Doctors in Distress: Burnout in Urology

Raj S. Pruthi MD FACS
Professor and Chair
Department of Urology
The University of North Carolina at Chapel Hill
Introduction

• Practicing medicine is **stressful**
  
  ✓ High level of responsibility / incomplete control
  ✓ Around people in crisis – boundaries are hard
  ✓ Things get stale – is this all there is?
  ✓ Shifting organizational structure – who is the boss?
  ✓ Shifting landscape – what will be in our profession?
Knowledge Explosion

- Biometric Data
- 1,500 Drugs
- 108,000 Medical Researchers
- Genomics
- Algorithms
- Super Computing
- 5,600 Journals
- 79,000 Clinical Trials
Burdens of Practice

- EHRs
- Millions of Clicks
- Administrative / clerical responsibilities
- Alert Fatigue
- 165,000 Health Apps
- Patient Messages
- Email Overload
- Inefficient practice environments
Unlike many industries in which advances in technology have improved efficiency, EHRs have increased clerical burden for physicians and can distract from meaningful interactions with patients.
Burnout

• **National, Complex** and **Systemic** issue
• First described in 1974
• Affects those with constant demands and intense interactions with high physical and/or emotional needs.
• Health care providers (MDs, RNs), teachers, police officers, social workers
• First large scale study in MDs in 2011 on 7288 physicians.
  • Lack of prior data makes difficult to give historical context
  • Appears to be rising

Shanafelt TD et al (2012)
Burnout: What is it?

• Maslach Burnout Inventory – Burnout is a form of personal distress characterized by:
  • Emotional exhaustion
  • Depersonalization - treating others as objects rather than people
  • Decreased sense of personal accomplishment

• Other symptoms of burnout
  • physical exhaustion, poor judgment, cynicism, guilt, feelings of ineffectiveness.
Burnout

Physicians 54%

Population 28%

2011 2012 2013 2014

Shanafelt TD et al (2016)
Percent Burnout by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Burnout Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro</td>
<td>48</td>
</tr>
<tr>
<td>Gen Surgery</td>
<td>49</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>52</td>
</tr>
<tr>
<td>Gen Surgery</td>
<td>52</td>
</tr>
<tr>
<td>Average</td>
<td>54</td>
</tr>
<tr>
<td>Ortho</td>
<td>60</td>
</tr>
<tr>
<td>Urology</td>
<td>64</td>
</tr>
</tbody>
</table>

Shanafelt TD et al (2014)
Which Specialty Most Burned Out?

Which Physicians Are Most Burned Out?

- Emergency Medicine: 59%
- Ob/Gyn: 56%
- Family Medicine: 55%
- Internal Medicine: 55%
- Infectious Disease: 55%
- Rheumatology: 54%
- Plastic Surgery: 53%
- Otolaryngology: 53%
- Critical Care: 53%
- Cardiology: 52%
- Urology: 52%
- Neurology: 51%
- Pediatrics: 51%
- Anesthesiology: 51%
- Gastroenterology: 50%
- Nephrology: 50%
- Orthopedics: 49%
- Surgery: 49%
- Pulmonary Medicine: 49%
- Radiology: 49%
- Oncology: 47%
- Dermatology: 46%
- Diabetes & Endocrinology: 46%
- Pathology: 43%
- Ophthalmology: 43%
- Allergy & Immunology: 43%
- Psychiatry & Mental Health: 42%

2017 Report
# Burnout in Urology – AUA Census

## How AUA Census Results Are Compared to Other Studies

<table>
<thead>
<tr>
<th>Sample Size</th>
<th>Mayo Study 2011 (Age 29-65)</th>
<th>Mayo Study 2014 (Age 29-65)</th>
<th>AUA 2016 (65 or Under)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>3,442</td>
<td>5,392</td>
<td>1,102 Validated Samples to Represent 12,186 Practicing Urologists in the U.S.</td>
</tr>
<tr>
<td>Physicians</td>
<td>6,179</td>
<td>5,313</td>
<td></td>
</tr>
<tr>
<td>Urologists</td>
<td>136</td>
<td>119</td>
<td></td>
</tr>
</tbody>
</table>

### Burnout Rate (2 Factors*)

<table>
<thead>
<tr>
<th></th>
<th>Mayo Study 2011 (Age 29-65)</th>
<th>Mayo Study 2014 (Age 29-65)</th>
<th>AUA 2016 (65 or Under)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>28.8%</td>
<td>28.4%</td>
<td>40.4%</td>
</tr>
<tr>
<td>Physicians</td>
<td>45.5%</td>
<td>54.4%</td>
<td></td>
</tr>
<tr>
<td>Urologists</td>
<td>41.2%</td>
<td>63.6%</td>
<td></td>
</tr>
</tbody>
</table>

