About half of practicing physicians suffer from burnout, which impacts productivity, morale and quality of care. Organizations must respond to factors leading to physician burnout because a healthy care system that eases stressors can lead to healthier physicians.

In an episode of the “AMA Moving Medicine,” Michael Tutty, PhD, group vice president of Professional Satisfaction and Practice Sustainability at the AMA, provides an overview of the AMA’s efforts to reduce physician burnout, which focuses on organizational and national changes.

This episode of “Moving Medicine” was the first of a three-part series from a talk on physician well-being originally presented at the 2018 AMA Interim Meeting. Below is a lightly edited transcript of that presentation.

You can listen to the whole episode on Apple Podcasts, Google Play or Spotify.

What we know

So, what do we know about burnout? In 2011, there was a national study, using the AMA Masterfile which includes not only physicians who are AMA members, but all the physicians in the country. The study showed that the percentage of physicians experiencing at least one symptom of burnout was 46%.

That increased to 54% in 2014.

We do this study every three years. We did it in 2017. It’s been accepted for publication and should be published in the next six-to-eight weeks. (Editor’s note: The article was published. Learn more, “New survey shows decline in physician burnout.”)

Everyone’s burnt out. Everyone’s really busy. We all have our phones in our pockets. We work all the time, but compared to the general working population, you can see that physicians experience
burnout almost double that of the general working population.

In our most recent paper, we decided to break up the general working population to look at people who have PhDs or more advanced degrees to see if that made a difference. But no matter how you slice it, physicians experience burnout more than the general working population. So we know there’s something unique about being a physician.

So what causes dissatisfaction? There’s been a lot of research around this. And I’ll highlight a few of the studies.

One is EHRs and CPOE and the amount of time spent on clerical tasks, doing documentation; the electronic health record increases burnout. More time doing after-hours documentation—and I’ll present more about that—leads to burnout. And if you have more administrative duties. What’s common about all of these things? What’s the commonality about all of these? Exactly! No patient focus. It’s all the things that take away from providing high quality patient care that is the frustration.

If you work in an environment where you have high stress, low work control, you have minimal control over your environment, and low values-alignment with your leaders—meaning you feel differently about your personal values than the organization you work for—you’re more likely to be burned out.

And this last study is very interesting: perceived ability to manage workload. It’s not the actual number of hours that physicians work, but the perceived ability to manage workload that increases burnout.

In 2015–2016 we did a study where we worked with medical students from Dartmouth. We had them go out to four different specialties at different practices, and we had them follow physicians all day long. They used a little app that says what the physician is doing, who are they interacting with, what activity are they doing. And we collected that observational data.

This study, which was published in *Annals of Internal Medicine*, showed that for every hour physicians were spending doing direct patient care, they’re spending nearly two additional hours doing administrative and EHR work and doing another one or two hours of work at home on administrative work.

Now is that a surprise to anybody? Everyone thought that resonates. And everyone’s probably thinking, "Michael, why did you invest money to do that study? We all could have told you that information."

But it is important to get this type of research in peer-review journal publications because it gives us the evidence when we are talking with health care leadership. It gives us the evidence when we’re talking with insurance executives.

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There was a follow-up study done by my colleague Chris Sinsky in Wisconsin with family physicians. Every time you click into the electronic health record, and every time you log in, that creates a data record. They were able to extract three years of Epic data out of this system to really track what physicians were doing. Family physicians were working an 11.4-hour work day; 5.9 of those hours were spent in the electronic health record—5.9, 11.4. Most of that—a big chunk of the administrative time—was clerical work.

What's also interesting, if you've seen this, the access here at the bottom is the hours of the day. So it's midnight back to midnight. And the percentage of working on the EHR. If you look over between 8 a.m. and 6–7 p.m. you see a spike when people are documenting during the week. During weekdays, the solid line. But if you look at the dotted lines, weekends, you're seeing a huge spike of documentation at 10 p.m. on weeknights. People are spending their evenings not with their significant others; they're spending their weekend evenings doing documentation.

Does that resonate with anyone at all? Is anybody going to be doing that this weekend? Some evening documentation? And so obviously this issue with the EHRs is a big one.

So why does it matter? We know that physicians have burnout levels that are higher than the general working population even when you slice that by different professions. We talked about some of the causes. But why does it matter?

It matters, and there's been a number of studies, this top one is a very interesting one where they actually asked patients, from the time they got discharged, very subjective questions like, “How many days did it take till you felt better post-discharge?”

And then they looked at the physicians who were treating them and looked at their depersonalization scores and burnout scores. With physicians who had higher depersonalization and burnout scores, their patients took longer for recovery even after you adjusted for severity of illness and other demographic factors.

There's something about that human interaction, that human connection, which I think all of us worry about with the electronic health record, that we're so focused on the technology and not the human and clinical interaction which is so important.

Obviously if you're more burned out, you're going to have lower patient satisfaction scores, lower health outcomes. It can increase costs.

We did a study looking at physicians who were going to leave the profession. Those who are burnt out, one in five, will reduce their schedules. Although that does work—there is evidence that if you reduce your schedule that can be a coping mechanism for dealing with burnout—about one in 50 are
going to leave the career.

