Healing Physician Burnout

Diagnosing, Preventing, and Treating

Quint Studer
in collaboration with
George Ford, MD
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It is provided as a sample of the book’s content in order to give the reader a sense of what the actual book is like.
This book is dedicated to all the physicians past, present, and future who have been, and continue to be, the lifeblood of healthcare.
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This is a book about burnout, but it’s also a book about physician engagement and alignment. I find that burnout and engagement are opposite ends of the same spectrum. When physicians are engaged, they won’t burn out, and when they do burnout, they’re not engaged. And that’s why this book is filled with tactics that health system leaders can use to proactively engage physicians to avoid burnout—as well as to ensure that everyone is working toward the same goals. Physicians deserve a positive work environment. This book is about helping to make that happen while shining a bright light on the burnout causes.

Many of the tactics in this book have been around for a while. And yet, despite sincere efforts, many physicians still are frustrated in their work. One might wonder why that is. Why, if those tactics are good and have been around for some time, aren’t they being practiced more consistently? My theory is that previously the time wasn’t...
right for making physician engagement and alignment work. Now, the time is right.

I bring this up early on because I don’t want anyone to read this book and think healthcare system leaders have not thought about physician engagement and alignment, or that it has not been a priority. It has been. In fact, in the late 1980s or perhaps it was the early 1990s, I remember reading a book on the need to create fully vertically integrated healthcare systems. However, the payment system in many ways just did not support hospital and physician alignment.

At What’s Right in Healthcare®, Studer Group’s annual conference, every year a few healthcare system leaders present on physician engagement and share their physician satisfaction survey results and steps they’ve taken to improve results. However, obviously, the tactics these leaders describe have not been implemented as well as everyone would like. Why? In the simplest terms, it’s because the healthcare payment system had always been set up to make physician and health system alignment very difficult.

So what has changed? For one thing, value-based purchasing has become a reality. For another, there are many, many more physicians employed by healthcare systems than there used to be. Now these physicians are part of the system in a way that they weren’t before. Even the ones who are not employed by a healthcare system will be connected to the healthcare system through an accountable care organization, or managed care contracting, or
population health management, or medical homes. All of a sudden, we all have skin in the game.

In the past, that wasn’t true. One might read a physician satisfaction survey, and, of course, want to get everybody engaged, but the payment system would sometimes create conflicting goals. So we had that very difficult situation where we had to decide: What do we collaborate in and what do we compete with? (The truth is you can run a good healthcare system and still have collaboration and competition in the group. However, it is very difficult and time consuming.) We even had situations where it was counter-productive to work together. As reimbursement was reduced, trying to figure out who does what (procedures, surgery, tests) and where they do it became a jousting match.

So what we found in the past was that even though the health systems had access to tools and tactics that could reduce physician burnout—and although all truly wanted to be successful—creating the consistency needed to optimize the tactics was not easy. Now with many organizations being more fully integrated, with increased employment of physicians, with accountable care organizations, with population health, with shared risk formulas, suddenly everybody is on the same page, or soon will be.

Physicians are highly intelligent. It doesn’t take them long to figure out “Now that I’m working on the same team, I’m now locked into the success of the healthcare system. If the healthcare system is struggling financially and operationally, that will impact my potential and my
compensation. And my own performance will impact the health of the organization.” In other words, the physician’s future and the healthcare system’s future are one and the same.

We’ve always said that physicians need a strong healthcare system, but now we mean it in a deeper way. Physicians need a strong healthcare system psychologically because they want their patients to have good care. But now they also need it to be successful because of their own job security. Their ability to provide good care to patients will rest on the health of the healthcare organization. They need equipment; they need supplies; they may need an upgraded facility and new patient access points. All of that depends on the healthcare system being a very strong one and everyone—physicians, leaders, and staff—working together to make it strong.

As value-based purchasing is phased in and as physician productivity relative value units (RVUs) become less of a major element in the evaluation tool or compensation formula, the greater good starts winning. And as the greater good is captured, everyone benefits.

