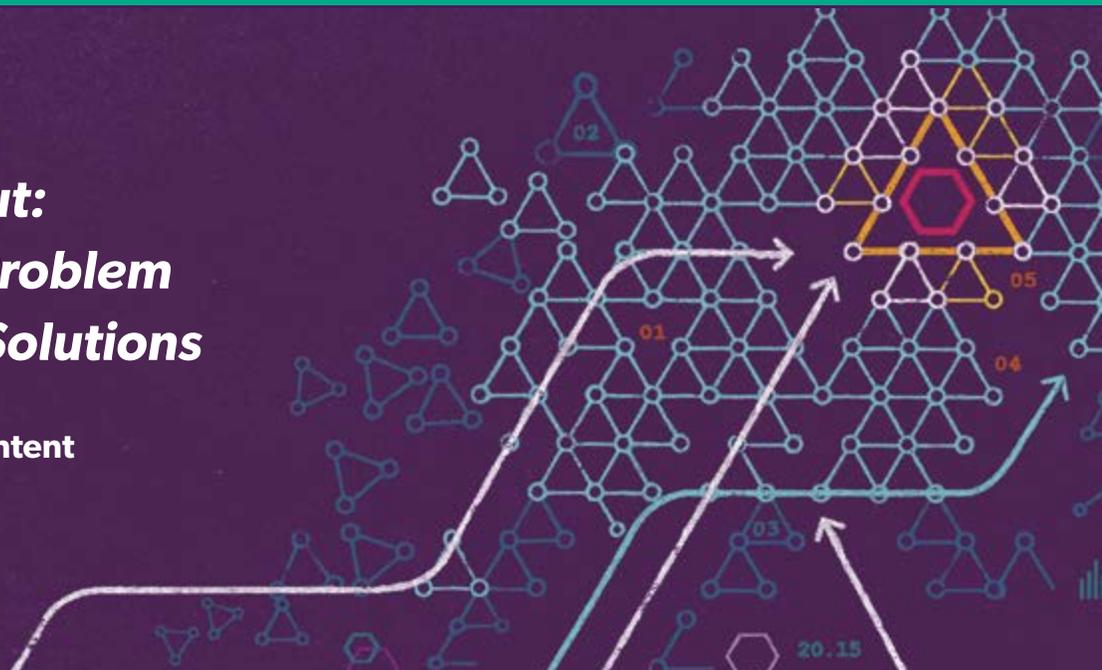


***Physician Burnout:
The Root of the Problem
and the Path to Solutions***

A collection of original content
from NEJM Catalyst



NEJM Catalyst

June 2017

Dear Colleague,

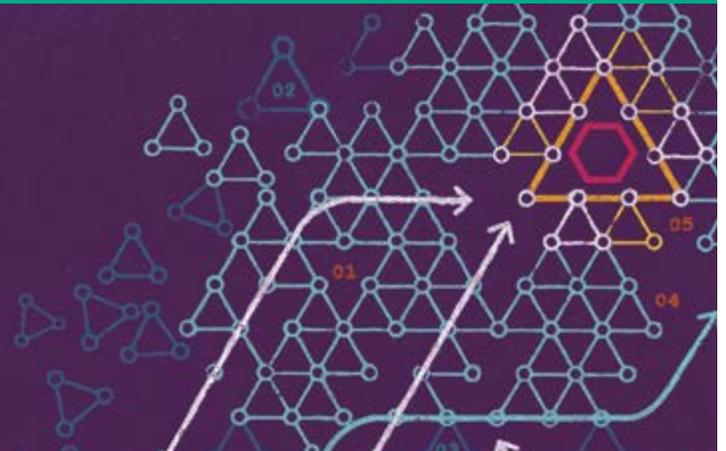
Physician burnout is a growing problem with no easy solutions. Two-thirds of NEJM Catalyst Insights Council members—comprising clinicians, clinical leaders, and health care executives—say that more than a quarter of the physicians they know are burned out, and 96% of Council members agree that burnout has become a serious issue for health care today.

In this collection of original articles, conversations, and data previously published by NEJM Catalyst, we feature some of the nation's leading experts on physician burnout, as well as frontline clinicians, leaders, and residents, and members of the Insights Council. Tait Shanafelt, MD, Director, Mayo Clinic Department Program on Physician Well-Being, underscores the systemic nature of the problem. Two physician leaders, Thomas Lee, MD, MSc, and Richard Gunderman, MD, PhD, emphasize the relationship between physician engagement and the patient experience. Steven Strongwater, MD, head of a large physician group, points to electronic medical records as a big part of the problem. And Christine Sinsky, MD, FACP, Vice President of Professional Satisfaction for the American Medical Association, reminds us that physicians are neither victim nor villain, but human.

We hope that this collection from NEJM Catalyst inspires you to find ways to address physician burnout productively, both in your own organizations and your own lives. Solutions are urgently needed.

The Editors,
NEJM Catalyst

**Physician Burnout:
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and the Path to Solutions**



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Physician Burnout: Stop Blaming the Individual

Event Talk · June 30, 2016

Tait Shanafelt, MD

Mayo Clinic

In 2011, 45% of U.S. physicians had at least one symptom of professional burnout, according to a study from the Department of Medicine Program on Physician Well-Being at Mayo Clinic. That number rose to 54% in 2014. And projections from the Department of Health and Human Services suggest that by 2020, the U.S. will face a shortage of 50,000 physicians. “The rising tide of burnout, coupled with its effects on quality of care and access, make burnout a major threat to the health care delivery system,” says Program Director Tait Shanafelt.

Burnout affects physicians across all specialties, but it is particularly acute in primary care. Yet only bandages have been applied to address the problem thus far, in the form of stress management, resiliency workshops, and teaching mindfulness to individual physicians.

“We tell physicians to get more sleep, eat more granola, do yoga, and take better care of yourself. These efforts are well intentioned,” says Shanafelt. “The message to physicians, however, is that you are the problem, and you need to toughen up.”

We tell physicians to get more sleep, eat more granola, do yoga, and take better care of yourself. These efforts are well intentioned. The message to physicians, however, is that you are the problem.”

“We need to stop blaming individuals and treat physician burnout as a system issue,” argues Shanafelt. “If it affects half our physicians, it is indirectly affecting half our patients.”

To move to a better framework, Shanafelt says we must:

1. Start trusting physicians again. Eliminate intrusive regulations that do not add value to patients’ medical care, and devise more accurate approaches to assessing quality.
2. Let physicians focus on doing the work that only they can do. While physicians work at the top of their licensure, mini tasks should be delegated to support staff.

3. Set workload expectations based on what it takes to provide good patient care. “The current reality of physicians working 14-hour days at the clinic or hospital and then going home to spend 2 to 3 hours charting in the EHR is not sustainable,” says Shanafelt. “We have the metrics and tools to determine the time necessary to provide good care.”
4. Measure, track, and benchmark the well-being of physicians as a strategic imperative necessary to provide high-quality medical care.

Realizing these changes requires effective leaders to work in partnership with physicians. “Physicians and leaders working together constructively to identify, develop, and implement solutions for problems in the practice environment demonstrates to physicians that improvement is possible,” says Shanafelt. “The approach transforms physicians from victims in a broken system to partners working with leaders to create their own future.”

From the NEJM Catalyst event [Leadership: Translating Challenge to Success at Mayo Clinic](#), June 2, 2016. See [“The Dangers of Physician Burnout”](#) to engage in the burnout conversation with other members of the NEJM Catalyst community.



[View video of Dr. Shanafelt's presentation.](#)

Tait Shanafelt, MD

Mayo Clinic

Dr. Shanafelt is the Director of the Mayo Clinic Department of Medicine Program on Physician Well-Being and a Professor of Medicine and Hematology at Mayo Clinic. Learn more about Tait Shanafelt...



Leadership Survey: Why Physician Burnout Is Endemic, and How Health Care Must Respond

Insights Report · December 8, 2016

Stephen Swensen, MD, MMM, FACR, Tait Shanafelt, MD & Namita S. Mohta, MD

Intermountain Healthcare, Mayo Clinic, NEJM Catalyst



Analysis of the second NEJM Catalyst Insights Council Survey on the Leadership theme.

For the first time since NEJM Catalyst began surveying our Insights Council members, there is overwhelming concurrence on an issue: 96% of executives, clinical leaders, and clinicians agree that physician burnout is a serious or moderate problem in the health care industry.

Let that sink in: 96%.

Physician burnout has gained notoriety of late, in part because of two [Mayo Clinic-AMA studies](#) (co-authored by TS) that showed rates of burnout among responding physicians at [54% in 2014, a 10% increase from 2011.](#)

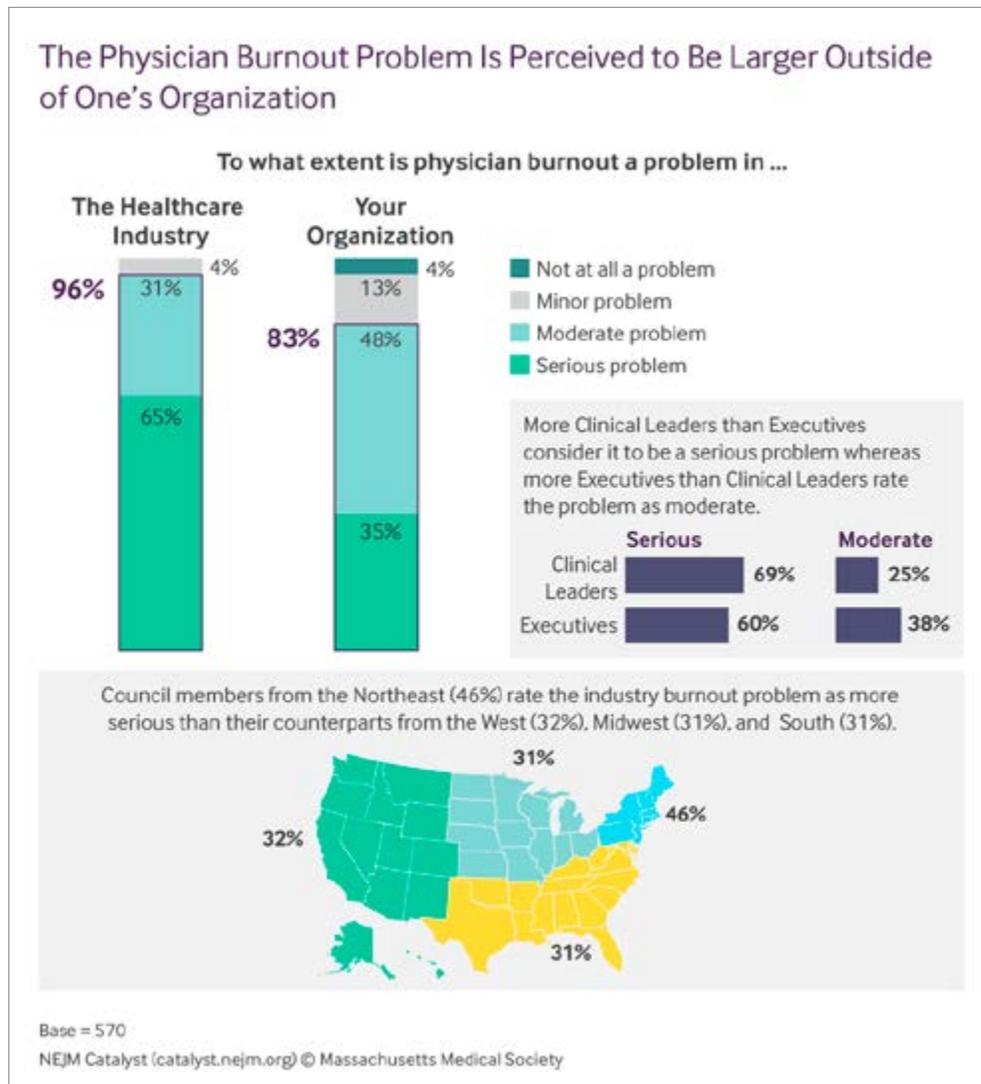
Burnout is a syndrome of depersonalization, emotional exhaustion, and a sense of low personal accomplishment. Physicians often develop burnout incrementally due to chronic increases of stress, inefficiency, and excessive workload.

