Burnout in Medicine: Interventions to Promote Retention and Resilience

- Beth Danehy, MA, Director, Strong EAP, U. of Rochester
- Geri Biamonte, EA Practitioner, U. of Illinois, at Chicago
- Karen Brouhard, LICSW, FSAO, Boston U.
- Andy Silberman, LCSW, Director, PAS, Duke U.
What is burnout?

- **Emotional exhaustion**
  - Emotionally overextended and exhausted by work

- **Depersonalization**
  - Negative, cynical attitude, treating patients as objects

- **Sense of low personal accomplishment**
  - Feelings of incompetence, inefficiency & inadequacy
Medical professionals are particularly susceptible to developing burnout above and beyond typical workplace (Ishak, et al., 2009).

Medical training and pre-existing tendency toward selflessness may combine to limit physician’s awareness of how stressed they are. (Privitera, Rosenstein, Plessow & LoCastro, 2015).
Add slide with video here – or have speaker
Prevalence

■ 25% - 60% of practicing physicians (several)

■ 60% to 70% of residents and climbing (Holmes et. al., 2016)

■ 45% of 3\textsuperscript{rd} year students (Dyrbye 2006)

■ Despite prevalence, limited data is available to direct effective approaches to address burnout in medicine.
Consequences of burnout

- **Systemic:**
  - Increased turnover
  - Patient care errors
  - Negative attitude/poor performance
  - Poor relationships, disruptive behaviors

- **On individual:**
  - Exhaustion and insomnia
  - Impedes cognitive functioning
  - Stress-related illness and health problems
  - Increased risk of substance abuse or dependence
  - Increased rates of depression and suicidal ideation
  - Diminished self-regulation
  - Marital/familial disruption

Source: Dyrbye & Shanafelt, 2016; Sargent et. al, 2009; Shanafelt TD et al. 2003 and 2005;
Contributing factors for physicians

- Increasing regulation
- Demands on productivity
- More patients/fewer resources
- Inefficient systems
- Electronic medical record

Source: Dimou, Eckelbarger & Riall, 2016; Brazeau et al., 2014

- Training & acculturation: factors during medical school further burnout and develops cumulatively over time.
- Blurred boundaries and conflicting responsibilities between work and home
- Lack of time for self-care/participation in enjoyable activities outside of work
- “inability to take time off from work to receive treatment”
- 25% of residents incorrectly believe that burnout was is reportable condition to state medical board

Source: Holmes et al., 2016
C4C at UIC
Care for Caregiver response

Geri Biamonte, MSW, LCSW
University of Illinois at Chicago
Pilotto was south suburban mob chief, experts say his brother Henry served as chief of police.

Tocco allegedly succeeded Pilotto as mob boss after Pilotto was imprisoned for labor racketeering. Prosecutors have charged that Panici once accompanied LoBue to a Minnesota prison and waited outside while LoBue asked Pilotto if Panici had Pilotto’s “blessing” to fire the chief of police. At the time, one source said, Doug Bogum, who had been Pilotto’s deputy police chief, agreed to fire Panici. "He gets the blessing," the source said. "He needs the blessing."
Objectives:

- Review of rationale for Peer Support Service and the Second Victim concept
- Describe Peer Support program for physicians
- Describe Care for Caregiver response process
Second Victim Definition

- Second victims are healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base.

(Scott et al., 2009).
Why peer support?

- “I’ve been there” – a powerful bridge to developing an enhancing relationship to promote support and recovery
- Promotes development of natural supports
- Enhances coping, self management and recovery from traumatic event
Literature in “support of support”

- N=108 / 88%
- Implemented Physician Support Survey
- Query domains include likelihood of seeking support for various domains including …. 
How likely to seek support regarding:

- Personal fatigue
- Interpersonal conflict outside of workplace
- Personal burnout
- Mental illness of family member
- Personal life struggles
- Physical illness in family member
- Poor patient outcome regardless of responsibility
- Mental illness in self
- Interpersonal conflict at work
- Physical illness in self
- Involvement in adverse patient event
- Substance abuse
- Involvement in medical error
- Legal situation
Yue-Yung, H. 2012 cont…
What are perceived barriers to support seeking?

