Physician Stress and Burnout

Understanding, preventing, relieving

Physician Health Program
British Columbia

Preface

Physician burnout is a multifaceted phenomenon, and within BC, many organizations have an interest in its prevention. While the goal of this document is primarily to articulate the role of the Physician Health Program in relieving and preventing burnout, it is hoped that the framework advanced here might be helpful to other organizations in understanding and describing their roles as well.

What is burnout?

Burnout is a syndrome of responses to chronic occupational stress.

It is not a diagnosis listed in DSM-V, but it is classified by ICD as phenomenon[1] under problems associated with employment.

BURNOUT HAS THREE COMPONENTS:

- feelings of energy depletion or exhaustion;
- increased mental distance from one's job, or feelings of negativism or cynicism related to one's job;
- sense of reduced professional efficacy.

Generally the sense of energy depletion is the first symptom of burnout. If an individual's cycle of renewal isn't modified, one of the other two components will generally emerge. Occasionally, an individual will experience all three components.

The hallmark features of burnout are similar to the criteria for endogenous depression, but ICD specifically excludes mood disorders from the definition of burnout. Sufficiently long vacations can help differentiate depression from burnout, but post-vacation burnout relief is short-lived.[2,3]

Two themes emerge consistently from all recent surveys of physician stressors[4–7]: 1) increasing burden of non-clinical work; and 2) implementation of electronic medical records (EMR). Other themes vary by practice context.[4–7] Many physicians say that some systemic changes (such as EMR implementation) have happened too quickly, while others (such as relief from chronic shortages of resources that affect patient care) have happened too slowly or not at all. To relieve some of these stresses, many physicians scale back or discontinue their involvement in hospital practice, which not only negatively affects their sense of relationship with their colleagues, but also reduces their influence over the system as a whole. As a result of all these factors, and some others, we are seeing reliable indicators that physician burnout is more prevalent and more intense than it has been in the past.[4–7]

Evidence informed strategies to address physician burnout

SYSTEM LEVEL

The factors that physicians cite as contributors to their burnout almost always resist quick resolution. As mentioned previously, non-clinical work burden and EMR implementation are almost universal factors. It's difficult to imagine system changes that would ease these burdens on a time scale of weeks to months. Even imagining changes that would take place over the course of years to decades is challenging, mainly because there are so many differing points of view on what kind of change is needed, and who has the power to bring it about. When the imagined scope of change broadens beyond these two often-cited factors, the situation becomes even more complex because there is even less agreement about the priorities for system change.

INDIVIDUAL LEVEL

So while looking at the system level for the root causes of physician stress and burnout and attempting to address them is certainly the right thing to do, the pace at which such change can occur still leaves many physicians suffering in the interim. Fortunately there are well described interventions that can be applied at the individual level that are effective at relieving burnout and preventing it from redeveloping. The two types of interventions that have proven effective in relieving burnout at the individual level are mindfulness interventions[8-15] and generic counselling.[16,17]

WORK UNIT LEVEL

Although the system and individual levels are most commonly mentioned in discussions of burnout interventions, there is another level that is sometimes forgotten, but where effective interventions are well described: the workgroup or "work unit".[18–22] Burnout prevention and relief at this level is mediated by increases in perceived social support, civility, collegiality, and respect. Interventions directed at this level have a beneficial side effect, in that they tend to build the capacity of workgroups both to explore and prioritize their change agendas, and to build meaningful alliances and collaborations with other groups who have similar priorities. This in turn builds capability for change at the system level.

Who is doing what in BC to prevent and relieve physician burnout?

DOCTORS OF BC

Doctors of BC coordinates and supports advocacy both to address system-level issues that contribute to physician burnout and to promote the IHI Triple Aim (which includes physicians' experiences of providing care). System change is a long-term process that requires a sustained, strategic effort over time. Further, because the health care system can only absorb change at a finite rate, Doctors of BC works to prioritize issues that will effect the most positive change for physicians.