A Widespread Problem Without Responses

Despite increasing recognition of the problem and intense media coverage, when asked what their organization is doing to address the issue of physician burnout, many of the NEJM Catalyst survey respondents replied “nothing,” “not enough,” “paying lip service,” and “talking about the problem in committees but no action plan yet.”

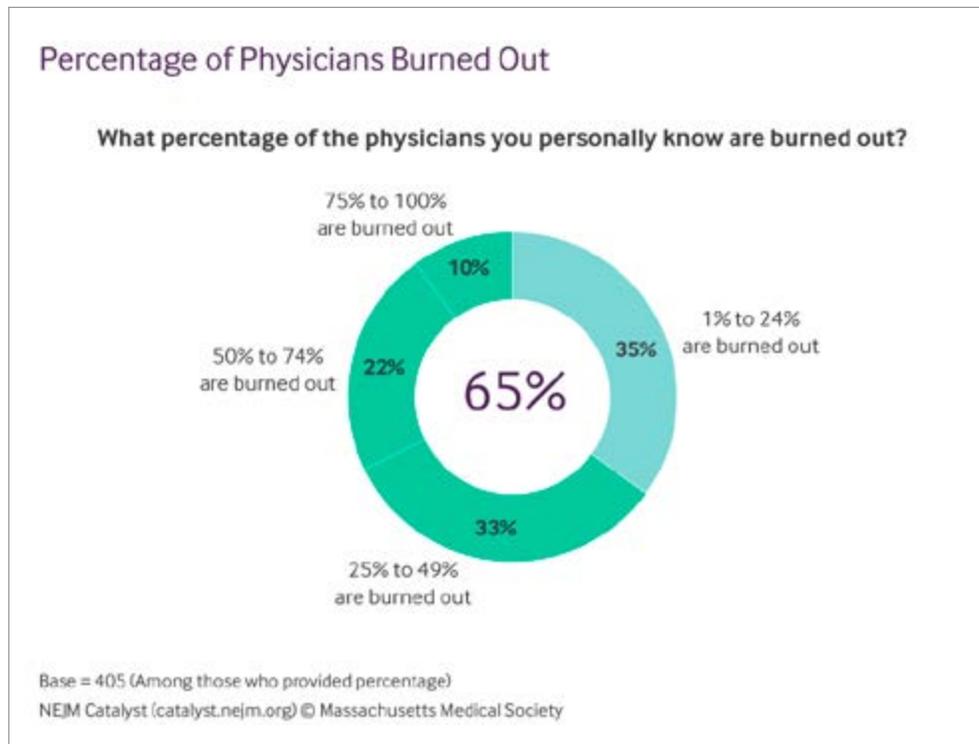
96%

agree physician burnout is a problem



The NEJM Catalyst survey reveals something of a disconnect between how respondents perceive the problem in the industry as a whole versus in their own organization. While two-thirds (65%) of respondents say physician burnout is a serious problem across health care, just over one-third (35%) rate it likewise in their own organization.

Are respondents fooling themselves about their own workplaces? Two-thirds (65%) of respondents say a quarter or more of the physicians they know personally are burned out.



While it seems no region of the country is spared from the problem, more Council members in the Northeast (46%) say burnout is a serious problem within their organizations than those in the West (32%), Midwest (31%), and South (31%).

NEJM Catalyst Council members cite decreased quality of care, which scores 63%, as the top reason to address burnout. Clinicians (67%) are more adamant than executives (57%) about this ranking. Well below that concern, at 38%, is the effect on the attitude of the rest of the health care team. Physician burnout creates an unsafe environment and can be contagious among team members.

“Are respondents fooling themselves about their own workplaces? Two-thirds (65%) of respondents say a quarter or more of the physicians they know personally are burned out.”

The least cited reason to address burnout is physician suicide (indicated by 8% of respondents). This is a concerning number given the severity of the outcome. Approximately one physician commits suicide each day in the United States.



VERBATIM COMMENTS FROM SURVEY RESPONDENTS

What is your organization doing to address the issue of physician burnout?

“The first step is to recognize the issue. That is just beginning.”
— Executive of a midsized nonprofit community hospital in the South

“Lots of talk, not much action.”
— Clinician at a large nonprofit teaching hospital in the Northeast

“Improving EMR Usability, trying to transfer tasks to other members of health care team.”
— Clinical leader at a large nonprofit health system in the Midwest

(CONTINUED ON NEXT PAGE)

VERBATIM COMMENTS FROM SURVEY RESPONDENTS (CONTINUED)

“Mostly lip service. I’m constantly reminded of how differently administrators and physicians see the world.”

— *Executive at a large nonprofit health system in the West*

“Discussion and scheduled time off.”

— *Clinician at a large nonprofit teaching hospital in the Northeast*

“Nothing!”

— *Clinical leader at a large nonprofit teaching hospital in the Northeast*

“Mindfulness training / resilience training.”

— *Vice President at a large nonprofit health system in the Mountain West*

“In theory, working on job doability by creating teams to share the work.”

— *Clinician at a large nonprofit teaching hospital in the Northeast*

“Trying to improve the focus on providing more efficient, cost-effective, patient-centered health care — a very difficult task with far too many bureaucratic, non-patient care barriers.”

— *Chief Medical Officer at a midsized nonprofit community hospital in the West*

(CONTINUED ON NEXT PAGE)

VERBATIM COMMENTS FROM SURVEY RESPONDENTS (CONTINUED)

“Improve staff training to better assist the physician.
Improve data accessibility.”

— *Director of a midsized nonprofit health system in the West*

“Presentations to physicians and staff, but administrative denial.”

— *Clinician at a large for-profit community hospital
in the Mountain West*

“Very little. Within our group, we have created a ‘relaxing’ or ‘time out’
zone to take a break. We are also trying to equally manage and control
workload.”

— *Clinical leader at a large nonprofit teaching hospital in the South*

“Working to support acceptance of the changes occurring within and
from without the profession. If they would lead more of the change
and shape it, it would feel less of a burden.”

— *Vice President of a large for-profit community hospital in the South*

“Aggressively telling us to get over it or leave. It’s very hostile.”

— *Clinician at a midsized nonprofit health system in the Midwest*

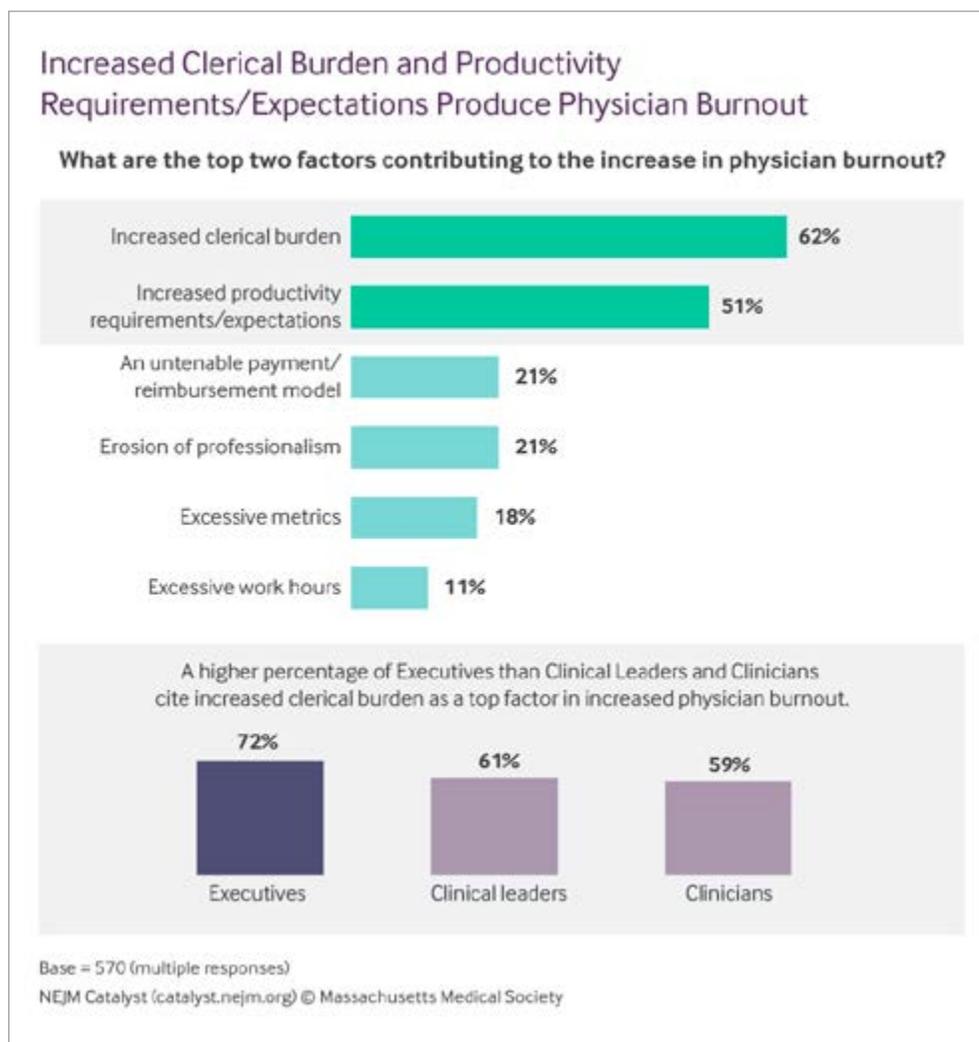
“Enlighten the masses to the fact it is a real thing, and establishment of
the fact that contrary to belief physicians are subject to the limitations
of a normal human being!”

— *Executive at a small nonprofit clinic in the Midwest*

Clerical Burden Is the Leading Cause

Pinning down the cause of burnout is difficult because many personal and professional factors contribute. For the purpose of this survey, we focused on the day-to-day workload factors that can contribute to physician burnout.

Respondents rate “increased clerical burden,” which is heavily influenced by expanded and more comprehensive use of electronic health records, as by far the biggest cause. In their current form, EHRs disrupt the workflow that many physicians have established over years in their practices, forcing them to carry their workload into off-hours, or “pajama time,” as it is often termed.



Ironically, one of the hopes for EHRs has been to improve the quality of care through improved documentation and measurement, yet it appears that quality may instead be decreasing because of the burdensome nature of EHR-related work.

When asked what their organization is doing to address the issue of physician burnout, many of the NEJM Catalyst survey respondents replied ‘nothing,’ ‘not enough,’ ‘paying lip service,’ and ‘talking about the problem in committees but no action plan yet.’”

A higher percentage of executives (72%) than clinicians (59%) point to increased clerical burden as the top issue behind burnout. Respondents say their organizations are solving some of these problems by using scribes for certain documentation tasks and redesigning EHR systems to align better with physician workflow.

More than half of survey respondents say increased productivity requirements/expectations contribute to burnout. Untenable payment/reimbursement models and erosion of professionalism tie for third in the results at 21%. Although excessive metrics score less than 20% as a contributing factor, metrics could be considered a sub-dimension of the increased clerical burden.

