

THE Physicians Report

FALL 2015

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Maintaining Joy

Building resilience to burnout



Burnout and Well-Being
Measuring, managing, and positivity



Avoid Being Drained in Your Life and Your Career
The pathophysiology & treatment of burnout



How We Make it Work
Profiles of resilience



Plus—
The Physicians
Desktop Guide to MBSR

ACHIEVING THE QUADRUPLE AIM IN HEALTH CARE

We all are familiar with the Triple Aim in health care—better care (individuals), better health (population), lower costs (through improvement). I, like many, now believe that these three principles, while laudable, are not enough. Stress, burnout, and professional dissatisfaction are starting to permeate the physician community, making it nearly impossible to achieve the original three aims. Consensus is building to address the work life of physicians, providers, and staff, thus expanding the Triple Aim into the Quadruple Aim. And the Washington State Medical Association (WSMA) is fully on board.

As the 126th president of the WSMA, I bring to this office a great sense of joy and optimism when it comes to our profession. But as a psychiatrist, I also hear stress in the voices of our colleagues as they go about their daily work caring for patients while coping with a health-care delivery system that's in major turmoil and transition.

You know as well as I do the litany of woes that can eat away at our time, sap the spirit, and diminish energy and passion for our work:

- Mastering the complex world of electronic health systems;
- Meeting the deadline for ICD-10; and
- Coping with the increasing demands for more data and more documentation.

It can make a cynic out of the happiest of folk. And it can lead to burnout, even causing some to leave the profession.

We cannot let that happen.

We must redirect our attention toward the Quadruple Aim in health care. This is how we can address the reams of data demonstrating that not only are physicians failing to find

joy and meaning in their work, but they are also at increased risk of serious physical and psychological harm on the job. A workforce compromised by dissatisfaction and burnout presents a serious threat to patient safety. And, as an increasing number of doctors decide to leave practice, access to care is also threatened.

So how do we address this fourth aim? The first step is to recognize that the health and well-being of our physician and staff teams are essential in the effort to achieve better care, better health, and lower costs in health care.

Many resources are available for managing stress and improving workflow in one's practice, but it all starts with taking care of ourselves.

I spend a lot of time on airplanes. When I buckle in, the flight attendant's instructions come over the PA system. When considering the Quadruple Aim, consider the familiar instruction: "In the event of turbulence, first put on your own oxygen mask and then assist others." It sounds selfish, but it's really not. If you are unable to function, you will not be able to assist others.

If we do not begin to take better care of ourselves, all too soon we may be unable to care for others.

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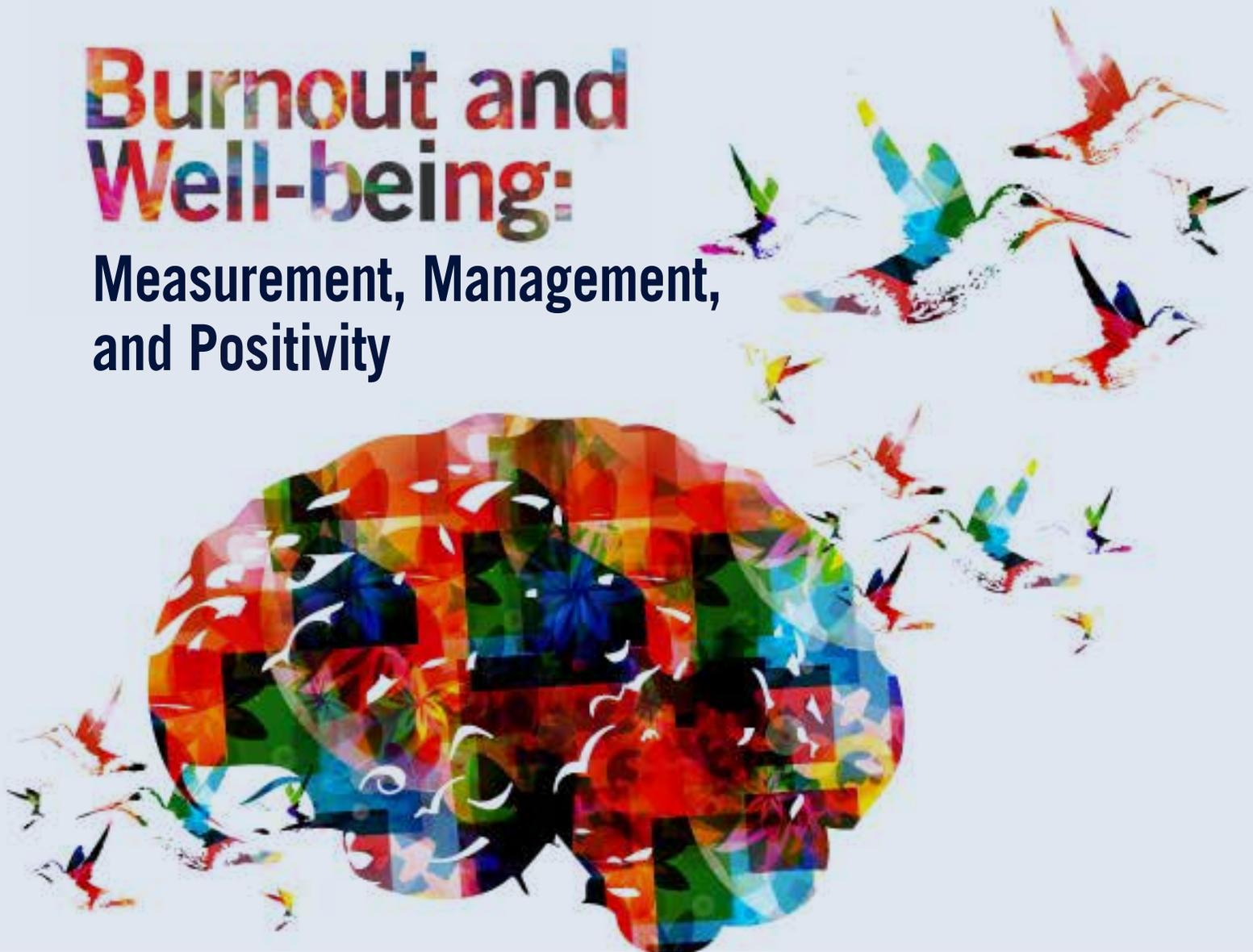
RISK MANAGEMENT

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Burnout and Well-being: Measurement, Management, and Positivity



In the last few years, studies have shown what is widely understood: burnout is a major problem that plays a silent role in preventing safe and error-free medicine.

Most providers are slow to acknowledge—to themselves or anyone—that they may be suffering the effects of burnout. And most organizations are not doing enough to support their staff. As a result, staff members suffer alone, they burn out, and sometimes they leave the practice of medicine altogether, despite years of hard work to get there.

FACTS & FIGURES

According to Dr. Mick Oreskovich, a Seattle psychiatrist and leading national researcher on burnout, over 45 percent of physicians meet the clinical definition of burnout. Oreskovich's

involvement in conducting the 2012 study, “Burnout and Satisfaction with Work-Life Balance among US Physicians Relative to the General US Population,” published in the *Archives of Internal Medicine*, has served to highlight the extent of the problem (see Figures 1 and 2)¹.

For this body of work, researchers conducted a national study with a large sample of US physicians from all specialty disciplines using the American Medical Association Physician Masterfile, the largest database of practicing physicians. The results concluded that burnout is more common among

Burnout: The Symptoms



Emotional Exhaustion

More than merely physical fatigue, this is the feeling of an emotional tank that has been emptied.¹



Depersonalization

When those around you do not register as human beings, when patients become merely a medical record or a room number with a condition to be treated.



Low Sense of Accomplishment

Experiencing feelings of not making a difference, or fear that others will discover you're just a fraud.

¹Christina Maslach, Wilmar B. Schaufeli, and Michael P. Leiter, "Job Burnout," Annual Review of Psychology, February 2001, Vol. 52: 397–422

physicians than among other US workers; those at greatest risk are physicians in specialties at the front line of care access.

WHO'S SATISFIED? WHO'S NOT?

While we may not know all the specific factors that may cause a given individual to experience burnout, according to Oreskovich, "it is very much related to specialty. Specialty is an independent, predictive factor."

In the 2012 study, physicians were asked if they were satisfied in their jobs, and if they were left with enough time for their personal lives. Not surprisingly, the physicians in specialties that allow more free time or flexibility of time reported higher levels of satisfaction. Among those most satisfied—occupational medicine, dermatologists, pediatricians—the hours are fairly regular, they conduct their work in their own office, and they might have the flexibility to modify their work week.

However, says Oreskovich, "Even among the most satisfied specialties, no one had a job satisfaction rating of higher than 60 percent. That's pretty low."

WHO IS USING SUBSTANCES? WHO ARE HURTING THEMSELVES?

In wanting to understand the impact of burnout and the relationship between substance dependency and major medical errors, Oreskovich and his peers queried physicians about their habits concerning alcohol and drug use. Among those who did not register

as having alcohol dependency, 8 percent acknowledged a major error in the preceding three months versus 11 percent among the group who did register alcohol dependency.

In another exercise to understand the effect of substance use, researchers trained laparoscopic surgeons on the Minimally Invasive Surgical Trainer Virtual Reality lab, then selected a random group to drink to intoxication the night before being assessed. Both consumers and non-consumers performed similarly at baseline, but the group instructed to consume excessively showed deteriorated performance throughout the following day.²

Finally, 15 percent of the physicians studied met the diagnostic criteria for being alcohol or drug dependent, compared to a 8.6 percent national average.³ However, it's the split between men and women that is perhaps most alarming: 13 percent of males met the diagnostic criteria for alcohol or drug dependence, while 22 percent of the female physicians—nearly twice as many—met the criteria.

The study also that showed suicide rates among physicians are more than double than the national average for men and four times more likely for women. This, too, goes against the national statistics, where males represent 77.9 percent of all US suicides.⁴

(UN)LIKELINESS TO GET HELP

Oreskovich observes that physicians put their own health and well-being behind that of others, which makes them all the more likely to get sick and suffer from depression or other challenges. Physicians tend to feel outside of their comfort zone when they need to ask for help. They also aren't comfortable when they, themselves, are in need of care.

"Those suffering from burnout and or depression often have pretty delusional thinking. They are going to work and thinking that they're still doing a good job," says Oreskovich. "They are often the last person in the room to know how depressed they are." The study showed that only 25 percent of those depressed had a prescription for an antidepressant, and half of those were prescriptions given by a surgical colleague rather than a psychiatrist providing treatment.

Routinely, when Oreskovich speaks at events, he'll query the audience and ask for a show of hands. "The same response patterns replicate each time," he reports. "When I ask who has had their annual exam, maybe 25 percent raise a hand. When I ask if they have someone they can confide in—a spouse or coworker—no male hands go up, but about 40 percent of the females put up a hand."

