

# PHYSICIAN'S WEEKLY UPDATES

**WORKPLACE BURNOUT**

**Hospitalist  
Workload**

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**Intensivist  
Shortage**

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**Nurse  
Burnout**

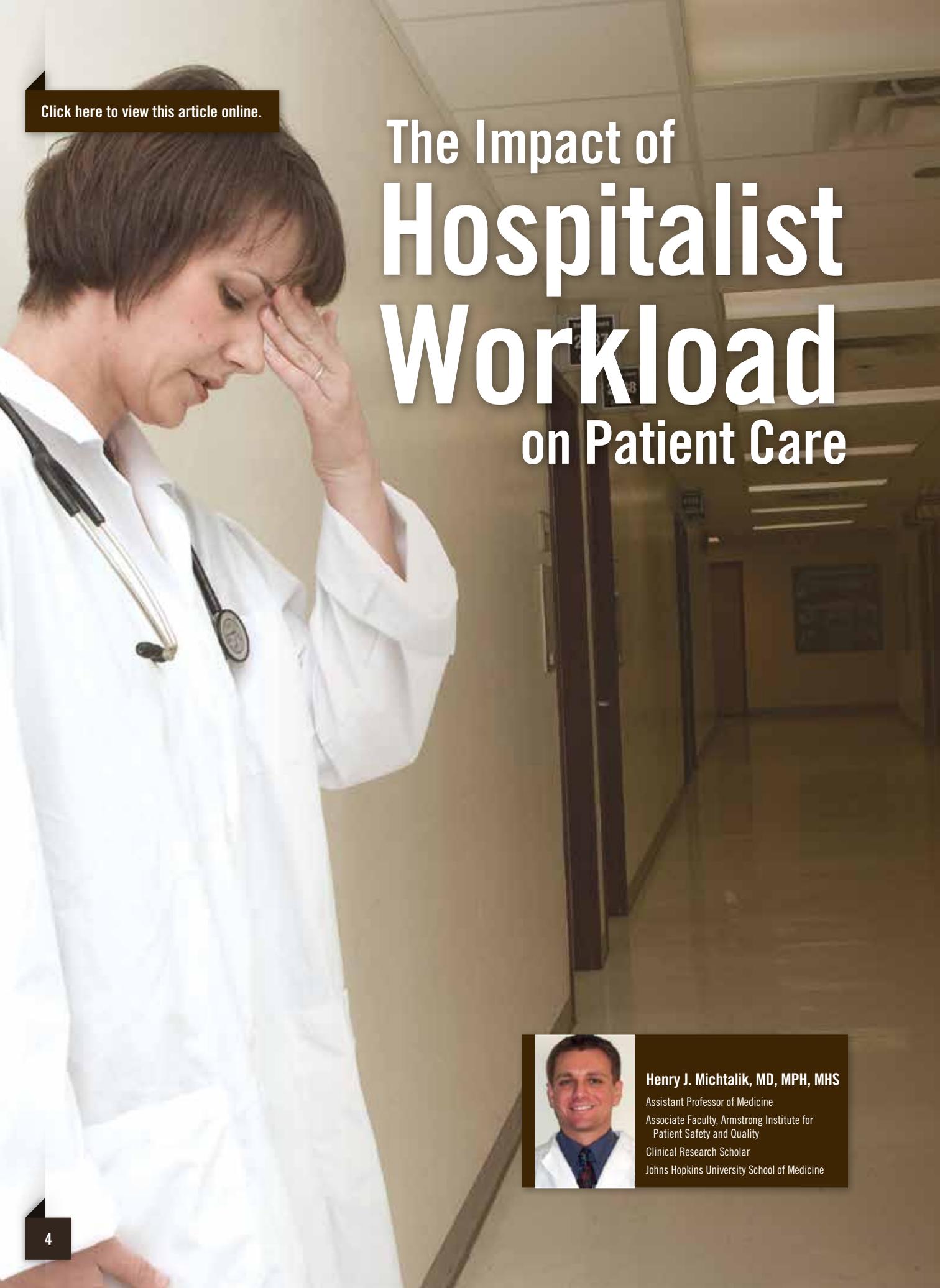
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**Physician  
Burnout  
Solution**



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# The Impact of Hospitalist Workload on Patient Care



**Henry J. Michtalik, MD, MPH, MHS**

Assistant Professor of Medicine  
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The workload for hospitalists has increased significantly, thanks in part to increased residency work-hour restrictions, greater access for patients to healthcare, and a general focus among hospitals to improve patient volume and throughput. Further complicating matters is that hospitalists are adept at functioning in different hospital environments and capacities, which has increased their use and workload. To assess the impact of workload on patient safety and quality measures, my colleagues and I conducted a national survey of hospitalists that was published in *JAMA Internal Medicine*.