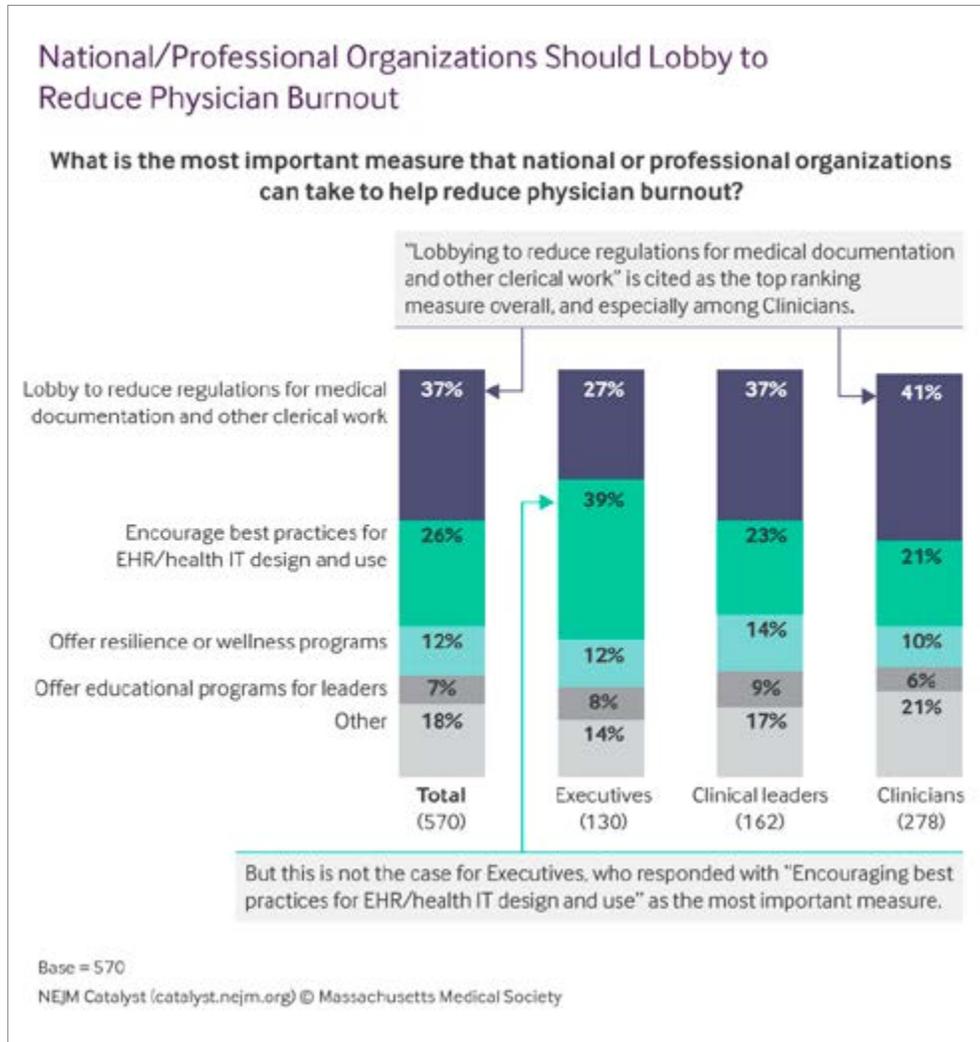
How Providers and Professional Organizations Can Respond

With a physician shortage under way and demand for access on the rise, health systems, hospitals, and physician practices can't afford to lose valuable clinical talent. Some physicians who experience burnout choose an exit strategy such as retirement (early/accelerated attrition in some cases), part-time practice, or leaving practice altogether for other industries such as insurance or pharmaceuticals.

The health care industry as a whole must work together to alter the burnout trajectory for physicians before it worsens and further jeopardizes patient care.”

It's time for the health care system to address the problem of physician burnout. To begin, leaders must understand the state of their organization's physicians, through a staff survey or other method of assessment. Once the level of burnout/well-being is assessed, leaders can begin to correct processes and introduce programs to intervene. Measure again, and organizations can assess whether the changes are making a difference.

While the majority of change has to come from within each organization, there is room for guidance from national and professional organizations such as the American Medical Association or American College of Surgeons. More than a third of survey respondents say such organizations should lobby to reduce regulations for medical documentation and other clerical work. Just over a quarter want to see these organizations encourage best practices for EHR/health IT design and use.



The health care industry as a whole — regulators, payers, EHR vendors, medical centers, and physicians — must work together to alter the burnout trajectory for physicians before it worsens and further jeopardizes patient care.

METHODOLOGY AND RESPONDENTS

- In October 2016, an online survey was sent to the NEJM Catalyst Insights Council, which includes U.S. health care executives, clinical leaders, and clinicians at organizations directly involved in health care delivery. A total of 570 completed surveys are included in the analysis. The margin of error for a base of 570 is +/- 4.1% at the 95% confidence interval.
- The majority of respondents were clinicians (49%), followed by clinical leaders (28%) and executives (23%). Most respondents described their organizations as hospitals (37%) or health systems (16%). These hospitals were predominantly midsized (34% had 200–499 beds) or larger (49% had 500 or more beds).
- Only 7% of respondents indicated that their major affiliation was with a physician organization. Those physician organizations tended to be big — 56% had 100 or more physicians.
- Nearly three-quarters of the organizations (73%) were nonprofit, with the remainder of respondents coming from for-profit organizations. Every region of the country was well represented.

Stephen Swensen, MD, MMM, FACR

Intermountain Healthcare

Stephen Swensen is the Medical Director for Professionalism and Peer Support at Intermountain Healthcare. He is also a Senior Fellow of the Institute for Healthcare Improvement, where he co-leads their Joy in Work Initiative. [Learn more about Stephen Swensen...](#)

Tait Shanafelt, MD

Mayo Clinic

Dr. Shanafelt is the Director of the Mayo Clinic Department of Medicine Program on Physician Well-Being and a Professor of Medicine and Hematology at Mayo Clinic. [Learn more about Tait Shanafelt...](#)

Namita S. Mohta, MD

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Survey Snapshot: Fixing Burnout Through Physician Input

Insights Report · December 15, 2016

Sandra Gittlen

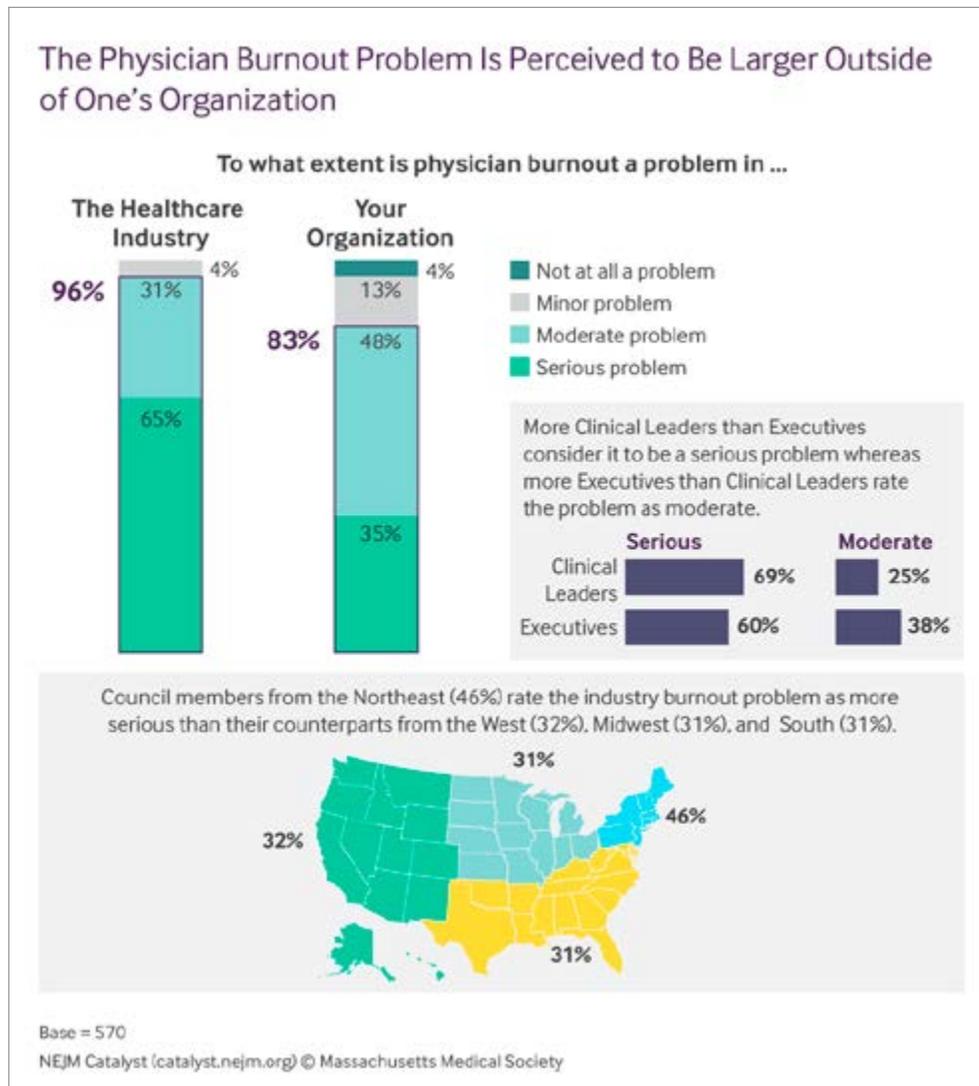
NEJM Catalyst



Mark Jenkins, MD, Executive Director at the University of Washington's Hall Health Center, primarily a student health center in Seattle, says physician burnout has been a problem for decades, starting in the 1980s and 1990s with the rise of HMOs.

"I saw it then in colleagues who were forced to take this 'next, next, next' approach and couldn't spend the time they wanted to with patients," he says. Since then, the problem has been magnified by electronic health record (EHR) systems and the financial pressures of keeping practices afloat.

Jenkins was among 65% of NEJM Catalyst Insights Council members who called physician burnout a serious problem in the industry, responding to the latest Council survey exploring this rising crisis. Although Jenkins' administrator role has removed him from the "trenches" of seeing patients day-to-day, he feels burnout is an issue "even more so" today.



We take people who are highly trained, highly educated individuals selected because of their motivations in terms of humanism and their ability to learn copious amounts of material, and we turn them into highly educated factory workers."

Michael Schneck, MD, Professor of Neurology and Neurosurgery at Loyola University Chicago Stritch School of Medicine, says fundamental changes in how physicians are asked to practice medicine have had a severe impact.

"We take people who are highly trained, highly educated individuals selected because of their motivations in terms of humanism and their ability to learn copious amounts of material, and we turn them into highly educated factory workers," he says. "We ask them: 'How many patients have you seen?' 'How many procedures have you done?' 'How have you met quality metrics?'"

These metrics do not translate to a good experience for physicians or patients, he says. “How is that being a physician where you’re supposed to relate to the individual and make things better?”

Because of these pressures, some of Schneck’s colleagues have opted out of clinical medicine, either to become administrators or medical educators, or to pursue business affairs. “But that’s only for a select amount — others who stay in clinical medicine as their primary daily activity generally have little opportunity to improve their situation,” he says.

As an example, he points to stroke code protocols that require neurologists, who tend to be at a higher risk of burnout than other specialties, to immediately respond within hospitals and emergency rooms when a stroke is suspected. “Half the time they are false alarms, they are very disruptive, and they require a large burden of documentation,” he says. “Ideas [like this] are good, but the process required to implement the idea is flawed. The devil is in the details and there are a lot of details.”

