Project Proposal: Burnout Assessment and Intervention

Physician burnout is widely prevalent in the United States, affecting an estimated 50% of physicians. A recent survey by the American Academy of Neurology (Busis, 2017) found that 60% of respondents had at least one symptom of burnout, leading the AAN leadership to declare physician burnout a “neurologic crisis.” (Sigsbee B, 2014). Burnout can affect workers in a wide variety of fields, but is particularly common in the “helping” professions, including medicine, where empathy is one of the key characteristics of an effective professional. Burnout is ‘a state of mental exhaustion caused by one’s professional life.’ (Freudenberger HJ, 1980) Key symptoms include emotional exhaustion, depersonalization and a reduced sense of accomplishment. Factors contributing to physician burnout include specialty, work hours, lack of control over the practice environment, workplace complexity and health habits and personality types of individual physicians.

Physician burnout has widespread effects within the healthcare system. Burnout is closely linked to low job satisfaction (Williams, 2007) and physician satisfaction is closely linked to patient satisfaction. More than 30 years ago, Linn et al examined the relationship between patient satisfaction and physician satisfaction in 15 academic internal medicine practices throughout the US. They found that practices with higher patient satisfaction were more likely to have higher housestaff and faculty physician satisfaction (Linn LS, 1985). Moreover, higher satisfaction among both patients and physicians were associated with improved continuity of care, lower no-show rates, lower outpatient costs and more efficient use of ancillary staff in providing direct patient care.

Medical error is now considered to be the 3rd leading cause of death in the US (Makary MA, 2016). High levels of physician burnout are associated with lower quality of care and higher rates of medical error. The MEMO study (Minimizing Error, Maximizing Outcome), a longitudinal study examining the relationship between workplace conditions and patient care in general outpatient practices found that burned out and dissatisfied physicians reported a greater likelihood of making errors. As far back as 1988, Jones, et al reported that departments at the highest risk for malpractice claims also manifested high levels of job stress and dissatisfaction. (Jones J, 1988) Therefore, it behooves health care organizations to address physician burnout.

The Affordable Care Act, aka Obamacare, a comprehensive legislation passed by the US Congress in 2010 was the first attempt to overhaul the US healthcare system since 1993. Its goals were manifold, but improving quality of care was a core motive. Recognizing the link between high patient satisfaction and improved health outcomes, the ACA restructured physician reimbursement linking a portion of reimbursement to patient satisfaction scores for providers and institutions. Since implementation of the ACA, health systems have increasingly monitored patient satisfaction and worked with health care workers to improve patient satisfaction with variable effect. Most organizations strive to improve patient satisfaction by sharing patient satisfaction data or scores with individual teams and provider. However, additional pressures on providers may further increase stress and reduce provider satisfaction and, potentially increase rates of physician burnout. Thus, increased pressure on physicians to improve patient satisfaction may, paradoxically, reduce it.

Physicians suffer disproportionately high rates of depression, anxiety and suicide. (Shanafelt TD, 2017) It may be argued that either depression, and potentially suicide, or physician attrition from the work force
are the end stages of physician burnout. The public, as well as legislators, are well aware of the patient’s needs but are generally unaware of physicians’ needs and their potential impact on health outcomes. Tait Shanafelt, a lead researcher on burnout, and John Noseworthy a neurologist, former president of the American Academy of Neurology and, presently CEO of the Mayo Clinic recently published a review of physician burnout (Shanafelt TD, 2017). They cite nine strategies that health care organizations can undertake to address physician burnout and improve physician engagement. Their well-timed review will form the backbone of my project.