Regarding these dramatic gender differences, Dr. Oreskovich says, "Work-life balance continues to be difficult for women, more so than for men. We have

(Continued on page 6)

Fig. 1

BURNOUT IN U.S. PHYSICIANS, 2012

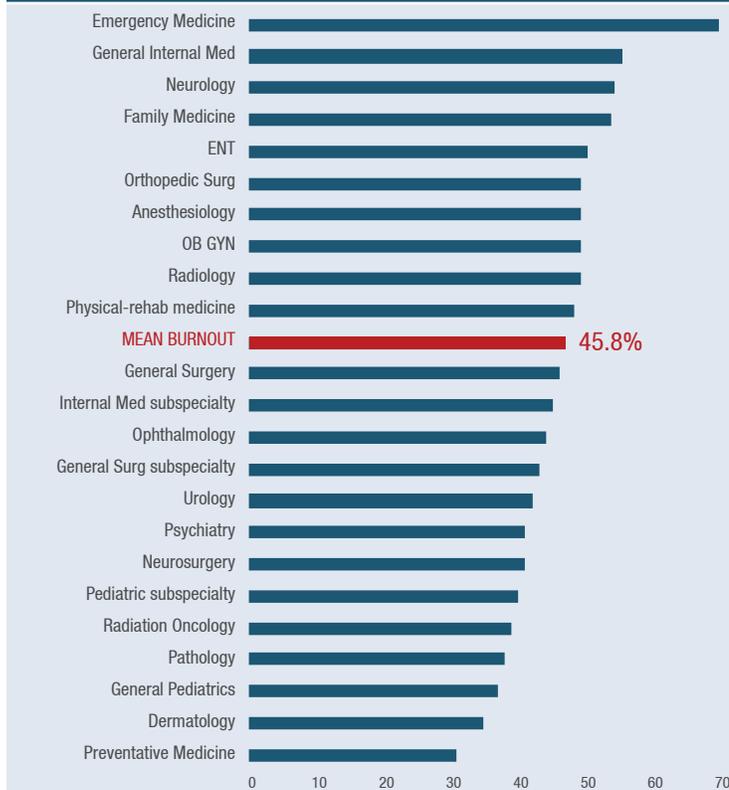
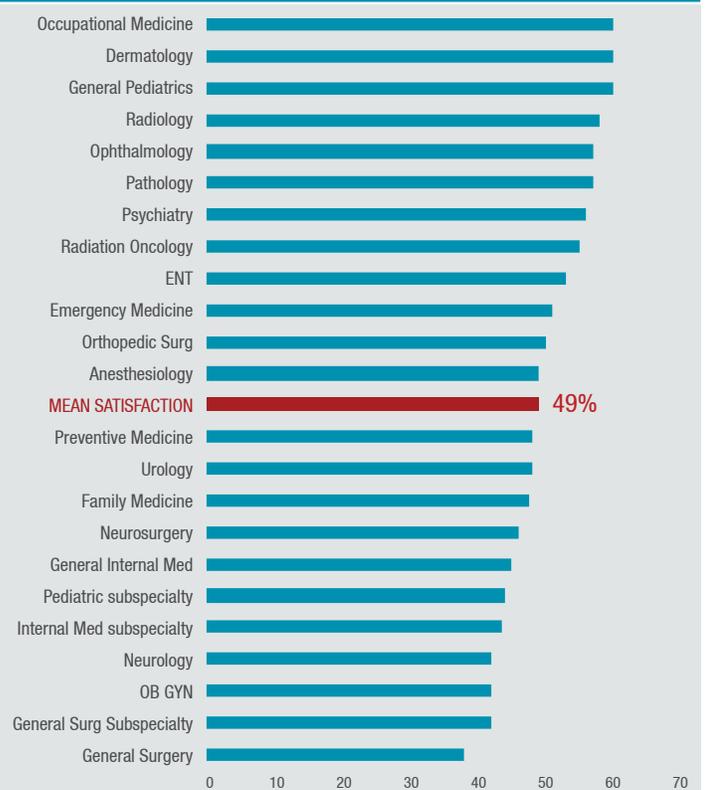


Fig. 2

SATISFACTION IN U.S. PHYSICIANS, 2012



(Burnout and Well-being, Continued from page 5)

much, much more to learn about the unique issues around work/life balance for women.”

GETTING HELP WHEN & WHERE IT IS NEEDED

If you're in senior leadership, you undoubtedly feel some responsibilities for ensuring that your providers are at their best in order to care for others. And if you're responsible for patient safety and reducing risk of liability, you have a stake in this, too. The cost to an organization for replacing a physician who quits or burns out can be \$200,000 or more. But the cost of a suffering physician's quality of life is immeasurable. That's not even taking into account the emotional cost to family and friends, or patients and the patients' families. The ripple effect—both emotional and financial—is huge.

“One of my biggest concerns is the prevalence,” says Chad Krilich, a family practitioner who is also CMO at Multicare's Auburn facility. “When you see the literature on burnout, you'll realize that physicians are leaving medicine at a high rate.” Krilich feels that, because of what is required of physicians, combined with

staffing shortages, our culture is doing a great job at burning out providers. “At the top of every CMO's agenda is how to successfully manage the workforce in such a challenging setting,” he says.

Krilich finds it important to make rounds in order to understand who has a rough road at the moment and to learn what kind of support might be needed, whether tangible support, such as additional resources or assignment shifts, or mental and emotional support, such as acknowledgement, a pat on the back, a peer to talk to, or more.

Krilich also cites having a code of conduct in place as important for documenting issues when they first surface. Establishing procedural guardrails helps bring others into the fold sooner rather than later so those professionals are better able help before an issue spirals into a serious hazard for the provider or his/her patients.

“With policies to guide us, I will have conversations early on that I might not otherwise be invited to have,” Krilich

says. “I can start with ‘so I heard you threw an instrument the other day,’ and start a dialog to begin understanding how I can help a situation.”

It is in the early conversations that leaders can do some of critical probing. “‘Are you feeling depressed? Are you having thoughts of hurting yourself?’ are questions that are or should be routinely asked,” says Krilich. “In Washington, we are fortunate to have the Washington Physicians Health Program (WPHP) as a resource. We use it often to connect physicians with resources around counseling, assessments, or treatment.” (Learn more about WPHP and similar organizations on page 23.)

Krilich points out, “We're accountable for acting accordingly when we see our physicians struggle, we need to have a plan for them. I like to see my surgeons coming through the halls saying, ‘I had a great day!’ I want them to have the emotional reserve for whatever kind of day they might face in the OR.”

LEARN MORE

VIDEO

The Happy Secret to Better Work

Dr. Shawn Achor, Psychologist
Harvard University



www.ted.com/talks/shawn_achor_the_happy_secret_to_better_work

The New Era of Positive Psychology

Dr. Martin Seligman, Psychologist
University of Pennsylvania



www.ted.com/talks/martin_seligman_on_the_state_of_psychology

ARTICLES

Gene Is Linked to Susceptibility to Depression

New York Times



www.nytimes.com/2003/07/18/health/18DEPR.html

BOOKS

The Happiness Advantage: The Seven Principles of Positive Psychology That Fuel Success and Performance at Work, by Shawn Achor

Flourish: A Visionary New Understanding of Happiness and Well-being, by Martin Seligman

Peace Is Every Step: The Path of Mindfulness in Everyday Life, by Thich Nhat Hanh

Flow: The Psychology of Optimal Experience, by Mihaly Csikszentmihalyi

The Upside of Stress: Why Stress Is Good for You and How to Get Good at It, by Kelly McGonigal

EARLY INDICATORS AND POSITIVE PERSPECTIVE

Residency Program Director Dr. Kerry Watrin has developed his perspective on burnout from working with residents at Tacoma Family Medicine for the past 20 years. During that time, he's thoughtfully observed who is struggling and who is doing better than others.

"Despite duty-hours restrictions, residents report burnout in the 50 percent range and are only getting an average of 22 more minutes of sleep per day," says Watrin. "Each situation is individual. Each young physician comes with their own genetic predispositions, imprinting from upbringing, thinking style, and current life situation—and it all impacts their resilience."

At the end of each year, he has asked residents to list the top three to five things that have supported them or made their work more stressful. Consistently, the residents reported the following as providing the most support to them when times were tough:

- **People:** loved ones or supportive colleagues
- **Activities that hold meaning for them:** sports, art, music, reading, spiritual practices, etc.
- **The outdoors:** spending time in nature, enjoying The Great Northwest

On the flip side, the contributors to stress were consistently reported as:

- **People:** struggling personal relationships, ill or dying family members, missed family events
- **Being witness to dying and suffering:** most had yet to experience the death of a loved one, yet in their first month will watch a patient die

- **Managing time effectiveness:** mastery of the task-oriented portion of the job (i.e., only typing 40 words a minute means spending an additional two hours per day completing administrative work.)

Concrete ways through which their program promotes resiliency in its training are by offering lectures, retreats, humanism gatherings, by building teams of classmates to rely on each other, and by assigning advisors who accompany and coach individuals in both positive and painful growth times.

Dr. Alan Shelton, who presents talks on burnout to residents at Tacoma Family Medicine, describes the remedy as exercise. Watrin elaborates: "If we exercise in each of the four realms of physical, intellectual, emotional and spiritual-meaning, we are balanced. If we are only exercising one realm, we are out of balance."

Residents are also involved in interviewing the incoming class, which offers a chance to look at the bright side of the work. "The focus of burnout is often on the negative side of the story, but there is a beginning body of knowledge on well-being as it relates to burnout," says Watrin. While burnout symptoms are measured by three key indicators—emotional exhaustion, depersonalization, and sense of accomplishment—"well-being has its own five measurable characteristics: pleasure, engagement, positive relationships, meaning, and achievement," he says.

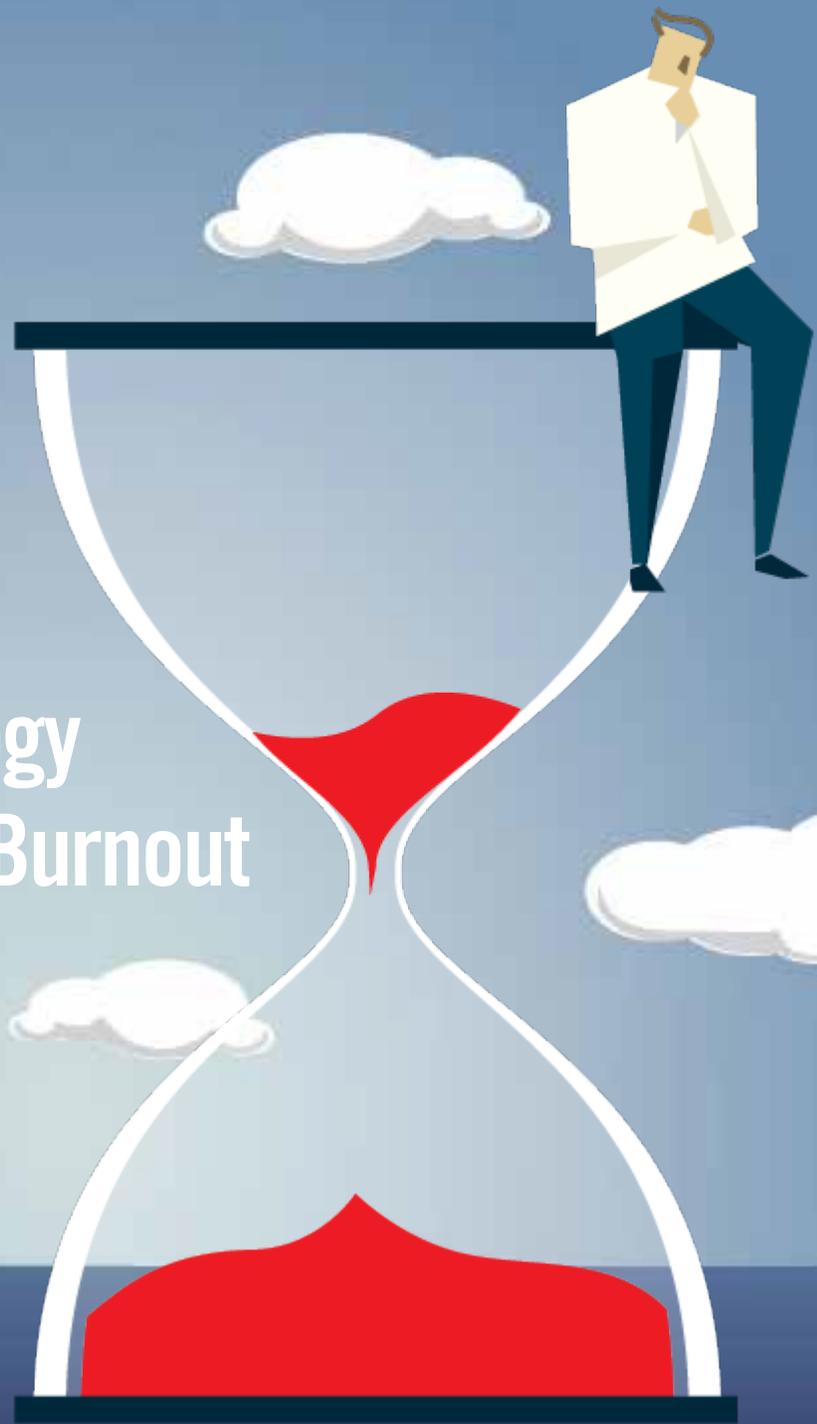
The body of work around positive psychology includes studies of people who consider themselves to be happy. The purpose is to learn what such people do differently or how they are different in makeup than those who do not consider themselves happy. For instance, something as simple as stating the three

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Avoid Being Drained in Your Life and Your Career

The Pathophysiology and Treatment of Burnout

By Dr. Dike Drummond



In my work with overstressed physicians, I have noticed a consistent misunderstanding of burnout's pathophysiology—the hidden methods burnout uses to sap your energy and steal your passion for medicine.