EHRs Need a Massive Overhaul

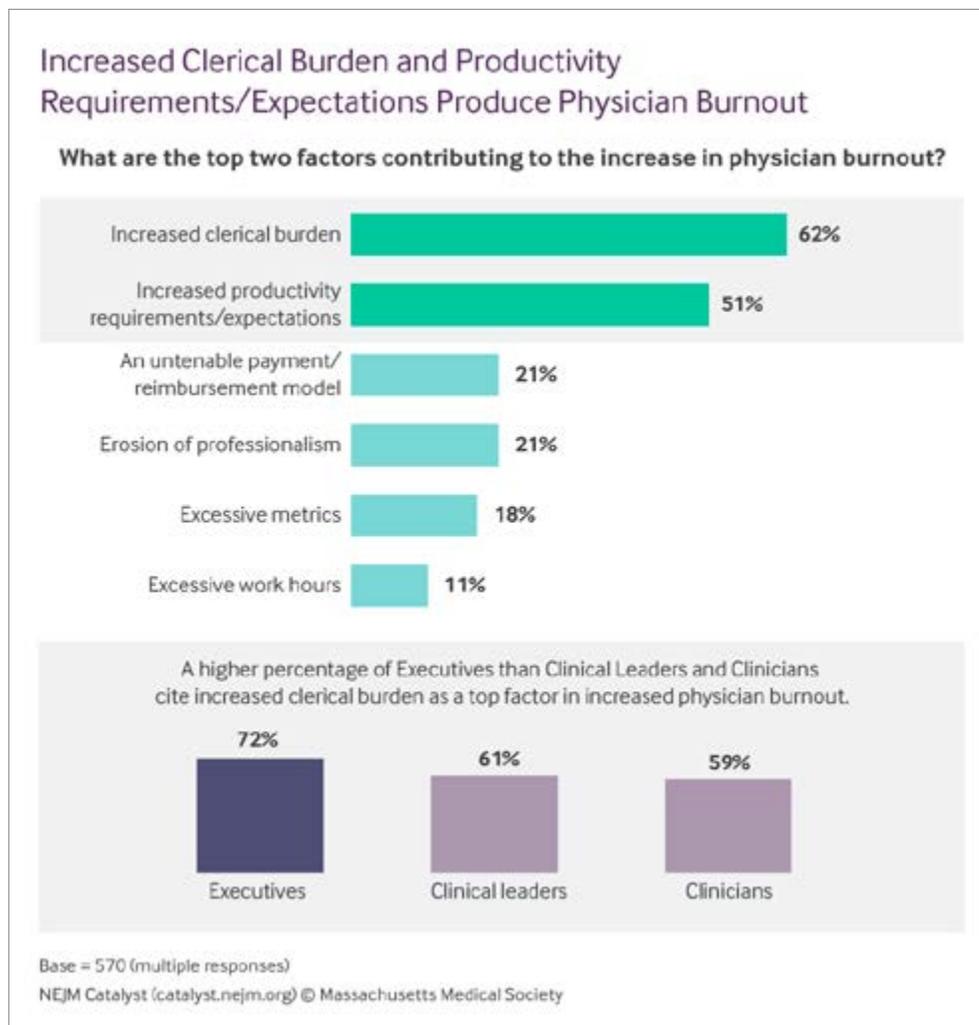
EHRs, considered a major part of the increased clerical burden — which respondents ranked as the top contributing factor to burnout — will improve in the future, Jenkins believes.

Getting there, though, will require a massive overhaul to address the lack of interoperability and to foster openness. He likens existing EHRs to trying to use a stethoscope with a big knot in it.



[EHR] redesign should be led by physicians, not software developers.”

A redesign should be led by physicians, not software developers, he says. Important additions would be better voice recognition, artificial intelligence to aid documentation, and other capabilities that reduce clerical burden.

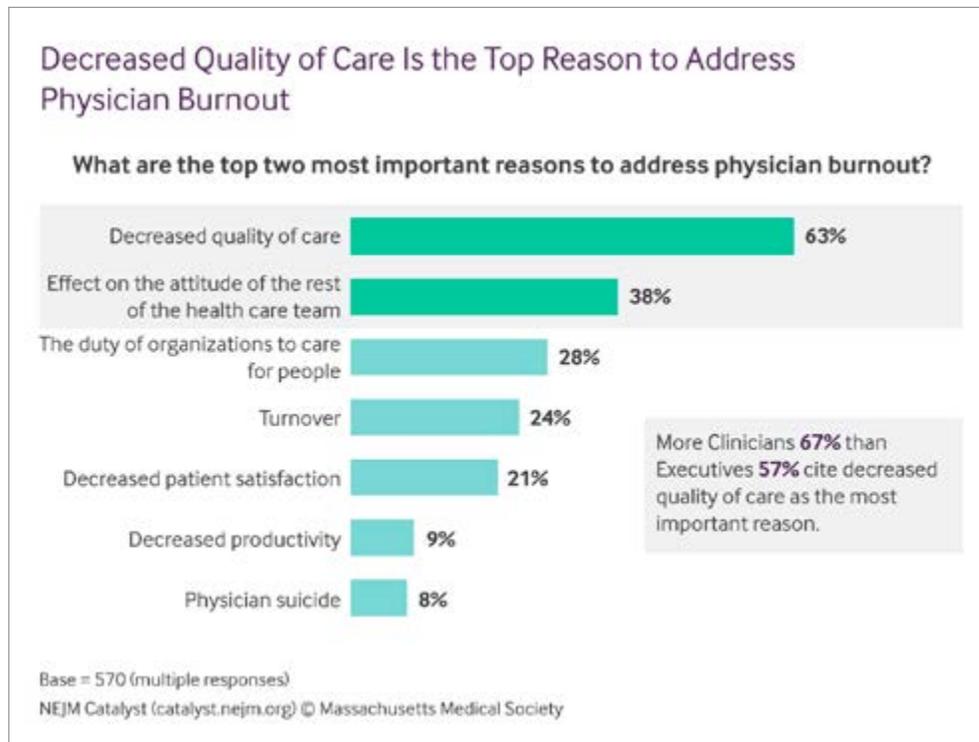


Schneck views proposed solutions such as scribes to help with documentation as a Band-Aid. “We need to fix the system so it doesn’t burn the physician out to begin with,” he says.

In addition to revamping EHRs, he sees a need for culture change. “Right now, burnout is treated as if there is something wrong with the physician rather than something wrong with the system,” he says. “The physician has lost stature as a team leader and is just another cog in the machine.”

Physician Input for Physician Engagement

Schneck feels a good place to start fixing burnout is to ask for physician input. “Nobody asks about how system processes impact the practicing physician,” he says. “None of the three top reasons we discussed to address physician burnout are physician-centric. However, if you improve physician satisfaction, you will improve patient quality of care and satisfaction.”



Physicians also must be fully engaged in the entire health system, not the microcosm of their own practice, he says. “You have to give the person an opportunity to grow, including defined career paths. Otherwise you perpetuate the day in, day out syndrome,” he says. He considers involvement in professional societies, which is a popular go-to in the industry, no more than a short-term solution. A better avenue is for medical schools to switch students from observers to active participants. “We could be teaching them how to engage in hospital activities or how to do quality assessments,” Schneck says.

Right now, burnout is treated as if there is something wrong with the physician rather than something wrong with the system. The physician has lost stature as a team leader and is just another cog in the machine.”

Jenkins recommends that health care leaders and physicians identify individualized solutions. He warded off burnout at his previous post by mentoring a student-run cycling team. He tries to help his physicians by encouraging them to volunteer outside of the work environment with community health programs and student organizations that personally interest them.

Excessive metrics also drive burnout, as noted by 18% of NEJM Catalyst survey respondents. Jenkins calls for restructuring federal Meaningful Use requirements. “We’re collecting all this data, but it’s not useful. It’s more of a billing record, but doesn’t do anything

to improve patient care or population health,” he says, adding that regulators should pump the brakes on tying reimbursements to this data. “They’re using a model that hasn’t been studied well enough. If a pharmaceutical company tried to release a drug without going through the double-blind studies, we’d never accept it.”

Multiple Sources of Support

Bart Hobson, MD, an urgent care physician at Marshfield Clinic, a health care system with over 50 locations in northern, central, and western Wisconsin, says fixing burnout will require leadership to consider it a top priority, which is difficult when there are competing interests for their time.



If an organization wants to attract and keep the best people, they have to watch out for and have a plan to deal with burnout.”

“If an organization wants to attract and keep the best people, they have to watch out for and have a plan to deal with burnout,” he says.

Physicians can help one another with burnout, Hobson says. He observed a practice partner not being able to keep up with charting because he was waiting until end of each day. Hobson encouraged the partner to do it after every few patients. “He made that change and was much happier,” he says.

Medical schools can be another source of support, Hobson says. They should put more emphasis on the emotional side of being a physician and give students tools they can use throughout their careers to cope with stress. “You want to develop a generation of physicians who understand burnout is part of life and can say, ‘I was told to expect this and now I need to do something about it.’”

Sandra Gittlen

Contributing Writer, NEJM Catalyst



Are EMRs to Blame for Physician Burnout?

Interview · October 24, 2016

Thomas H. Lee, MD, MSc & Steven Strongwater, MD

Press Ganey Associates, Atrius Health



Physician burnout is a hot topic these days — for good reason. As Steve Strongwater, President and Chief Executive Officer for Atrius Health, notes in his discussion with Tom Lee, 54% of U.S. physicians are experiencing physician burnout. Are electronic medical records worsening the problem? In short, yes. Find out why, and how we can address this to improve not only the quality of care for patients, but also the quality of life for physicians.

 [Listen to audio interview.](#)

Tom Lee: This is Tom Lee from NEJM Catalyst, and I'm here with Steve Strongwater, a rheumatologist who is the CEO for Atrius Health in Boston. I first met Steve when he was Chief Transformation Officer at Geisinger Health System, and he came in the summer of 2015 to be the CEO of a very respected integrated delivery system built around physician practices in Boston: Atrius Health.

Now, Steve and his colleagues have been dealing, like so many of us, with clinician burnout, particularly among physicians. We recently had an interesting conversation about physicians and their long love-hate relationship with electronic medical records, which we all know are essential to high-quality care in this day and age, but it does seem like the ratio of love to hate seems to be moving in the wrong direction. In fact, EMRs are being blamed as a cause of physician burnout by many clinicians. So, I wanted to take time with [Strongwater] today to hear from him on his take on these issues and what Atrius is doing about them. So, Steve, what's your take? Are EMRs a symptom of burnout, or are they the actual cause of the disease?

Steve Strongwater: Tom, that's a great question, and I really appreciate the opportunity to talk this over with you. First, I would hope that everybody agrees that physician burnout or physician wellness is a real problem in this country. As measured by objective studies, 54% of U.S. physicians are experiencing physician burnout, and there are many reasons for it. It's not a function that people just are whining and they're not as tough as physicians used to be.



What has happened over time is we have asked our clinicians to become sophisticated coders. They are clicking through screens that are cluttered, that are not designed with human factors in mind."

About 80% of physician burnout is really due to workflow issues, and as it turns out, the way the electronic medical records have evolved — unlike in other industries where automation has made work easier — the electronic medical records have added work. Now, that may be a function of many different things: requirements for more data capture for things like quality, or coding for billing purposes, or regulatory requirements. But the electronic medical record has clearly added work to a physician's day, and people who are so dedicated and committed are working late into the evenings in what we would call "pajama time."

In general, what seems to happen is that our docs will work during the day — they'll work a full day, sometimes eight or 10 hours or longer — they'll go home for a brief period of time, and then they'll get back on their record in order to finish the work of the day that evening. So, we are adding work, and over time what we're seeing is that people, by virtue of wanting to meet the needs of their patients, reduce their amount of FTE (full-time equivalent time), so that they can use that time to finish the work during the week to maintain balance in their lives.

So, the short answer is that the electronic medical record has contributed to burnout as one component of burnout, and I think it's really important for the designers of EMRs to try and work to improve the user interface, the workflow, in a way similar to the way smartphones work or when you start a search on a search engine and it almost anticipates your needs. We're just behind. We're almost in generation one of that electronic medical record.

Lee: Before we go to the solutions, let's go a little bit deeper into the path of physiology. I know that there's been tremendous medical progress, and there are many more people involved in care today than when I was coming out of my training, but how is it that electronic records might actually be worsening the problem? Is there something more than just putting in front of me all the work that I need to do to take care of my patients?

Strongwater: The short answer is yes. What has happened over time is we have asked our clinicians to become sophisticated coders. They are clicking through screens that are cluttered, that are not designed with human factors in mind. They are filling out forms that at one time would have been triaged to a medical assistant or health assistant. They're having to respond in their inbox to messages that otherwise historically would not have come to their inbox, that would have been filtered away, and so it literally has added work to a busy day.