## Hospitalists Reporting Unsafe Workloads

According to our results, about 40% of hospitalists reported that their workload exceeded safe levels (more than 15 patients per shift) at least monthly, and 36% said it happened more than once a week. Approximately one-quarter of respondents reported that excessive workload delayed the admission or discharge of patients until the next shift or hospital day, which in turn impacted length of stay and workloads among ED providers.

In addition, 25% of respondents reported that they failed to fully discuss treatment options or to answer questions from patients and family members, and 19% said patient satisfaction soured due to unsafe workloads. Furthermore, 18% reported that it

adversely affected patient handoffs. More than 20% of physicians reported that their average workload likely contributed to patient transfers, morbidity, or even mortality.

## High Hospital Admissions Taking a Toll

High levels of admissions and unexpected health changes among admitted patients can dramatically affect the workload of hospitalists and ED physicians. In turn, these changes can increase lengths of stay and clog processes of care in the ED. To overcome these issues, a mutual understanding and collaboration is needed between emergency care providers and the physicians who receive patient admissions. A specific system should be put in place to ensure proper hand-offs so that continuity of care isn't sacrificed. An understanding of the upstream and downstream effects that workload has on both groups is also necessary.

The decision to admit patients typically falls to emergency physicians, but this is a sensitive area of concern in regard to safety and quality events that occur in hospitals. Ultimately, the care provided in the inpatient setting requires that ED physicians and hospitalists work together to design proactive—not reactive—strategies aimed at providing patients with high quality and safe medical care. Our survey results illustrate the need for clinicians to have discussions about workload so that the efficiency, safety, and quality of care from ED, inpatient, and outpatient providers can be optimized throughout patients' entire course of care. 

Henry J. Michtalik, MD, MPH, MHS, has indicated to *Physician's Weekly* that he has received grants/research aid from The National Institutes of Health, Johns Hopkins University School of Medicine, and Johns Hopkins Hospital.

RELATED FEATURE ARTICLE

**Improving Collaboration Between Emergency Physicians & Hospitalists**

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## Additional Resources:

Michtalik H, Yeh H, Pronovost P, Brotman D. Impact of attending physician workload on patient care: a survey of hospitalists. *JAMA Intern Med*. 2013 Jan 28 [Epub ahead of print]. Available at: <http://archinte.jamanetwork.com/article.aspx?articleid=1566604>.

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# Hospitalists & the Intensivist Shortage

hospitalists into the critical care workforce through rigorous sanctioned and accredited 1-year training programs could open a new intensivist training pipeline. It can also offer more critically ill patients the benefit of providers who are unequivocally qualified to care for them.

## Thinking Outside the Box to Alleviate the Shortage

The key is for hospitals, clinicians, and other key constituents to think outside the box when developing strategies to address the intensivist shortage. Rigorously training hospitalists as intensivists could dramatically alleviate some of the burden and should be part of a broader initiative to reform critical care training through a unified, cross-disciplinary approach to developing an intensivist workforce. 

Eric M. Siegal, MD, SFHM, has indicated to *Physician's Weekly* that he has no financial disclosures to report.



Efforts are needed to ensure that hospitalists manage critically ill patients safely, effectively, and seamlessly. In the *Journal of Hospital Medicine* and *Critical Care Medicine*, the Society of Hospital Medicine and the Society of Critical Care Medicine co-published a position paper on training the hospitalist workforce to address the intensivist shortage. In this paper, we discussed the potential value of hospitalists in the ICU and the importance of enhancing hospitalists' skills to provide critical care services.