- Nobody will understand
- My problems are not important
- Cost (residents)
- Using services means I am weak
- Fear of legal consequences
- Fear of unwanted intervention
- Difficulty accessing services
- Not knowing who to go to
- Stigma of mental health care
- Fear of documentation on my record
- Fear of negative impact on my career
- Lack of confidentiality
- Lack of time
I digress.....Medical Studies Act 1997 amended.

“In order to encourage the evaluation of adverse patient events, certain communications and information gathered through the peer review process about an adverse patient are protected from discovery in litigation”

- LeFevour and Szatkowski
Yue-Yung, H. 2012 cont…

Respondent choice of resources

- GME
- EAP 😊
- Clergy
- Program Chairperson
- Physician Health Service
- Resident Peer Support
- Psychiatrist or mental health professional
- Faculty Peer Support
- Chief resident
- Program Director
- Resident colleague
- Faculty Colleague
Peer support

- Helping another to discover one’s own path or journey to recovery through relationship, open discussion and caring interaction.
- Reduces isolation, inspires hope, strengthens the ongoing recovery process.
Stages of Recovery following Adverse Event (Scott et al. 2009)

- Chaos and accident response
- Intrusive reflections
- Restoring personal integrity
- Enduring the inquisition
- Obtaining emotional first aid
- Moving on-dropping out, surviving or thriving
Second Victim Responses

- Physicians report
  - Significant emotional distress
  - Feelings of guilt and responsibility
  - Feeling unsupported by institutions
  - Desire to receive counseling
  - Concerns about barriers

(Waterman et al. 2007)
Second Victim Responses

- Residents report
  - Complex blend of emotions (distress, guilt/self-doubt, frustration/anger)
  - Desire to talk with other residents/attendings as family members/friends lack medical training and ability to understand
  - Attending input and feedback crucial in coping process
  - Appreciate constructive learning opportunities (Engel et al. 2006)
BICEPS

- **Brevity:** Brief, focused
- **Immediacy:** Soon after event (72hrs)
- **Centrality:** All affected staff, centrally located, organized
- **Expectancy:** Assumption-return to work
- **Proximity:** Near place of work
- **Simplicity:** Focus on issue of adverse event

**References:**
Peer Support Skills

- Active listening
- Crucial Conversations (book and website)
- Stress management techniques (exercise, deep breathing, physical activity, social contact)
- Crisis intervention
- Be alert for indications for professional counseling needs
Challenges & Boundaries

- Providers who
  - need professional counseling but are resistant to seeking services
  - have a significant substance abuse issue that could compromise patient care

- Process Clarification
  - Confidentiality—no reporting back to Safety/Risk Management
  - Follow-up with peers
  - Inclusion of group debriefing/discussion
  - Identification of EAP referral options
Individual Clinician Support

ADVERSE EVENT

RM staff advise to expect outreach call

PV contacts clinician within 48-72 hrs

PV makes introduction and extends support

Provider declines

Follow-up email / call may be agreed upon

Provider accepts

Time to talk/meet is established; follow up occurs
(Email example)

Dear X,

My name is XYZ and I am a physician at UIC. I am contacting you today as part of the UIC Care for Caregivers program in response to the recent adverse event which you have experienced. As physician volunteers, our mission is to provide confidential peer support to fellow-physicians at times such as this. I would like to make myself available to you at your convenience. Please feel free to contact me at......

If you prefer not to communicate at this point, may I follow up with a note or phone call in a week or so?

Sincerely.....
Make Friends with Risk Management!

