

PRESIDENT'S COLUMN

Practice (still) Imperfect: Can your clinical team help protect you from burnout?

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Almost three decades ago, as I was preparing to begin work for the National Health Service Corps at a community health center, I read Kurt Kroenke's paper "Ambulatory Care: Practice Imperfect," which describes how primary care physicians can approach the imperfect process of a clinic visit. To paraphrase, he said that time is short, problem lists are long, and patients have chronic problems and immediate needs, requiring us to set priorities and address tasks over time. "First things first" was one of eight patient-centered principles he suggested we consider as we entered the clinic fray.¹ In clinic we could address problems over time; we weren't required to do everything in one visit. In fact, my mentor Bryant Kendrick would frequently ask residents, "How much time do you have to take care of patients in clinic?" In response to the typical "30 minutes," he would say, "No. You have three years!" Both advocated for a long-term view for addressing our patients' needs. Since then I have abided by the principles set out by Dr. Kroenke as I have continued to see patients in clinic despite my evolving academic roles.

However, over the last few years I have felt increasing trepidation as I approached clinic days. I love seeing patients, so why had I become unsettled by clinic? Then with the recent electronic health record (EHR) conversion, I really began to dread my clinic! I spoke to other faculty and colleagues; it was worse for them—more clinic, more stress! We invited SGIM leader Mark Linzer,

MD, to come to the Medical University of South Carolina, and using audience response during grand rounds, he demonstrated a high rate of stress and burnout among generalist faculty. We discussed stress and burnout at the SGIM annual meeting and within the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM), and we all agreed it was a major problem and plan to assess its prevalence in academic general internal medicine. The American College of Physicians has decided to look at the issue of stress and burnout in practice as well.

Let's concede that a lot has changed in the 28 years since "Practice Imperfect." The patients we care for are on average older and more complex. The time allocated to visits has shortened, and there are more clinical tasks (both routine and urgent), more guidelines, more medications, and especially more measures of the care process. Regulatory reporting requirements and the dramatic practice changes precipitated by the EHR have caused great dissatisfaction for physicians in practice.² We face more clinical documentation; order entry; the dreaded "in basket" with patient e-mails, lab results, imaging, and consults; and complex and tenuous care transitions. For many clinicians, the care process is confounded by seemingly meaningless mouse clicks and frustrating EHR idiosyncrasies. Hammered with RVU tallies, quality metrics, and patient satisfaction measures, many internists—ambulatory care and hospitalists—find time has become the

enemy. No longer do we have the luxury of putting off tasks—the work needs to be done *today*. So we as professionals tend to sacrifice personal time to make sure patients get the care they need. We bring work home, finish our notes after the kids go to bed, and end up checking the "in basket" on weekends and days off.

Unfortunately, this highly professional response to an increasing workload is also a prescription for stress and burnout. Physician burnout affects women more often than men and leads physicians of both genders to leave practice. Those who remain frequently provide lower quality care despite their best efforts.³ And when learners see stressed faculty in clinic or in the hospital, they think twice about generalist careers.

What do we do to reduce stress and burnout? Several authors have proposed short- and long-term interventions to reduce stress and burnout in order to help make practice enjoyable again.^{4,6} All start by acknowledging that we are increasingly stressed and that many of our colleagues have symptoms of burnout. They posit changes to the practice environment including more effective care teams. Although we remain ultimately responsible for patients' care, we can no longer do all the work. We need to explicitly trust our team members and rely on them to complete many of the important care tasks. SGIM and other professional organizations are working to define and explicitly allocate the work

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needed to care for patients in our environments: urgent access to care, care coordination and transitions, high-risk medication management, in-basket management, medication reconciliation, and many more. Others are working to determine which tasks are appropriate for specific team members, including administrative assistants, medical assistants, nurses, advanced practice providers, pharmacists, social workers, and mental health professionals. This is work critical to achieving acceptable work-life balance for general internists, and many questions remain: What training is necessary to ensure that team members have the knowledge and skills to function as a high-reliability team? What leadership skills do we need? What information system tools will identify and assign high-risk patients to our team members, and how many patients can they follow? Finally, how do we pay for teams under new payment models such as the medical home and the accountable care organization?

One principle has not changed in the 28 years since "Practice Imperfect": first things first. In providing the best care we can for our patients, we also need to care for ourselves and our colleagues. One critically important ingredient in achieving this goal is how we train, trust, and rely on our care teams. Ultimately, we need a long-term strategy for addressing our personal and professional health within an increasingly complex delivery system caring for increasingly complex patients.

References

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