Positive Peer Pressure

Sejal Mehta MD MBA

Objectives

- Understand the enormous scope of the burnout with the physicians.
- Understand the options available for getting help to our peers and ourselves.
- Learn different skills to manage burnout and stay well.

Elephant in the room

Physician Burnout

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Internal Factors

- Long work hours, increasingly burdensome documentation, and resource constraints
- Malpractice litigation.
- Death of a colleague or caring for victims of a mass trauma,
- Emotional stability
- Emotional intelligence
- High frustration tolerance
- Empathy

Resilience

Forward looking outlook

High risk tolerance

Resisting addictions

Ambition

Female Gender Specifics

workload and job demands, higher: More time with patients and with EMRs

efficiency and resources, lower

control and flexibility, lower

organizational culture and values,: lack of women role models, gender bias, microaggressions, and harassment

social support and community at work,: compensation disparities, lower rates of career advancement and academic promotion

work-life integration, : Disproportionate responsibilities outside of work, including childcare and elder care , lower self-compassion and perceived appreciation

leading to **decreased professional fulfillment and higher burnout rates** among women physicians.

External Factors - Family

- Make-up and support
- Dynamics
- Values/Traditions
- Expectations
- Health
- Generational span

External Factors: Community

- Expectations
- Entitlement
- Social status of physicians
- Patient load
- Ancillary services availiabity
- Local rules

External factors: physician community

- Supportive
- Trusting
- Collegial
- No backstabbing
- No power struggle
- Medical board: non-punitive

External factors: private practice

- Overhead
- Staffing issues
- Low reimbursement
- Timed codes: loss of autonomy
- Billing complexity
- PA/Denials
- Recouping
- Liability
- EMR
- PMP check
- Coverage
- Patient expectations

External Factors : Practice Scope

- APRNs
- PAs
- Chiropractors
- Pharmacists

External factors: Corporate medicine

- No autonomy
- Bottomline is priority
- Cost cutting measures : poor staffing, more MLPs
- Supervisory liability
- Muffled voices due to termination threats
- Cultural issues
- Leadership on paper only

External factors: State rules

- Autonomy
- Prescribing/dispensing
- Law-makers' views on Medicine
- Medical Board support

External factors : Medical board

- Charged with ’Patient safety’
- No room for error
- Easy click for Disgruntled spouses, employees, patients
- Every complaint has to be reviewed no matter how frivolous
- Needing legal assistant adding financial distress to emotional agony.
- Makes getting help for depression difficult by reporting requirements.

External factors: Litigious Mindset

- No room for human error
- Raising Liability insurances premiums
- Assigned lawyers make more if case drags on
- Settlement to avoid Jury trial has to be reported to National practice data bank
- Liability insurance can indirectly force to settle
- Liability insurance then can increase rates and/or cancel the coverage
- High risk pool liability insurance premiums are 5-10 times higher.
- NPDB will leave that info on for eternity
- Everything has to be reported every time any form is filled out. Forever.

External factors: Commercial insurances

- Complicated contract language
- No transparency for physician reimbursement
- Needing PA for common services
- Restrictive formulary
- Restrictive referral network
- Delayed payment
- Recouping money months/years later without recourse
- High deductibles that patients can’t/don’t pay
- No impromptu rates increase
- Peer review burdens
- Asking for too much documentations
- Sending checks of few cents to physicians when CEOs make millions

External factors: Medicaid

- Reimbursement in form of peanuts
- Restrictive formulary
- Restrictive network
- Mostly charity cases for physicians without tax credits.

External factors : Medicare

- False pretense of ‘Managed Medicare’
- Fear of fraud billing
- Ever changing confusing rules
- Ongoing reduction of reimbursement at the same time , more money going to commercial insurances to ‘manage’ Medicare patients.

External factors: Government

- HIPAA
- DEA
- RH act
- State restrictions
- EMR requirements
- Can not own hospitals
- Stark provisions

External factors: Practice Setting

- Highly competitive
- Ever changing
- Scope creep
- Dr Google

External Factors: Internet

- Google reviews
- Tweets
- Social media defamation

Culture Change

Current culture of invulnerability, isolation, and shame

Change to humane expectations, community sense and satisfaction.