- The “yuk” department
- Performs investigations into patient safety concerns
- Natural avoidance of lawyers!
- How can RM and EAP collaborate?
- Get to know your risk managers and get your risk managers to know EAP
Friends with Risk

- RM is fully on board with the peer support and C4C concepts
- RM is the 1st line in initiating both processes
- Cultivate a physician partner!
ADVERSE EVENT

- Risk Management contacts Ms. Biamonte and Dr. Devens with basic event and provider contact information (within 0-24 hours)
- Outreach call to all involved providers (within 24-48 hours)
- Group meeting (within 48-72 hours)

At any time, if the following are observed in a provider...
- Mood instability, obvious tearfulness or anger at work
- Reasonable suspicion of substance abuse—signs and symptoms of intoxication
- Perceivable changes in presentation (such as personal hygiene)
  - Changes in attitude
  - Absenteeism
  - Irritability, distractibility
  - Work performance errors

... concerns should be directed to Dr. David Marder, Occupational medicine.

- Additional counseling needed?
  - NO
    - Follow-up call (within 1 week)
    - 2nd follow-up call (time frame TBD)
  - YES
    - Ms. Biamonte or Dr. Devens
    - Brief phone follow-up after 1:1 meetings end
    - Provider support program Peer consultant (when available)
Sample introduction – phone call

“Hello – my name is Geri Biamonte and I received your information from Rena at RM. I am calling in response to the UIC C4C program to follow up and see how you’re doing in light of XYZ. I’m an LCSW and would be happy to meet with you if you’re inclined.”
Outreach call

- Unique feature is that rather than “referring” to helping resource (EAP or other), the helping resource makes the initial contact. This “breaks the ice” and enhances the likelihood that Dr/Rn will accept extended support.

- “No, but I really appreciate the call”. I’ll keep your number. Thank you!”
Problems and Challenges

- Initiatives are not housed at the organizational level (EAP? GME?)
- Requests for service tends to be reactive rather than proactive
- Feels “fragmented” –
- Little $$ for innovation
University of Rochester Medical Center

- 500 physicians
- 1500 APPs
- 750 residents/fellows
Staff support and CIR provided by team of 20 trained facilitators from multiple disciplines: palliative care, psychiatric nursing, EAP, chaplaincy

- Increased education of importance of emotional support for staff
- Promotion of support team in communication vehicles
- Materials developed “live” on EAP web site
- Presentations to leadership and nurse managers

Group support following CI and for chronic stressors

EAP is “triage”

125 responses since 9/15
Medical Faculty & Clinician Wellness Program

- Began 2015
- Target: Attending physicians, residents, fellow, clinical psychologists, clinical social workers, NPs and PAs
- Director 0.2 FTE

- Web resources
- CME workshops (participants eligible for malpractice cost reduction)
- Surveys on burnout prevalence
  Grand Rounds on burnout causes and reduction
- National and state level Collaboratives
- Clinical consult by Director
- Emotional life of clinician group
- Collaborates internally: resources and leadership
- Coaching (in development)
Pilot in Anesthesia Residency Program

- Began in 2015
- Collaboration of EAP/BHP
- Measured awareness of EAP/BHP
- Also used PWBI (Physician Well-being Index)
- 2016 developing “family focus”
- Increasing utilization of EAP/BHP
- EAP observations in work setting
- Participation in orientation
- Individual onboarding of PGY1s
- 4 “wellness” presentations to all residents
- Relationships w/ program director & leadership
Considering a Family Focus

- EAPs consider interrelationships of work and family
- Positive experiences in one life domain result in positive behavioral responses in other life domains (Grzywacz, 2007)
- Most powerful social support appears to be trusted relationship (typically with spouse or lover) (Cohen & Wills, 1985)
- Unique stressors in “medical marriage”
- Committed, harmonious relationship correlates with reduced levels of burnout and psychological distress for medical residents
- Majority of physicians younger than 45 reported that most toxic stressor was struggle with work/family imbalance and effects created in home life (Powers et al., 2004)
- Residents may be at greater risk due to less autonomy and flexibility than more senior colleagues (Dyrbye et al., 2014)
Family focus

- EAPs have important opportunity to champion issues related to families and advocate for programs that address family needs

Ideas:

- MBSR for resident and family member?
  Inviting partners/spouses to participate in financial education programs (address debt burden)

- Onboarding for spouses/partners

- Vanderbilt program supporting medical marriages

- Education module on recognizing stress/warning signs of depression or suicide for residents and significant others
Research on physician stress suggests:

- Adopt a healthy **philosophical attitude** toward life
  - Not taking yourself too seriously, simplifying, balance, self-forgiveness

- Find **support** in the workplace
  - Good mentoring, setting limits, administrative support

- Engage and find **meaning**
  - Sense of self-worth and self-efficacy

- Develop **healthy relationships**
  - Time with friends and family, supportive partner, support group

- **Take care of yourself**
  - Exercise, nutrition, treat depression, avoid intoxicants, vacation

- Cultivate **self-awareness**
  - Meditation, support groups, narrative writing

*Source: Shanafelt TD et al. 2003 and 2005, Horowitz 2003*
According to the nurse’s note, the patient had received a clean bill of health from his regular doctor only a
<table>
<thead>
<tr>
<th>BUMC Employees</th>
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<tr>
<td>800 physicians</td>
<td>650 residents</td>
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<tr>
<td>? NP’s, PAs</td>
<td>6000 staff members including most nursing and non MD clinical staff</td>
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Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians

Michael S. Krasner, MD
Ronald M. Epstein, MD
Howard Beckman, MD
Anthony L. Suchman, MD, MA
Benjamin Chapman, PhD
Christopher J. Mooney, MA
Timothy F. Quill, MD

Primary care physicians report alarming levels of professional and personal distress. Up to 60% of practicing physicians report symptoms of burnout, defined as emotional exhaustion, depersonalization (treating patients as objects), and low sense of accomplishment. Physician burnout has been linked to poorer quality of care, including patient dissatisfaction, increased medical errors, and lawsuits and decreased ability to express empathy.

Substance abuse, automobile accidents, stress-related health problems, and marital and family discord are among the personal consequences reported. Burnout can occur early in the medical educational process. Nearly half of all third-year medical students report burnout and there are strong associations between medical student burnout and suicidal ideation.

Context Primary care physicians report high levels of distress, which is linked to burnout, attrition, and poorer quality of care. Programs to reduce burnout before it results in impairment are rare; data on these programs are scarce.

Objective To determine whether an intensive educational program in mindfulness, communication, and self-awareness is associated with improvement in primary care physicians' well-being, psychological distress, burnout, and capacity for relating to patients.

Design, Setting, and Participants Before-and-after study of 70 primary care physicians in Rochester, New York, in a continuing medical education (CME) course in 2007-2008. The course included mindfulness meditation, self-awareness exercises, narratives about meaningful clinical experiences, appreciative interviews, didactic material, and discussion. An 8-week intensive phase (2.5 h/wk, 7-hour retreat) was followed by a 10-month maintenance phase (2.5 h/mo).

Main Outcome Measures Mindfulness (2 subscales), burnout (3 subscales), empathy (3 subscales), psychosocial orientation, personality (5 factors), and mood (6 subscales) measured at baseline and at 2, 12, and 15 months.

Results Over the course of the program and follow-up, participants demonstrated improvements in mindfulness (raw score, 45.2 to 54.1; raw score change [SEM], 8.9; 95% confidence interval [CI], 7.0 to 10.8; burnout (emotional exhaustion, 26.8 to 20.0; Δ = −6.8; 95% CI, −8.8 to −4.8); depersonalization, 8.4 to 5.9; Δ = −2.5; 95% CI, −3.6 to −1.4); and personal accomplishment, 40.2 to 42.6; Δ = 2.4; 95% CI, 1.2 to 3.6); empathy (116.6 to 121.2; Δ = 4.6; 95% CI, 2.2 to 7.0); physician belief scale (76.7 to 72.6; Δ = −4.1; 95% CI, −1.8 to −6.4); total mood disturbance (33.2 to 16.1; Δ = −17.1; 95% CI, −23.2 to −11.0); and personality (conscientiousness, 6.5 to 6.8; Δ = 0.3; 95% CI, 0.1 to 0.5); and emotional stability, 6.1 to 6.6; Δ = 0.5; 95% CI, 0.3 to 0.7). Improvements in mindfulness were correlated with improvements in total mood disturbance (r = −0.39, P < .001), perspective taking subscale of physician empathy (r = 0.31, P < .001), burnout (emotional exhaustion and personal accomplishment subscales, r = −0.32 and 0.33, respectively; P < .001), and personality factors (conscientiousness and emotional stability, r = 0.29 and 0.25, respectively; P < .001).

