Discomfort in Health Care Professionals. How to Care for Those Who Care?

Malestar en los profesionales de la salud. ¿Cómo cuidar a los que cuidan?

As a remedy against all ills,
only one thing is absolutely necessary;
a liking for work.

Charles Baudelaire

INTRODUCTION

In medical health care, professionals are guided by tacit ethical principles. The main principle is the commitment to benefit patients and avoid harm; it is also necessary to respect the autonomy of their decisions and to do everything possible as physicians to ensure justice in health care. This underlying foundation guides the vision of the vast majority of health care providers, rewarding their daily actions.

However, in recent decades, and due to the increasing and overwhelming demand, with longer hours of work devoted to clerical work not directly associated with health care, there has been a sense of frustration among clinicians for being unable to comprehensively fulfill their role as healers. This has led to increasing stress with alarmingly high rates of professional burnout (a term first used in the English literature in 1974, which is a metaphor from the physics of metals that indicates that even when it is burned or melted, it continues to function), (1) depression and even suicide, threatening not only their professional but also their personal well-being.

To paraphrase Baudelaire's epigraph, rather than "a remedy against all ills", the work that professionals do, paradoxically, makes them ill.

"More than half of U.S. physicians report significant symptoms of burnout -a rate more than twice that among professionals in other fields. Moreover, we know that the problem starts early. Medical students and residents have higher rates of burnout and depression than their peers who are pursuing nonmedical careers. Nor is the trend limited to physicians: nurses also experience alarming rates of burnout. Clinicians are human, and it takes a personal toll on them when circumstances make it difficult to fulfill their ethical commitments and deliver the best possible care." (2)

In a university hospital of Argentina, 6 out of 15 residency programs participated in a burnout study, and 92, among a total 196 residents, completed the survey on burnout. Eighty percent of residents presented some burnout symptoms, and 20% had moderate to severe symptoms. (3)

In an anonymous and voluntary survey conducted among 280 cardiology residents participating in the 2009 XXIX CONAREC (Argentine Council of Cardiology Residents) Conference, different variables were analyzed, including the three categories of the Maslach Burnout Inventory (MBI): 45% had emotional exhaustion (30% moderate to high), 25% showed depersonalization (17% moderate to high) and 40% experienced lack of personal fulfillment (27% moderate to high). Fifty-five percent of residents were frequently disappointed with their job, and 50% declared to feel frustrated with the job. (4)

According to the three MBI categories, burnout is described as a syndrome characterized by *emotional exhaustion*, which is a combination of emotional, physical, and mental fatigue with lack of enthusiasm and a sense of worthlessness; *depersonalization*, which includes negative feelings, cynicism towards co-workers, and inability to express empathy or grief; and a diminished sense of personal *accomplishment* at work, a tendency to value oneself negatively in one's work ability and job performance, dissatisfaction with one's professional role and a feeling of reduced effectiveness.

This is expressed through a) *avoidance of emotional involvement* with patients, contact loss and lack of response to the emotions of others; b) *instrumental dissociation* with rigid and automatic behaviors, technical language and unnecessary interventions; c) *denial* with disqualifying attitudes and hypercritical interventions; d) *impulsiveness* with repeated confrontations with colleagues, patients and mistreatment of staff; e) *demotivation* with low self-esteem, lack of initiative and low participation. (1, 2)

OTHER COMPLICATIONS OF HEALTH PROFESSIONAL BURNOUT

So far we have dealt with the human cost of burnout syndrome in health professionals, with the feeling that we are spending our days doing the wrong work. The introduction of "electronic health records can be a double-edged sword, because they give you more flexibility about where you work, enabling physicians to get home for dinner", argues Tait Shanafelt, professor of medicine at Stanford University and a leading researcher on physician burnout. "But physicians are working a staggering number of hours at night, and this has enabled organizations to continuously

increase productivity targets without changing the infrastructure or support system, effectively adding a whole extra workweek hidden within a month." (5)

Undoubtedly, increasing clerical burden is one of the biggest drivers of burnout in medicine. As Wright and Katz point out: "Time-motion studies show that for every hour physicians spend with patients, they spend one to two more hours finishing notes, documenting phone calls, ordering tests, reviewing results, responding to patient requests, prescribing medications, and communicating with staff. Little of this work is currently reimbursed. Instead, it is done in the interstices of life, during time often referred to as 'work after work' - at night, on weekends, even on vacation." (5)

This is emphasized by the devastating rates of suicide in the United States: almost 400 physicians commit suicide each year. It is possible that each of us has been touched by the tragedy of a colleague.