Knowing these hidden methods is vitally important, because once you can clearly understand how physician burnout operates, you will begin to see the simple ways you can keep normal physician stresses from crossing the line into threatening your career, your marriage, and even your life.

STRESS VS. BURNOUT

The activities and responsibilities of being a physician are always stressful. Each and every shift in the clinic or hospital requires a significant input of energy. Doctors are drained on multiple levels by the demands of the clinical practice of medicine every single time they see patients.

In addition to the “normal” stresses of clinical practice, they are also drained by dozens of additional stressors that have nothing to do with clinical activities. Here are just a few: billing, coding,

maintaining one's Electronic Medical Record, malpractice risk, clinic culture, and political uncertainty.

STRESS IS WHEN YOU ARE DRAINED AND STILL ABLE TO RECOVER

Physician burnout begins when you are drained and are not able to recover between your shifts. Burnout can take you on a relentless downward spiral that has been graphically described by Christina Maslach, the original burnout researcher, as "an erosion of the soul caused by a deterioration of one's values, dignity, spirit and will."¹

PHYSICIAN BURNOUT PATHOPHYSIOLOGY: THE THREE ENERGETIC BANK ACCOUNTS

When you cross the line from the normal stresses of being a doctor into physician burnout, you will begin to notice one or more of the following symptoms. These three main symptoms of physician burnout are measured by a standardized research survey tool called the Maslach Burnout Inventory (MBI). The measurements are 1) Emotional Exhaustion, 2) Depersonalization, and 3) Personal Accomplishment (see page 5).

A battery metaphor is often used to describe stress and burnout. "My batteries are run down," or "I'm recharging my batteries" are common phrases you might hear. But that analogy is inaccurate.

Consider what happens to a child's toy when the batteries run out. It stops working, right?

That's what happens with batteries. But physicians are perfectly capable of running on empty and continuing to see patients long after they are completely drained and exhausted. Developing this capacity to work despite complete exhaustion is a core component of today's medical education. Learning how to keep going no matter what is part of surviving residency.

This survival mechanism makes sense if you have a defined end point, such as graduation. However, once you enter private practice, your whole life stretches out ahead of you. You can continue to function on empty for only so long before something bad happens. And for many, empty is just the beginning.

A more accurate metaphor is that of an Energetic Bank Account. And like most bank accounts, this one can have a negative balance. You can overdraw your energetic bank account and continue to see patients. Your work will not be the very best you're capable of, but you will keep at it, just like you did as a resident.

MBI SYMPTOMS AND THE THREE ENERGETIC BANK ACCOUNTS

The key to understanding the pathophysiology of physician burnout is to recognize that each of these scales on the Maslach Burnout Inventory corresponds to its own Energetic Bank Account within the individual physician.

- 1 Exhaustion = your Physical Bank Account
- 2 Sarcasm, Cynicism, Blaming = your Emotional Bank Account
- 3 "What's the use?" = your Spiritual Bank Account (which refers to your deeper connection with meaning and purpose in your practice)

This energetic bank account metaphor helps to explain physician burnout and its treatment.

Each time you are seeing patients in

YOUR ENERGETIC BANK ACCOUNTS

Fig. 1



the clinic or hospital, you expend physical, emotional, and spiritual energy. Once you become aware of the existence of the three energetic bank accounts, your job becomes very clear: keep all three accounts in a positive balance.

Evaluate where you are right now by considering this simple visual representation (Figure 1). Point to where you feel your current balance is in each of the three accounts.

Physical - How is your energy? Are you in a positive balance?

Emotional - How are you feeling emotionally? Are you getting your needs met in your most important relationships?

Spiritual - How connected are you to feeling like your work makes a difference and is a meaningful path for you?

PREVENTING PHYSICIAN BURNOUT - THE TWO CORE METHODS

With the three Energetic Bank Accounts as a way to understand how physician burnout does its dirty work, it quickly becomes obvious there are two main ways to both prevent and to treat physician burnout.

- 1 Decrease the Drain
- 2 Become Skilled at Making Deposits

Preventing and treating burnout involves a series of simple steps, but those steps aren't easy for a practicing physician to carry out because they sit in a huge blind spot created by one's medical education.

Doctors have never been taught how to lower their stress levels or create work-life

(Continued on page 10)

¹Neil Baum, Roger G. Bonds, Thomas Crawford, Karl Kreder, Koushik Shaw, Thomas Stringer, and Raju Thomas, eds., *The Complete Business Guide for a Successful Medical Practice* (Springer International Publishing: Switzerland, 2015), 250.

(Avoid Being Drained in Your Life and Your Career, Continued from page 9)

balance. An entire wall of shame and guilt has been built around getting one's own needs met. A second wall, denial, prevents doctors from asking for help or support, no matter how burned out they might be, because that would be admitting they aren't tough enough to take it. Physicians have deeply ingrained unconscious habits from their training that set them up for burnout in the first place.

Preventing physician burnout is not a simple flip of a switch. It involves a series of little steps, done consistently, that collectively produce significant changes. It is a process that takes some time and will absolutely require you to do things differently. No sudden moves, such as resigning, are advised here. Most physicians find that 70 percent of the time, they will be able to get back to positive balances without having to quit their

Physicians have deeply ingrained unconscious habits from their training that set them up for burnout in the first place

current positions. Here's how to get started:

DECREASE THE DRAIN

When you think back over the last several months:

- How draining is your average shift at work? What are the situations, people, activities, and other elements that drain you the most? How can you set yourself up to do fewer of those?
- What are the things you find the most rewarding and enjoyable at work? How can you set yourself up to do more of those?

Decreasing the drain begins when you

take a good hard look at what you hate about work, accept it for what it is – stop the blaming, complaining and making excuses – and make changes to eliminate some of that stress. Here are a few examples:

- Learn how to lead your team more effectively so that members do some of the activities you find draining and also activities that don't require an MD in the first place (you know the ones I am talking about). Delegate them now!
- Get some lessons on how to become a Power User of your EMR from the person in your practice who is acknowledged to be the best at it and the least stressed by it.
- Exercise any flexibility you have over work hours and days. Make your schedule work for you.
- Work less, give up call-and-refer to a hospitalist service, and stop taking an insurance that is a major pain.

You can also decrease the drain by doing more of the things you love at work. Here are some possible examples:

What types of patients and/or procedures do you really enjoy? How can you get more of them on your schedule? If you are expert at a particular diagnosis/treatment you love to do, consider who doesn't know about your skills in your local community and when and how you will reach out and tell them. These people are potential referral sources who could help you have a better day.

INCREASE YOUR DEPOSITS

What are your favorite recharging activities?

Physical:

- What things do you do outside of work that you find the most restful



and rejuvenating? When can you do more of those?

- How can you take better care of yourself through exercise and eating right?
- Which of these things could you begin to incorporate into your office day?

Emotional:

- What relationships in your life give you the most joy and satisfaction?
- When was the last time you paid them significant attention?
- When can you spend some quality time with these people? (Schedule it now!)

THE PARADOX OF PURPOSE

Your Spiritual Bank Account is the only one where triple deposits are possible. Whenever you have a patient encounter that leaves you feeling so good, you say to yourself, "Oh yeah, that is why I became a doctor," you have just made a deposit into your Spiritual Bank Account. At the same time, you will notice increased Physical and Emotional energy. Connecting with purpose and meaning in your practice is a leveraged activity that drops deposits in all three accounts.



How can you get more of those encounters in your work day?

You must first be clear on the kinds of things that feed your spirit at work. Remember the last office encounter that gave you the feeling described above? Take a moment and write down the details of that patient/problem/situation/diagnosis so that you are very clear on who and what you are looking for.

How can you structure your week so that there is a higher likelihood of having these types of interactions? What if you set an intention at the start of each office day to be on the lookout for an interaction like this? One of my clients calls this creating a “treasure hunt.” You can do it too.

NEXT STEPS

As you look at the lists of options above, pick one and get started. Notice the difference this change makes in how you feel on the very first day you try it. If you would like specific advice and support on getting started, consider a confidential Discovery Session with a burnout prevention specialist.

Your goal is to develop new habits that maintain a positive balance in all three accounts. If you look closely at your colleagues who never seem to be stressed or burned out, you’ll find that they have all accomplished this feat. Very rarely does it happen naturally. More often it is because of a brush with physician burnout that motivated them to do the exact work outlined above at some point in their careers. [PR](#)



Dike Drummond, M.D., is a family physician, executive coach, and creator of the *Burnout Prevention Video Training Series*. He provides stress management, burnout prevention and physician wellness, and engagement coaching and consulting through his website, *The Happy MD*.



(Burnout and Well-being, Continued from page 7)

things that one is grateful for each day is reported to lead to increased happiness. Conventional thinking is that working hard leads to success and, in turn, to happiness. Rather, Watrin notes, current research promotes the reverse: that positivity and happiness are what breed success. (See the additional resources in Learn More on page 7.)

“Medical providers are known as overachievers in getting successfully through undergraduate school,

“Medical providers are known as overachievers in getting successfully through medical school and beyond — they’re geared for excellence. Perfection is their enemy.”

DR. KERRY WATRIN

medical school, and so on. They’re geared for excellence. Perfection is their enemy,” says Watrin.

Amidst unprecedented change and a continual push for improvement, the entire medical field is working hard on perfecting itself. While “perfection” may not be a realistic goal, the increased importance of satisfaction scores, the growing number of insurance codes and patient visits, and ever-evolving technology (and more) are sure to keep pressure high. All professionals owe it to themselves to learn, use, or create tools that will assist them in maintaining the joy in their careers. [PR](#)

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THE FOUR HORSEMEN of the PHYSICIAN-BURNOUT APOCALYPSE

By Dr. Dike Drummond

Our medical education indoctrinates us. Yes, indeed. While in training, we are expected to adopt attitudes and behaviors that become subconscious and automatic by the time we are board certified. To most doctors, these behavior patterns are invisible and unrecognized. However, if they continue to sit in your blind spot, they virtually guarantee physician burnout in your forties and fifties.

Here are the four horsemen of the physician-burnout apocalypse in all their glory. See if they feel familiar to you:

- 1 **Workaholic**
- 2 **Superhero**
- 3 **Emotion Free**
- 4 **Lone Ranger**

Burnout results when these four horsemen become “overused strengths.”

Basic training in the military lasts eight weeks. In that time, an 18-year-old can be conditioned to take a bullet on command.

Medical education lasts a minimum of seven years. Take a second to count up the time between your first day in medical school to your first day in private practice. I believe there is no conditioning program on the planet more thorough than the one that leads to becoming a practicing doctor.