Conclusions Participation in a mindful communication program was associated with short-term and sustained improvements in well-being and attitudes associated with patient-centered care. Because before-and-after designs limit inferences about intervention effects, these findings warrant randomized trials involving a variety of practicing physicians.

JAMA. 2009;302(12):1284-1293

For editorial comment see p 1338.

CME available online at www.jamaarchivescme.com and questions on p 1374.

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Components

- Mindfulness Practices
- Narrative Medicine
- Appreciative Inquiry
Findings:

Sustained improvement in (<.001):
- Mindfulness
- Physician well-being (burnout, mood)
- Emotional stability
- Patient-centered attitudes (empathy)

- participants credited skill development, sense of community and giving themselves permission to take time for self-development
Resilience and Mindfulness Program for Clinicians
Bringing Intention, Attention, and Reflection to Clinical Practice

Objectives/End-Point Competencies
- Improve resilience, health, and well-being
- Increase self-awareness and improve relationships with patients and with other health care team members
- Support empathy and compassion; prevent burnout, apathy, and exhaustion

Structure of the Program
- Eight 1.5 hour meetings (Tuesday am 7:30 to 9 am starting August 4, 2015)
- Three follow-up sessions throughout the year
- Located conveniently on BMC campus. Breakfast and materials will be provided
- There is a $120 materials fee, scholarship available

Facilitators:
- Paula Gardner, M.D., Assistant Director, Program for Integrative Medicine and Health Disparities
- Karen Brouhard, LICSW, BU Faculty & Staff Assistance Office

If you have questions and/or are interested in participating in this program, please contact Paula.Gardiner@bmc.org
Mindful practice

Moment-to-moment purposeful attentiveness to one’s own mental processes during every day work with the goal of practicing with clarity and compassion
Mindfulness and clinical practice

- Attentive observation
- Critical curiosity
- Beginners mind
- Presence

- Quality of care
  - Noticing
  - Clinical reasoning
  - Technical skills

- Quality of caring
  - Compassion
  - Empathy
  - Ethics

- Well-being
  - Adaptability
  - Self-care
  - Self-monitoring

©Mindful Practice Programs, University of Rochester, 2010
Narrative exercise: Noticing

- Divide into pairs

- Take 5 minutes to write a story when you were surprised by something that you had not noticed before, when something obvious escaped notice, or when you noticed something that others did not – preferably an event in a clinical context, but not necessarily so.
Listener

Focus on your partner’s experience

- Set your intention to:
  - Spend most of the time listening
  - Be curious about your partner’s experience
  - Ask questions that aim to deepen understanding

  …and be aware of your own responses

- Note what is attracting your attention about the story
- Observe - but do not act on – your urge to comment, interpret, give advise or talk about your own experience
Reflective questions

- **Attentive Observation**
  - “If there were data that you ignored, what might they be?”
  - “What did you notice?” What were you unable to see?”

- **Critical Curiosity**
  - “What are you assuming that might not be true?”
  - “What was surprising or unexpected?”

- **Beginner’s Mind**
  - “What would a trusted peer say about how you managed or feel about this situation?”
  - “Can you see the same situation/patient with new eyes?”

- **Presence.**
  - “What do you notice about yourself when you are at your best?”
  - “What moved you most about this situation?”
“The art of asking questions that strengthen a system’s capacity to apprehend, anticipate and heighten positive potential.”

Assumptions of AI

- For every person or group, something is working.