(Data source: AUA Department of Data Management and Statistical Analysis. Weighted samples from the 2016 AUA Annual Census)

* High score in either the emotional exhaustion (score≥27) or depersonalization (score≥10) categories
Burnout Rates by Primary Practice Setting

(Data source: AUA Department of Data Management and Statistical Analysis. Weighted samples from the 2016 AUA Annual Census)
Burnout Rates by Age

(Data source: AUA Department of Data Management and Statistical Analysis. Weighted samples from the 2016 AUA Annual Census)
Job Satisfaction - Age

Sukhu (2017)
Causes of Burnout

• **Traits** that define a good surgeon heighten risk for burnout: idealist, perfectionist, tendency for work immersion

• And **environmental stressors**: lack of autonomy, personal/professional imbalance, excessive administrative tasks, high patient volume
The “Surgical” Personality

• Job description:
  ➢ Skiing, sailing, living in a lake house 15 minutes from work – a good life and a good living, with the time to enjoy it all!
The “Surgical” Personality

• **Job description:**
  - Work long hours!
  - Deal with life-and-death situations!
  - Make personal sacrifices for career!

• Such an **environment** attracts individuals of a particular character

• **Self-perpetuating culture:**
  - coming in early and staying late; working nights and weekends
  - performing high volumes of procedures
  - meeting multiple simultaneous deadlines
  - never complaining
  - keeping emotions or personal problems from “interfering”
The Dilemma

• A fine line separates dedication from overwork
  — Overwork is counterproductive, unhealthy, even destructive for self and family
  — Overwork may affect patient care
Causes of Burnout

• We learn poor coping habits: long hours and lack of control during training may result in habits that are counterproductive to achieving a balanced and full life after training.

• A strategy that puts personal life on hold during training fosters a habit of delayed gratification that some perpetuate in practice.

• Many physicians decide they cannot have a fulfilling personal and professional life, so they put their personal life on hold until retirement.
Causes of Burnout

Work Hours?

• Most urologists/surgeons > 60 hours per week (AUA Census = 57)

• The average US workweek = 34 hours (US Bureau of Labor)

• Hours worked – varying impact as predictor of burnout
  • No control group – difficult to truly evaluate the relationship between work hours and burnout.
  • Independent predictor in survey of AUA members
<table>
<thead>
<tr>
<th>Provider Characteristic</th>
<th>Bivariate Analysis p-value</th>
<th>Multivariate Analysis p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.6361</td>
<td>0.3772</td>
</tr>
<tr>
<td>Annual salary</td>
<td>0.0469</td>
<td>0.0385</td>
</tr>
<tr>
<td>Hours worked per week</td>
<td>0.1113</td>
<td>0.0602</td>
</tr>
<tr>
<td>Call days per month</td>
<td>0.0062</td>
<td>0.3360</td>
</tr>
<tr>
<td>Fellowship</td>
<td>0.0062</td>
<td>0.4011</td>
</tr>
<tr>
<td>Employment type (Ref=Self-empl)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Academic</td>
<td>0.0020</td>
<td>0.0108</td>
</tr>
<tr>
<td>- Employed</td>
<td>0.3954</td>
<td>0.3366</td>
</tr>
<tr>
<td>Practice location (Ref=Urban)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Suburban</td>
<td>0.3792</td>
<td>0.3885</td>
</tr>
<tr>
<td>- Rural</td>
<td>0.2510</td>
<td>0.8629</td>
</tr>
<tr>
<td>Use of APP</td>
<td>0.0257</td>
<td>0.1084</td>
</tr>
</tbody>
</table>
Burnout Rates by Number of Work Hours/Week

(Data source: AUA Department of Data Management and Statistical Analysis. Weighted samples from the 2016 AUA Annual Census)
**Causes of Burnout?**

**What Are the Causes of Burnout in Urologists?**

<table>
<thead>
<tr>
<th>Cause</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too many bureaucratic tasks</td>
<td>6.0</td>
</tr>
<tr>
<td>Spending too many hours at work</td>
<td>5.6</td>
</tr>
<tr>
<td>Increasing computerization of practice (EHRs)</td>
<td>5.1</td>
</tr>
<tr>
<td>Feeling like just a cog in a wheel</td>
<td>5.1</td>
</tr>
<tr>
<td>Too many patient appointments in a day</td>
<td>4.7</td>
</tr>
<tr>
<td>Income not high enough</td>
<td>4.6</td>
</tr>
<tr>
<td>The impact of the Affordable Care Act</td>
<td>4.5</td>
</tr>
<tr>
<td>Maintenance of certification requirements</td>
<td>4.4</td>
</tr>
<tr>
<td>Insurance issues</td>
<td>4.4</td>
</tr>
<tr>
<td>Threat of malpractice</td>
<td>4.2</td>
</tr>
<tr>
<td>Too many difficult patients</td>
<td>4.1</td>
</tr>
<tr>
<td>Lack of professional fulfillment</td>
<td>3.9</td>
</tr>
<tr>
<td>Inability to provide patients with the quality care that they need</td>
<td>3.7</td>
</tr>
<tr>
<td>Difficult employer, colleagues, or staff</td>
<td>3.5</td>
</tr>
<tr>
<td>Compassion fatigue (overexposure to death, violence, and/or other loss in patients)</td>
<td>3.1</td>
</tr>
<tr>
<td>Inability to keep up with current research and recommendations</td>
<td>2.1</td>
</tr>
<tr>
<td>Family stress</td>
<td>2.8</td>
</tr>
</tbody>
</table>
Consequences of Surgeon Burnout