If your only tool is a hammer, everything looks like a nail.

That is the problem. Not everything in a doctor's world is a nail—especially after you graduate to private practice and the rest of your life. Burnout results when these four horsemen become “overused strengths.”

Being a workaholic / superhero / emotion-free / lone ranger is an absolute requirement to making it through a 72-hour shift in your residency, but it is not a great way to:

- Be in a loving relationship
- Raise your kids
- Get your own needs met
- Live your life



THE PHYSICIAN WELL-BEING INDEX

The online, interactive tool helping both individuals and their organizations assess and promote well-being

Leading researchers on physician burnout and well-being have developed an anonymous, interactive self-assessment tool for organizational use. Created by and launched for internal use at Mayo Clinic earlier this year, the online tool provides feedback on how a physician's well-being compares to physicians nationally, plus it tracks an organization's internal trends over time. For physician users, the tool can be customized to provide local resources for support and the ability to track their own well-being.

"We designed this tool to create a reliable method of calibration that would provide helpful feedback for individual physicians and an anonymous overview of physician wellness for their organizations. In a national study involving over 1,000 physicians, use of this tool stimulated physicians to pursue behavioral changes to improve personal well-being," says Dr. Lotte Dyrbye, a provider at the Mayo Clinic and co-developer of the Index. The original abstract can be found at www.ncbi.nlm.nih.gov/m/pubmed/23979287.

Since its launch, several groups outside the Mayo Clinic have begun the process of licensing and implementing the tool at their own organizations. Pricing varies based on the size of the group.*

LEARN MORE



www.mededwebs.com/what-we-do#section-well-being-index

* Mayo Clinic and Dr. Lotte Dyrbye have a financial interest in the technology referenced in this article. Revenue Mayo receives is used to support its not-for-profit mission.

> When you micromanage, can't let things go, and drive yourself and everyone around you crazy by having to do everything yourself, that is just your Lone Ranger programming. Yes, you are ultimately responsible for the outcomes in your practice (and your life), but you can ask for support. You can delegate and create systems that will take away some of your burden while delivering the quality you demand. It is possible.

For most of us, these four horsemen and their automatic behaviors are deeply subconscious. Remember that you spent a minimum of seven years installing them in your psyche—deliberately, consciously, and through thousands of hours of dedicated study and on-the-job training. No wonder they poke their heads into all areas of your life—and not always in a good way.

NEXT STEPS

Here's a simple way to expose your own brainwashing and lower your physician burnout risk.

Whenever you find an area of your practice or life that is not working the way you would like, ask yourself: "How am I perhaps acting like a workaholic / superhero / emotion-free / lone ranger here?"

When you notice one of the four horsemen as the source of your automatic behavior in this area, ask, "What might I do differently that will get me more of what I really want?" The power is yours. By being aware of the four horsemen of the physician-burnout apocalypse and making appropriate changes, you can achieve greater health and success in your life and medical career. 

I help my clients see this conditioning when it appears as automatic behavior that is driving their physician burnout; when they are using this set of hammers to drive things that are not nails.

A FEW EXAMPLES:

> When your only response to a challenge or "problem" in your practice is to work harder, that stems from your workaholic programming. I can assure you there are other ways to address almost any practice issue that do not involve you personally working harder.

> When you feel as if every challenge for your patients, your staff, your family, and yourself sits on your shoulders and you should be able to solve them all, that is your Superhero programming. The truth is, you are human. You are not a god. Learn to say, "I don't know the answer to that," or "I wish I could help here; I wonder what you will decide to do?" and let things go that are outside your control. Breathe.

> When you have strong feelings of fear, sadness, anguish, helplessness, love, joy, compassion, empathy... don't stuff them according to your emotion-free programming. And please don't feel guilty for having those feelings in the first place. You are human; you will have feelings. They are part of what makes life rich, juicy, and worth living. Let them flow. Don't bottle them up. And never be afraid to tell someone—especially your work team—what you are feeling in the moment. It lets them know you are not superhuman.

How We Make it Work

Profiles of Resilience



Whether reshaping a career, taking more “me” time, or exploring and expanding other meaningful life roles, every professional has a unique route to avoiding burnout and making life work. The following are profiles of a few physicians who wanted to share their stories.

A Life Outside Medicine

“We all have those patient stories which haunt us. We think about them every day.”

This doctor recalls a trial he endured years ago. “Even though the jury returned a unanimous verdict in my favor at trial, I was troubled because I still did not know what had happened—why the patient had died.” The doctor eventually conducted research that revealed exactly what had happened. Procedures are now in place to prevent recurrence of that unfortunate

event. What satisfied the doctor wasn’t the jury verdict; it was a clear understanding of why the event occurred and the knowledge that the research resulted in changes that would probably save many lives.

That specialist, a rising star, enjoyed the recognition and positive reinforcement he was receiving from his local medical community due to his level of expertise. He was referred to as the “cream of the crop.” But his hectic schedule and the resulting stress helped him realize he was living someone else’s dream, and the glory wasn’t worth the steep price. That led him to quit the high-profile

job and choose a path that permitted him to feel challenged and make significant contributions while providing a better balance between his professional and personal life.

“When you’re just starting out, be flexible,” he says. “You might realize that you don’t want to do the thing for which you have for so long prepared yourself, or circumstances might change. If your five-year plan doesn’t pan out, or your choice of specialty isn’t what you thought it would be, make a change—sooner, rather than later. Don’t continue down a track that isn’t making you happy. One of the measures of my professional success has been whether or not I look forward to going to work.”

With a son in medical school, this doctor has concerns about the demands his son will face. He recognizes that residents have considerably more support now than when he was undergoing the training process himself, but he feels there should be a system in place to help physicians beyond their training.

“We have quite a network, but it’s more of a gossip network. Word of bad news spreads fast—we get a call saying ‘did you hear what happened to so-and-so?’ We’re all pretty interested to hear, and I suppose to be glad that it didn’t involve us.” Let us imagine if that network was used for support, rather than sharing someone else’s bad news.

Having an identity outside of medicine can also help physicians remember the many ways they contribute to those around them. This physician found that joining a photography class, full of people doing what they loved, provided an additional outlet. No one knew he was a physician. They related to him as an artist. He found it refreshing and satisfying to be in a group that had a different benchmark for recognition and accolades.

“I tend not to socialize with medical people,” the physician says. “I welcome the opportunity to spend an evening chatting with a crane operator to learn about how he/she assembles massive pieces to build skyscrapers. My curiosity, which brought me to medicine, extends beyond that field.”

A big music fan, he frequently enjoyed concerts at a local venue, where over the years he had lively conversations with both fellow patrons and employees.

“One day at the hospital, I encountered one of the servers who was in for surgery. He knew my face, but couldn’t recall my name. He asked, ‘What are you doing here? Are you a doctor?’ I laughed—it made my day.”

Staying Connected and Mindful

“I love the richness of being a part of people’s lives. Every patient has a unique and fascinating story.”

During medical school she was buoyed by a strong sense of a greater purpose. Yes, there was the basic science information to learn, study, and memorize. But what made all the hard work worthwhile was the strong desire to help people during their greatest times of need. “It’s more about the person than the technical side of medicine for me,” she says.

This desire and sense of patient connectedness is probably what makes so many providers good at what they do. But how does one keep that strong sense of purpose and human connection alive during the stresses of practice? While she is now seasoned enough to be mentoring several others, this doctor acknowledges the importance of her own mentor in

helping shift her perspective. “It is incredibly powerful to just be there with someone, as a witness, and not take on the problem,” she says. “I had to learn that for my own well-being.”

To remain connected to patients while holding clear boundaries, she uses mindfulness practices. “I pick moments for mindfulness during the day. For instance, right before I enter an exam

room, I can stop, breathe, and think before I enter.”

Regular Balint group participation with other physicians has been another way she’s maintained a connection to patients. Balint groups provide monthly touch points of peer connection and support for some of the most challenging—and discouraging—patient relationships.

This physician’s longtime commitment to a church choir also provides a channel

(Continued on page 16)

It’s been said that balance is a point you cross as you swing back and forth along a pendulum between two extremes.

WHAT’S A BALINT GROUP? HOW DO I FIND ONE?

Developed by Dr. Michael Balint in Britain after WWII, Balint Groups meet regularly and confidentially over the course of many years, to better understand their own patient relationships through case discussion. Physicians focus on improving their ability to connect with and care for patients—especially during those interactions that are frustrating, annoying, or unsettling.



Learn more at:
www.americanbalintsociety.org

(How We Make it Work, Continued from page 15)

for refueling. “When we’re singing, we breathe together. It is powerful—communication takes place without words.” The essence of a choir group is not about performing; it’s more about using song as a channel of worship. For this physician, it also provides a rejuvenating connection with others outside of work.

She has also benefitted by adjusting her work schedule to accommodate the rest of her life. While raising her children, she cut back to work part-time. Some years that meant getting more involved in administrative work and seeing fewer, if any, patients—and putting her years of medical experience to use in new ways.

“I always get back to the joy in what I do,” she says. “My work is intellectually challenging, spiritually rich, and pays well. Remembering that, I have very little to complain about.”

Layers of Meaning

“Working with medical students keeps me mentally sharp. They question me. It makes me stay in touch with the literature and go with them to find answers. Teaching helps sustain me.”

Initially pursuing a career of social justice, she envisioned herself as a community organizer and educator. But around the age of 25, she realized that as she advanced in her career, she would become farther removed from the person-to-person



“I’m on vacation for the next two weeks and I need this time for my resilience,” replied one of the physicians invited to be interviewed for this article. Saying no—or not right now—can be very important.

work she loved. Then the thought of a medical career occurred to her.

“I realized I wanted to own a skill that no policy could control, that I could use to help people all over the world, whether individually or as an entire community.” Bringing her interests of educating and organizing to her medical career, she now also teaches and has long been an advocate for underserved urban populations by working to fill the pipeline of providers for that community. Bringing her core passions to medicine provides layers of meaning for her and keeps her invigorated.

She is passionate about relationship-centered care. “The reciprocity of this style of care really speaks to me,” she says, “the notion that the physician can also be getting something out of the relationship.” She believes in it so strongly that she has published a book

time off at the insistence of others, but I was thinking, ‘Well, this is backwards!’” She gained a more realistic view of how physicians need to support each other in taking care of their personal lives by covering for each other when necessary.

“Overall, medicine is stressful. But it’s really fun. We just have to set up our own tools to preserve sanity, have lives outside medicine, and remember what components of the career are important to us.”

Rational and Emotional Coping Skills

“Suicide is a hard topic for me.”

Choking back tears this doctor shares that four of her friends, acquaintances, and

“Overall, medicine is stressful. But it’s really fun. We just have to set up our own tools to preserve sanity, have lives outside medicine, and remember what components of the career are important to us.”

of collected essays on the lessons that patients have taught their physicians. She blogs about meaningful moments she’s had with her patients and finds the creative expression to be invigorating.

“Residents are almost burned out at the thought of constant giving,” she says. That’s why she teaches workshops to help students form doctor/patient relationships that fuel them with meaning, rather than drain them.

She also learned early in her career to take time off when needed and to allow others to cover for her. She recalls the months before her mother died: “I was working full tilt as a second-year resident. After she passed, I finally took

colleagues have taken their lives. “The most recent one helped me realize what’s really important about success, so I can focus on that with my family and in how I’m raising my kids,” she says. Recalling those who took their lives, perhaps because they were living up to someone else’s ideal or were considered a bright star by everyone but themselves, she says, “It’s not building a resume that matters; it’s learning how to manage life’s problems. If you’re doing great by others’ measurement, but not your own, you’re just in pain.”