Healthcare : Options

- Do acknowledge the elephant in the room
- Do seek strategic interventions
- Do reach out to authorities
- Do say No when appropriate
- Do unite
- Do become your brother’s/sister’s keeper
- Do avoid backstabbing

Mindset Shift

Physician must be able to diagnose, prescribe, dispense and treat in patient's best interest, without external interference/ threats

Patient must be able to pay directly to physician providing care, without third party involvement

Physician must be able to have **autonomy**

Physician must be able to look up to Medical Board for guidance and support

Society needs to refresh the framework of **law-suits**.

Think beyond

IDENTIFY COMMON FACTORS [LIABILITY THREATS, INSURANCES, LACK OF AUTONOMY ETC.]

UNITE! [IF CAN NOT UNIONIZE]

RESPECT THE PROCESS

ARISE AND TAKE SMALL STEPS TOWARDS BIGGER GOALS

TEAM

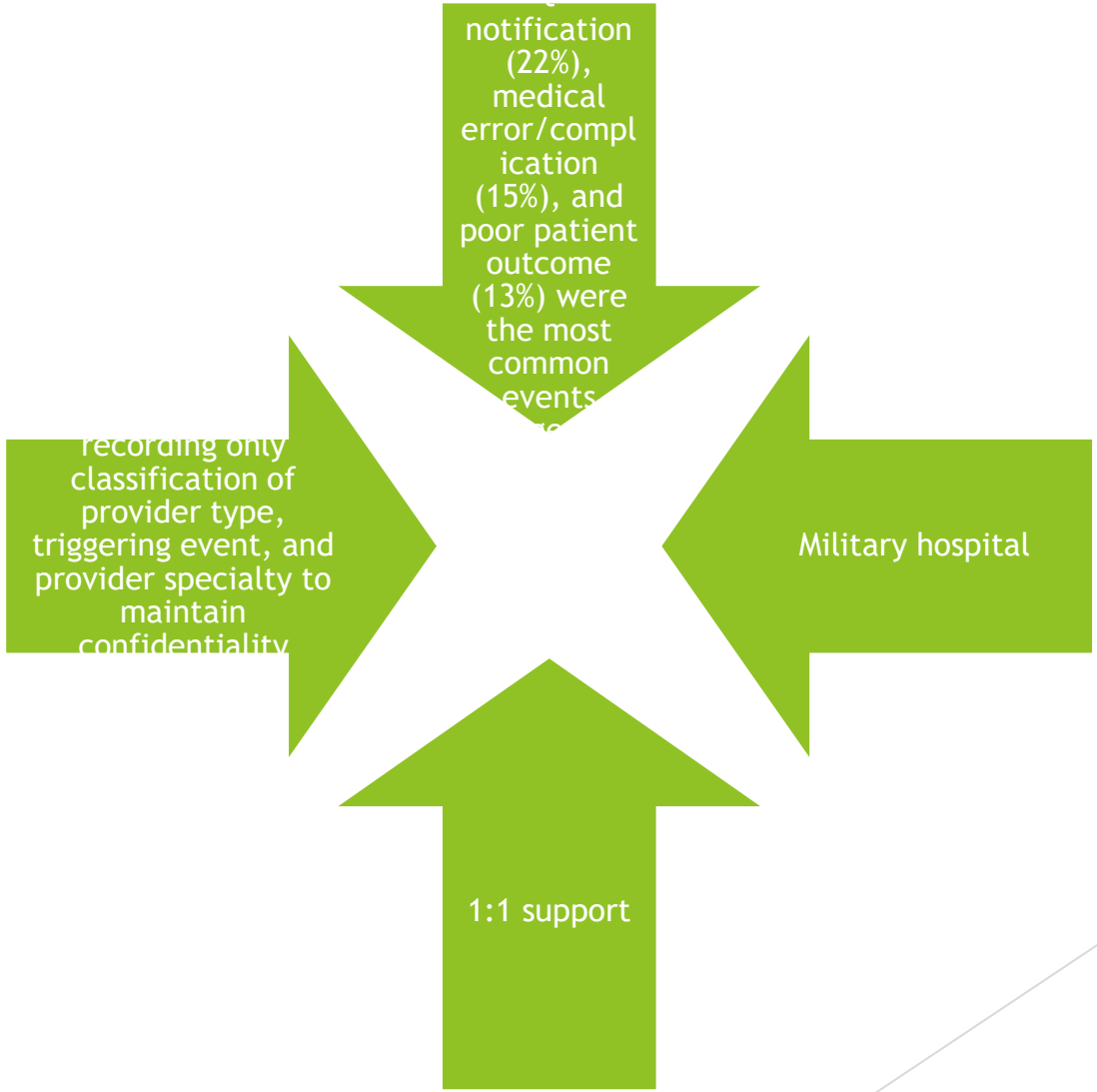
CALL TO THE TMA LEADERSHIP

INITIATE PROCESS OF CREATING SAFETY NET

Physicians, Say No To

- Backstabbing
- Bad mouthing
- Documenting negative remarks
- Inner fighting
- Superiority complex
- This is the only way
- Testifying against a physician when that physician hasn’t done anything wrong

Peer Support Programs (PSPs)



Triggers

- Serious adverse patient event and/or a traumatic personal event within the preceding year (79%)
- legal situations (72%)
- Involvement in medical errors (67%)
- Adverse patient events (63%)
- Substance abuse (67%),
- Physical illness (62%)
- Mental illness (50%)
- Interpersonal conflict at work (50%)

Barriers to be lowered

- Lack of time (89%)
- Uncertainty or difficulty with access (69%)
- Concerns about lack of confidentiality (68%)
- Negative impact on career (68%)
- Stigma (62%).

Resources

- Physician colleagues (88%)
- Employee assistance program (29%)
- Mental health professionals (48%)

Peer Support conversation

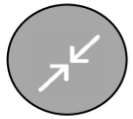
- Outreach call
- Invitation/Opening
- Listening
- Reflecting
- Reframing
- Sense-making
- Coping
- Closing
- Resources/Referrals

INTRODUCTION & SET UP

Outreach	Reaching out to the resident can be framed as routine practice after a stressful event. It should also identify a dedicated time for a private conversation. • "I always try to reach out after an adverse event to make sure you're doing OK." • "Let's set a date and time that we can dedicate to talking about this."