In the past, the external environment made it more difficult to get physicians aligned and engaged. Today, the external environment has actually created conditions in which the healthcare system, the physicians, and other providers are closer to being on the same page than ever before. This makes the ability to implement these tools and tactics not only a bit easier, but absolutely necessary and desired by not only the healthcare system, but also the physicians.
I want to make one other point as well: Right now there is a lot of conversation happening around physician leadership and performance improvement. There is so much great work being done in these areas. For example, the American Medical Association (AMA) is zeroing in on these issues with its STEPS Forward™ series of educational modules for physicians. I applaud this effort and the efforts of other organizations doing similar work—however, that is not the focus of this book.

The focus of *Healing Physician Burnout* is on creating better work environments for physicians. For physicians to grow as leaders and learn vital new skills, they first have to be fully engaged and aligned. When health system leaders master the tactics in this book, they’ll go a long way toward meeting that goal.

Physicians who are engaged and aligned are more successful in improving their own skill sets. We’ll touch on this later in the book when we discuss the steps physicians can take to prevent and treat their own burnout. Physicians are more motivated than they’ve ever been before to make these tactics work. We all are.

You may have heard the adage “When the student is ready, the teacher appears.” I believe a similar statement could be “When the environment is ready, the tactics can be more easily executed.” That time is here.

Quint
I’m sitting in a patient care room at Doctors Hospital in Sarasota, Florida. I’m alone with my sister, Susan, my only sibling, seven years older than me, who passed away just minutes earlier. As I sit here with my sister, I make a commitment to her: Now that she is gone, I will take care of our mother and father. I don’t realize that my father will pass away just two months from now. All I know as I sit here alone in a room with the sister I love, saying goodbye, is that her entire illness and particularly the hours before her death are flashing before me—and the calming presence of Dr. Pamela Hodul is there the whole time.

When Susan took her last breath, her husband, Jerry, was on her left side. Ruth Ann and Frank Miller, the dear friends who were with her from the beginning, were in the room. Pam Beitlich, a nurse at Sarasota Memorial Hospital who also works with Studer Group®, was there
in the room, stunned because she had just seen Susan a
day earlier and she seemed to be doing so much better.
(In fact, they had been talking about going home.) I was
there, next to her right hip. There, also next to her on the
right side, holding her hand, was Dr. Hodul.

Dr. Hodul isn’t on the medical staff at Doctors Hos-
pital in Sarasota. She’s a surgeon at Moffitt Cancer Cen-
ter in Tampa, Florida. After I had texted her to say that
things were bad, she’d gotten in her car and driven to
Sarasota. She’d walked into the room and became com-
pletely intent on trying to save my sister’s life. After asking
the nurse and others a number of questions, it became
apparent she couldn’t do that. She took me out in the hall
and said that Susan could not be saved. She went back in
and she held Susan’s hand, and Susan passed away.

On December 18, I heard from Dr. Hodul again. She
had texted me a message, just saying that she knew it was
Susan’s birthday, and she knew that this would be a day
that we were thinking about Susan and so was she. I don’t
think Dr. Hodul is the exception. I think she’s the rule.
She is a very, very dedicated physician, who sacrificed
much of her own life in order to make a difference in the
lives of other people.

I first met Dr. Hodul on September 13. On Septem-
ber 12, my sister had undergone an operation, a Whipple
procedure, for pancreatic cancer. Frank and Ruth Miller
were with her at the hospital, as was her husband, Jerry,
while I stayed in Fort Meyers, FL, with my parents, Quin-
ton and Shirley Studer. The next day, Jerry had to come
home because of his own medical condition. It was then
that we got word from Dr. Hodul that there were many complications. We had been expecting a stay in the ICU of about four to six days, followed by a 17-day hospital stay and then home care. Instead, a critical situation had developed. Mother looked at me and, without even a pause, said, “I want you there.”