Her first bad outcome took place after she had performed about 1,500 successful eye surgeries. A patient developed an infection and sustained serious vision loss. Although the physician knew she was a good

(Continued on page 19)



Burnout Due To Litigation



Over 20 years ago Dr. Ron Hofeldt assisted Physicians Insurance in creating a support program for physicians involved in litigation.

The goal, which still remains, was to promote resilience as physicians deal with the daily demands of medicine during the slow-moving process of litigation. His unique role as Director of Physician Affairs working closely with physicians in litigation has provided him insights on burnout.

Why are physicians suffering? Our culture promotes hard work, along with the belief that to dedicate one's life to medicine is noble. However, physicians do not receive adequate training in self-care. Instead they are "rewarded" for sacrificing or postponing their personal needs. They are bright, high achievers who want to help those who are in need. They too frequently shed other parts of life—family, exercise, recreation, relaxation—for medicine.

How can a distressed physician be helped? Offer education and hope. Let them know burnout is a common occupational risk, they're not alone, and resources are available. They also need to regain balance and their connection with other physicians. We've stopped attending department meetings and rely on e-mail and other technology for communication. This reduced personal engagement leads to isolation and a breakdown in teamwork; collegiality and collaboration lessens the stress of medicine.

How can organizations help? They need to address burnout earlier. More organizations are starting to develop resources to address physician burnout.

Unfortunately, many fail to address the fact that burnout contributes to medical errors. This awareness should be instilled during medical school. We need conferences to educate physicians, help them gain insight, and to develop tools to mitigate the risk. We must get the word out – silence does not work.

What can physicians do? Physicians should follow the advice they give their patients: slow down, step back, eat healthy, exercise, and take time to laugh. Medicine is demanding and requires physicians to function at the highest cognitive level. Healthy physicians make better decisions regarding their patients.

Just as the heart pumps blood to itself first, physicians must address self-care before caring for others.

Promoting resilience and encouraging physicians to take care of themselves is a win-win-win for patients, physicians, and medicine. Just as the heart pumps blood to itself first, physicians must address self-care before caring for others

How does litigation impact physicians? Physicians dedicate their lives to provide the highest quality care to each and every patient. There's a sense of satisfaction knowing you are doing your best. When a lawsuit alleges professional wrong doing, physicians are confused, shocked, and saddened. The suit quickly becomes a personal attack that causes physicians to

question their competence and whether they want to continue practicing medicine. Unfortunately, many physicians believe that good doctors don't get sued, and that is not true. Addressing the feelings of isolation, shame and burnout associated with a lawsuit helps physicians handle the stress of litigation. A resilient defendant is less impacted by the stress of litigation and is a more effective witnesses as they go through this process.

I've seen highly skilled physicians wanting to leave medicine. I've also seen that with support, guidance, teamwork, and redirection, distressed physicians are able to find life and the practice of medicine exciting again. The entire Physicians Insurance team is focused on supporting physicians throughout this confusing process, and takes pride in helping physicians sustain the joy of caring for patients. 



The work of Dr. Hofeldt, a psychiatrist with more than 30 years' experience, has resulted in support resources available at no expense to all Physicians Insurance members. Learn more at www.phyins.com/providersupport.

8 Ways to Respond

to a Provider Who Has Experienced a Medical Error



Mistakes happen. In fact, as many as seven out of 100 hospital inpatients experience a significant medication error, according to Don Berwick, MD, former administrator of the Centers for Medicare and Medicaid Services¹, and one in seven Medicare patients experience a medical error in the hospital.²

Humans are prone to making mistakes—regardless of their training—so it’s not a matter of asking if errors will occur, but when. Thinking about your own care setting, how would you and your facility support a coworker if an adverse event occurred today?

Some settings and specialties carry higher risk: intensive care units, operating rooms, code teams, emergency medicine, pediatrics, obstetrics, oncology, and palliative care. But adverse events are not limited to these environments.

When an event occurs, the clinicians who are involved typically respond in three ways. For some, a first instinct is to drop out of the profession. Others survive the event and cope, but may be haunted with sadness and thoughts about the event or even resort to addictive behaviors to cope. Others choose to thrive. They do so by practicing self-care, by maintaining a good work/life balance, and by gaining wisdom from the experience. They realize they

needn’t define their practice or career by the single event. Some clinicians recover by advocating for patient-safety initiatives.

ORGANIZATIONS AND PEERS CAN HELP

Coworkers and organizational leaders can support clinicians by knowing how to respond when an error occurs. Here are some ways department leaders and medical colleagues can help:

- 1 Reach out to the affected clinician, demonstrating a caring attitude and conveying faith in the provider’s clinical skills.
- 2 Actively listen to what the affected clinician wants to express.
- 3 Swap “war stories” to provide an outlet for stress.
- 4 Offer the clinician flexible scheduling as needed.
- 5 Brief the clinician on any investigation that may occur.
- 6 Be visible and transparent to all staff on the unit.

¹ Donald Berwick, *Escape Fire: Lessons for the Future of Health Care* (New York: The Commonwealth Fund, 2002): 20, http://www.commonwealthfund.org/usr_doc/berwick_escapefire_563.pdf.

² Agency for Healthcare Research and Quality, “20 Tips to Help Prevent Medical Errors: Patient Fact Sheet” (September 2011), <http://www.ahrq.gov/consumer/20tips.htm>.



PHYSICIANS INSURANCE PEER SUPPORT PROGRAM

Many of your peers have dealt with the aftermath of unanticipated outcomes of patient care. They know how helpful it is to share the experience with someone who has already walked this path.

Our peer consultants are volunteer member physicians. They understand the impact on your personal and professional life, and have been trained to reach out to colleagues following an unanticipated outcome. This support is confidential and meant to help you process the effects of an unanticipated outcome.

Learn more at
www.phyins.com/peersupport.

7 Deploy multidisciplinary rapid-response teams, especially in high-risk areas, to reach out to clinicians as part of a formal provider support program. These employees should be specially trained to monitor colleagues for second-victim signs and provide support.

8 Develop external referral networks, which might include employee assistance programs, social workers, chaplains, and clinical psychologists.

After a serious event, one health professional in five will require counseling or other form of support. A provider who lived through an event referred to the experience as “an emotional tsunami.” Another described it as “the darkest hour of my life.” As health care professionals and organizations, we have a responsibility to protect and heal the clinicians on our team. **PR**



(How We Make it Work, Continued from page 16)

surgeon, she felt depressed for a month. She thought about the case several times a day, wondering how much might have been her fault and what, if anything, she could have done differently.

“I was feeling upset that I could have caused someone to lose sight,” she says. “I was anxious it could happen again. But there was no time to process that. With a surgical schedule that was booked solid for the next month, I had to keep going.” Meanwhile, she received two or three thank-you notes from patients for whom she had made a big difference. “But I couldn’t get excited about it. I was too depressed and feeling so bad about the surgery.”

Coping is a two-pronged process for this provider. Her first defense is emotional support—relying on family relationships, close colleagues, and her strong sense of faith and prayer. Her second is rational support for herself—developing an action plan.

“The responsible physician in me wanted

to make sure I was updated with the latest research to avoid this ever happening again. I did adjust my incision point slightly, based on what I researched, in case it could make a difference. I started scrutinizing the techniques of nurses who were on the team. I adjusted my recommendations for antibiotic use. I’m still not sure how the infection was caused, but having done the research, I know I’m a good surgeon and am using good techniques.”

She acknowledges that not having control is what eats away at a Type A personality like hers. But it’s simply not possible to control all circumstances or outlying factors that could affect a patient.

“I realized I don’t have a very thick skin,” she acknowledges. “I should have gone into a field with less risk! It’s fine for my patients, because I’m making a big difference for a lot of them—but it’s really hard on me. You have to be okay with what could go wrong beyond your control, while knowing that you are doing everything possible.” **PR**

The How & Why

of the Evergreen Medical Staff Health Wellness Program

By Dr. James D. Brown



The genesis and momentum for putting together a wellness program for EvergreenHealth's medical staff started approximately 18 months ago when drug diversion was discovered, and two valued employees were found to have significant substance-abuse problems.

At that time, our CEO, Bob Malte, first asked the obvious question of why our systems failed to prevent the diversion. His second question was, how did we fail to see that our valued employees and coworkers were struggling? What followed was a focused effort around the questions of substance abuse in health care and how we could identify and help those finding themselves in that situation.

During additional discussions, our medical staff president, Dr. Scott Burks, and immediate past president, Dr. Jack Handley, asked us to make sure we were addressing issues around physician burnout and stress management. In addition, our department chair for obstetrics and gynecology, Dr. Dawn Russell, emphasized the importance of having a strong process to help medical staff members who find themselves in either a professional or personal crisis.

From these discussions, we developed our EvergreenHealth Medical Staff Wellness Program Charter:

Improve patient safety and quality of care by developing a safe and respected program that fulfills our pillars of accountability:

1. Provider impairment and support
2. Provider resiliency/burnout prevention
3. Crisis intervention during difficult times (divorce, litigation, death of loved one).

The goal of this program is to achieve the following:

For medical staff members

1. Focus on medical staff wellness

2. Prevention through education
3. Safe and confidential communication
4. Honest and factual interventions
5. Effective treatment pathways
6. Respectful monitoring processes
7. Effective support for medical staff leadership committees

For the referring party

1. Commitment to follow through on any referral
2. Clear communication on process and disposition of referrals
3. Prevention through education

For the organization

1. Improved safety and quality of care delivered to our patients
2. Integration with the EvergreenHealth Employee Wellness initiatives
3. Effective support for medical staff and administrative leadership committees
4. Compliance with regulatory statutes

INSTITUTING PEER SUPPORT

We have established an EvergreenHealth Practitioner Peer Support Committee comprised of interested members of the medical staff from various specialties, our Chief Medical Officer, and our Vice President of Human Resources. Our first order of business was to develop a set of rules and regulations, as well as bylaws, that would guide and govern the activities of the committee.

In addition, we put together a wellness survey to get a baseline understanding of the overall status of our medical staff with regard to stress and burnout.

MEDICAL STAFF SURVEY HIGHLIGHTS

The survey's quantitative results show us that the vast majority of respondents—82 percent—are satisfied with their practice at EvergreenHealth. Nonetheless, many are experiencing some degree of burnout (41 percent) and are feeling a negative impact of their medical career on their family life (42 percent).

These quantitative results are echoed in the qualitative results from the survey's open-ended questions. The qualitative results suggest that:

- Stressors are large and have a great deal to do with:
 - “Work and family” conflicts and pressures
 - Frustration over the quantity and efficiency of work, with particular concerns over staffing levels and the EMR system
- Despite the stressors, there is a strong sense of community among respondents:
 - The community is now seen as collegial
 - Respondents want even more collegiality in the future

With the benefit of a strong, collegial community, we have the opportunity not only to listen, but also to act. We can look to an engaged medical staff, medical staff leaders, and supportive administrative leadership to assist this process.

EXTERNAL RESOURCES

We also engaged Washington Physicians Health Program and Physicians Insurance to help us understand the scope and challenges of the issues we are facing. The wellness committee as well as our administration elected to contract with Physicians Insurance to help us in several areas.

First was to help the EvergreenHealth Practitioner Peer Support Committee explore its strengths, weaknesses, and the opportunities to develop resources to effectively fulfill our charter. The second area was in developing an initial schedule of educational forums during which Physicians Insurance experts will help our medical staff understand the impact of stress and burnout on their professional and personal lives and begin to understand how to mitigate that impact.

OTHER INGREDIENTS FOR SUCCESS

As with any important initiative, many contributors will ensure our effectiveness. Top administrative support has been present from the beginning. EvergreenHealth's IT professionals will be engaged to support the technology infrastructure imperative to delivering on our goals. We've also enlisted ongoing input from the medical staff we aim to serve. We've learned it is important to “know your audience”—for instance, if the term “wellness” elicits a tiresome groan from providers or sounds pedantic, it's wise to consider other relevant or more apt terms. For us, “peer support” rings true because it is an understood concept; plus, it reinforces continued collegiality and the notion that we're all in this together.

