonclinical responsibilities. Being creative in addressing time commitments and on-call requirements will help reduce burnout allowing increased work-life balance. Mayo Clinic researchers, who have been publishing on physician burnout for more than a decade, expressed it aptly in the March 7, 2017, issue of The Journal of the American Medical Association. "Meaningful progress will require collaborative efforts by national bodies, health care organizations, leaders, and individual physicians, as each is responsible for factors that contribute to the problem and must own their part of the solution. Solving this problem will require cooperation and coordination at every level of the healthcare system."[98] Hopefully, the introduction of artificial intelligence might play a big role in reducing documentation burden. The healthcare workforce burnout epidemic is a national crisis. The time to act is now.

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