## Adding Value & Enhancing Skills of Hospitalists

Hospital medicine and critical care medicine share similar structures, competencies, and values, positioning hospitalists as a logical solution to the intensivist shortage. Many of the competencies needed for practicing critical care medicine are encompassed in internal medicine training as

well as in core competencies in hospital medicine. The ideology and mechanics of high-performing hospitalist and intensivist programs are similar, yet despite these commonalities, hospitalists remain largely untapped as a potential source of new intensivists.

## Exploring Alternative Critical Care Models

With no solution to the intensivist shortage in sight, alternative critical care delivery models are needed. We proposed a 1-year critical care fellowship track for experienced internal medicine hospitalists. Although critical care medicine is a 2-year fellowship, only 1 year of clinical rotations is required for board eligibility. Furthermore, a 1-year critical care training track already exists for other medical specialists and should be relevant and available to experienced hospitalists as well. Bringing qualified

## Additional Resources:

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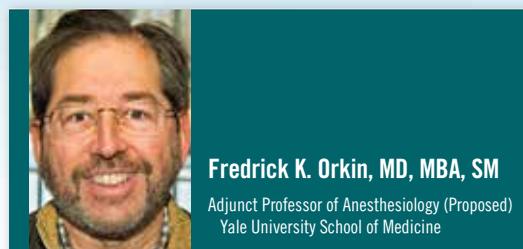


# Retirement Decisions & Workforce Implications in Anesthesiology

*Greater attention is needed to address potentially modifiable factors to prevent premature retirement in anesthesiology, including workplace wellness and professional satisfaction.*

Anesthesiology is one of 21 medical specialties in the United States that is currently experiencing a physician shortage or expected to have one in the near future. The causes of physician workforce shortages are multifactorial and include the aging physician population, burdensome debt from medical school, a static production of new physicians, and reduced physician work hours, among others. Expectations for work-life balance, hours spent at work, a culture involving high stress, and burnout are other key contributors to physician shortages.

“It’s important to increase our understanding of the issues contributing to the physician shortage in anesthesiology,” says Fredrick K. Orkin, MD, MBA, SM. “By identifying practice patterns and retirement plans of older anesthesiologists, we can use this information to guide how we manage consequences resulting from the undersupply of these specialists. These data could also be used by physicians and their employers to prepare for shortages in the future.”



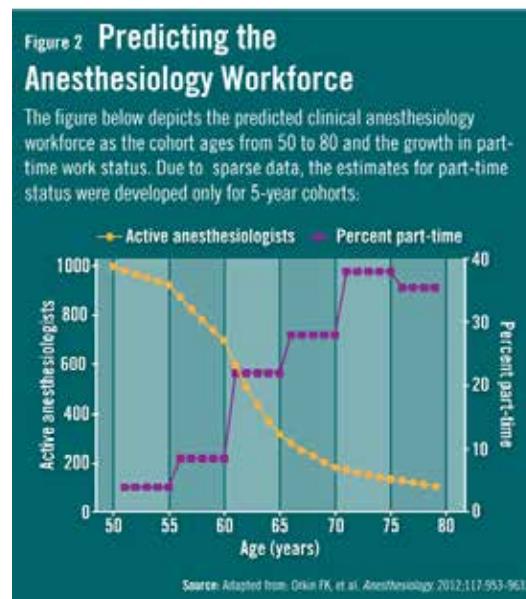
**Fredrick K. Orkin, MD, MBA, SM**  
Adjunct Professor of Anesthesiology (Proposed)  
Yale University School of Medicine

## Analyzing Trends in Retirement

A study published in *Anesthesiology* by Dr. Orkin and colleagues surveyed thousands of anesthesiologists and other specialists aged 50 and older to determine trends in work activities, professional satisfaction, health and financial status, and retirement plans and perspectives. The goals included identifying the major factors influencing decisions to continue practicing or to retire and evaluating the impact of retirement decision making on the size of the current and future workforce.

Several important findings emerged from the study by Dr. Orkin and colleagues. First, older physicians logged significantly more hours of work during the week than other professionals. On average, older anesthesiologists and other older physicians worked about the same number of hours per week (49.4), but this average topped that of attorneys (44.9), engineers (43.0), and registered nurses (37.3). Although the length of the older anesthesiologists' workweek was similar to that of other older physicians, anesthesiologists spent more of their time (81%) in clinical care, especially those specializing in critical care medicine or pain management.