MOVING FORWARD

This effort is gaining significant momentum as our organization creates the space for constructive dialogue about the difficult and frustrating aspects of health care and how they impact us on a personal level. We are moving forward with the express goal of working together to create positive change where we have the opportunity.

While we're pleased to know that our providers can rely upon a sense of collegiality for support, we have a goal of further formalizing that support to avoid the chance that anyone who may be suffering will slip through the cracks. Our providers are highly trained with exceptional skills to help people be well. We need the supportive structure that also keeps them well so they can continue to thrive and put their exceptional skills to use in the patient communities that need them. [PR](#)



Dr. James D. Brown
is an internist/family doctor and former medical staff president and Chairman of the Practitioner Peer Support Committee.



Fighting Back Against Burnout

Where to Turn for Help

By Charles Meredith, MD

“I’m so burned out. I’ve got to get off this unit,” said the social worker.”

What does burnout mean? The term is commonly employed by staff in medicine and other industries, but does it mean anything more than having a bad day? And is it serious? It must be, as this exceptional social worker had tears in her eyes when she shared her statement with everyone in a morning staff meeting. The staff around her quickly realized it wasn’t a complaint. For that individual, it was a crisis.

My social-work colleague was suffering, and she knew it was decreasing her effectiveness at work. We were working in a large, rapid-paced inpatient psychiatric unit with high case volumes, and she felt powerless to impact the homelessness and other external factors that often precipitated our patients’ cycle of frequent re-hospitalization. Gradually this led her to develop a chronic feeling of low personal accomplishment.

Daily hearing patient stories of traumatization left her emotionally exhausted, so that when she went home she had nothing left to give her family, and she felt “checked out.” To protect herself against further emotional injury and feeling further burned out, she began to experience depersonalization. Rather than seeing each patient as an individual, like herself, with a unique story, she began to see them as objects in a queue that she was to move

towards discharge as rapidly as possible. Subsequently, she had moved away from her natural empathy for our patients, and as she worked with the area’s most vulnerable patients, they could sense she had checked out. This led them to feel as if they were afterthoughts, and sometimes it made them angry. They were certainly less likely to engage with her and to trust the strong treatment plans she was still able to design.

Unfortunately for us, burnout is endemic to the practice of medicine—a gratifying but emotionally exhausting profession. Many researchers feel it has increased in prevalence over the last decade, primarily with economic and logistical changes in medicine, resulting in increased patient loads and increased demand for a higher number of clinic visits per day, along with decreased appointment times, decreased autonomy, and decreased control over our external working environments. Other stressors include feeling enslaved by health-care organizations’ focus on competitive ratings in terms of patient wait times, Press Ganey scores, and easily quantified measures of health-care quality, such as smoking cessation rates and vaccination rates.

Several years ago, a survey of American Medical Association members identified the prevalence of burnout in practicing



physicians in the US to be approaching 46 percent.¹ Not surprisingly, the prevalence of burnout in specialties with high volume, rapid-paced care (e.g., emergency medicine) or extended work hours (e.g., general surgery) was significantly higher. Research has consistently shown that the number of hours worked, number of patient visits per day, and call frequency are all correlated with the prevalence of burnout.² For reasons we do not yet understand, burnout is more common among younger providers than it is with senior physicians.

If burnout continues long term, some believe it can precipitate more serious diseases. Burnout is associated with an increased likelihood of meeting diagnostic criteria for major depressive disorder or alcohol use disorders, such as alcohol abuse or dependence.³ It has been associated with increased likelihood of an episode of significant suicidal ideation in both attending level physicians and fourth-year medical students.⁴

Finally, the presence of continued burnout has been shown to increase the likelihood of the affected person making a significant medical error⁵ in the near future. Furthermore, when physicians lose their ability to tap into their natural empathy, patients are less likely to follow their behavioral recommendations. Patient satisfaction scores decrease, as do patients' general health outcomes and their compliance with health-care advice. And unfortunately, over the long term, burnout increases the likelihood

Combating burnout and advancing provider wellness over the next year has become a focus for Washington Physicians Health Program. If you are interested in WPHP's wellness offerings mentioned in this article, contact them at wellness@wphp.org or visit their website for more information. www.wphp.org

that providers will leave the field due to their chronic disillusionment.⁶ This happened with my social-work friend. Sadly for her colleagues, within several months after that memorable staff meeting, she elected to move to a career much different than mental health-care delivery, and she never returned.

NOW THE GOOD NEWS

Research is growing concerning strategies to target burnout. While many physicians have experienced or will experience burnout at some point, the good news is that it is often a transient state. Individuals can do several things to combat burnout, all of which revolve around maintaining a healthy work/life balance. Utilizing vacation time is important, as is having the courage to exercise what control you can over work hours and call frequency. Reflective writing on meaningful clinical experiences and sharing these experiences with colleagues has also been shown to be helpful.

LOCAL NORTHWEST RESOURCES

In addition, multiple researchers have shown that learning and implementing the practice of mindfulness meditation can combat and prevent the development of burnout.⁷ As a result, for the last several years UW Medicine has been offering to its faculty members and their families a free six-week course on mindfulness-based meditation. Read more about mindfulness-based resources on page 28, and see the insert included in this issue on the Physician's Desktop Guide to MBSR.

Individuals who don't have access to a wellness program through their own organizations are now turning to their state physician health program for assistance. Over the last five years, the Washington Physicians Health Program (WPHP) has been assisting physicians who self-refer for burnout, helping them restore their work-life balance and find help through psychotherapy or other means so they



FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS

The Federation of State Physician Health Programs, Inc. (FSPHP), is a nonprofit corporation whose purpose is to provide a forum for education and exchange of information among state programs; to develop common objectives and goals; to develop standards; to enhance awareness of issues related to physician health and impairment; to provide advocacy for physicians and their health issues at local, state, and national levels; and to assist state programs in their quest to protect the public.

The mission of FSPHP is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care. Their Web site offers the following health programs for physicians by state:

IDAHO

Idaho Physician Recovery Network
Southworth Associates
www.southworthassociates.net
(208) 323-9555

OREGON

Health Professionals' Services Program
www.rbhhealthpro.com | 800-922-7009

WASHINGTON

Washington Physicians Health Program
www.wphp.org | (206) 583-0127

WYOMING

Wyoming Professional Assistance Program, Inc.
www.wpapro.org | (307) 472-1222

(Continued on page 35)

Disability Insurance: Your Mental Health Safety Net

By Steve Hoglund

Jennifer thought she had it made. She was a successful pediatrician and a partner in her busy practice. She had two beautiful, smart daughters, along with a husband she adored, who had just launched his own small business.

When her youngest daughter, Sarah, was diagnosed with leukemia, Jennifer felt her perfect world begin to crumble. She took leave from work to stay with her girls and spent many days at the hospital, watching helplessly as Sarah fought for her life. As time wore on amid mounting medical bills, Jennifer and her husband struggled to make ends meet without Jennifer's top earnings. Soon, the only way she could get through the day was by taking increasingly higher doses of benzodiazepines to try to calm the anxious thoughts racing through her head.

It's a mistake to believe that disability insurance is intended only for physical disabilities.

The family endured more than a year of medical ups and downs and, eventually, young Sarah died. After the funeral, Jennifer thought that she might be able to cope better if she went back to work full-time. However, she was often late for appointments, she struggled to remain present during exams, and her prescription drug use was spiraling. Her levels of anxiety and depression were notable, and her patients started scheduling with other providers.

Worried about how Jennifer's condition could damage the practice's reputation, the other partners met with her and requested that she leave the practice. They gave her no other choice. Not long afterward, unable to keep up with mortgage payments, the grieving family lost their house.

While this was a worst-case scenario, situations like this can and do happen, unfortunately, even if they are not this extreme.

Could Jennifer have done anything to prevent this complete collapse? She could have taken more time to grieve, cope, and seek treatment for her eventual depression and drug use. Long-term disability insurance could have given her the money required to remain financially secure, even if she needed to stop working for an extended period of time for recovery. Additionally, Practice Overhead and a Buy-Sell Agreement with her partners would have protected the reputation and value of the practice.

DISABILITY INSURANCE: NOT JUST FOR PHYSICAL INJURY

Discussing mental health is often avoided, even among those who treat it every day. It's easy to believe that if you feel good one day, you will feel good the next, but that isn't always the case.

¹ Principal Financial Group, What if You Couldn't Practice Medicine? Individual Disability Insurance fact sheet, Series 700 (Des Moines, IA: Principal Life Insurance Company, September 2009).





ADDITIONAL INSURANCE RESOURCES

It's also a mistake to believe that disability insurance is intended only for physical disabilities.

According to Principal, a noted national disability carrier, 18 percent of the claims it pays are for disability due to either mental health or to substance abuse.¹

18 percent of disability claims paid by Principal Financial Group are due to either mental health or substance abuse.¹

When depression, stress, and anxiety become disabling—to a level where the insured is unable to work and needs long-term treatment—some forms of long-term disability insurance may cover the insured's time away from work. There are usually waiting periods before coverage kicks in, ranging from 60 to 180 days, but the average waiting period is 90 days. Medical professionals who have this kind of coverage should understand the parameters in case they need to rely upon this income-protection tool.

It's no secret that physician stress levels are high. These high levels of stress are associated with increased rates of burnout, depression, alcoholism, suicide, and medical errors. Physicians struggling with these symptoms may leave the field of medicine entirely, which means that we, as a society, miss out on skilled and experienced providers. The physicians themselves are left with heavy debt that will be more challenging to pay off. How can this all be avoided?

Understanding Your Disability Insurance as a Resource for Mental Well-Being

Long-term disability insurance is a valuable resource that can be tapped during crises in mental health, such as when an individual cannot work for an extended period. Here are a few keys to using this resource appropriately:

1. Does your insurance policy include mental health? It's worth checking your policy right now to see what kind of mental-health coverage you have and to inform yourself about the waiting periods. If you don't have mental-health coverage, contact the Physicians Insurance Agency to ask about adding it.

2. How much mental-health coverage do you have? Many policies offer two years of mental-health benefits, whereas premium policies provide coverage all the way to retirement. Consider your needs and see if upgrading to a premium policy would be a wise choice for you.

3. Do you have a history of depression? Unfortunately, a history of depression could exclude you from some policies. There are other options, however, so contact your insurance broker and talk frankly about your needs.

4. Recognize the signs that mental-health leave may be needed. Identifying the signs, symptoms, and severity of burnout in yourself is perhaps the most challenging aspect of using your disability insurance properly, so it may be worth asking a trusted friend or colleague to let you know if they notice you struggling.

None of us is invincible, and we must acknowledge our limitations. Responsible and judicious use of our resources, including disability insurance, can help us stay on our feet during the times when life seems to be pulling the rug out from under us. Examine your disability insurance policy and to see if you have the coverage you need. 

For more information, please contact Janet Jay at (800) 962-1399 or janet@phyins.com.

In addition to disability insurance, there are other protections that you should put in place in case you need to take any kind of extended leave.

Practice overhead insurance, a form of disability insurance, makes sure that practice expenses are covered in case you are not earning income. For a sole provider or a provider in a small partnership practice, this is a necessity. Replacing a physician is incredibly expensive. The process of finding and hiring a new physician can take up to six months and often costs a practice \$200,000 to \$250,000. With practice overhead insurance, the practice can more easily stay afloat and, hopefully, replacement won't be necessary.