In addition, physicians with burnout symptoms are replaced more often and have double chances of leaving an organization than those who do not have burnout, and the cost for replacing a physician in the United States is estimated at $500,000 to $1,000,000, since this estimate reflects the loss of income and expense of recruiting, training, and inserting the physician within the organization.

But in addition to the financial institutional costs, there are also costs for patient safety. Physicians with burnout symptoms are more likely to make some major medical error in the last 3 months, have more malpractice suits, have more health care-associated infections, and receive a lower patient satisfaction score.

TO REDUCE BURNOUT, SHALL WE IMPROVE THE PERSON OR THE ENVIRONMENT?

With the onset of burnout, personal factors predisposing for this syndrome were first described. For instance, being a woman, single or parent of young children and experiencing job dissatisfaction, among others; however, a causal relationship of personality traits in order to identify professionals at high risk of burnout syndrome has not been identified yet. Nowadays, it is known that burnout is largely due to the external environment that "includes work-process inefficiencies (such as difficulties with IT systems), excessive working hours and workload, work-home conflicts, problems with the organizational culture (such as team dysfunction and management styles that neglect clinician input), and perceived loss of control and meaning of work." (2)

In the Argentine hospital with university medical residencies mentioned above, a significant correlation was found between "educational environment" (EE) surveys and the MBI. The correlation was negative between EE and *emotional burnout* (r -0.24) and between EE and *depersonalization* (r -0.35), and was positive between EE and personal accomplishment (r 0.44). This means that the greater the "educational environment", the lower the *emotional burnout* and *depersonalization*, and at the same time, the greater the *personal accomplishment*.

Today, there would be no disagreement about the severity or urgency of the current professional burnout crisis and the need to take action in order to improve it; but it is necessary to coordinate and join the scattered, growing efforts to accelerate progress and involve important influences beyond the health community, such as vendors of new information technologies, payers constituted by non-voluntary public insurance organizations (health insurance plans) or voluntary private insurance companies (prepaid medical care), regulatory agencies and those generating health policies.

Recently, the U.S. National Academy of Medicine (NAM) has taken over the leadership launching an "Action Collaborative on Clinician Well-Being and Resilience". Its collaborative purpose was to create a database with all the available relevant evidence, facilitate knowledge sharing and catalyze collective action on the basis of existing efforts.

The NAM issued an open call that surpassed their expectations; 55 central organizations and a network of more than 80 other organizations are currently involved in it.

"Four central goals guide the collaborative initial work: to raise the visibility of clinician stress and burnout, to improve baseline understanding across organizations of challenges for clinician well-being, to identify evidence-based solutions, and to monitor the effectiveness of implementation of these solutions." (2)

In turn, collaborative efforts have been organized into four main work streams. The "Research, Data, and Metrics" workgroup is compiling validated survey instruments and evidence-based interventions and identifying benchmarks for gauging progress in supporting clinician well-being. The "Conceptual Model" workgroup has created a comprehensive conceptual model and will establish a taxonomy that can share key factors. The "External Factors and Work Flow" workgroup is exploring approaches for optimizing team-based care and documentation in a rapidly evolving digital health environment. And finally, the "Messages and Communications" workgroup is identifying key interested parties and developing targeted messaging to disseminate available evidence and knowledge and thus inspire action in different health care systems.

A key point of communications is an "online knowledge hub" (to be launched in 2018) that will serve as a user-friendly repository for available data, models, and tools which will provide opportunities for clinicians and other interested parties to share information and build productive relationships. The NAM encourages all interested organizations and individuals to become involved in the use of its products in their own endeavors (for more information, see the project website).

