Physician Engagement Beats Burnout

By: Sharon Worcester

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LOUISVILLE, KY – Physician engagement, which involves a willingness and motivation to perform, is important, but often elusive in the long-term care setting, according to Arif Nazir, MD, CMD.

Dr. Nazir, medical director at Eskenazi Health Center Extended Care, Indianapolis, described one facility that implemented a program to reduce avoidable hospital transfers only to find that after 3 months, the rate of such transfers was unchanged despite strong staff buy-in. The problem was that most transfers were made by a physician who was not engaged in the process.

The physician declined an invitation to meet with the medical director and administrator to discuss the program and goals, saying he was too busy, Dr. Nazir said at the AMDA Annual Conference.

Often, physician burnout stands in the way of engagement; if engagement is a willingness and motivation to perform, burnout might be considered its converse state, according to Dr. Paul Katz, MD, CMD.

Burnout has been defined as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity,” said Dr. Katz, vice president of medical services and chief of staff at Baycrest Centre for Geriatric Care, Toronto, Ontario.

Dr. Katz, Dr. Nazir, and Jurgis Karuza, PhD, presented a session at the conference entitled, “Is the Doctor In? Defining, Measuring and Enhancing Physician Engagement in Skilled Nursing Facilities.”

Widespread and Costly

Although there is some debate about whether burnout is at the opposite end of a spectrum from engagement, it can be helpful to conceptualize the two states this way, said Dr. Katz, a past AMDA president, adding that to promote engagement, burnout must be addressed.

Unfortunately, the nursing home environment itself may facilitate burnout, he noted. “Many of us have at one time or another felt burned out … these are emotions that everyone has experienced,” he said.

In fact, in a 2012 study, nearly 50% of nearly 7,300 physicians across specialties reported burnout, with general internists second only to emergency physicians in the percentage reporting burnout (about 55%), and family physicians coming in fourth at just over 50% (Arch Intern Med 2012;172:1377-85).

Of nearly 6,200 working physicians in that study, 40% reported being “not satisfied with work-life

balance," compared with 23% of non-physician controls. Female physicians were more likely than male physicians to experience burnout, and on multivariate analysis, older age and married status were associated with lower risk of burnout, and number of hours worked per week was associated with an increased risk (odds ratio of 1.02 for each additional hour).

Numerous factors can contribute to burnout, including personality factors, family stressors, and work stressors. Specific factors in the nursing home environment that may be conducive to burnout include professional autonomy, staff conflict, ethical and legal challenges, patient and family conflict, time pressures and workload, and resource constraints, Dr. Katz said.

The consequences of burnout can include medical errors, decreased patient satisfaction, increased staff turnover, increased costs, physician impairment (burnout is associated with substance use, depression, and suicide), absenteeism, and family disruption, he noted.

Measuring Burnout and Engagement

Conversely, physician engagement is associated with improvement on a number of measures (see Simply Being There Improves Outcomes).

A starting point for identifying burnout – and promoting engagement, is measuring both. The Utrecht Work Engagement Scale (UWES) is useful for measuring engagement. The scale focuses on three personal dimensions representing the "opposite pole" of burnout, including vigor, dedication, and absorption, said Dr. Karuza, a professor at Buffalo State College, NY.

The Medical Engagement Scale (MES) captures organizational/cultural dimensions that contribute to or detract from an individual's likelihood of engaging.

"And of course there is the grandmother of them all – the Maslach Burnout Inventory (MBI), which has a history going back to the 1970s and 1980s to measure burnout. The three dimensions that define burnout are exhaustion, cynicism, and inefficacy," he said, noting that there is "robust literature" looking at burnout in other fields, but little has been done specifically targeting burnout in physicians, and virtually no studies have looked at burnout in the LTC setting.

Efforts to address burnout in physicians have included interventions in a variety of settings since the 1980s, including in mental health social services, and educational settings. More recent attention has focused on health care settings, including both hospitals and primary care practices.

"So there is the beginning of an evidence base," Dr. Karuza said, noting that the theoretical underpinnings of burnout center around work-life balance issues such as workload, control of your work, reward, having a sense of community, fairness, and values.

"These are key components that drive a person's feeling of burnout. When you have a mismatch between what is expected and what is available, that's the fertile ground for burnout. The key here, to try to develop interventions to deal with burnout, is to optimize that fit between the physician and the areas of work life," he said.

Among the reportedly useful methods for engaging physicians are promoting stable leadership, developing trust with honest bidirectional communication, creating a culture of responsibility by empowering physicians to make decisions with clear roles and accountability, encouraging open and effective communication, establishing boundaries (in part, by clarifying expectations and enabling firm decision making), offering support and development opportunities to physicians, and looking to the future (for example, encouraging participation in outside events and enabling continuous professional development), he said.

Holistic and Group Training

Another method being used to engage physicians is mindfulness training, Dr. Karuza said.

In a recent randomized controlled trial of 74 practicing physicians and 350 controls, a 9-month intervention involving 19 biweekly facilitated physician discussion groups that incorporated elements of mindfulness, reflection, shared experience, and small group learning was shown to promote physician well-being, job satisfaction, and professionalism all (JAMA Intern Med 2014;174:527-33).

Much of the burgeoning effort to facilitate engagement focuses on burnout prevention and intervention, and two main approaches have emerged: those that focus on the individual, and those that focus on the organization, Dr. Karuza said.

Individual approaches may promote mindfulness, stress-coping skills, relaxation and exercise, time management, and social support. Coaching can also help physicians harness existing resources.

Coaching is being used to improve the internal locus of control, to enhance self-awareness, and to reduce self-doubt and increase physicians' sense of accomplishment, purpose, and engagement, he said.

Group-focused approaches may include unstructured small group interventions to tackle many of the topics and issues that are also addressed on the individual level, as well as community-building skills. These approaches have been shown to decrease depersonalization, emotional exhaustion, and burnout.

A particularly interesting approach at the Cleveland Clinic involves a holistic care rapid response program entitled "Code Lavender," which rapidly dispatches a holistic care team to any provider who requests emotional support, Dr. Karuza said.

The team of nurses provides Reiki and massage, healthy snacks and water, spiritual support, counseling, mindfulness training, and lavender arm bands to promote relaxation.

Although the evidence base regarding approaches to enhance engagement and to reduce burnout among physicians is small, these and other approaches are showing promise, Dr. Karuza said.

However, much work remains to be done.

"There really is an important need to translate the nice theories that we have … into workable preventions, especially organizationally-based interventions that the nursing home can employ," he concluded.

The speakers reported having no disclosures.

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