It has also negatively impacted what I would consider face-to-face time with patients. If you're a clinician in a room, you're often not looking into the eyes of your patients, you're looking into the screen of the computer, and as a consequence it's impacted the [patient experience] as well. So, it has definitely negatively impacted the workflow and the patient experience as a function of the way the EMR has been designed.

Lee: The EMR has put work that ought to be done in front of us, but it's created work and it's distracted clinicians and others from some of the important interactions that lie at the core of health care. So, what's the solution?

Strongwater: Well, we talked a little bit about some of the solutions. I would refer to this generally as intuitive design, that the designers, who have the ability to watch and monitor physician workflow, begin to understand the dynamics in an outpatient setting of what an office visit is like: what could be done before the visit, what needs to happen during the visit to present information to the clinicians in advance of the clinician having to go through a series of clicks and screens to make that interaction easier, to move more toward an intuitive user interface like your iPad or your smartphone, and to begin to use artificial intelligence and machine learning to anticipate the needs of clinicians, and then to automate as much as possible during that workflow.

It's really important for the designers of EMRs to try and work to improve the user interface, the workflow, in a way similar to the way smartphones work.... We're just behind. We're almost in generation one of that electronic medical record."

One of the things I didn't talk about are these best practice alerts, which [are] alerts in Epic that you need to do something. Often, there are so many of these best practice alerts that the clinicians just bypass them. Again, I think that has to be looked at from the perspective of better human-factors engineering. I think we're in version 1.0. I think we also need to add in much better analytics to anticipate who's sick and who has care gaps and to make that as easy as possible.

And when I talk about machine learning we've added so many clicks on the conversion from ICD-9 to ICD-10 coding, there just has to be a better way to do that work. I think about the way Quicken was originally designed, where it sort of learns as you go

along. If you've seen a thousand patients and you've never used a particular ICD-10 code, why should it be on your screen? And you need to maintain updated problem lists as it relates to being sure that you can close all the care gaps and you know what interventions need to be done. It's a bit of a long-winded answer, but the short version I think is that the user interface and artificial learning would go a great deal toward improving the workflow and reducing burnout.

Lee: Part of the problem is almost surely the electronic records, the software as it were, but part of it is likely to be humanware: how we're organized, the extent to which we're organizing teams that can actually trust each other. Can you comment on some of the human-factor design that actually has to go on with humans?

Strongwater: Yeah, it's a great observation, Tom. I do think we have definitely moved into team-based care. If you could filter away work, triage it to the top-of-license person — whether that's a nurse or a medical assistant or a pharmacist or a social worker — that would reduce the workload for the clinician. I think it has to be done in such a way that there's confidence in the team that that work will be done, because what tends to happen, at least with our primary care docs, is they're insecure that we have higher liability, that is that things happen 100% of the time, and so they want to check on it.

So, if I as an example say, "Look, I can take all your normal labs out of your inbox, would that work?" They'll say, "No, I want to take a look at them." In and of itself, checking those normal labs doesn't take that much time — until you add 150 patients, and then it adds work in that results review. So, if we could get the team to work at a high level of reliability and people had trust and confidence, I think you could do a great deal to reduce the demand time on the clinicians. I think that is absolutely the case.

Lee: One other thing that runs through my mind is customization of electronic medical records. I wonder whether we sometimes shoot ourselves in the foot. I recently visited an organization who said they can't upgrade to the new version of their electronic medical record because they've done so much customization of their current edition that it would be too complicated. Could we be making life more complicated than it needs to be, and that it would be better for us all to get used to vanilla, for example?

Strongwater: It's a great question, and I would want to reframe the question and somewhat the answer. When we started out with electronic medical records, every organization wanted to customize it to their own needs. In part, that's because there wasn't a good enough product out there. I would argue that we need to allow the best product available to evolve and then make that more broadly available.



Over time, we're going to see the IBM Watsons of the world providing supplemental content and workflow information that complement the available tools inside an embedded electronic medical record like Epic. And when that happens, it'll be possible to go with vanilla."

In the case of Epic, when you have one instance of Epic, you have one instance of Epic. You get sort of a vanilla shell, and then you customize it and there are no two instances that are exactly the same. But I would argue that if you had a mechanism like a library of apps that you could choose from and then import into your baseline system, that you would still be able to upgrade much as you upgrade your iPhone and have best of breed available in the practice. It hasn't happened that way.

When I refer to more artificial intelligence, nothing would be better than to have a wrapper that would provide pretty current upgrades of content — medical content, workflow content — that marries up to a basic EMR program. A lot of this has to do with whether the electronic medical record is going to be able to do all these things all at once for everyone.

I have a feeling that over time, we're going to see the IBM Watsons of the world providing supplemental content and workflow information that complement the available tools inside an embedded electronic medical record like Epic. And when that happens, it'll be possible to go with vanilla because you could pick from an outside library of enhancements that you could pull in seamlessly into your ecosystem, which would be wonderful.

Lee: I know that better days do lie ahead. I just don't know how far ahead, and I also know that you and your team at Atrius are doing some innovative things to hold your own feet to the fire to hasten the arrival of those better days. Could you comment on that?

Strongwater: Well, we have an initiative modeled after the ABIM [American Board of Internal Medicine] called Returning Joy to the Practice of Medicine. In order to make that real, our C-suite and senior administrators' incentive plans are in alignment with that, really tracking the time spent on Epic — particularly that pajama time — and we expect that we should be able to reduce that time out of work, meaning out of the office, materially. And that is built into our C-suite incentive plan.

We hope that the administrators and the physicians come into alignment. Certainly the docs would love that. We need to have our administrators understand that workflow matters, quality of life matters, returning joy to the practice of medicine — not only for the physicians but for the rest of the practice — is really important. And we hope that joy returns really quickly.

Lee: Well, I know that your physicians are rooting for you to hit those incentive targets, and I hope we can check back in a year and see how it went.

Strongwater: We look forward to it. I hope we'll have great news to report.

Thomas H. Lee, MD, MSc

Press Ganey Associates

Dr. Lee is the Chief Medical Officer for Press Ganey Associates, Inc., a member of the Editorial Board of The *New England Journal of Medicine*, and the NEJM Catalyst Leadership Board Founder. [Learn more about Thomas H. Lee...](#)

Steven Strongwater, MD

President and CEO, Atrius Health



Poor Care Is the Root of Physician Disengagement

Blog Post · January 10, 2017

Richard Gunderman, MD, PhD

Indiana University

In many locales around the country, hospitals and health systems are scrambling to respond to poor physician engagement scores. Boards of directors are becoming exercised, task forces on “physician alignment” are being assembled, and managers are losing bonuses and even their jobs. But beneath this hubbub lie important truths about “engagement,” many of which are just emerging into view.

The cause for concern is clear: disengaged physicians are bad for health care. They reduce recruitment and retention rates. They increase the frequency of errors. They lower rates of patient adherence to treatment recommendations and quality of care. Broadly speaking, disengagement undermines morale. Health care organizations at which physicians do not like to work are generally bad places to get care.

I can no longer practice medicine the way I teach it to the next generation of physicians. Either I take the time necessary and fall further and further behind, or I stay ‘on task’ and cut corners on being really present and attentive to my patients.”

How Disengagement Happens

I have been interviewing young physicians who are thinking of leaving or have in fact left the practice of medicine. The stories they tell would be humorous if they weren’t so sad. One physician, Jill, a family physician in her late 30s who works in a highly productivity-driven hospital-based practice, describes practicing medicine as “running on a hamster wheel.” Throughout each day, she feels that she is “constantly behind, and never doing quite well enough.”

As Jill sees it, her hospital-based manager's principal role is to keep raising productivity targets, with the expectation that physicians will work harder. "It becomes a mentality for them, and they don't question it." From her point of view, however, the complexity of her patients' needs makes practicing faster impossible. As a physician, her goal is not simply to meet productivity targets, but "to take the time to get to know my patients and intervene in ways that actually improve their lives."

Quality indices, which are supposed to improve care, "are the bane of my existence," she says. "Many times those numbers reflect not what my patients or I perceive as quality of care, but simply what managers are able to extract from the health record system." And often, she says, the data turn out to be wrong. "In one case, our managers were wildly miscalculating well-child visits. Only those who actually cared for patients could recognize the error."

Jill continues, "Getting in and out quickly, ticking off all the boxes, and getting your records completed promptly — these are the things the system values. But my patients want me to listen to them and make sure their concerns are addressed. Being assessed every day by measures that don't really improve patient care — over time, it takes a real toll on you. The people in charge don't realize that you simply can't pull real quality out of large data sets."

To my surprise, Jill says that the problem that bedevils her most is hypocrisy. As an academic physician, she spends a substantial amount of her time with medical students and residents, and as she expresses it, "I can no longer practice medicine the way I teach it to the next generation of physicians. Either I take the time necessary and fall further and further behind, or I stay 'on task' and cut corners on being really present and attentive to my patients."

The core problem, then, isn't managerial. It isn't even ethical. It's ontological, pertaining to the most fundamental question of all: what in medicine is most real?"

For now, Jill worries most about her younger colleagues. "A friend of mine is brand new in practice. She takes care of medically complex patients. She is extremely smart and caring and provides excellent care. But the demands are wearing on her. When you talk to her, you can just see the physical exhaustion. She is so new in practice, yet the need to make her numbers is already burning her out."

Jill describes another colleague, a pediatrician who took care of children with developmental issues and chronic diseases. "She is an exceptional physician, but now she has gone to work for a health insurance company. She doesn't see patients. I thought she would hate it but it turns out she likes it. All day she is doing the paperwork for insurance approvals. Knowing that patients are losing a physician like her — it just makes me want to cry."

What Is Medicine For?

The core problem, then, isn't managerial. It isn't even ethical. It's ontological, pertaining to the most fundamental question of all: what in medicine is most real?

Recent efforts to convert medicine from a relationship-centered profession to an efficiency-focused production process have shifted the focus of attention from aspects of care that Jill regards as real and significant to others she sees as neither. What she and others are describing is a health care culture seriously out of step with what matters most in patient care. This imbalance inevitably erodes the engagement of health professionals.

The term *disengagement*, when used to describe physicians, is both revealing and symptomatic. To call physicians or other health professionals “disengaged” presumes that there is something they ought to be committed to. As many managers see it, doctors and nurses are not sufficiently aligned with health care organizations' priorities, their extensive metrics, and the need for efficiency.



When it comes to disengagement, we don't need a new electronic information system, a new set of metrics, or a new CEO. We need a renewed commitment to the most central of all medicine's ends: caring well for patients.”

Yet those who care for patients feel differently: that face-to-face interactions with patients, not board meetings or creative huddles, are where health care needs to focus.

Viewed from this perspective, it is not difficult to see why physicians and other health professionals would become disengaged. The problem is not simply that paperwork is proliferating, compliance standards are becoming more onerous, and health professionals are spending less time actually caring for patients — though each of these is highly problematic. The fundamental problem is deeper: hospitals and health systems are becoming increasingly detached from the reality of medicine.

As organizations grow in size, they rely less on relationships and more on aggregate data and policies. As health care shifts from relationships to data-driven, process-oriented approaches, it inevitably discounts the needs of particular patients and the people who care for them. As many physicians see it, collecting evidence to demonstrate that health care organizations and their executives are performing well is ultimately less important than taking good care of patients.

Jill and other disengaged physicians are not asking for a promotion, lighter work hours, or more money. Instead they are seeking something much more significant: the ability to take good care of their patients. When it comes to disengagement, we don't need a new electronic information system, a new set of metrics, or a new CEO. We need a renewed commitment to the most central of all medicine's ends: caring well for patients.

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Physician Burnout and Patient Experience: Flip Sides of the Same Coin

Blog Post · June 20, 2016

Thomas H. Lee, MD, MSc

Press Ganey Associates



Why is physician burnout an urgent issue in so many health care organizations, seeming to worsen every time it is measured? Explanations abound, including crushing workloads, loss of autonomy, and pressures to improve patient experience along with other components of quality.