A buy/sell agreement is also a must-have. This type of agreement prevents a physician in a situation like Jennifer's from being "kicked out" of the practice. Regardless of the reason she needed to leave, with a buy/sell agreement in place, the partners would have had to buy her out, giving her the money needed to continue paying bills until she could get back on her feet. Contact your attorney either to create this type of agreement or, if you already have one, to review it and make sure that it is equitable and up to date. Be sure your agreement is properly funded for both death and disability.

Reducing Stress and Burnout through Mindfulness

By Elizabeth Griffin

What you do is amazing. Your work ethic is stellar, and you're highly respected by your peers. But the voice in your head often says it isn't enough. You can't seem to shake the feeling that you should have taken a few more minutes with your elderly patient the other day or that the boy with leukemia would be doing better if you had caught his condition earlier.



This inner dialogue keeps you awake at night, and it's taking a toll on your relationships at home. Sometimes you feel overwhelmed by all there is to do. But worse than all that, you are starting to feel less and less connection with the very people you do all this for—your patients. What's going on? According to the Maslach Burnout Inventory on page 5, you are burned out or close to it.

A NEW VIEW OF STRESS

We all experience stress that can lead to burnout, regardless of our life situation. But according to psychologist, coach, and conflict mediator Dr. Wallace Wilkins, there is a difference between stress and strain, and one of those factors doesn't necessarily have to cause the other.

Wilkins says, "The amount of strain a person experiences in a stressful situation depends on the perspective a person has on that situation. His or her degree of strain can be connected to his or her genetic propensity and personality, or it can be learned behavior. If it's all genetic, then it's nearly impossible to change, but if even 5 percent is learned, he or she can optimize their ability to handle



he would have become angry and depressed when he ultimately did not achieve it. But he didn't demand it. Instead, the aspiration enabled him to do some noble things as a result of his injury. It helped him fix his eyes ahead and accomplish more than he would have otherwise, without demanding a fixed result and getting angry about the outcome falling short.

Wilkins encourages clients to examine these steps and to look for vulnerability when under stress. He asks clients which steps they have overlooked and helps them work on those areas in order to handle stress without strain.

MINDFULNESS AND ITS ROLE IN REDUCING STRAIN

Karen Schwisow, owner of Work Well Northwest, defines mindfulness as “paying attention, on purpose, moment by moment, non-judgmentally.”

“Most of us are completely in our head and disconnected from our body,” she says. “This serves us for the moment but depletes us over time. Mindfulness is the idea of being present to what’s here, right now, as it arises, moment by moment. We are aware of what comes up in our mind, but step back from it and watch it rather than reacting to it. It is teaching ourselves how to respond rather than react.”



stress. It is always possible to retrain ourselves to respond to stress in a way that does not strain us.”

Wilkins lists three steps to reducing strain, regardless of the level of stress in a given situation:

- 1 Accept yourself, the world, and people exactly as they are, without struggle.
- 2 Acknowledge the situation for what it is.
- 3 Strive to improve yourself and the people you interact with without demanding that your efforts succeed.

Wilkins cites Christopher Reeve as an example of this three-step process. When faced with a spinal-cord injury, Reeve accepted and acknowledged what had happened, but he also looked beyond it for change. He aspired to be standing on his 50th birthday and to give himself a champagne toast for overcoming his injury. If he had demanded that result,

Research has shown that mindfulness, when practiced in day-to-day living, reduces stress, anxiety, chronic pain, high blood pressure, sleep disturbances, and other health concerns. According to Carolyn McManus, PT, MS, MA, who gives Mindfulness Based Stress Reduction (MBSR) training to physicians, as well as patients—including veterans—who are chronic pain

(Continued on page 28)

(Reducing Stress and Burnout, Continued from page 27)

sufferers, research proposes that mindfulness increases four essential abilities worn down by stress:

- Attention regulation, which results in improved performance on executive-attention tasks; when given a lot of information, those who practice

instead of being hard on yourself and quick to find fault.”

Living in the present moment has a bad reputation in our culture, according to McManus.

“We feel it’s not enough; we have

“Living in the moment doesn’t mean we throw out the to-do list. It means we allow ourselves to rest in the present moment with self-kindness and compassion.”

CAROLYN MCMANUS, PT, MS, MA

MBSR are better able to stay focused on what’s most important

- Body awareness, which helps with regulation of the nervous system
- Emotional regulation, which increases non-reactivity to situations and the ability to reframe things in a more positive framework
- Change in perspective of self so we realize our bodies and emotions are in a constant state of flux, and we see our lives as more fluid than stagnant, causing us to be open and more flexible toward ourselves and others

PRACTICING MINDFULNESS

McManus narrows the practice of mindfulness to two basic steps:

- 1 Take a slow, deep breath
- 2 Pay attention to yourself as you would a good friend

“Our instinct is to prepare for fight or flight when under stress,” she says, “and that’s not adaptive to the complex structures of modern life. The amygdala gets activated under stress, and that impairs executive functioning, so it’s valuable to be able to self-regulate this reaction. Mindfulness trains us to focus on what’s happening in the present moment. Notice how the body is reacting, and respond to it, with a mind that is stable and open, friendly and kind—feeling good will,

to keep running and achieving. But living in the moment doesn’t mean we throw out the to-do list. It means we allow ourselves to rest in the present moment with self-kindness and compassion,” she says.

Wilkins adds, “Practice never did make perfect; practice makes permanent. People have been practicing their anxiety-producing thinking patterns, and that’s what makes it hard to unlearn. But you can also practice self-soothing and personal mentoring thoughts and make those permanent. It’s a little awkward during the transition, but the more you practice, the better it will be.”

Mindfulness can be practiced anywhere, at any time. Here are a few specific ways to build it into your day:

 When you wash your hands, focus on the sensations of soap and water and allow your mind to let go of the rest of your day.

 When you wait for an elevator to arrive, a meeting to begin, or while in line at the store, take slow deep breaths and check in with what your body and mind are telling you. Are your shoulders up around your ears? Are you replaying critical tapes about your work performance? Use this as a time to mentor yourself with kindness and compassion.

 Before going into a patient’s room, pause to take a slow, deep breath and let go of the previous patient with well wishes so you can be fully present for the one you are about to meet.

 End the work day with a routine, such as hanging up your stethoscope and mentally wishing your patients well. Let that be a signal to leave work behind.

 Drive mindfully, keeping your thoughts focused on the road and concentrating on the feeling of your hands on the steering wheel instead of thinking back to the day or forward to the future.

 Focus on your body as a means of anchoring yourself to the moment instead of being preoccupied with the past or future.

Other practical tools for mindfulness include walking a bit between patient visits during the day; yoga or tai chi; listening as well as you can to another person, noticing how you want to interrupt, and not allowing yourself to do so; being aware of what you are eating and enjoying every bite; being fully present for that first sip of coffee in the morning; sitting meditation; and doing a body scan where you focus on each part of your body from your feet to the top of your head, noticing how each part feels at that moment in time.

“In these ways, mindfulness becomes a habit all day long, and you begin working and living from a place of responding rather than reacting,” says Suzanne Green of Work Well Northwest.

LOVING-KINDNESS TRAINING AS AN ANTIDOTE TO BURNOUT

A specific type of meditation that can help mitigate burnout is called loving-kindness or metta meditation. It is a way to strengthen both compassion and inner reserves so a practitioner can be empathetic without burning out from taking on the burdens of his or her patients’ emotions.



“In one of our classes a physician said, ‘I can’t be empathetic with everyone who walks through the door. It will kill me.’ But he also felt guilty for not caring about his patient’s pain,” Schwisow says. “With empathy I might take on your pain, but mindfulness teaches me to step back and observe it; to be with a person in their pain and witness it, as well as my own pain; and rather than getting swept away with it, just being with it. When I learn mindfulness, I don’t have to disconnect from your pain to protect myself.”

Loving-kindness meditation involves offering heartfelt wishes for the well-being of yourself and others. Practitioners use phrases such as, “May you be safe, healthy, and at ease. May you be happy.” Green describes it as a progressive meditation during which you wish this first for yourself, then for someone who is easy to love, then for a close friend or family member and a neutral person, and finally for someone who is difficult for you to love.

After one of McManus’s clients practiced loving-kindness meditation, he gave this report:

My son didn’t get on the baseball team

he wanted to be on, so he was crying and really upset. Usually I would have told him to stop crying and look at how fortunate he was to get to play baseball at all. But instead, I focused on my own breath and realized that I was in pain because my son was upset. I wanted him to stop crying so I could get away from my own pain. When I realized that, I just kept breathing and stayed with him. I said, “I can see that this has really disappointed you. I’m so sorry about that.” It turned out to be a wonderful moment of connection instead of ending in frustration.

In another situation, a participant in a nine-week mindfulness training at St. Francis Hospital in Federal Way encountered an abusive patient in the emergency room. By taking slow deep breaths and being mindful of her own responses, she was able to remain calm and kind toward the person. Later, security guards said they were impressed at how her responses prevented an escalation of the situation.

Comparing initial responses to a survey given at the end of the course at St. Francis Hospital, it was found that in the 17 emergency medicine participants, emotional

exhaustion dropped by 23 percent, depersonalization dropped by 25 percent, and personal accomplishment scores went up.

RESPOND RATHER THAN REACT

Mindfulness reduces strain and burnout by giving those who practice it the tools to better control their nervous systems through diaphragmatic breathing. It gives them the ability to respond rather than react to those around them as they learn to listen to their bodies and thoughts, and mentor themselves as a good friend.

“Just stepping back stops the cascading slide of events that happen in the body when we are stressed,” said Green. “Mindfulness helps us step back and not go there. The better we get at observing our body’s reactions, the better we are at cultivating a healthy response from ourselves.” 

Individual coaching and classes in Mindfulness Based Stress Reduction are offered by Carol McManus and Work Well Northwest. Individual coaching with Dr. Wallace Wilkins is also available. For more information, visit www.workwellnw.com, www.carolynmcmanus.com, and www.take-risks.com.

RESOURCES FOR RESILIENCE

All CME is offered at no charge to our members

ON-DEMAND VIDEO



Empowering Patients: Tools for Effective Partnership and Behavior Change

Featuring Baruch Roter, MD

"I run out of breath just walking to the bus stop," says Michelle. "It's been like that ever since I started on the diabetes pill. I'm fed up with that pill!" She's been your patient for years, but time never allows for a conversation about her increasing weight or aversion to checking blood-sugar levels. Now you notice that her hypertension is also edging into the danger zone.

This 1-hour video course demonstrates how to engage patients, within the timeframe of a regular office visit, as active participants in their care. You'll learn motivation techniques by observing them in use during the patient interview, along with ways to reduce your frustration with challenging patients. See how the patient-provider partnership can develop into an essential process to improve outcomes and reduce costs. This activity approved for *AMA PRA Category 1 credit™*.



Baruch Roter, MD is a family physician who teaches patient-centered care as a Clinical Associate Professor at the University of Washington School of Medicine. He worked for 25 years in a community health center and has taught since 2007 to help clinicians live and work with greater ease and happiness.

www.phyins.com/CME

PUBLICATIONS



The following white papers, blog articles, and CME resources are available on our Web site at www.phyins.com/providersupport.

WHITE PAPERS

- Reducing Clinician Burnout
- The Value of Provider Support

TAKING CARE BLOG ARTICLES

- Promoting Patient Safety and Provider Support through Just Culture
- Halting Clinician Burnout to Increase Resiliency
- Taking a One-Minute Timeout to Improve Medical Skill and Help Patients
- When a Physician Is Devastated by the Loss of a Patient
- Let the Healing Begin: Caring for the “Second Victim”

RELATED CME

- **Adverse Event Response Team (AVERT) Program Training** – This 2½-hour training offers a groundbreaking, experiential education to ease the traumatic effects of a poor outcome, enabling clinicians and/or organizations to address the needs of patients, families, caregivers, and facilities.
- **Provider Support: Ensuring Effective Support after Adverse Events** – This on-site program raises awareness around the emotional impact of adverse events on the health-care team. Contact us to schedule.
- **Don’t Leave Me Standing Here Alone: Making the Case for Peer Support** – This self-study program enables providers to recognize the impact of adverse outcomes, to access appropriate support when needed, and to administer emotional first aid to peers.