So I drove up there to Moffitt Cancer Center with my wife, Rishy, to be with my sister. We talked to Dr. Hodul, who I am sure was exhausted from the 13.5-hour surgery the day before on Susan. Later when I talked to Frank and Ruth Miller, who had been there after the surgery, they told me that Dr. Hodul had cried, totally exhausted. She said she had done everything she could because she had told Susan she was going to give it all she had.

Susan wasn’t a great candidate for surgery. One could probably debate whether surgery should have been done. However, because of her extremely close relationship with our mother, she felt she had to try. My mother gave birth to my sister, Susan, during World War II. My father had gone into the Navy and was in the Pacific when Susan was born. In fact, Susan was three years old before my father even met her. For three years, it was just my sister and my mother, which created an unbelievable bond. Susan never could have children, so she and my mother became even closer. In fact, I used to joke that because they lived in the same condo development, my sister’s big act of rebellion was that she moved across the street into a townhouse!

When my sister became ill, my mother had said to her, “I don’t want you to die before me.” This was not out
of selfishness, but out of fear and sadness. This meant the only option my sister saw was to have this surgery after she was found to have pancreatic cancer. If she didn’t have this surgery, she knew she would most likely die before my mother. So she begged and pleaded, and finally it was agreed upon that the surgery would happen.

From September all the way through December, there was always someone near Susan, either Frank and Ruth or myself. We had those “good days” that many of you who have had sick loved ones may be familiar with—those days that feel quite promising. Susan got transferred to the complex hospital in Sarasota. In fact, she was doing so well that we were setting up home healthcare for her, and she was going to go home on Tuesday, December 2. But you already know what happened on December 1.

We had some challenges throughout this process, but Susan’s remarkable physicians were a constant. There were hospitalists in the ICU who were there constantly trying to make sure that Susan made it in her critical condition. There were pulmonologists, who seemed to be there constantly, trying to figure out what they could do to be helpful. And Dr. Hodul was the one we got to know the best. We saw her cry at times, when she was disappointed in what was going on. We saw her smile later when Susan was doing a little bit better. Yeah, I know that in healthcare you’re not supposed to tie your emotions to other people, but how can you not? We all know physicians are people who care deeply about their patients.

Life can be really tough on physicians. One of my good friends, Dr. Ernie Deeds, is a case in point. As a
young physician, he inherited a practice from a retiring physician named Dr. Guttman. When Ernie took over the practice, many of his patients were about 15-20 years older than him. Ultimately, he also retired from being a physician when he was 55 years old. One reason he gave me was that he had gone to three funerals in one week. He said he realized that the age of his patients meant that was pretty much what he’d always be doing and he just couldn’t take it.

Dr. Hodul is another example. She’s a young physician. She has spent most of her life getting her medical degree and completing her residency and then her fellowship so she could do the surgery that she loved. She knew that many of her patients had a bleak prognosis, so she has also chosen to do some procedures where the patients have a better chance for long-term survival.

I learned Dr. Hodul’s schedule, and it was brutal. She would come in before 7:00 in the morning, many times even before 6:30, to see her hospitalized patients. Then she would either go on to do surgery on another patient—and these were long surgeries—or she would go to her outpatient clinic. She would stick around at night to make another round. She worked six days a week. On Sundays, she would periodically go to the computer just to check on how her patients were doing.

One time I asked Dr. Hodul about her social life, and she just sort of looked at me and said, “I really don’t have time for that.”

It hit me then, as it has before, the great price physicians pay to take care of us the way they do. Dr. Hodul
and all the physicians who worked on Susan all those days and nights…what a sacrifice they make… And all physicians do this everywhere.

As I alluded to earlier, my father died not long after Susan, passing away on January 26, 2015. He was in Hope Hospice in Fort Myers, FL. The physician who was with him when he passed away had been an Emergency Department physician at one time. He told me he just couldn’t do emergency medicine anymore, and that’s why he was now a hospice physician—and he was a great one.