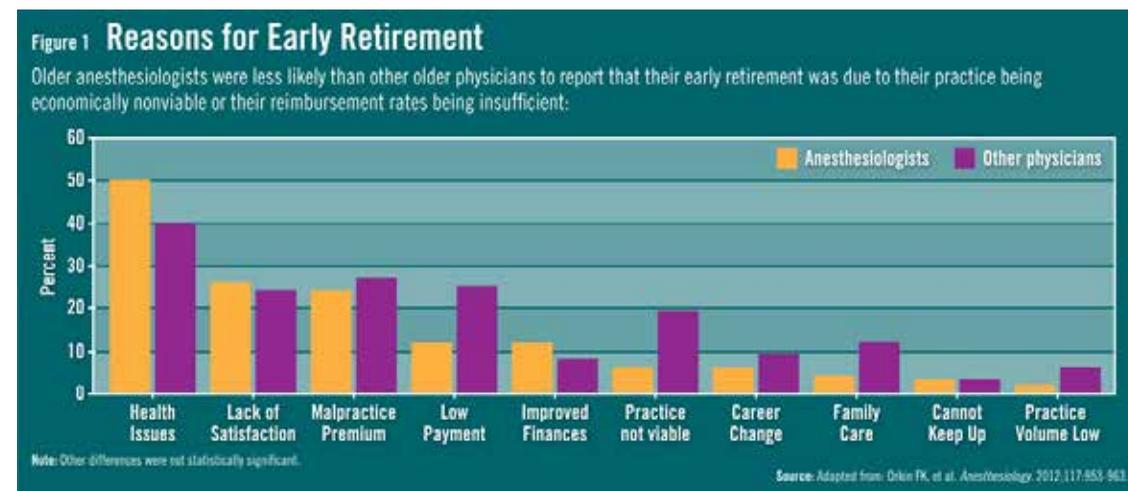
Anesthesiologists also participated in clinical care well into their 60s. As anesthesiologists aged, time spent in clinical care decreased and more began working on a part-time basis, particularly women. One-sixth of respondents reported working in a



self-defined part-time mode. “Since part-time status is more prevalent among women and more women are entering anesthesiology, this work model is likely to be even more common in the future,” says Dr. Orkin.

## Reasons for Retirement Among Anesthesiologists

When compared with other older physicians, several factors were cited as “very important” in retirement planning by older anesthesiologists. More than half reported that their decision to retire from patient care was based on on-call responsibilities. More than one-third cited insufficient



*“It’s important to increase our understanding of the issues contributing to the physician shortage in anesthesiology.”*

reimbursement, lack of professional satisfaction, increasing regulation of medicine, and decreasing clinical autonomy. Conversely, more than two-thirds of older anesthesiologists reported that career satisfaction was the driving force behind deciding to remain clinically active.

Poor health was cited by 64% of anesthesiologists retiring in their 50s, compared with a 43% rate observed among those retiring later, according to the study (Figure 1). On the other hand, subspecialists in pain management and critical care who left their practice cited loss of clinical autonomy as a major influence. In forecasting models, 30% of anesthesiologists were predicted to work past the age of 65; about 18% will work past age 70, and 10% will work at age 80 (Figure 2). Based on these results, Dr. Orkin says “interventions to retain physicians in the workforce may need to be age-specific or subspecialist-specific.”

the anesthesiologist workforce shortage. “Several initiatives have already been launched throughout the U.S., including workplace wellness programs in anesthesiology. Other interventions have been initiated to enhance professional satisfaction so that the incidence of premature retirement decreases. Unfortunately, more of these efforts are needed due to the fact that aging will inevitably play a role, affecting everything from muscle to mind.”

Dr. Orkin urges thinking outside the box as new initiatives are developed. “There is an under-recognized trend toward part-time work,” he says. “Despite the potential role of this employment model to decrease the aggregate clinical workforce, part-time work also offers the possibility of retaining older anesthesiologists with needed skills in the clinical setting for longer periods.”

## Retaining Physicians

The study by Dr. Orkin and colleagues further supports the notion that greater attention should be focused on potentially modifiable factors to alleviate



Fredrick K. Orkin, MD, MBA, SM, has indicated to *Physician's Weekly* that he has or has had no financial interests to report.