NEW CME

ON-DEMAND VIDEO

No Perfect Answer: Partnering for a Shared Decision

Designed for physicians of all specialties and affiliated health-care professionals



This 1-hour course incorporates videos contrasting a patient visit using the traditional approach with the same visit using shared decision-making and decision aids. The course includes a dynamic presentation on the principles of shared decision-making by Dr. David Arterburn, a pioneer in research and use of decision aids. This activity approved for *AMA PRA Category 1 credit™*.

ON-DEMAND VIDEO

Causes and Consequences: Malpractice Issues in Radiology

Designed for radiologists and affiliated providers



In this 1-hour webinar, Dr. Jeffrey Robinson will help radiologists better understand the types of errors typically being made. He will also provide tools and technology strategies to help prioritize findings and improve documentation and communication between referring providers. The net effect, ultimately, is to provide better, safer care to patients. This activity approved for *AMA PRA Category 1 credit™*.

TO SUBSIDIZE OR NOT TO SUBSIDIZE

King v. Burwell



On June 25, 2015, the US Supreme Court ruled, with a 6 to 3 vote, that the Internal Revenue Service (IRS) may promulgate regulations to extend tax-credit and cost-sharing subsidies to coverage purchased through exchanges established by the federal government under Section 1321 of the Patient Protection and Affordable Care Act (ACA). The majority was written by Chief Justice Roberts, joined by Justices Kennedy, Ginsburg, Breyer, Sotomayor and Kagan. Justice Scalia wrote the dissent, joined by Justices Thomas and Alito.

For Washington and Idaho this ruling has little if any impact because they have state-based health insurance exchanges. For Oregon, a federally supported state-based health exchange, this ruling means that individuals will be able to continue receiving subsidies to purchase health insurance through the federal market.

In simple terms, the ruling holds that regardless of whether you live in a state that has its own exchange (Washington and Idaho) or in one of the many states (Oregon) with a federally supported exchange, you are entitled to the federal tax credit. Chief Justice Roberts stated in the opinion that “Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter.”

“Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter.”

CHIEF JUSTICE ROBERTS

KING, ET AL. V. BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL

This case is truly about six words in the Patient Protection and Affordable Care Act: “an exchange established by the State,” challenging that the Internal Revenue Service regulations allowing tax subsidies in a federally supported exchange was in violation of the Act. The dissent argued that the Court improperly held that when the Patient Protection and Affordable Care Act says “exchange established by the state,” it means “exchange established by the state or the federal government.”

If you qualify for the tax credit, you will get it, regardless of whether the exchange was set up as a state-based, federally supported, state-partnership, or federally facilitated exchange.

Under the Patient Protection and Affordable Care Act, states were required to have a health-benefit exchange in place by January 1, 2014. If the Court had ruled in favor of the plaintiffs, an estimated seven to nine million Americans in 34 states, including Oregon, could have lost federal assistance in paying for health insurance because those states have not set up state-based health exchanges. Washington and Idaho are two of the very few states that have developed and implemented state-based health exchanges as permitted by the Patient Protection and Affordable Care Act.

The impact of the decision: The Patient Protection and Affordable Care Act will remain intact. If you qualify for the tax credit, you will get it, regardless of whether the exchange was set up as a state-based, federally supported, state-partnership, or federally facilitated exchange.

As a result of the decision, many people will retain their health insurance and access to health care. Physicians Insurance works to improve community health and access to health care while promoting a sustainable and efficient health-care system that supports physicians and the patients they serve. 



To see the case syllabus, visit

www.supremecourt.gov/opinions/14pdf/14-114_qol1.pdf



For more information on Physicians Insurance's Government Relations and Community Outreach Program, contact



Anne E. Bryant,
Senior Director of
Government Relations
Anne@phyins.com

WASHINGTON: 2015 MEDICAL MALPRACTICE ANNUAL REPORT



The Washington State Office of the Insurance Commissioner recently posted the 2015 Medical Malpractice Annual Report at:

www.insurance.wa.gov/about-oic/commissioner-reports

OREGON: CALL FOR NOMINATIONS FOR PUBLIC HEALTH ADVISORY BOARD



The Oregon Health Authority (OHA) Public Health Division is seeking nominations of individuals interested in serving on the state Public Health Advisory Board. Learn more at:

<http://public.health.oregon.gov/About/Pages/ophab.aspx>

WELCOME TO OUR NEW MEMBERS!

Columbia Memorial Hospital, Astoria, OR
Diagnostic Imaging NW, Portland, OR
Emergency Specialists of Oregon, Newberg, WA
Family Foot Center, Spokane, WA
Grays Harbor Community Hospital, Grays Harbor, WA
Grande Ronde Hospital, La Grande, OR
HealthSource Partners Idaho, Lewiston, ID
Modern Dermatology, Seattle, WA
Mount Rainier Emergency Physicians, Puyallup, WA
Northwest Eye Surgeons, Seattle, WA
Rainier Internal Medicine, Puyallup, WA
Salem Emergency Physicians, Salem, OR
Si Steinberg PA, Boise, ID
Syringa Hospital and Clinics, Grangeville, ID
South Lincoln Medical Center, Kemmer, WY
Summit Urgent Care, Bellevue, WA
Three Rivers Hospital, Brewster, WA
Viewpoint Medical, Puyallup, WA
Whidbey General Hospital, Whidbey Island, WA

Trial Results



The following summaries are Physicians Insurance cases that have gone to trial and are public record. In reporting these legal results, it is our goal to inform members about issues that impact health-care professionals. While we share information we think may be informative, we choose not to disclose the names of plaintiffs or defendants when reporting these results.



Lack of Informed Consent/ Improper Performance

SPECIALTY: General Surgery

ALLEGATION: A 52-year-old male alleged lack of informed consent and improper performance of a low anterior resection. The patient had undergone a screening colonoscopy, at which time three polyps were removed. One of them, a well-differentiated adenocarcinoma, had invaded the superficial submucosa and had a negative margin of .8mm. Anastomosis couldn't be achieved at the time of surgery, so the patient had a temporary colostomy, which was successfully reversed. The pathology from this surgery showed no evidence of residual cancer or cancer spread. The plaintiff argued that meant surgery was never indicated. The patient claimed altered bowel habits affecting his quality of life and ability to work. The plaintiff claimed past and future medical expenses, past and future wage loss, and general damages.

PLAINTIFF ATTORNEY: Nathan Roberts and Anna Price, Connelly Law Offices, Tacoma, WA

PLAINTIFF EXPERTS: Joseph Scoma,

MD, Colorectal Surgery, San Diego, CA; Peter Wasserman, MD, Oncology, Seattle, WA; Bennet Omalu, MD, Pathology, Lodi, CA; Anthony Choppa, MEd, Life Care Planner, Seattle, WA; Christina Tapia, PhD, Economist, Seattle, WA

DEFENSE ATTORNEYS: John Graffe, Johnson, Graffe, Keay, Moniz & Wick, Seattle, WA and Tim Allen, Bennett, Bigelow & Leedom, Seattle, WA

DEFENSE EXPERTS: Edward (Chip) Freimanis, MD, General Surgery, Renton, WA; Mark Welton, MD, Colorectal Surgery, Stanford, CA; James Cunningham, MD, Oncology, Walla Walla, WA; Emily Volk, MD, Gastrointestinal Pathology, San Antonio, TX; Brian Fennerty, MD, Gastroenterology, Portland, OR; Charles Blanke, MD, Gastrointestinal Oncology, Portland, OR

RESULT: Defense Verdict. Thurston County Superior Court, Judge Wilson

Failure to Diagnose

SPECIALTY: Radiology

ALLEGATION: The estate of a plaintiff alleged failure to report a pulmonary nodule

on a kidney-ureter-bladder (KUB) CT scan obtained in 2008 when the patient presented with symptoms of a urinary tract infection. In 2011, the patient presented with lung symptoms, was diagnosed with metastatic lung cancer, and subsequently expired in 2012. Interestingly, a PET scan in 2009 for other reasons was negative. The estate claimed medical expenses and general damages.

PLAINTIFF ATTORNEY: Thomas Golden, Otorowski, Johnston, Morrow & Golden, Seattle, WA

PLAINTIFF EXPERTS: Randall Patten, MD, Radiology, Olympia, WA; Howard West, MD, Oncology, Seattle, WA; Steven Rostad, MD, Pathology, Seattle, WA; Richard Whyte, MD, Cardiothoracic Surgery, Boston, MA

DEFENSE ATTORNEY: Aeff Street and Brad Piscadolo, Hodgkinson Street Mephram, Portland, OR

DEFENSE EXPERTS: Tim Larson, MD, Radiology, Seattle, WA; Jonathan Berlin, MD, Radiology, Chicago, IL; Rodney Pommier, MD, Oncology, Portland, OR; Mark Wick, MD, Pathology, Charlottesville, VA

RESULT: Defense Verdict. Kitsap County Superior Court, Judge Hauser

Improper Treatment

SPECIALTY: Obstetrics

ALLEGATION: The estate of a newborn male alleged failure to urgently deliver a term infant after a non-stress test was performed on the mother due to a lack of fetal movement. The non-stress test was not reassuring but was not ominous. The pregnant mother was asked to return to the clinic within hours for a biophysical profile when the technician would be available. The biophysical profile found no fetal breathing or gross fetal movement, among other concerning findings. The results were discussed with the patient, and she was advised that an immediate delivery by cesarean section was possible. The patient was instructed to report to the labor and delivery unit at the hospital. The patient went home to arrange care for an older child, and when she presented at the hospital, a fetal demise had occurred. The estate claimed future economic loss and general damages.

PLAINTIFF ATTORNEY: Derek Radtke, Phillips Law Firm, Renton, WA

PLAINTIFF EXPERTS: Harold Zimmer, MD, Obstetrics, Bellevue, WA

DEFENSE ATTORNEYS: Amy Forbis and Jennifer Churas, Bennett, Bigelow & Leedom, Seattle, WA

DEFENSE EXPERTS: Nancy O'Neill, MD, Obstetrics, Spokane, WA; Beth Sanford, MD, Obstetrics, Tacoma, WA; Trevor Macpherson, MD, Pathology, Pittsburgh, PA; Intestinal Oncology, Portland, OR

RESULT: Defense Verdict. King County Superior Court, Judge Rogof. [PR](#)



(Fighting Back Against Burnout, Continued from page 23)

can regain the joy they once felt in the practice of medicine. WPHP has also been offering mindfulness workshops around the state for physicians interested in building an individual wellness practice to protect against the advent of burnout. Physicians' significant others are also welcome to participate. Like the UW mindfulness offerings, registration fees for these five-week workshops are heavily discounted compared to what they would cost attendees in the general community. WPHP will likely hold five to seven additional workshops in 2016.

Lastly, WPHP is piloting a new mindfulness offering in Compassion Cultivation Training (CCT) in October 2015. Designed at Stanford University by a multidisciplinary team of neuroscientists and psychologists, CCT draws originally from compassion practices found in Tibetan Buddhist traditions and trainings. While prior mindfulness training is not mandatory to benefit from CCT, this workshop builds on mindfulness practices to improve resilience, well-being, and tolerance of challenging individuals, feelings, and situations. Individuals working in high-stress environments or with high-stress problems outside of their direct control have reported benefit from CCT workshops. These individuals include trauma victims, PTSD patients, cancer-support community groups, hospice staff, and various health-care groups in Southern California. [PR](#)

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