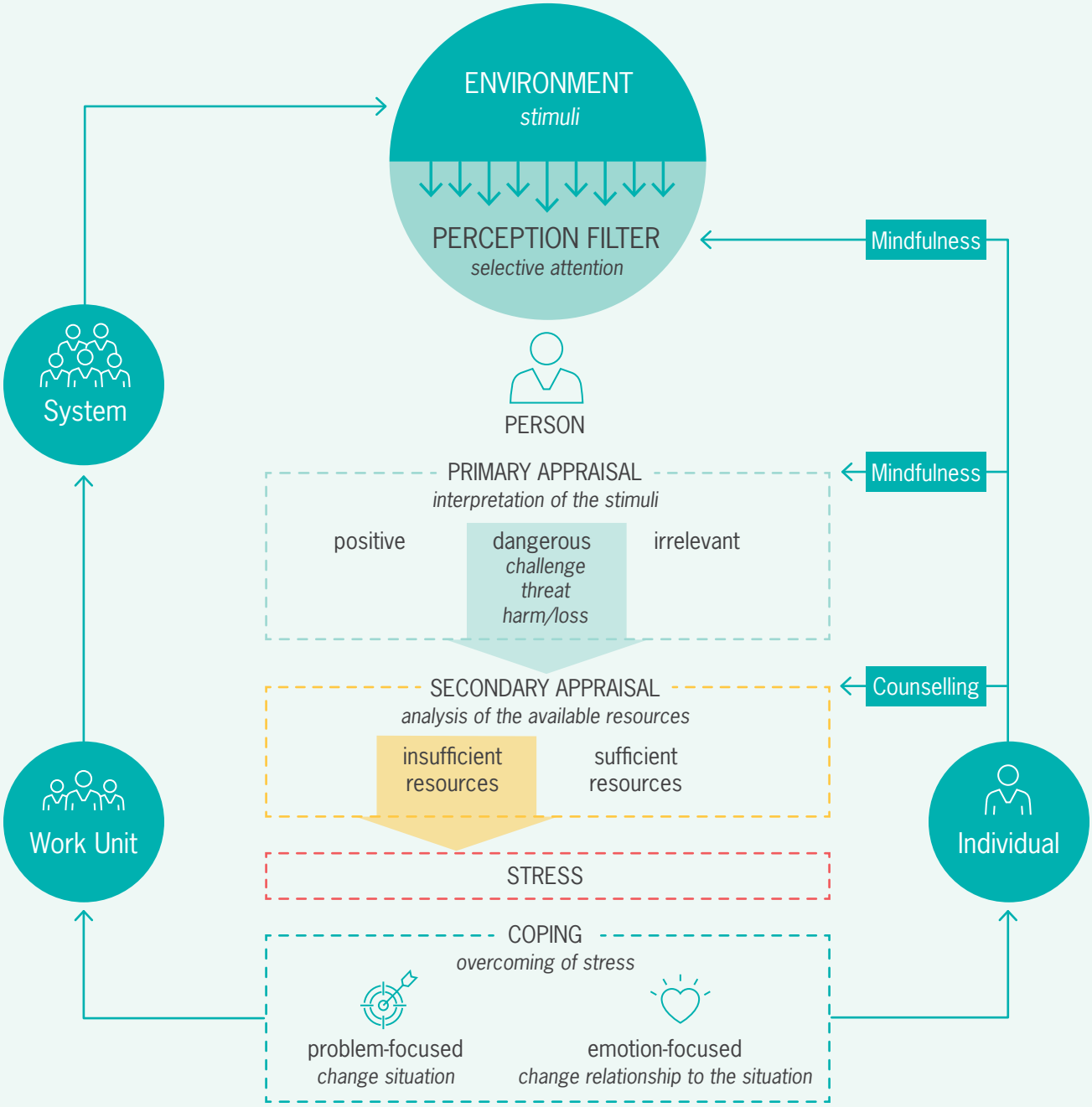
PHYSICIAN HEALTH PROGRAM

The Physician Health Program's focus in this context is on supporting individuals in their emotion-focused coping. Through counselling, physicians learn cognitive re-appraisal and mindfulness skills. Peer reviewed literature supports the acquisition of these skills as sustainable strategies to relieve and prevent burnout.

GPSC & SSC THROUGH DIVISIONS AND MEDICAL STAFF ASSOCIATIONS

A priority for both the General Practice Services Committee (GPSC) and the Specialist Services Committee (SSC) has been to enable physicians to develop and sustain the capacity for collective voice through the creation of the Divisions of Family Practice and the various societies incorporated under the Facility Engagement Initiative. The very existence of these opportunities for collegial discussion not only helps reduce burnout directly[4], but also creates space where priorities for collective action at the provincial level can be determined.

Extended Transactional Model of Stress and Coping



SYSTEM	Doctors of BC	Collective voice at the provincial level
WORK UNIT	GPSC, SSC	Civility, collegiality, and collective voice at the local level
INDIVIDUAL	Physician Health Program	Counselling and Mindfulness support