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# HOW Nurse Burnout Affects Hospital-Acquired Infections

*Reducing nurse burnout by 30% could prevent more than 4,000 UTIs and more than 2,200 SSIs each year and save up to \$69 million annually in healthcare costs.*



**Jeannie P. Cimiotti, DNSc, RN**

Associate Professor & Executive Director  
New Jersey Collaborating Center for Nursing  
Rutgers College of Nursing

Previous research has linked invasive devices and clinical practice to hospital-acquired infections (HAIs). There is now evidence suggesting that elements of nursing care are also linked to the prevalence of HAIs.

Few studies have rigorously examined the possible underlying mechanisms of the relationship between nurse staffing and HAIs. In the *American Journal of Infection Control*, my colleagues and I had a study published that assessed job-related burnout among registered nurses to determine its accountability for the relationship between nurse staffing and infections acquired during hospital stays.

## Burnout Affects Infection Rate

Our findings show that job-related burnout among nurses appears to be a plausible explanation for some HAIs. Nurses had an average total of 17 years experience, caring for an average of about six patients. Almost 37% reported high levels of burnout. At the hospitals involved in the study, 16 of 1,000 patients acquired some type of infection, particularly urinary tract infections (UTIs), surgical site infections (SSIs), and gastrointestinal infections, as well as pneumonia.

For modeling and further analysis, we limited the types of infection to UTIs and SSIs. As patient loads escalated, the number of UTIs and SSIs increased significantly. In additional modeling, nurse burnout was highly associated with these infections, a finding that hasn't been reported in previous research. A 10% increase in a hospital's composition of high-burnout nurses was linked to an increase of nearly one UTI and two SSIs per 1,000 patients.

Perhaps the most important finding from our model was that reducing nurse burnout by 30% could prevent more than 4,000 UTIs and more than 2,200 SSIs each year and save up to \$69 million annually in healthcare costs. Even a 20% reduction in nurse burnout could prevent about 2,600 UTIs

and nearly 1,500 SSIs each year and save about \$46 million annually.

## Alleviating Burnout Cheaper than HAIs

The results from our study are significant, considering the enormous burden of HAIs and the fact that insurance providers nationwide are denying payment for costs associated with these infections. It has been speculated that the cognitive detachment associated with high levels of burnout may result in inadequate hand hygiene practices and lapses in other infection control procedures among nurses. More data are needed to better understand these relationships. In the meantime, healthcare facilities can take many simple, cost-effective steps to alleviate job-related burnout in nurses at a much lower cost than those associated with HAIs. 

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Jeannie P. Cimiotti, DNSc, RN, has indicated to *Physician's Weekly* that she has no financial disclosures to report.

## Additional Resources:

**Cimiotti JP, Aiken LH, Sloane DM, Wu ES.** Nurse staffing, burnout, and health care-associated infection. *Am J Infect Control.* 2012;40:486-490. Available at: [www.ajicjournal.org/article/S0196-6553\(12\)00709-2/fulltext](http://www.ajicjournal.org/article/S0196-6553(12)00709-2/fulltext).

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# At the Boiling Point Physician Burnout & Work-Life Balance

*Burnout appears to be more common among physicians than among other workers throughout the country, particularly for those in specialties at the front line of care access.*



Previous research has indicated that many physicians throughout the United States experience professional burnout, a syndrome characterized by emotional exhaustion, depersonalization, and a low sense of personal accomplishment.



**COLIN P. WEST, MD, PHD**  
Associate Professor of Medicine & Biostatistics  
Department of Internal Medicine  
Mayo Clinic

Studies suggest that burnout can reduce quality of care and increase risks for medical errors, among other negative consequences. Furthermore, there are other adverse personal consequences for physicians that have been linked to burnout, including contributions to broken relationships, problematic alcohol use, and suicidal ideation (click here to read guest blogger, Dr. Rob's, Top 10 Burnout Triggers).

“We have limited data characterizing physician burnout, but few studies have evaluated rates of burnout among U.S. physicians nationally,” says Colin P. West, MD, PhD. “Previous investigations

have speculated on which medical or surgical specialty areas are at higher risk, but these analyses have not been definitive.” He adds that research is also lacking on how rates of burnout for physicians compare with rates for U.S. workers in other fields.