• Physicians
• Patients
• Organizations / Systems
Consequence of Surgeon Burnout

For physicians...

• Burnout can affect work satisfaction

• Burnout can spill into personal life and contribute to broken relationships, substance abuse, other distress.

• Burnout is associated with poor health, including headaches, sleep disturbances, hypertension, anxiety, alcoholism, and myocardial infarction, depression, suicide.
Depression and Suicidal Ideation

• Academic / basic science faculty survey (N=2000)
  – 20% had significant depressive symptoms
  – higher levels in younger faculty

• ACS study (N=7905)
  – 38% had depression symptoms
  – 1 in 16 (6%) reported suicidal ideation in prior 12 months
  – Only 26% of these sought help
  – Correlation with burnout domains (emotional exhaustion, depersonalization, low personal accomplishment) & depression

Schindler (2006)
Shanafelt (2011)
Depression and Suicidal Ideation

• Among surgeons, suicide is a disproportionately high cause of mortality

• Compared with other professionals
  • male physicians’ ratio 1.5 to 3.8-fold higher
  • female physicians’ ratio 3.7 to 4.5-fold higher

Depression and Suicidal Ideation

• Medical culture puts **low priority on physician mental health** despite the evidence of untreated mood disorders.

• Depression is **often unrecognized or untreated** until one’s personal distress compromises patient care.

• Physicians seeking help may suffer **discrimination** in medical licensing, hospital privileges, or professional advancement.

• These regulatory and workplace **barriers dissuade many** from seeking help.
Consequence of Surgeon Burnout

For patients...

• Burnout can affect **quality of care**

• Burnout can contribute to **medical errors**

• Dose-response relationship between burnout and measures of suboptimal patient care

• ACS Board of Governors Survey (N=7905)
  • **8.9%** reported a major medical error in last 3 months
  • Burnout and depression associated with major medical error.
  • (Frequency of call, practice setting, compensation, hours worked did **not**.)
Consequence of Surgeon Burnout

For organizations...

• Dissatisfied workers - less productive, more likely to change practice or early retirement (> $1M per MD; 3-6% operating budget at AHC )- $$$

• Medical errors/patient dissatisfaction increase malpractice litigation - $$$

• Cost of burnout should be of interest to physician leaders and practice administrators
How to Address Burnout?

• Individual
• Organizational
• National problem (crisis)

• Solutions need to be multi-pronged at many levels
National / State Level

• Alleviate current **burdens of documentation**
  • Billing, quality, and justification/authorization
  • Reduced and streamlined
• Clarification and use of **non-physicians** for such tasks
• Future **regulations** on documentation, EHR, workflow needs to include **physician stakeholders**
• NIH support of **research** evaluating the implications of clinician well-being and determining how to **improve the work-life** of health care professionals.
Others

• Insurers
  • Limitations on unnecessary requirements and justifications
  • *Simplification* of billing and coding
  • More efficient pre-approval processes

• ABMS and Licensing Boards
  • *Simplification of MOC* requirements – integrated with CME and clinical practice/EHR
  • *State licensing disclosure* of mental health conditions – may prevent MDs from seeking help
Healthcare Systems

- Routine assessment of engagement and well-being
- **Institutional performance metrics** should include well-being (along with costs, operating income, payer mix, volumes, RVUs, quality, patient satisfaction, etc)
- Allocate resources to those areas / units that are in need

*The Lancet*

**Physician wellness: a missing quality indicator**

Jean E Wallace, Jane B Lemaire, William A Ghali

When physicians are unwell, the performance of health-care systems can be suboptimum. Physician wellness might not only benefit the individual physician, it could also be vital to the delivery of high-quality health care. We review the work stresses faced by physicians, the barriers to attending to wellness, and the consequences of unwell physicians to the individual and to health-care systems. We show that health systems should routinely measure physician wellness, and discuss the challenges associated with implementation.
Adoption of the Quadruple Aim