A sense of the history of medicine suggests that the conventional wisdom is wrong, and that these issues are not the drivers of physician burnout. They are flip sides of the same coin. The same forces that are causing physician burnout also make the physicians' job more and more demanding, increasingly complex, and often annoying. And they create a sense of chaos for patients, which makes improvement of patient experience an imperative.

The implication is that the solution to physician burnout is not to wind back the clock, or ignore the need for coordination and compassion in care. These issues can only be taken on together. In other words, physician burnout can only be improved with better patient experience — and the other way around.



The same forces that are causing physician burnout also . . . create a sense of chaos for patients, which makes improvement of patient experience an imperative.”

The reason: the root cause of our challenges is medical progress, which is, of course, wonderful in so many ways. But the price of progress goes beyond the costs of new tests and treatments. To take advantage of these advances requires increasing numbers of clinicians, with narrower and narrower expertise. Most patients have to come in contact with dozens, sometimes even more than a hundred personnel important to their care during a hospitalization.

The experience can be chaos — for patients and for the clinicians themselves. To master their areas of expertise and get their work done, physicians circumscribe their work and their scope of activities. They focus on one organ, or one disease process, or just perform one type of procedure. The outpatient physicians do not go to the hospital, and the hospital-based physicians may not interact with their patients or other colleagues outside their disciplines.

For patients, the experience of being ill and receiving care from a large number of personnel — who, despite their hard work and good intentions, are not always perfectly coordinated — is nothing less than frightening. When it is obvious that clinicians do not actually know each other, are giving slightly different answers to questions, and may not even trust each other, it is hard for patients to feel confident that they are getting good care.



I am a part-time clinician, but whenever I open my “inbox” in my electronic medical record, I feel like a fire hose is blasting me against the wall.”

But these dynamics are no fun for physicians either. With all those clinicians involved in any patients’ care, the work of staying in touch with each other becomes close to a full-time job. Entering information into the electronic medical record so other clinicians know what is happening is one type of burden — but even worse is having to digest information about one’s patients from those clinicians. I am a part-time clinician, but whenever I open my “inbox” in my electronic medical record, I feel like a fire hose is blasting me against the wall.

And here is one of the sadder secrets of modern medicine: even though physicians interact with more clinicians in the course of their day, it is a lonelier type of work than a generation ago. Physicians struggle just to get through their day, and walk by other clinicians trying to do the same thing. They may walk down the hall of a hospital where they have worked for decades, and no one says hello.

It is not reasonable to hope that these side effects of medical progress can be eliminated the way we address side effects of a drug — by stopping the offending agent. We cannot turn back progress, and wouldn’t want to if we could. Instead, we have to recognize that 21st-century medicine is different, and change health care delivery so that it reduces the suffering of patients but clinicians as well.

To do that requires coordination. No one can deliver state-of-the-science care on their own anymore, so embracing teamwork — rather than grudging acceptance of it — is the right path forward for organizations and for individual physicians. Real teams are more than a group of non-physicians who increase the number of patients a doctor can see. Real teams have more than complementary job descriptions. Real teams are actually greater than the sums of their parts.



The answer to physician burnout is not reducing our aspirations for the care that we deliver to our patients. It is in fact becoming more ambitious.”

In real teams, the members know one another, feel loyalty to one another, trust one another, and would not want to disappoint one another. The reinforcement that comes from earning the respect of colleagues that surround physicians goes beyond what financial incentives can ever achieve.

So what is the path forward? First, physicians and their organizations should commit to organizing their care around reducing the suffering of patients. That is the noble goal that

resonates with the motivations of every clinician, and trumps all other concerns.

Second, physicians and their organizations should focus on *how* they are going to achieve that goal. What their patients want, and what will bring pride to physicians, is to deliver care that is safe, compassionate, and coordinated.

Third, organizations should assess and manage their progress, by measuring and learning and creating systems for accountability for improvement.

With clarity on those goals, physicians and their organizations can organize care so that it does not harm patients and meets their patients' needs. Beyond pride, such work will bring business success through greater market share, more effective collaboration with patients, and enhanced ability to recruit and retain colleagues.

The bottom line: the answer to physician burnout is not reducing our aspirations for the care that we deliver to our patients. It is, in fact, becoming *more* ambitious. There is only one way out of our problems, and it is to move forward.

Thomas H. Lee, MD, MSc

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Despite Burnout, There's Still Joy in Medicine

Interview · July 7, 2016

Stephen Swensen, MD, MMM, FACR & Liselotte Dyrbye, MD, MHPE

Intermountain Healthcare



Physician burnout is a persistent problem, particularly among residents. “Somewhere upwards of 50 percent of them can have substantial symptoms of burnout,” says Lotte Dyrbye, Associate Director of the Department of Medicine Program on Physician Well-Being at Mayo Clinic. She sat down with Stephen Swensen, Lead Advisor for the [NEJM Catalyst Leadership theme](#), to discuss just how widespread the problem is, what causes it, and what we can do about it. In other words, as Swensen says, “how we can get back to the core of the joy of helping people and families?”

“I think action is needed — action is very much a necessary piece,” Dyrbye says. “There’s a lot of conversation around physician burnout and its consequences to patient care.” But the tide is shifting, she says, adding that she believes there is hope. “Many of those who are burned out do recover.”

 [Listen to audio interview.](#)

Steve Swensen: Good afternoon, this is Steve Swensen. I’m the [former] Medical Director for Leadership and Organization Development at Mayo Clinic. I’m here for NEJM Catalyst and today we have the opportunity to have a conversation with a great leader in health care, Dr. Lotte Dyrbye. She’s a Professor of Medicine at Mayo Clinic, and a well-published author and physician, [in the] burnout area, [as well as] researcher. She’s the Associate Director of the Department of Medicine Program on Physician Well-Being at Mayo Clinic. So, Lotte, thank you so much for spending some time with us today.

Lotte Dyrbye: It’s my pleasure, Steve.

Swensen: How did you get interested in professional burnout?

Dyrbye: I think my interest spawned back in early 2000 when [Dr. Shanafelt](#) published a study about how [residents with burnout](#) were more likely to have sub-optimal patient care practices. Things like discharging patients just to make the service more manageable, not fully discussing treatment options, those sorts of behaviors we're seeing much more frequently in residence. And it was really the first time that I started to think about professional burnout and what that meant. And when people were more likely to experience that during their career and it made us think about, as a group, well, when does this phenomenon of burnout start? Is it something that's unique to residents and physicians in practice, or could it possibly have its origins in medical school? And it was really [that paper](#) and that conversation with Dr. Shanafelt that started our very first research project, looking at burnout in medical students back in 2004 or so.

Swensen: So, beyond the well-being of medical students and residents and fellows, it sounds like you see a large opportunity to improve the care and experience of patients and families?

Dyrbye: Yeah, that's very much true. We typically think about patient safety and quality of care, looking at systems factors. But one of the aspects that hasn't been very well explored yet is the relationship between health care provider well-being and career satisfaction, and how that [relates to quality of patient care](#). I think it's come to light more recently, as there have been published studies around burnout and quality of care, burnout and professionalism, burnout and intent to leave practice or actually reducing clinical hours. But how the phenomenon of professional burnout can be impacting, not only quality of care, but also access to care.

Swensen: So, how big, how pervasive, how widespread is this opportunity among our medical students and residents in America?

Dyrbye: Unfortunately, we see a very high prevalence of burnout in physicians. All specialty types with some specialties appearing to be at higher risk for having burnout. Particularly, those that are at the frontline of care. For example, general internists, such as myself — we have higher risk of burnout than other specialties.

When we look at residents, they also have a very high prevalence of burnout — somewhere upwards to 50 percent of them can have substantial symptoms of burnout. And when we look at medical students, especially in the third and fourth years, or the years where they're more clinically engaged, we also see very high prevalence of burnout. And we see more burnout in physicians and in trainees than we would expect, based on national norms of other U.S. working adults.

When we look at residents, they also have a very high prevalence of burnout — somewhere upwards to 50 percent of them can have substantial symptoms of burnout.”

Swensen: Fascinating. So we take what I think is a generalization — I hope it's true — enthusiastic, upbeat, mainly younger students in medical school, and put them through medical school and residency, and we say that joy and enthusiasm, and a large proportion end up being burned out? So, what are the causes, what happens during those years of training, and is it different than for practicing physicians, like you just talked about? What are the drivers, the causes?

Dyrbye: Yeah, a really important point for us to remember is that when medical students matriculate . . . so the very beginning of medical school, they have mental health profiles that [are] better than other age-match U.S. college graduates. Even though they went through really rigorous college education and took the M-CAD and were very competitive in their process of applying to medical school, they had less burnout, less depression, better quality of life in multiple domains at matriculation than did other U.S. college grads.

But once they've been exposed to our environment, are acculturated to medicine, are exposed to our daily work lives, that switches, with higher levels of burnout, depression, worse quality of life, in our trainees, medical students and residents. And that persists out into practice. So, given that information, we think that the major driver has to do with the learning environment or the workplace conditions, more so than individual characteristics or personality traits. So, it's more what's going on in the learning and the work environment, that's really driving the burnout in trainees and in physicians.

Swensen: Wow, so in this work environment, are there characteristics or drivers or specific things that you've learned through research and being an expert in this area that's stand-out in that environment, that's different from the premed years that changed this whole, file from matriculation that's pretty good, to something that causes them to suffer, over the years?

Dyrbye: There are numerous contributors that have been delineated. If we think about the resident trainer, the resident trainee, as with physicians, excessive workloads. So, high patient volumes, frequent/erratic call, greater work hours, are associated with resident burnout, just like they are in practicing physicians. Residents also don't have a lot of autonomy and they experience work/home conflict and that contributes to their burnout. As does their educational debt. So, the more educational debt they have, the higher their risk is for having burnout, as well. Now, there are other factors that are related more to supervising physicians.

We think that the major driver has to do with the learning environment or the workplace conditions, more so than individual characteristics or personality traits.”

So, if residents don't get timely feedback, if they have stressful relationships with their supervisors, if they feel that their personal needs are inconsequential and aren't being met. Those sorts of factors within the learning environment also contribute to resident burnout. Another interesting thing that we've uncovered is residents feel uncertain about their future, which you just imagine, in today's era of rapidly evolving health care reform and how we're delivering health care. Residents have a really hard time imagining what their practice is going to look like, once they're done with training. And the more uncertainty they feel about the future of the profession, the greater their risk of burnout, as well.

Now, we back it up and we look at the medical student, we look at the very, very beginning, one of the things that we've identified is that grading scheme, it makes a huge difference. So, if you look at year one and two of medical school and you examine things, like the number of hours they have to be in lecture, or small group, number of exams they have, how much vacation they have. Anything you can think about from a curricular structure point of view, the only factor that matters, is whether or not they're going to pass their grading scheme in the first two years, or not. The students in pass-only curriculum in years one and two have much lower risk of burnout. And perhaps more important, they have a greater sense of group cohesion or social support, which is really important in this area, where we're trying to form teams and teach students about interprofessional relationship building. So, with the medical students, it doesn't matter what rotation they're on, it doesn't matter how many hours they're working in clinic, or how often they're on call, how many patients they're taking histories and physical exams on. I think the students want to work hard, they expect to work hard. But they need to do so in a supportive, well-organized environment.

Swensen: So the pass/fail grading schema. Am I correct that that promotes more social support because there's less competition than groups that are graded on a curve and only 10 percent get A's or something? Is that the cause of that?

Dyrbye: Yeah, we think it promotes more of a peer collaboration environment, which then comes with more social support. And it's interesting, studies using historical cohorts, have found that students perform just as well in step one and step two, they perform just as well in the courtships, with respect to grades, number of honors, shelf exams in the courtship years. So, even if you move to a pass only curriculum in the first two years, the students are still learning, they're still becoming competent. But it is helping to preserve their mental health and also building those very important relationships.