During all of these several months in hospitals, with my sister and then with my father, I talked to many physicians who are frustrated. They were frustrated at times because they wanted things done on the weekends that couldn’t get done. They were frustrated that sometimes at 6:00 at night, certain things didn’t run like they ran throughout the day.

They were also frustrated because of the new electronic medical record (EMR)—deep down they know it’s going to be a good thing, but right now it’s creating so much stress. They were upset because they’re measured mostly on RVUs. Some of them are working harder than they ever worked in the past, and yet to other people looking at analytics and metrics, it looks like they’re working less. I support analytics, metrics, EMRs, and RVUs. However, other things have to work well for those to work well, too.

I’ve been a big fan of physicians since early on in my career when I worked as the administrator on call and
I heard a doctor talking to a family about whether or not to resuscitate their father who was in the critical care unit. And now that I see all the massive changes physicians must endure, I admire them more than ever.

As I look back over the history of Studer Group, I question some things about myself and about what we have accomplished. We have done some great things, and there are some things I believe we could have done better—and one of the things I think we could have done better has to do with physicians. I’ll come back to that, but first I will start with the positive.

We’ve been fortunate to win the Baldrige Award and a lot of other awards, but that’s really not why we got into this work. We got into it to fulfill our mission statement, which is to make healthcare better for patients to receive care, for employees to work, and for physicians to practice medicine. When I look at the Baldrige Award and I look at our statistics, I can feel pretty good that we delivered on the first part of that promise, to make healthcare organizations better places for patients to receive care.

I feel really good about making healthcare a better environment in which employees can work. In the 1990s, I would see published healthcare to-do lists and I would notice that patients and employees were not in the top 10 of the to-do lists. I think we’ve done a very good job of helping put patients and employees much higher on those lists. In fact, I can’t think of an organization that doesn’t have patient experience as a top priority on their to-do list, or doesn’t understand the importance of employee engagement.
Back in the early to mid-1990s, when I was working in a hospital, we needed a chief recruitment officer because we needed more nurses. We were paying nurses for 80 hours a week to work for 72 hours. We were spending a lot of money for agency nursing. And what we heard was that it was only going to get worse, because nurses were unhappy and disengaged. This was not because they wanted to be unhappy and disengaged, but because the quickly changing work environment created changes that were hard to adjust to quickly.

And so we made changes and improvements to make sure we recaptured the nurses. When I was at Holy Cross Hospital in Chicago and it won some awards, Tom Badal, an environmental services worker, was interviewed by a magazine. They asked Tom what the difference was between the hospital then and the hospital now. He said, “We used to worry about money and we lost it. Today we worry about people and we make it.”

We knew if we didn’t figure out a better way to make our organizations better places for all people to work, particularly nurses, we were going to be in big trouble. Today it’s not like that. There are waiting lists for people wanting to go to nursing school. When somebody says they’re going to be a nurse, they hear, “What a great profession.” People are actually leaving other professions because they want to become nurses. Or they want to come into healthcare in some other capacity, like nurse practitioner, or physician assistant, or some other professions. But we don’t hear that so much about physicians.
When I hold up the mirror and do my own self-inventory, I will admit that I’ve fallen short in making healthcare a better environment for physicians to practice medicine. We’ve written books on the subject of physician engagement. We have tactics that we know will work. But up until now I’ve never really figured out, to the level of expertise that I want at least, how to execute it all in the most effective possible way. And my career is going to be dedicated to finishing up what I hope we’ve started, which is creating better places for physicians to practice medicine.

As an industry, we’ve made a lot of leaps forward, and when I say “we,” I mean you. We’re more integrated than we’ve ever been before, which is a good thing. There is better technology, even though specific parts of it, like the electronic medical record, must get better. Many facilities are world class. There is more and more integration. We’re figuring out how to create an aligned healthcare system. There is focus on how to manage population health, but if the physicians are not totally engaged—remember, engagement is the opposite of burnout—all of our efforts will fall short.