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

Thomas Bodenheimer, MD
Christine Sinsky, MD

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

ABSTRACT

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

The Missing Aim

Better Outcomes

Improved Clinician Experience

Lower Costs

Improved Patient Experience
Healthcare Systems

• Avoid cost-cutting measures that reduce MD support (documentation, clinical)
• Employ new practice models that maximize MD efficiency and efficacy
• Reduce clinical and non-clinical burdens (e.g. scribes, APPs, team-based care)
Medical scribes help relieve doctors’ digital record keeping
1. My patients seemed satisfied with the time I spent with them as part of each encounter.
2. I was able to spend time with my patients without feeling rushed.
3. Overall, I was able to complete each patient encounter and note in a satisfactorily timely manner.
4. Overall, my personal effort/workload was satisfactory.
5. I was able to provide appropriate documentation/coding for each patient encounter.
6. The number of patient encounters today was manageable.
7. I left clinic feeling satisfied with my work.

- Note time (4 = <15 mins; 3=15-30 min; 2=30-60min; 1=>60 min)
Healthcare Systems

- Embrace **process improvement** techniques (Lean, Six Sigma, etc) to improve workflow and efficiency for MDs (not just increasing productivity)
- Allocate **dedicated time** for admin work, CME, MOC, education, research
- Role of supervisors
  - Need for **participatory** management
  - Listen and facilitate improvements in work units (“gemba”)
  - Actively recognize and support MD accomplishments and development
- **Physician leaders** in operational decisions
“Physician heal thyself...”
Luke 4:23
Stigma

*What stops us from healing the healers?*

Doctors perceive that many of their colleagues hold stigmatizing views about depression and mental health

Stigma reduces help-seeking behavior
Stigma as Defined by Physicians

- Letting colleagues down 73%
- Confidentiality 53%
- Letting patients down 52%
- Career progression 16%

Adams et al, 2013
Achieving Wellness

• Recovery from burnout is possible, but prevention is better
• Physicians who nurture personal & professional well-being on all levels (physical, emotional, psychological) are more likely to limit burnout

• Promotion of wellness is necessary from medical school to retirement
• This is a task for physicians and organizations
• This is a task for academic faculty
1. Establish wellness as a quality indicator for your practice
2. Start a wellness committee and/or choose a wellness champion
3. Distribute an annual wellness survey
4. Meet regularly with leaders and/or staff to discuss data and interventions to promote wellness
5. Initiate selected interventions
6. Repeat survey within the year to re-evaluate wellness
7. Seek answers within the data, refine the interventions, and continue to make improvements
Well-Being Index Tracking Tool

• For individual and organizational assessment Mayo-designed online well-being self-assessment indexes
• 100% anonymous
• Brief Web-based tool evaluating multiple dimensions of distress:
  • Fatigue, depression, burnout, anxiety/stress, mental/physical quality of life
  • Personalized feedback
  • Metrics for leadership

• Extensively studied and validated
• Spending <20% effort in most meaningful activity strongly associated with burnout (53.8% vs 29.9%; p<0.001)
• No correlation above 20%

• Conclusions: The extent to which faculty are able to focus on the aspect of work that is most meaningful to them has a strong inverse relationship to their risk of burnout. Efforts to optimize career fit may promote physician satisfaction and help reduce attrition among academic faculty physicians

What is your 20%?
Achieving Wellness Outside of Work

• Strategies may include:
  • participating in educational activities outside of work
  • paying attention to important personal relationships & spirituality
  • cultivating personal interests outside work
  • creating a balance between personal and professional life
Interventions

Physician Burnout: Coaching a Way Out

Gail Gazelle, MD, Jane M. Liebschutz, MD, MPH, and Helen Riess, MD

Physician Burnout: Coaching a Way Out
Coaching Addresses Burnout

- Coaching provides a results-oriented and stigma-free method to address burnout
  - Increases one’s internal locus of control
  - Enhances self-awareness & draws on individual strengths
  - Questions self-defeating thoughts and beliefs
  - Examines new perspectives
  - Aligns personal values with professional duties

- **GOAL**: To increase sense of accomplishment, purpose, and engagement
Conclusions: An intervention for physicians based on a facilitated small-group curriculum improved meaning and engagement in work and reduced depersonalization with sustained results at 12 months.
Achieving Wellness - Conclusions

**Personal**

- **Acceptance**
  - Be well for self and others

- **Habits**
  - Personal renewal
  - Emotional self-awareness
  - Connection with colleagues and support systems

- **Culture change**
  - Set an example of good health
  - Mentor learners in wellness

**Organizational**

- **Awareness**
  - Programs on wellness

- **Recovery**
  - Programs to support those with burnout or depression

- **Prevention**
  - Avoid systems that pit employees against one another
  - Ensure systems are fair to leave no one at risk