## Medical Specialty Matters in Burnout

In the *Archives of Internal Medicine*, Dr. West and colleagues published a study on burnout involving a large sample of U.S. physicians from all specialty disciplines using the American Medical Association

Physician Masterfile. Surveys were used to assess the prevalence of emotional exhaustion, enthusiasm dissipation, cynicism, depression, suicidal tendencies, negative views on work-life balance, and low professional esteem among physicians.

After collecting responses from 7,288 physicians from various healthcare settings, 45.8% reported experiencing at least one symptom of professional burnout. “We observed substantial differences in burnout by specialty,” says Dr. West (Figure). The highest rates of burnout were seen in physicians at the front lines of care, most notably family doctors,

general internists, and emergency physicians. In addition, the following was observed among surveyed physicians:

- 37.9% reported high levels of emotional exhaustion.
- 29.4% reported that cynicism was an issue.
- 12.4% reported having a low sense of personal accomplishment.

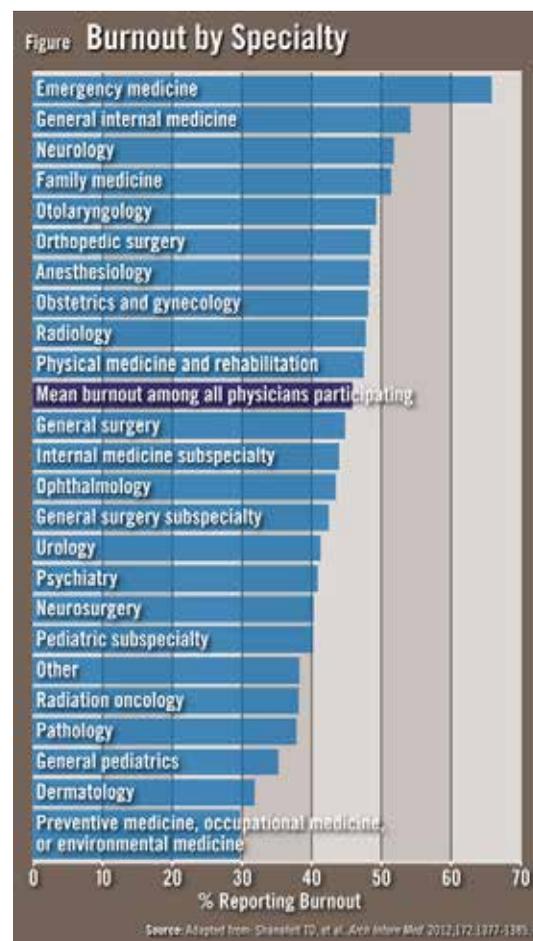
Importantly, Dr. West notes that not all physicians reported an equal tendency toward professional unhappiness. “Our findings suggest that while many

of the medical community’s first responders were more likely to suffer from some form of burnout, others were less likely to experience such issues.” These specialists included dermatologists, pediatricians, and preventive medicine physicians.

## Burnout Among Physicians vs General Workers

The study by Dr. West and colleagues also compared physician burnout data with survey data from 3,442 working Americans. In these analyses, physicians were more likely to have symptoms of burnout and

*“It’s not surprising that many physicians are experiencing more stress than other U.S. workers because the healthcare system and consumers are increasingly putting higher demands and expectations on physicians.”*



to be dissatisfied with work-life balance than general workers (Table). “It’s not surprising that many physicians are experiencing more stress than other U.S. workers because the healthcare system and consumers are increasingly putting higher demands and expectations on physicians,” Dr. West says. “The implications are important. These findings raise concerns about the negative impact physician distress can have on quality of care.”

## Increasing Efforts to Find Solutions

With data showing that front-line physicians are experiencing greater distress than other working Americans, Dr. West says it is critical to target future research efforts on potential solutions for physicians. “When combined with positive changes in the healthcare environment, our findings emphasize the need to help physicians learn how to reach out to friends, family members, and work colleagues to get help when symptoms of burnout emerge.”