I’m on the board of a health system that has an exciting strategic plan. They have a nice geographic footprint. They have a lot of pieces in place, and people are working very hard. But, the physician engagement survey that recently came back was disappointing, as the results had gotten worse. My statement at the board meeting was “If we don’t get physician engagement right, nothing else will matter.”
That’s where we are right now. How do we proactively engage physicians so they won’t burn out? I’m optimistic we will, and I’m not blaming anyone. It’s just that sometimes things happen. Life gets in the way. We have all these things hitting us at the same time. Healthcare is one of the most complex environments that exist. But there are bright spots out there. We see bright spots across the country. And that’s what we do: As the Heath brothers, who wrote the book *Switch: How to Change Things When Change Is Hard*, would say, we find these bright spots and we learn from them.

What we’ve learned is many of the tactics we’ve written about are being implemented to some degree, but they can be very hard to execute consistently. Of course, there are also some tactics in this book that are new. If we implement these, and if we do a better job of executing the ones we already knew about, we will recapture the hearts and minds of physicians, just as we have done with other people in the healthcare profession.

As an industry, healthcare has accomplished remarkable things, and more remarkable things will be done in the future. I have no doubt. Physicians and health systems working together was always meant to be.

The title of this book is *Healing Physician Burnout* because there’s every indication that burnout is here and it’s a big challenge. But the most important part of the title is the first word: *Healing*. Our physicians really can heal and they really can be even better than they’ve ever been before. The working title for a while was *Who Moved My Future?* We meant it to be a *Who Moved My Cheese?* for
doctors. The future has been moved; there’s no doubt about it. But let’s not make the move a bad thing. Let’s make the move a good thing.

Thank you for your dedication and desire to create that special place for physicians so they enjoy practicing medicine. When the recruitment and retention of physicians takes place today, the foundation to attract the physicians for the next generation and the generation after that is set in place. Physicians have great purpose, do worthwhile work, and make a difference.

I’m grateful to have known many great physicians in my life. Thank you for all you’ve done and all you continue to do every day.

Quint
PART ONE:

WHY ARE PHYSICIANS SO BURNED OUT, ANYWAY?
Effective medical care begins with understanding. Likewise, when we set out to help physicians overcome the burnout that many are experiencing, we must first know why they are experiencing it. There are many reasons. Ask any group of physicians why they believe they’re feeling exhausted, dissatisfied, discouraged, helpless, and/or hopeless and there are any number of replies.

For example, one may hear, “I work too hard for too little pay-off. These brutal hours and endless bills are draining the life out of me.”

Or, “I went to medical school so I could help patients, not to be buried in an avalanche of paper work.”

Or, “I can’t help patients to the extent I want. Even if I had enough time to really talk to them—which I don’t—all they want to do is tell me what they read online.”

Or just, “Government funding. Enough said.”
Yes, there are many complicated and intertwined factors that are plunging too many physicians into a state of depression and burnout: uncertainty created by the ever-changing landscape of healthcare, a lack of control over their future, highly stressful jobs, bureaucratic pressure that interferes with optimal care, time constraints that keep them from forming meaningful patient relationships, salary concerns, and the feeling of being stuck in a career they no longer enjoy.

Meanwhile, many physicians are being evaluated to the greatest extent on relative value units (RVUs) as a comparable service measure and are under a lot of pressure to perform. Yet according to research, many physicians are not receiving the feedback or coaching on how to meet these performance standards or metrics.

And while physicians’ income is high compared to most professions (though not nearly as high as many believe), they’re burdened with massive education debt on top of their mortgages and other expenses. These financial realities force most physicians to keep practicing medicine whether they want to or not. (It’s not like physicians can drop out of the game and “find themselves” while backpacking across Europe.)

It’s no surprise that, as Sandeep Jauhar, MD, PhD, wrote in a 2014 *Wall Street Journal* article, “American doctors are suffering from a collective malaise. We strove, made sacrifices—and for what? For many of us, the job has become only that—a job.”