References

1. ICD-11 For Mortality and Morbidity Statistics, QD85 Burnout. *International Classification of Disease, 11th Edition* (2019). Available at: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/129180281. (Accessed: 29th May 2019)
2. de Bloom, J. *et al.* Effects of vacation from work on health and well-being: Lots of fun, quickly gone. *Work & Stress* 24, 196–216 (2010).
3. Westman, M. & Eden, D. Effects of a respite from work on burnout: Vacation relief and fade-out. *Journal of Applied Psychology* 82, 516–527 (1997).
4. Shanafelt, T. D. & Noseworthy, J. H. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. *Mayo Clinic Proceedings* 92, 129–146 (2017).
5. West, C. P., Dyrbye, L. N., Erwin, P. J. & Shanafelt, T. D. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *The Lancet* 388, 2272–2281 (2016).
6. Shanafelt, T. D., Dyrbye, L. N., West, C. P. & Sinsky, C. A. Potential Impact of Burnout on the US Physician Workforce. *Mayo Clinic Proceedings* 91, 1667–1668 (2016).
7. Shanafelt, T. D. *et al.* Longitudinal Study Evaluating the Association Between Physician Burnout and Changes in Professional Work Effort. *Mayo Clinic Proceedings* 91, 422–431 (2016).
8. West CP, Dyrbye LN, Rabatin JT & et al. Intervention to promote physician well-being, job satisfaction, and professionalism: A randomized clinical trial. *JAMA Internal Medicine* (2014). doi:10.1001/jamainternmed.2013.14387
9. Asuero, A. M. *et al.* Effectiveness of a Mindfulness Education Program in Primary Health Care Professionals: A Pragmatic Controlled Trial. *Journal of Continuing Education in the Health Professions* 34, 4–12 (2014).
10. Di Benedetto, M. & Swalding, M. Burnout in Australian psychologists: Correlations with work-setting, mindfulness and self-care behaviours. *Psychology, Health & Medicine* 1–11 (2013). doi:10.1080/13548506.2013.861602
11. Fortney, L., Luchterhand, C., Zakletskaia, L., Zgierska, A. & Rakel, D. Abbreviated Mindfulness Intervention for Job Satisfaction, Quality of Life, and Compassion in Primary Care Clinicians: A Pilot Study. *The Annals of Family Medicine* 11, 412–420 (2013).
12. Bazarko, D., Cate, R. A., Azocar, F. & Kreitzer, M. J. The Impact of an Innovative Mindfulness-Based Stress Reduction Program on the Health and Well-Being of Nurses Employed in a Corporate Setting. *Journal of Workplace Behavioral Health* 28, 107–133 (2013).
13. Wang, P. & Gao, F. Mindful Communication to Address Burnout, Empathy, and Attitudes. JAMA 303, 330-a-331 (2010).
14. Chapman, B. P., Krasner, M. S. & Epstein, R. M. Mindful Communication to Address Burnout, Empathy, and Attitudes–Reply. *JAMA* 303, 331 (2010).
15. Krasner, M. S. et al. Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians. *JAMA* 302, 1284–1293 (2009).
16. Isaksson-Rø, K. E. *et al.* A three-year cohort study of the relationships between coping, job stress and burnout after a counselling intervention for help-seeking physicians. *BMC Public Health* 10, 213 (2010).
17. Isaksson-Rø, K. E., Gude, T., Tyssen, R. & Aasland, O. G. Counselling for burnout in Norwegian doctors: one year cohort study. *BMJ* 337, a2004–a2004 (2008).
18. Maslach, C. & Leiter, M. P. New insights into burnout and health care: Strategies for improving civility and alleviating burnout. *Medical Teacher* 39, 160–163 (2017).
19. Leiter, M. P., Day, A., Oore, D. G. & Spence Laschinger, H. K. Getting better and staying better: Assessing civility, incivility, distress, and job attitudes one year after a civility intervention. *Journal of Occupational Health Psychology* 17, 425–434 (2012).
20. Maslach, C., Leiter, M. P. & Jackson, S. E. Making a significant difference with burnout interventions: Researcher and practitioner collaboration. *Journal of Organizational Behavior* 33, 296–300 (2012).
21. Laschinger, H. K. S., Leiter, M. P., Day, A., Gilin-Oore, D. & Mackinnon, S. P. Building empowering work environments that foster civility and organizational trust: Testing an intervention. *Nursing research* 61, 316–325 (2012).
22. Leiter, M. P., Laschinger, H. K. S., Day, A. & Oore, D. G. The impact of civility interventions on employee social behavior, distress, and attitudes. *Journal of Applied Psychology* 96, 1258–1274 (2011).
23. Losada, M. & Heaphy, E. The Role of Positivity and Connectivity in the Performance of Business Teams: A Nonlinear Dynamics Model. *American Behavioral Scientist* 47, 740–765 (2004).
24. Braund, T. A., Palmer, D. M., Tillman, G., Hanna, H. & Gordon, E. Increased chronic stress predicts greater emotional negativity bias and poorer social skills but not cognitive functioning in healthy adults. *Anxiety, Stress, & Coping* 0, 1–13 (2019).

Physician Health Program
British Columbia

Physician Health Program
Administrative Office
Suite 600 – 1665 Broadway West Vancouver, BC V6J 1X1
www.physicianhealth.com