Swensen: That's really interesting, Lotte. So, I think you've already started to answer this question. Let's say you are now the dean of a major medical school that includes not only medical students but residents and fellows. And you had a pretty decent budget and the priority of yours is addressing burnout of these students, residents, fellows. It

sounds like you'd move to pass/fail grading. But what else would you do, what else would you recommend to other leaders who wanted to have the wellness of their students and residents and fellows, to be in the best possible situation when they finish up their training and go into practice as board certified professionals?

Dyrbye: Yeah, I think that's a very important question, Steve. From my perspective, I think it's really important just to start with the shared framework that well-being of a trainee, trainee well-being, it's a shared responsibility of the individual trainee, as well as the training program, whether that's medical school or the residency, as well as the academic medical center, from a broader perspective, accreditation organizations and organized medicine. It really takes a multi-pronged effort. When we focus on just what should medical school leaders or program directors, leaders of GME, think about, I think there's a couple of what I think of as big buckets or big areas. One would be to think about wellness curriculum. So the students and the residents can benefit from learning about what are some of the self-care strategies that have been shown to be effective to promote resiliency, decrease the risk of burnout. And some of that can be framed within having personal wellness be part of core competency and have milestone frameworks around that. The other big bucket for me is these new educational strategies, which include the pass only grading, like you mentioned. And also organizing students who are in very big medical schools into smaller learning communities, which is being done at several medical schools across the United States. Again, to promote group cohesion and social support, and also to provide opportunities for trainees to have meaningful patient care roles, which can give them a sense of value that they're contributing. That they're making a difference and they start to get meaning out of their work.

Unfortunately, despite our best attempts, students continue to report perceptions of being mistreated or being harassed, so we do need to continue to work on promoting a culture of

no tolerance of harassment. And also, just working on developing our faculty, to raise awareness, and helping them also facilitate a positive learning environment. Beyond that I would say, it's really important to implement screening tools. It turns out, it's really hard for us, even as physicians, to self-assess our level of distress and see how close are we to the edge, so to speak. Even as physicians and skilled diagnosticians, it's really hard to hold that mirror up to yourself and say, how's my level of fatigue, how is my burnout, how is my stress? How is it compared to peers? So, I think, thinking about how can we help trainees self-assess their level of well-being would be another important part. And

When we step back and think globally about having distress, not feeling well mentally, not performing optimally, who are the types of people that would be helpful to interact with, to help us get into a better place?"

the fourth big area that I think about is access to care, which continues to be a huge public health problem. And certainly, also, a problem, even for us, within the walls of medicine. The willingness to access care and barriers to that, and then also just the ability to be able to get the mental health care that's needed.

Swensen: And so the access to care would be for young professionals who either self-identify or become aware of their situation through these screening tools? And you're talking about burnout, not depression, and the access to care would be with a psychologist or psychiatrist or some counseling?

Dyrbye: Yeah, I do think that would be helpful. When we think about professional burnout, that is different than depression. But when we step back and think globally about having distress, not feeling well mentally, not performing optimally, who are the types of people that would be helpful to interact with, to help us get into a better place? And some of those people are going to be mental health providers. They might be, as well, your primary care physician, it might be the program director, or the dean of student affairs. It's going to take a variety of individuals to help a person come from a spot of not being well, to being pulled back or guided back into a spot of a better mental health profile.

Swensen: Very interesting. Dr. Dyrbye, when I listen to those recommendations and what you do as a dean, I'm thinking that most of them involve time and attention [and] programs. And in this share of responsibility you talk about I'm not seeing a huge capital budget here. So, is that a fair interpretation of what you've shared with us? That this is not a terribly expensive way to address a very important issue for patients and for providers and students, but is more about time and attention of leaders and not so much about throwing a lot of money at it?

Dyrbye: I do think it needs to be a thoughtful strategy. And any sort of strategy should engage the trainees in addressing what are some of the local drivers of burnout? Some of these risk factors are going to be beyond the control of even an academic medical center. But there are some factors that are going to be within local control. So, identifying what those are, with help of the trainees, getting their perspective on what [are] some of the low hanging fruits, what are ways to build more social support, or how can we address work compressions better? What are the opportunities within the curriculum, or within the training program, to make work life or learning on the job better and more effective? So, I think we need to engage the trainee in those conversations and step up to our own responsibilities, figure out what is in our sphere of influence. And then, nationally, work on the other issues that are driving some of this.

Swensen: You mentioned about this culture of harassment and tolerating some attending physicians' behaviors that promote burnout and disengagement of students and residents. How can organizations identify opportunities to help attending staff increase their mutual respect and improve the ways they interact, or what would you recommend in that space if you're in charge?

Dyrbye: You want an important comparative stick? Continue with 360 evaluations. Because for these physicians, they're probably themselves struggling with their interactions with a variety of members on the allied health professional team. So responding to that feedback, I think, is very important. The medical students and residents also fill out learner or faculty evaluation forms. Similarly, it's very important to look at those and to address themes. But I have to admit, there's been a lot of work and a lot of effort going on in this space about how do we get students and trainees to talk about or to report when do feel like they're harassed and belittled, rather than just anonymously saying it on an end of graduation survey? Because that's really hard to act on. And although there's been a lot of effort in the field, we continue as an organization or as a culture to make a difference, so we need to just continue to partner with our trainees to identify some novel ways of monitoring and responding to reports of harassment, and how can we better deal with sub-optimal role modeling by faculty. But this is, unfortunately, an area that continues to be challenging.

Swensen: One thing we haven't talked about is medical errors and preventable harm and the second victim area. So, on a regular basis, there are patients in a country who are harmed by systems and processes and human factors and medical errors that competent, conscientious, hardworking students and fellows and staff make. And [of] most of those harm events for patients and families, there's a second victim of the providers that are involved in the care that also have some influence on their emotional well-being. How does that play into burnout?

Dyrbye: We know from [Colin West's longitudinal work](#) that was published in JAMA a few years ago is there's a bidirectional relationship between perceptions of having committed a major medical error, and well-being. So, what I mean by that is if you perceive that you've committed a major medical error, that is associated with subsequent distress across multiple domains, whether you look at burnout, depression, quality of life. So, if you think you've committed a major medical error, it's highly likely, if we were to assess your mental health, two to three months down the line that it would be worse. But we also know that residents who have burnout are also much more likely to subsequently perceive that they've committed a major medical error.

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We have to remember that not all physicians or health providers are burnt out. Many of those who are burned out do recover. But nonetheless, there's a serious issue that's facing health professionals."

So, we think that it's a complicated relationship that goes both ways. And as you point out, physicians, we tend to be very attentive to detail, very thorough, very committed to our patients. And when we perceive we've had a role in a major medical error, it really hits home. And it's hard to let go of and often results in substantial stress, which leads to burnout, as well as other forms of mental health problems. I'm not sure that all organizations think about that. Organizations have lots of processes in place for, okay, how do we communicate this with the family? How do we work on identifying what went wrong? How do we remediate that to make the chances of this happening again smaller? But where

in that whole cycle or flow chart is there, let's make sure we address the excessive self-blame that can happen with the team members who are involved?

Swensen: Thanks, Lotte. I'd like to end with just a more of an upbeat approach to this dreadful problem. And so, when you look at all of the different professions and careers and work opportunities, one might make an assessment that there should be so much joy in this helping profession. Health care is all about healing and caring for people in need that are in pain that have cancer or heart disease. It's a wonderful, professional opportunity to find joy and meaning and purpose in one's work. And from a distance, someone might conclude that the burnout rate in health care should be so low because of this opportunity to have all of the gratification and gratitude, meaning, purpose, and joy in helping families and patients, either heal, get better, or deal with a condition. And yet, the health care profession has the highest levels of burnout, doesn't it? So, in the beginning, you talked about getting back to the core of the joy of helping people and families?

Dyrbye: I think there still is an enormous amount of joy in medicine. We have to remember that not all physicians or health providers are burnt out. Many of those who are burned out do recover. But nonetheless, there's a serious issue that's facing health professionals. I think action is needed — action is a very much a necessary piece. Patients deserve and they should be receiving care from committed, competent, professional physicians who are enjoying what they do.

We know that physicians who find meaning in their work are less likely to have burnout. So, getting back to meaning, how do we get more meaning and joy out of our everyday interactions with patients? And one of the things that's getting in the way is the electronic health record and how that is interfering with our ability to connect with our patients, spend

the time with them that we want to be able to spend. So, I think that there is hope. There's a lot of conversation around physician burnout and its consequences to patient care. I see that the tide is shifting, change is going to come, and we're going to work hard on being able to make a difference.

Swensen: Outstanding, Dr. Lotte Dyrbye, Professor of Medicine at Mayo Clinic, thank you so much for your time today. And thank you on behalf of NEJM Catalyst for your work to help bring back joy in work for people who need that help. Thank you very much.

Dyrbye: Thanks a lot for talking to me, Steve. It was a pleasure, thank you.

Stephen Swensen, MD, MMM, FACR

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Stephen Swensen is the Medical Director for Professionalism and Peer Support at Intermountain Healthcare. He is also a Senior Fellow of the Institute for Healthcare Improvement, where he co-leads their Joy in Work Initiative. [Learn more about Stephen Swensen...](#)

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What If Joy in Practice Were a Metric?

Talk · August 25, 2016

Christine A. Sinsky, MD, FACP

American Medical Association

“The men and women upon whom health care depends are running out of reserve because of the cumulative effect of well-intended regulation, performance measurement, and technology,” says [Christine Sinsky](#), the American Medical Association’s Vice President of Professional Satisfaction. “We have to stop doing this. Collectively, we have to stop burning out those who have chosen medicine as a career, and we have to stop giving our patients burned out care.”

What if joy in practice were a core metric of our health care system? What if every new policy and technology was assessed in part for its impact on the people who are doing the work?”

Fortunately, there are “bright spots” we can learn from. Sinsky describes Minneapolis-based HealthPartners, for example, which has embarked on an initiative to shorten the physician workday by 90 minutes. One aspect of this is a flow station where physician and nurse are seated side by side. In another example, at a family physician practice in Green Bay, Wisconsin, a medical assistant stays with each patient for the duration of their appointment. Having the MA record the patient’s information and relay it to the physician in this way enables him to give the patient his undivided attention.

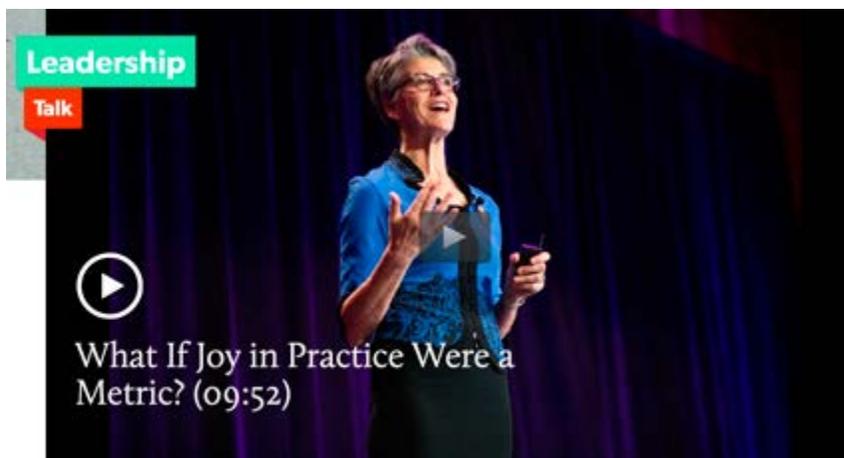
“The most impactful solutions are at the systems level, of improving operational efficiency, culture, and teamwork,” Sinsky says. “What if joy in practice were a core metric of our health care system? What if every new policy and technology was assessed in part for its impact on the people who are doing the work?”