Indeed, according to an editorial published in the *Journal of General Internal Medicine*, burnout rates range
from 30-65 percent across specialties such as critical care (53 percent), primary care (50 percent), and ED physicians (52 percent).²

What is burnout, anyway? A simple definition could be expressed as the “progressive loss of idealism, energy, and purpose.”³

Psychologist Christina Maslach codified burnout in the MBI (Maslach Burnout Inventory). This 22-item inventory is broken down into three dimensions: Emotional Exhaustion, Cynicism, and Ineffectiveness. It has been the validated tool and gold standard for measuring burnout since the 1970s. (To access the MBI, please visit http://www.mindgarden.com/117-maslach-burnout-inventory.)

Here’s a brief description of these three dimensions:

- **Emotional Exhaustion.** This is the sense of being emotionally drained while working with other people and the dread that accompanies thoughts of having to go to work. Rather than being energized by one’s job, one is exhausted by it. It’s the loss of the “passion” that’s so fundamental to providing excellent healthcare.
• **Cynicism.** This dimension may also be expressed as depersonalization, withdrawal, and compassion fatigue. In short, the burned out person becomes numb to the humanity of others. In medicine this manifests as the physician no longer regarding the patient as a unique individual with fears, needs, and hopes. The patient becomes another “number,” or just another member of a disease group (diabetic, hypertensive, etc.). The heart becomes “hardened,” and empathy is lost.

• **Ineffectiveness/Lack of Efficacy.** Essentially, one loses their desire to accomplish great goals and make the world a better place. This is very serious, as physicians (much like nurses, teachers, ministers, and counselors) by their nature want to serve. The burned out clinician, who started out with such idealism, really begins to doubt that their work has purpose and that they are able to make a difference.

What’s more, Geneia’s Physician Misery Index Survey revealed that “two-thirds (67 percent) of all surveyed doctors know a physician who is likely to stop practicing medicine in the next five years, as the result of physician
burnout. This includes both younger and more experienced doctors.”

The real surprise is that numbers like these aren’t bigger—faced with the changes and challenges physicians deal with every day, who wouldn’t be burned out?

In Part 1 we will discuss some of these issues. As I sat down and tried to make sense of all the “burnout factors” that are found in my own and others’ researched perceptions (and that I know firsthand from my work with physicians across the country), it made sense to divide them into five major “groupings.” These are:

- The Healthcare Environment
- Practical Hurdles
- Psychological Challenges
- Training Challenges
- Organizational Structure Changes

Of course, not all of the issues fall neatly into their assigned category. There is a fair amount of crossover. After all, practical hurdles often lead to psychological challenges. Training needs and adjusting to new organization structures are clearly related. The disconnect obviously has psychological implications, too. You get the picture: The lines are blurred.

Also, each factor is addressed, and I’d like to add that burnout isn’t happening only because doctors feel personally overwhelmed, stressed, neglected, and
put-upon. This would imply a lot of self-interest on the part of physicians, and that’s just not true. I’ve worked with hundreds of physicians and I know their great dedication and stamina and their concern with their patients’ well-being more than with their own. I find much of their burnout is due to the perception that their most powerful driver—the ability to provide the best possible patient care—is being challenged.

As a research report produced by the Rand Corporation and sponsored by the American Medical Association noted:

“We found that, when physicians perceived themselves as providing high-quality care or their practices as facilitating their delivery of such care, they reported better professional satisfaction. Conversely, physicians described obstacles to providing high-quality care as major sources of professional dissatisfaction. These obstacles could originate within the practice (e.g., a practice leadership unsupportive of quality improvement ideas) or could be imposed by payers (e.g., payers that refused to cover necessary medical services).”