The other thing we've been doing is looking at the cost of burnout. Particularly, we're meeting with hospital CEOs or financial executives who for some reason don't get all the other stuff we just talked about, why it's important to address burnout, and putting a financial dollar behind it.

It costs their organization between a half a million and a million dollars to recruit and replace a physician. When you talk about recruiting costs, credentialing, obviously billing up a patient panel takes more time than someone who's an established physician—there's a cost to the organization. So we built this interactive calculator, which is on STEPS Forward™, that allows you to put in burnout rate turnover and figure out what it costs your organization. This is very eye-opening.

So how do we change? We're going to change with awareness and commitment, and I would argue since the AMA's been involved in this since 2013, the awareness of this issue is rising. It seems like I am at many, many specialty and state associations talking about this issue and many of them are doing a number of great projects. The National Academy of Medicine has created a health care professional project to look at burnout in the health care professions.

So where are we focused at the AMA? I think there are three ways to focus on this issue. One is the individual. Giving the individual skills to deal with environments. Many might think of yoga or mindfulness, wellness. Then there's the organizational changes. What can you do in your practice, your organization, your hospital? And then there are just these large problematic U.S. health care system issues that are going on.

We at the AMA have focused very much on the organizational and U.S. health system issues. Not that individual solutions aren't important, but we focused on the organizational and U.S. health systems for three reasons.

One is the evidence shows that organizational changes will do more to address burnout than individual, what I would call coping mechanisms: yoga, mindfulness, wellness programs. Not that they're not important, but if you actually change the work environment—surprise, surprise—that might do more than telling someone to do some yoga on their own time and then come back into a chaotic work environment.

Second is we're a national organization and, obviously, doing these things at a local level would be hard for us to scale. Although I know a number of county medical associations are offering psychologists and psychiatrists, so you can go and get treatment outside of your health system without people in your health system knowing, or if you're in a small practice having that resource. And I think that's great at the local level.

Third, and we actually heard this from hospital executives who were sort of forward-thinking and
thought they were doing a good thing, hearing about this high burnout level saying, "We're going to offer a wellness program. We're going to offer yoga or mindfulness."

But when they implemented that how physicians receive that is, "You're blaming us. Right? It's our problem." So we don't want to reinforce that issue, which is why we focus on the organization and environmental issues because physician burnout is a symptom of system dysfunction, and we need to fix the system dysfunction.

I'll just highlight a couple of the things we're doing. We're doing a lot more than this. But at the organization level we did launch something in 2015 called STEPS Forward. There are about 50 modules, activities you can do in your practice to create a more efficient work environment that can eliminate some of the administrative hassles. There's checklist tools. That calculator I showed is on STEPS Forward.

You can just go to stepsforward.org and see that content. Every module has a little deck, if you want to just download that and present it to your colleagues at a staff meeting.

But what we really need to be doing is spending more effort on researching practice solutions. We have a lot of research on the frequency, the causes. We don't need another study that says physicians are frustrated with their EHR.

We have a lot of research on the impacts, but we need to have more research on what works, what practice interventions create a better work environment. And to that end, I'm happy to report the AMA board is supporting us in a multi-million dollar effort over the next few years that we're going to be putting out a call for organizations who are willing to implement a practice intervention with pre- and post-measurement around that quality of care, with the satisfaction of the care team so that we can see what types of interventions create a better work environment. So, there's more to come on that.

And I'll just end with some of the examples for the U.S. health care system. One of the big things is EHRs. This past summer we did a study comparing Epic and Cerner. We created standardized use cases, like prescribe a taper dose of prednisone. And what you saw could be a 5x or more difference in the number of clicks in the time it takes to do that even though they're the same company products at different implementations.

But there's also this new wave of technologies going on. Software with artificial intelligence. All new hardware, sensors and the infrastructure with high speed internet access that is happening. And if you've gone to a tech conference recently, it is mind-blowing some of the technologies that people are working on in health care.

I was at one recently and this woman from the main stage—3,000-4,000 people in the audience—was presenting this technology, and she proudly said, "And you can access health care without seeing
your physician!"

And I said, "Oh dear! That doesn't sound appealing to me."

So, we've got to work and look at that. And we have a lot of initiatives going on from our innovation studio that the AMA runs. It's a wholly-owned subsidiary called Health2047 in Silicon Valley. But I'll point you to two that I think would be very interesting is we have a physician innovation network that connects physicians with innovators.

We have a relationship with the health care incubator—Matter—in Chicago which boasts about 200 startups that are always looking for physicians to help test their products.

We used to do it by making human-to-human connections, but that wasn't scalable, so we have this Physician Innovation Network, which we're going to be expanding to other incubators that allow physicians to connect with tech startups. They may be looking for a board member, they may be looking for a review of their product—we'll be doing that matching service. And we also have a new digital health playbook for practices to help assess how to implement new technologies like patient remote monitoring in your practice.

There's a lot of work going on there. We are really focused on trying to create a better work environment for physicians that is very supportive of mindfulness, wellness and those types of things, but it's important that you get involved in your organization. Obviously you're getting involved with the AMA, which is key for us to move the trends and move the organizations that are making it more difficult for you to practice medicine. So I thank you for your involvement.

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