Project Proposal
1. Build “Burnout Team” and generate meeting schedule and timeline for Burnout Assessment Project within the Department of Neurology. Team members to include Chief Quality Officer, or both Chief Residents, Residency Program Director and administrative assistant for team (at a minimum)
2. Assess levels of physician burnout in the Neurology Department at my home institution, SUNY Upstate Medical University. (Shanafelt & Noseworthy’s Strategy 1) Attending neurologists in all sections and residents will be surveyed. The Maslach Burnout Assessment tool (Maslach C, 1996), a validated instrument used by the AAN in its recent survey of neurologists in the US will be used. The survey will be web-based.
3. Simultaneous with the Burnout Survey, survey attending and resident neurologists with regard to a number of work-related factors, including average work hours/week, subspecialty focus, inpatient or outpatient concentration, years of service. The possibility of utilizing a modified version of the survey tool employed by the AAN (Busis, 2017) for its recent analysis is being explored.
4. Create focus groups of 3-4 physicians in the department to identify specific environmental and personal factors (Shanafelt & Noseworthy’s Strategy 3) that contribute to burnout in the Upstate Neurology work environment
5. Once key factors are identified, meet with leaders in the inpatient and outpatient areas (Strategy 2) to identify areas of work flow, personnel and scheduling that may improve work environment. Utilize PDSA models to drive improvements.
6. Meet with department chair, chief medical and quality officers (Strategy 2) to review findings and obtain support for implementation of measures identified as critical to improving burnout. Consider expanding assessment to other departments, utilizing ‘lessons learned’ in the Neurology project.
7. Reassess physician burnout levels within Neurology on an annual basis and report them to the residents, faculty, Chair, Dean, President, Chief Medical Officer and Chief Quality Officer.
8. Meet annually with physician focus groups to obtain feedback as to which system changes were most helpful. Generate ideas for additional improvements.
9. Develop a tool to track individual physician burnout levels and satisfaction levels among their own cohort of patients and their staff to determine to what degree they are correlated and to provide feedback to providers in relatively real time to permit intervention.
10. Develop a residency curriculum to educate resident physicians about burnout, develop self-assessment skills and train them to acknowledge the importance of their own physical and emotional health to sustaining a high quality, impactful and satisfying career in medicine.
a. The resident curriculum will be implemented first within the Neurology Residency Program. An iterative process using the PDSA model will be used to optimize the curriculum over at least one academic year
b. If successful, the curriculum will be offered to all residency programs at my home institution through
the Graduate Medical Education Committee.
c. The curriculum can be implemented, revised, improved and eventually shared as a packaged
educational tool for use by the CPND through the AAN, similar to the EBM course now available to PDs.

As this project qualifies as a quality improvement project, the process known as PDSA, recommended by
the Institute for Healthcare Improvement, will be employed.

Who will benefit?
1. Institutional and departmental leadership as well as faculty and residents will become more aware of
the nature and effects of physician burnout. This should drive a culture shift toward concern and
awareness of physician health needs
2. Individual physicians will feel valued and heard. If the project is successful, they will be happier, more
productive and more successful in supporting the health of their patients. They will enjoy their work
more, be less inclined to leave the institution and more likely to recruit and retain residents and faculty
successfully.
3. Staff members will become more aware of their critical role in improving patient satisfaction through
maximizing the work efficiency of physicians. Staff will enjoy working with physicians more because the
physicians will be happier and more satisfied.
4. Patients will benefit from improved physician work efficiency and happier, more engaged physicians.
Patient health outcomes could improve.
5. Patient satisfaction scores will improve for both inpatient and outpatient areas.
6. Residents will begin to view themselves as agents of their own health and job satisfaction. They will
be better positioned to choose career tracks and specific jobs that will preserve their health and
professional satisfaction. They will perceive a renewed dedication in the faculty that will have
downstream positive effects on the work environment and teaching quality.
7. ACGME site visit will uncover less faculty burnout and a higher degree of faculty commitment to
teaching and scholarship.

Potential barriers:
1. Resistance from staff who may feel overworked already and who may feel that physicians already
enjoy enough privilege.
2. Inadequate outpatient staff to support changes in workflow intended to relieve MDs of clerical
burdens.
3. Cynicism among faculty, preventing engagement in survey process as well as in developing solutions
to drivers of burnout.
4. Lack of funding for administrative assistant to keep project moving forward.
5. Faculty time constraints.

References
88, 797-808.