Without a doubt, many of the barriers we’ll cover in Part 1 of this book are seen by physicians as challenges to their goal of providing high-quality healthcare. This is deeply upsetting to them. It’s up to all of us collaboratively, as leaders and physicians alike, to work together to knock down these barriers. We need to a) assist physicians to master the tools and techniques to alleviate the obstacles that can be alleviated, and b) help physicians shift their perceptions to focus on the good that they’ve
always done for their patients and will continue to do—whatever the future holds.
Chapter One:

“Big Picture” Changes That Are Driving Day-to-Day Realities (The Healthcare Environment)

The Affordable Care Act (ACA) has forever altered America’s healthcare industry. And no one has seen more change than physicians. Many physicians have moved from solo practices or small groupings to joining ever-larger practices and systems. Employment has moved from solo to a group LLC to often a large organization. All kinds of changes are upon physicians—from how they get paid (and how much) to how they make decisions about treatment to how they interact with patients to how they keep records.

Coping with these pressures and new ways of doing things is incredibly stressful. The logistical and psychological implications are huge. And in the eye of this storm, under tremendous pressure to standardize care and reduce the cost of care, physicians keep on keeping
on—doing everything possible to deliver the best possible clinical outcomes and improve efficiency, while keeping patients and their families informed and well cared for. Physicians have always wanted to do these things (it’s a cornerstone of their calling), but new regulations and the ever-looming threat of withheld reimbursement have created an unprecedented sense of alarm.

The purpose here is not to cover every nuance of the external environment, but to offer an overview of the high spots. While these will not be new to most readers, putting them together helps better explain why physicians are feeling as they are today. Here are just a few of the big, overarching trends that are shaking up the healthcare industry:

**Healthcare funding has reached worrisome levels.** According to CMS.gov, healthcare spending now consumes 17.4 percent of gross domestic product (GDP). In 2013 spending on healthcare was $2.9 trillion, which comes out to $9,255 per person.¹

If healthcare spending keeps growing at this rate, it will consume GDP—a course that is not feasible.

**Value-based purchasing increasingly ties reimbursement to clinical quality and patient experience outcomes.** This is a major paradigm shift from “services delivered” to “outcomes performed,” and it includes both public and private payers. Not only does this new reality ramp up the pressures physicians feel to perform, it’s counter to their “rugged individualist” roots.
Note that “quality” and “patient experience” both factor into reimbursement. CMS’s value-based purchasing formula is linked both to quality metrics like outcomes and process of care measures and results on patient surveys: HCAHPS (for hospitals) and CG CAHPS (for physician practices). (The good news is that plenty of research shows quality and perception of care are two sides of the same coin.)

If you’d like to learn more about the quality/experience connection, I invite you to read The CG CAHPS Handbook: A Guide to Improve Patient Experience and Clinical Outcomes, by Jeff Morris, MD, MBA, FACS; Barbara Hotko, RN, MPA; and Matthew Bates, MPH; and The HCAHPS Handbook: Tactics to Improve Quality and the Patient Experience, by Lyn Ketelsen, RN, MBA; Karen Cook, RN; and Bekki Kennedy.

A physician shortage is imminent. Lots of attention has been focused on the upcoming shortage of primary care physicians (and in many parts of the country this is already a problem). But specialists, too, are becoming an endangered species. According to an article in the Journal of Clinical Oncology, “an acute shortage of medical oncologists is projected in the U.S. by 2020.” This same article also referenced a 2007 survey projecting that the visit capacity of oncologists rising 14 percent by 2020 would be dwarfed by the projected demand of 48 percent! In general, it’s estimated that there will be a deficit of 200,000 physicians by the year 2025. This is a deeply alarming number and one that calls for changes in how we as an industry deliver care as well as how we fund and encourage physician education and training.
Meanwhile, our aging population will need more and more care. This physician shortage becomes even more serious when we consider the strain that 75 million aging baby boomers will place on those few who remain. According to a *Hospitals & Health Networks* article by Paul Barr titled “The Boomer Challenge,” “About 3 million baby boomers will hit retirement age every year for about the next 20, and will affect how caregivers and policymakers shape the healthcare system for decades to come.”