Sinsky shares some action steps to bring back joy in practice:

- ▶ *For institutions:* **“Be bold.”** Recognize the importance of higher staffing ratios for optimal patient and provider care, and reengineer workflows to increase physician time spent with patients and with family at home.
- ▶ *For measure developers:* **“Keep it simple and add it up.”** Add the total time for compliance with all regulations and measures. “Less is more here,” says Sinsky.
- ▶ *For regulators and technology vendors:* **“Support advanced models of team-based care.”** Physicians often spend more time documenting care than delivering it. Health care regulations and electronic health records designed to support team-based care will help reverse that problem.

“Our work going forward, from wherever we stand in the health care ecosystem, is to consider: How can we contribute to transformation so that our patients no longer receive care from nurses and physicians who feel working in clinic is unbearable, but instead receive care from nurses and physicians who come to work every day feeling entrusted and empowered by technology and by policy and by teamwork?” asks Sinsky. “And can say, ‘practicing medicine is fun again.’”

From the NEJM Catalyst event [Leadership: Translating Challenge to Success at Mayo Clinic](#), June 2, 2016.



[View video of Dr. Sinsky's presentation.](#)

Christine A. Sinsky, MD, FACP

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Dr. Sinsky is the Vice President of Professional Satisfaction at the American Medical Association. A board certified internist, she also practices at Medical Associates Clinic and Health Plans in Dubuque, IA. Learn more about Christine A. Sinsky...



Performance Training and Public Health for Physician Burnout

Article · March 15, 2017

Rich Joseph, MD, MBA

Brigham and Women's Hospital



As I take stock at the slightly-over-midway point through my medical internship, I can't shake an unspoken but disturbing irony: medical training is often antithetical to health itself. Like the time I was discussing the logic of a salt-restrictive diet for a patient in heart failure, and my beeper announced the pizza had arrived at a noon conference. Or that morning when the attending brought donuts and pastries for breakfast during a lecture on insulin dosing for diabetic patients. And daily, as I encourage patients to get adequate rest for optimal healing, I suppress my own yawns and yearn for my own bed. Practicing my own basic self-care requires near-herculean effort against antiquated institutional policies and noxious cultural norms. No wonder many residents nationwide register signs of burnout.

Today, at any given time, more than half of physicians experience burnout, characterized by decreased enthusiasm for work, cynicism, depersonalization, and a low sense of personal accomplishment and professional satisfaction. The seeds of burnout are often sown during residency. One third of all residents suffer from depression or depressive symptoms. Nearly 1 in 10 residents and medical students have active suicidal thoughts. Ignoring this epidemic would be malpractice, both for physicians and the patients we serve.

For years, physicians and physicians-in-training have operated under the belief that our obligation to patients comes at any cost, even when this cost is our own health."

Thankfully, the governing bodies of graduate medical education are bringing the issue to light and searching for solutions. The Accreditation Council for Graduate Medical Education held its first Symposium on Physician Well-Being in 2015 and is hosting follow-up webinars to involve key players in the discussion. The ACGME, in partnership with Mayo Clinic and the American Foundation for Suicide Prevention, recently launched a library of educational resources for training programs to use when responding to a resident suicide or developing resident well-

being plans. The American Medical Association endorses an expansion of health care's Triple Aim — lower cost, enhanced quality, and increased access — to a Quadruple Aim that includes professional satisfaction. AMA's [STEPS Forward program](#) offers a series of online modules educating physicians on best practices to streamline clinical workflow, reduce administrative burdens, and boost efficiency. As AMA President Steven Stack, MD, recognizes, "A healthier, happier nation is going to require a healthier, happier physician workforce."

The Problem with the Current Prescription

These are laudable first steps. But the approach is problematic. First, consider pure practicality — the hope that busy clinicians, already spinning in a revolving door between patients and documentation, will take their free time to sit by themselves, watch modules, and then revamp their clinic's workflow, seems like a reach. Second, delivery — we already spend our days isolated behind a computer screen, and we know how difficult it is to motivate behavior change through educational resources alone, yet this is what we self-prescribe. Third, resource allocation — precious hours are being expended to "medicalize," research, debate, and over-describe burnout rather than experimenting to innovate solutions. And most importantly, the message and action plan itself — that to avoid burnout, the solution is for individual clinicians to practice self-defense against increasingly untenable clinical demands.



The medical profession is attempting to address burnout with symptomatic management and treatment of the individual. This is akin to giving metformin to a diabetic who lives in a food desert."

Burnout is a [symptom of a systemic disease](#). The medical profession is attempting to address burnout with symptomatic management and treatment of the individual, similar to how our health care system approaches illness. The current prescription is resiliency training, which teaches physicians the ability to survive the long and grueling training process, to be adaptable and flexible to the stresses of work, and to remain compassionate caregivers in the face of adversity. This is akin to giving metformin to a diabetic who lives in a food desert, or an antidepressant to a victim of domestic violence. It is necessary, but by no means sufficient.

Instead, a public health approach is needed to prevent burnout during medical training through inspired messaging, institutional reform, and ultimately, cultural evolution.

Performance Training for Physicians

Rather than resiliency training, how about performance training? In addition to training to be competent clinicians, we must train in order to maintain that high performance — both for ourselves and for our patients. Meeting our high professional standards day in and day out requires systematic and intentional training. Whereas stress management is defensive

and reactive, performance is offensive and preemptive. Depression screenings and mental health resources help with coping, whereas performance training optimizes for thriving. A campaign against burnout combats disease, whereas a campaign for performance promotes vitality. Self-care sounds soft, whereas performance is hardcore. Performance is immediate and tangible, whereas wellness is delayed gratification — a notoriously hard sell. Mindset is important; building a new skill set in personal performance to enhance both self- and patient care generates an internal locus of control, which drives motivation and action.

Given that medical culture is learned and perpetuated during training, performance efforts should be focused on medical students and residents. During medical school, part of the curriculum should be devoted to learning and practicing the fundamentals of human performance — sleep, physical activity, nutrition, mindful awareness, energy management, and self-compassion.



Rather than resiliency training, how about performance training? In addition to training to be competent clinicians, we must train in order to maintain that high performance — both for ourselves and for our patients.”

It is no surprise that these are also the tenets of what is termed “lifestyle” or “preventive” medicine. In addition to clinical mentors, trainees should have access to personal trainers, dietitians, sports psychologists, and psychotherapists to develop a personal performance plan. Physicians, just like business executives and Olympic athletes, need coaches, drills, and routines to stay at the top of their game. Peer groups in which to troubleshoot, process emotions, and practice leadership skills should be woven throughout medical education to provide social support and accountability. For example, in the [Mind Body Medicine Program](#) at Georgetown University School of Medicine, medical students experiment with techniques like meditation, guided imagery, and biofeedback to enhance self-awareness and

stress management. And through [The Balance in Life Program](#) at Stanford Medicine, surgical residents receive leadership training and practice team dynamics with a clinical psychologist. Such innovative programs could help pioneer the path forward. Indeed, common sense and [research](#) affirm that doctors who practice healthy behaviors provide [better counseling and motivate](#) their patients to adopt such health advice.

As medical trainees are encouraged to train for peak performance, so must the medical training environment be concurrently redesigned to support such behaviors. A starting point is to consider a few simple fixes. Most residents spend 12-plus hours each day jam-packed into windowless rooms lined with computers and littered with stale food. Now that nearly all of our work is done on the computer, team rooms could be built with space to stretch,

standing desks, and natural lighting. If we are expected to work nights and weekends, what if we had affordable and energizing food options? Pizza, pastries, and bagels — the standard fare — satisfy our sleep-deprived carb cravings while slowing us mentally and physically. Instead, provide a refrigerator explicitly for resident use in a designated break room.

What's more, every few weeks, we are uprooted and transitioned onto different services, with different teams, in different recesses of the hospital. This transience is unsettling. If we are indeed “residents” of the hospital, we should have a home base for relaxation, gathering, and laughter. Community and belonging are essential human needs. As the nature of our work evolves, professional and personal commitments are no longer mutually exclusive. Our workplace must reflect this.

For years, physicians and physicians-in-training have operated under the belief that our obligation to patients comes at any cost, even when this cost is our own health. Martyrdom is a prideful part of our identity. However, as patients become empowered consumers of health care, they question the doctor who does not walk the talk. “Do as I say, not as I do” is no longer a valid prescription. When empowered and supported to take care of ourselves as whole people, we are more willing to treat our patients in kind.

Rich Joseph, MD, MBA

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Physicians: Neither Victim nor Villain

Event Panel Discussion · January 6, 2017

Stephen Swensen, MD, MMM, FACR, Christine A. Sinsky, MD, FACP, Tait Shanafelt, MD

Intermountain Healthcare, American Medical Association, Mayo Clinic

If we consider physician burnout to be a shared problem, what can we do to address it? asks Steve Swensen.

“As physicians, we’re not victims, but the external environment isn’t necessarily the villain either, and we have to take some responsibility,” says Christine Sinsky. Physicians are too used to just taking on “one more thing,” she says. “It’s time to say no. It’s time to draw a line and say at this time I am done with work, and I am going home to my family. I am not shortchanging my children of my time.”

We need to find solutions for what Sinsky refers to as “pajama time,” or documentation work at home. Because physicians, she adds, have a responsibility to say that what they’re being asked or expected to do is not sustainable.

“We can’t continue to do that. We have to find solutions, for ourselves, and for the next generation.”

It’s time to say no. It’s time to draw a line and say at this time I am done with work, and I am going home to my family. I am not shortchanging my children of my time.”

In addition to finding those solutions, Sinsky emphasizes reflection on both personal and professional life. “What is the meaning and the mission of the work that I do? What’s the meaning and the mission of the life I lead outside of medicine? And to not lose sight of those things,” she says.

Tait Shanafelt agrees, and offers three key tactics. The first is to perform an exercise he has physicians do — including himself — which is to create a list of personal priorities and professional priorities. The hard part is integrating them. “What I usually tell folks is, ‘I don’t know what you wrote down in your professional priority or personal priority list, but I can guarantee you that your two lists are not compatible.’”

“I use the example that if I think that I am never going to miss a soccer game *and* I’m going to be a world expert in the treatment of folks with chronic lymphocytic leukemia, that those

are incompatible values. I *am* going to miss some soccer games to make a difference and care for the patients with this disease,” says Shanafelt. “But how many games is it okay to miss and still have the relationship with my wife and kids that I want?”

The second tactic is to optimize meaning at work, and to be cognizant of your motivations and interests, and then be intentional of how to achieve growth in those areas, recognizing that, over time, those interests may change.

Lastly, Shanafelt says to focus on what really matters in your personal life — loved ones, self-care, hobbies, etc. — and to protect them by building firewalls around those activities. “You have to have those spaces in the personal life where, no matter what, work will not intrude on it.”

From the NEJM Catalyst event [Leadership: Translating Challenge to Success at Mayo Clinic, June 2, 2016](#).



[View video of the discussion.](#)

Stephen Swensen, MD, MMM, FACR

Intermountain Healthcare

Stephen Swensen is the Medical Director for Professionalism and Peer Support at Intermountain Healthcare. He is also a Senior Fellow of the Institute for Healthcare Improvement, where he co-leads their Joy in Work Initiative. [Learn more about Stephen Swensen...](#)

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Tait Shanafelt, MD

Mayo Clinic

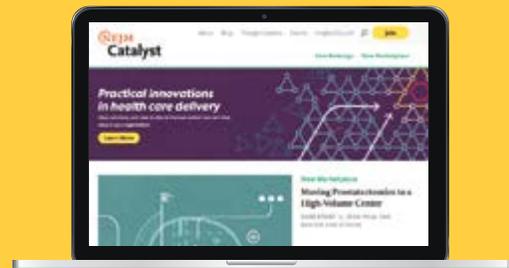
Dr. Shanafelt is the Director of the Mayo Clinic Department of Medicine Program on Physician Well-Being and a Professor of Medicine and Hematology at Mayo Clinic. [Learn more about Tait Shanafelt...](#)



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