A resolution for the new year: Responding to a call to organize against burnout crisis

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DEFINING THE PROBLEM

If you have read any major journal in the last few years, you have probably heard about burnout. Burnout is a syndrome characterized by emotional exhaustion and depersonalization, a feeling of reduced personal accomplishment, loss of work fulfillment, and reduced effectiveness.^{1,2} An increased volume of literature focused on physician well-being has led to increased recognition and awareness of physician burnout.^{1,2} The reports have been alarming, with more than 50% of physicians experiencing symptoms of burnout, a rate twice-as-high as other professions.^{1,2} The issue is not isolated to physicians because of a similar prevalence amongst mid-level providers and nurses.^{1,2} The increased recognition of this important issue has led thought leaders in medicine to describe burnout as a “crisis”.³

The impact of burnout is felt on many levels of the healthcare system. For hospital systems, higher burnout rates have been associated with higher rates of physician turnover and lower rates of productivity.¹ Physicians experiencing burnout are twice as likely to leave their

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jobs as those without burnout, a costly problem for healthcare organizations. The cost of replacing a physician is estimated to be \$500,000 to \$1 million, when taking into account expenses for recruitment, “onboarding,” training, and lost revenue.³

On the individual level, there is a significant toll on the clinicians directly involved. The rate of suicide in male physicians is 40% higher than that of other males in the population and among female physicians, 130% higher than that of other females in the population. In physicians with burnout, the suicide rate is double that of matched controls. Burnout also affects patients; burnout was an independent predictor of clinicians reporting recent medical mistakes or being involved in a malpractice lawsuit. Higher rates of burnout on nursing units have also been associated with increased risk of health-care-associated infection.¹

There are both personal and systemic causes that predispose individuals to burnout. Physicians who are female, younger, early-career, and/or those who have young children are especially at risk for burnout.¹ Work-related factors such as hours spent at work, night or weekend call, time spent at home on work-related tasks and work-home conflict independently predict rates of burnout amongst physicians.¹ Characteristics of immediate supervisors have also been shown to independently predict rates of both satisfaction and burnout in the physicians under their supervision. In a survey by Shanafelt et al, for each 1-point increase in composite leadership score amongst supervisors, there was significant reduction in likelihood of burnout and an increase in the likelihood of satisfaction of the physicians supervised. Interestingly, the supervisors in the study were physicians or scientists themselves.⁴

The electronic health record (EHR) has received much of the blame for depersonalizing the interaction between physicians and patients. In the clinic, for every hour that physicians provide direct clinical face time to patients, nearly 2 additional hours are spent interacting with the EHR and completing other clerical tasks. Outside of regular hours, physicians spend another 1-2 hours of personal time completing work-related tasks (mostly on the computer),⁵ termed “work-after-work”.³

There is no doubt the EHR has led to improvements in information sharing. However, system changes often have unintended consequences. A single-network specialty practice recently reported its experience with EHR implementation. While implementation of an integrated outpatient and inpatient HER improved flow of information between each setting, both physicians and patients were dissatisfied with their overall experience after implementation. Furthermore, when compared with other providers and office staff, physicians were unilaterally dissatisfied with the EHR, suggesting that much of

the burden after implementation fell upon their shoulders.⁶

In a recent editorial in the New York Times, Abraham Verghese, Professor for the Theory and Practice of Medicine at Stanford University Medical School, described the patient in America today, as “just the icon, a place holder for the real patient who is not in the bed but in the computer. That virtual entity gets all our attention...The living, breathing source of the data and images we juggle, meanwhile, is in the bed and left wondering: Where is everyone? What are they doing? Hello! It’s my body, you know!”⁷ Indeed, the increased burden of documentation is not only felt by physicians but by patients themselves.

A CALL TO ACTION

But, as an individual, what can one do about this issue? To the practicing physician, who is already spending over half of his/her time on documentation, it seems like an insurmountable task to reverse the momentum of the “medical machine” which has taken us in a direction of more clerical work and less time with patients. We should heed advice from someone in his pre-clinical or perhaps “pre-cynical years”. Leo Eisenstein, a fourth-year medical student at Harvard Medical School, recently wrote an editorial entitled “To Fight Burnout, Organize.” In his paper, Einstein linked much of the source of burnout to physicians’ desire to help patients with hopeless socioeconomic situations, while being helpless to do so as an individual, a concept previously underrepresented in the literature. He points out that advocacy amongst physician groups could be considered both strategic and therapeutic and may serve as an avenue to help ourselves and our patients.⁸

To fight burnout, we believe that: On an individual level, physicians should be organized in planning for their own wellness (both physical and mental). Addressing time for meaningful tasks should be deliberate and not allowed to only happen by chance. On a system level, organizations should commit resources to track rates of burnout and provide support to clinicians experiencing emotional stress or depression. Leaders, who we know can positively or negatively impact rates of burnout should be adequately trained to support the clinicians whom they lead. Lastly, on a national level, individual involvement in professional societies may help physicians organize to enact healthcare policy changes, both for themselves and for their patients. We are pleased to see that ASNC had organized a special session on this topic at its 2018 annual scientific sessions in San Francisco CA. To our knowledge, there are no data on burnout rate amongst imagers but have no reason to believe it is lower.

SIGNS OF HOPE

Regulatory bodies seem to have recently heard the calls to reduce clerical burdens on clinicians. The Centers for Medicare and Medicaid Services (CMS) have recently launched a “Patients over Paperwork” campaign, which is designed to evaluate and streamline CMS documentation regulations in an effort to reduce regulatory obstacles and reduce unnecessary burden to increase efficiencies its medical reviews. Proposed changes include: changing the required documentation of the patient’s history to focus only on the interval history since the previous visit and eliminating the requirement for physicians to re-document information that has already been documented in the patient’s record by a medical student, practice staff or by the patient. We are hopeful that increased efforts by physician advocacy groups will lead to further initiatives that may allow us to spend more time with our patients.

A recent meta-analysis examined 19 studies on 1550 physicians assessing a variety of physician-directed and organization-directed interventions to reduce burnout. This analysis demonstrated a small, but significant decrease in burnout rates amongst the studies included. Compared with individualized interventions, organization-directed interventions were more likely to lead to significant reductions in burnout. The authors suggest that burnout is “rooted in the organizational coherence of the health care system” and that system-level interventions may be more ideal to effect change in burnout rates. There were large variations in terms of actual approaches, components of the intervention, and intensity; therefore, the optimal approach to reduce burnout unknown. This study and others may give direction to future research in this area.⁹

Authors of a recent editorial in the New England Journal of Medicine have identified the National Academy of Medicine (NAM) as an organization uniquely suited to tackle the challenge of affecting system-wide change. The NAM has recently launched a national Action Collaborative on Clinician Well-Being and Resilience, in collaboration with the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME). This collaborative effort has four initial goals, that will guide subsequent work: to increase the visibility of clinician stress and burnout, to improve health care organizations’ baseline understanding of the challenges to clinician well-being, to identify evidence-based solutions, and to monitor the effectiveness of implementation of these solutions. Since its inception, over 100 national organizations have publically declared

support for the endeavor.² We applaud these efforts and look forward to a meaningful progress in the years to come as we work toward evidence-based interventions which may alter the course of the current system-wide spread of burnout.

In the last year, we have seen a few examples of how organization may impact change. As we approach the New Year, we propose a new resolution, which may not have been at the forefront of your mind. Fight to find and preserve the joy which attracted you to medicine. Remember that it may require deliberate thought and action. Through an organized approach, we can come together to continue to reverse the recent epidemic of burnout in our profession.

Disclosure

The authors report no conflict of interest.

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