SOME PRELIMINARY EXPERIENCES TO REDUCE PROFESSIONAL BURNOUT

A survey at the Stanford School of Medicine found that few female professionals reported "feeling supported" in their career development. Therefore, novel ways to improve work–life integration and prevent burnout

were considered. Stanford piloted a "time bank" to ensure that university professionals were rewarded for activities that are rarely recognized by medical centers, such as serving on committees. This program also allowed professionals to trade time spent on these activities for in-home support, such as food delivery and cleaning services, or support at work, including grants for writing articles and a secretary for academic assistance. Though this initiative was meant for all physicians, women used these services more frequently than men, and the number of female professionals who reported "feeling supported" had nearly doubled by the end of the pilot program.

Other interested parties in the health care system are starting to consider the challenge of burnout, as for example, managers. Chief executives from 10 major health care organizations in the United States gathered at a summit to share strategies for fighting physician burnout, and recommended 11 actions, including measuring physician well-being. For example, the Mayo Clinic President and Chief Executive Officer John Noseworthy, argues "fundamentally, you manage what you measure," and for his CEOs' performance, in addition to financial and quality conditions, he measures staff engagement, satisfaction, and burnout which he reports to the board of trustees. As demonstrated in a 2013 study at the Mayo Clinic, every 1-point increase in a 60-point leadership measurement was associated with 3.3% decrease in physician burnout. "There was a linear relationship between how empathic, engaged, and involved leaders were with their staff and burnout rates." (5)

At the same time, the Department of Family Medicine at the University of Colorado instituted a team-based model called ambulatory process excellence, or APEX. This is a system in which medical assistants, whose ratio per clinician increased to 2.5, collect routine data, prescribe and reconcile medications, identify opportunities to increase preventive care, set the agenda for patient visits, which they share and report to a physician or nurse practitioner, and document the visit. When the clinician leaves, the medical assistant provides patient health care education and coaching. This arrangement allows physicians and mid-level clinicians to focus on synthesizing data, perform physical exams, and make medical decisions without distractions.

Corey Lyon, Associate Professor at the University of Colorado, explains that: "The chaos in exam rooms before APEX was akin to writing while driving." And he adds: "The greatest advantage now is that the computer no longer stands between me and my patients. This allows for deeper thinking and connection." (5)

The development of the system implied a series of tasks, not only to increase the number of medical assistants but also to provide rigorous training, structured protocols, control, updates and, above all, flexibility in implementation.

APEX has been successful; within 6 months after its launch, burnout rates among clinicians dropped from 53% to 13%. There was also an improvement in the practice's pneumococcal vaccination rates and patient referrals for mammography and colonoscopy screening tests, with a neutral cost because it was possible to add extra patients per doctor per day and reduce waiting times.

DISCUSSION

The health care system is reaching a critical turning point, and the current rate of professional burnout cannot be brought into line with the provision of safe, suitable health care at the same time.

This is reflected in what is currently happening with cardiology residents: 1 out of 3 first-year residents are on-call 8 times per month, and some of them up to 11 times. Seventy percent work more than 60 hours a week, and 1 out of 3 work more than 80 hours. In turn, 87% residents sleep less than 45 hours a week and less than 6 hours a day, and 1 out of 3 sleep less than 35 hours, i.e. less than 5 hours a day. (6)

Changing this situation requires not only concern but State administration involvement, which should regulate and control medical activities, recognizing and measuring the extent of the problem. Only then will the resulting data be able to inform whether the necessary political and cultural changes are being made to adapt the health care system and, at the same time, promote professional well-being.

Clinicians' distress is a fact, and well-being has become a growing priority, not only for practitioners but also for those outlining health policies, private and public payers, and the society as a whole that is interested in decisions that can lead to the necessary changes.

Through collective action, in which medical societies are involved the in well-being improvement of their members, we can not only reduce burnout and promote professional well-being but also help each other to carry out the mission that led us to work in the healing professions, promoting and providing the best possible care for our patients.

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