- Looking for what works well and doing more of it is more motivating than looking for what does not work well and doing less of it.

- People have more confidence to journey to the future when they carry forward parts of the past.

- If we carry parts of the past forward, they should be what is best about the past.
Representative AI Questions:

- What do you think were the core factors that made this success possible?
- What did you do or bring to that event that contributed to its success?
- Who else was involved and what did they contribute?
- What was it about the setting or situation that made a difference?
- What lessons do you take from this experience?
- What aspects of this situation make you feel resourceful/satisfied? In what way?
Body Scan
Imperfect Perfectionists: Physician Well-Being and Burnout

Andy Silberman, MSW, LCSW
Director, PAS
Duke University and Health System
Duke - Physicians and Residents

• PAS has Director, Asst Dir, and 5.5 FTE counselors
• Duke Univ and Health System – 37,000 faculty and staff
• 3 hospitals, 80 clinic sites
• Approximately 3500 MDs and PhD researchers
• Approximately 1000 Residents
Measure and respond to burnout by:

- Reducing sources of stress
- Intervening with programs and policies that support professional well-being
- Preventing burnout
Stress During Residency

• Residency is a time of significant personal and professional transition.
• Heavy workload (80 hour rule)
• Think they are already supposed to know
• Time demands, conflicting needs
• Abnormal sleep patterns/Shiftwork
• Fatigue
• Indebtedness
Duke’s Pilot with Psychiatry Residents

• Emotional Wellness Consultations
• Psychiatry 1rst and 2nd yr residents (24)
• Opt-out
• Not an intake
• Opportunity to learn more about PAS, review residency stress, and get feel for what client may experience.
Several Duke Task Forces

Second Victim Task Force (2015):
Resource Identification, Training, Policy

Duke Hospital “CEO” Task Force (2016):
Address burnout and stress among all hospital staff.

Resident Task Force (2016):
Address learning environment and Enhance the emotional/physical resources for Residents
Second Victim Task Force

• Identified resources for support and response
• Developed a policy for the Health System
• Developed training slides for leaders and staff
• Developed checklist for leaders
CEO Task Force (proposals)

- Develop one website with all Duke’s health and wellness resources and services.
- Coordinate to align activities with other Health System committees.
- Creation of regular seminars and use digital recordings for anytime access
CEO Task Force (continued)

- Create Advisory Committee to assess entity needs and develop sustainable programs.
- Explore how to create program for “event management” in hospital, with 24/7 availability.
- Initiate a sustained program to develop managers in service of staff self-care.
- Establish an Office for Staff Well Being responsible for strategic plan for staff care.
Residency Task Force (recs)

- Need for consistent, predictable, “protected personal time” during weekday hours (minimum of two half days per 6 months).
- Each program should identify at least one person, nominated by residents, to serve as a resource or ombudsman for GME trainees.
- Identify and/or hire necessary personnel to provide 24/7 real time support in the clinical environment to address the second victim phenomena.
Residency Task Force (recs)

- Hire personnel to assist GME and institutional leaders develop and implement an institutional wellness and well-being educational program
- Identify and/or hire personnel to provide 24/7 access to a resource to triage and address urgent/emergent medical and behavioral health issues.
- Comprehensive wellness center and well-being program
Residency Task Force (reps)

- Consider waiving MH co-pays for Residents
- Consideration of a concierge or care coordination model for medical and behavioral health care for GME trainees
- Expansion of some programs to include family members.
Residency Task Force (recs)

Identify and provide necessary support for behavioral health and medical providers both at Duke and within the community to allow them to provide priority and flexible scheduling for appointments for GME trainees. These appointments should specifically include evening and weekend availability.
So ...... Why Not Just Have The EAP Do It ?!
Opportunity, Over Extended, or Outside the Limit?
Challenges for the EAP

• Managing Expectations
• Your EAP mission vs what is wanted
• Specialized services to segment of population
• Services after hours and weekends (24/7)
• Resources required
• Another Administrative component
• Other?