Medical and physician support programs are already in place in every state throughout the country and have

Variable	Physicians	U.S. Workers
<b>Emotional exhaustion</b>		
- Never	12.7%	11.8%
- A few times a year	26.5%	30.9%
- ≤Once a month	12.7%	15.6%
- A few times a month	15.5%	17.7%
- Once a week	9.9%	6.9%
- A few times a week	13.3%	10.8%
- Every day	8.7%	5.6%
<b>Depersonalization</b>		
- Never	32.7%	39.4%
- A few times a year	24.9%	23.9%
- ≤Once a month	11.0%	10.1%
- A few times a month	11.4%	10.9%
- Once a week	6.6%	5.1%
- A few times a week	8.8%	5.9%
- Every day	4.0%	3.9%
<b>Burned out</b>	<b>37.5%</b>	<b>27.6%</b>
<b>Depression and suicidal ideation</b>		
- Screen positive for depression	40.4%	41.4%
- Suicidal ideation in the past 12 months	6.9%	6.6%
<b>Satisfaction with work-life balance (Work schedule leaves me enough time for my personal or family life)</b>		
- Strongly agree	14.2%	19.5%
- Agree	30.7%	37.5%
- Neutral	14.7%	19.7%
- Disagree	26.2%	17.6%
- Strongly disagree	13.9%	5.5%

Source: Adapted from: Shanafelt TD, et al. Arch Intern Med. 2012;172:1377-1385.

reported many successes in helping physicians with burnout and other kinds of stress-related problems. The challenge, according to Dr. West, is that physicians—just like other people in general—often have trouble finding where to turn for help. Support systems are available for physicians, he says, but they must be encouraged to look at their own stresses, determine what kind of help they need, and feel comfortable reaching out for that help when it is needed.

With increasing evidence that physician burnout adversely affects quality of care, findings from the study by Dr. West and colleagues suggest that this problem threatens the foundation of the U.S. medical care system. “The problem of burnout

won’t go away anytime soon as healthcare reform efforts are likely to increase demand for front-line care providers,” says Dr. West. “It’s important to remember that the origins of burnout are rooted in the environment and care delivery system rather than in the personal characteristics of a few susceptible people. Policy makers and healthcare organizations must address this problem for the sake of physicians and their patients.”

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**Top 10 Physician Burnout Triggers**

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Colin P. West, MD, PhD, has indicated to *Physician's Weekly* that he has or has had no financial interests to report.

## Additional Resources:

- Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med.* 2012;172:1377-1385. Available at: <http://archinte.jamanetwork.com/article.aspx?articleid=1351351>.
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# *Locum Tenens:* My Solution to Physician Burnout

I found myself depressed, angry, and considering closing my solo practice altogether. Fortunately, I've discovered a cure for burnout.

As the shortage of experienced and skilled physicians continues to grow nationwide, so will cases of physician burnout. There simply aren't enough physicians and enough hours in the day to cover all the needs.



Duane Gainsburg, MD, FACS

After many years of practicing neurosurgery, my professional life was being eaten into by the inevitable hassles of insurance matters, hospital politics, and the business side of my practice. If my wife hadn't been working as my office manager, I probably wouldn't have seen her more than a few hours every week. I found myself depressed, angry, and considering closing my solo practice altogether.

**Fortunately, I've discovered a cure for burnout: *locum tenens*.**

In early 2004, I met a fellow neurosurgeon who had been through the same challenges as I, and had opted for a career as a locum tenens physician. It didn't take much convincing, and after completing a few trial neurosurgery assignments, I closed my office in favor of ongoing locum tenens work.

*Burnout is still a big problem in our profession, but it's no longer an issue for me.*

The change in my attitude and energy is remarkable, and thanks to the example of other doctors working in locum tenens, I now look forward to my monthly 7- to 10-day assignments. My family has benefited from my improvement in attitude and energy, and I tell my colleagues that my new-found career path has created the balance in my life I was searching for. My income is steady and predictable. I am no longer bound by or bogged down in day-to-day office bureaucracy and insurance company stratagems. And I have the freedom to spend quiet evenings and vacations with my family without the constant stream of phone calls.

My practice and my income are no longer tied to "production units" or how many surgical procedures I do. Now, I am able to spend my time working with patients and their families, listening to their issues, explaining the scope of the illness or disease, and discussing treatment alternatives. There is a professional satisfaction that comes from doing what is best for the patient and for the hospital. And there's a personal satisfaction that comes from being able to divorce what I do from my compensation. Doctors are not businessmen, and locum tenens provides me the opportunity to do what I wanted to do in the first place: take care of patients. 

Dr. Duane Gainsburg works as a locum tenens physician with Weatherby Healthcare.