The volume and acuity of healthcare needs have increased dramatically in last 40 years. Look at the explosion of diagnostic tools (ultrasound, CT, MRI), medications, and surgeries (both invasive and non-invasive) we’ve seen in recent decades. None of this existed in the early 1970s! Largely as a result of these medical advancements, people are living longer and consuming more healthcare of an intrinsically more expensive nature. The exponential growth of the cost of funding all of this is not sustainable.

Patient expectations have changed. The public’s expectations and demand for healthcare have grown exponentially in the last 40 years. It’s easy to see why. Medicine has delivered high quality and sometimes miracle cures. A strong “consumerism” orientation and perhaps even an element of entitlement have developed. With increasing copays and deductibles, consumer intensity in selection of care providers and in what is expected in terms of treatments and outcomes will continue to grow.
The Internet is a big part of this. Now that it’s so easy for people to do online research, they may sometimes come to doctor visits with preconceived ideas about what their treatment should be. Also, in a larger sense, the Digital Age has created a marketplace that favors the consumer. If you don’t like what one company is offering, you can quickly and easily purchase goods and services from a competitor. This has taken the adage “the customer is always right” to new levels—and people naturally bring that same attitude to their healthcare.

There is more transparency than ever before. Thanks to the public reporting on Hospital Compare and Physician Compare websites, consumers can see how health systems, group practices, and individual clinicians are performing on certain quality and patient perception of care metrics. And, of course, thanks to social media, patients and families can post their healthcare experiences—positive or negative—at any time.

While transparency can be a very good thing, it can lead to discomfort in physicians. For example, physicians and organizations may feel that transparency may not accurately reflect their performance.

Technology is changing rapidly. Changes and advancements in technology, including electronic medical records (EMRs), cause discomfort as new skills are learned and demonstrated. As technology changes, there are more and more diagnostic and treatment options for patients. While more options is theoretically a good thing, the stress of having to learn about them all, and factor
them into already-complex decisions on patient care, can contribute to burnout.
To Get Health System Leaders and Physicians Working Together, We Must Tackle Physician Burnout.

This is a book about physician burnout. It’s also a book about physician engagement. Why? Because these two concepts are deeply connected. When physicians team up with the organizations they work for to pursue mutual goals, they are far less likely to burn out. And when organizations seek to prevent and treat physician burnout, they go a long way toward getting everyone—physicians included—working together to meet the same goals.

There has never been a better time for organizations and physicians to join forces to make sure this happens. High rates of physician burnout and a rapid push toward integration demand it. And while it will surely be challenging, together we can create the right environment to facilitate massive change while keeping physicians physically, mentally, and emotionally strong. Healing Physician Burnout—written by healthcare performance expert Quint Studer in collaboration with George Ford, MD—explains how. You’ll find:

- Evidence on why burnout is so high in physicians and why organizations should care
- Tactics health system leaders can use to partner with physicians to help them avoid burnout—and to ensure that everyone is working toward the same goals
- Burnout “red flags” leaders and physicians should watch for so that help may be provided early on
- Personal profiles that tell of physicians’ triumphs over burnout and showcase the passion and purpose that keep them persevering
- Actions physicians can take to heal their own burnout and help others to do so as well

Physicians need understanding and empathy for the massive changes they must endure. While no one can stop the shift our industry is undergoing, we can create the kind of positive, supportive work environments that help physicians cope and, ultimately, thrive.

Quint Studer is the founder of Studer Group, a Huron Healthcare solution and a recipient of the 2010 Malcolm Baldridge National Quality Award. Inc. magazine named Quint its Master of Business, making him the only healthcare leader to ever have won this award. Twice Modern Healthcare has chosen him as one of the 100 Most Powerful People in Healthcare. He is the author of numerous books. There are currently 700,000 copies of his BusinessWeek bestseller, Hardwiring Excellence, in circulation.

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