Confidentiality	The precedent of safe space and confidentiality should be established early. Chief Residents should clarify which 'hat' they are wearing because residents know them to serve in many roles. • "I am here right now just to support you and this conversation will remain confidential."
Opening	Focusing the conversation on the experience and emotions of the resident can begin by starting with open-ended questions. • "Can you tell me what you went through in experiencing this event?"

EXPLORATION

Listen	Empathic listening is a priority, knowing the pain from an experience cannot simply be cured. In this conversation, chief residents should resist the urge to dig into clinical details. • "How are you feeling about all this?"
Reflect	Reflecting emotions and naming a reaction can mitigate intrusive or disruptive thoughts, validate the resident's feelings and ensure he or she feels heard. • "I can hear in your voice how painful this experience was to go through."



NORMALIZING WITHOUT MINIMIZING

Reframe	Reframing can help residents view experiences through a different lens without minimizing the emotional tolls. • "This patient was so sick; despite best supportive treatments, we knew this outcome might happen." • "The fact that you care so much makes this situation hard but also demonstrates your compassion."
Normalize	Sharing personal anecdotes can help reduce feelings of isolation after stressful events. • "Many of us have gone through something similar during training."
Sense-making	In some cases, residents may benefit from engaging with systems or quality improvement programs, though this should not detract from supportive listening. • "This case highlights the need for a systemic improvement. There may be ways to get involved if you think that would help you."

CLOSING

Acknowledge and Thank	Acknowledging the resident's hard work and bravery required to share raw emotions can build trust. • "Thank you for your willingness to be vulnerable with me."
Pause and Coping	Pausing before closing can allow residents to identify supports and plans and make those known. • "I can share my thoughts, but do you already have an idea of what your next steps may be?" • "What have you done in the past to help you through difficult times?"
Resources and Referrals	Chief residents should be prepared to share local wellness and mental health resources. • "If you find this gets under your skin and is impairing your ability to heal, I can make sure you get the resources to help. You are not alone."

FOLLOW UP

Follow up	Making a plan to reengage is critical and may go overlooked. Chief residents may schedule a time to check in or simply reach out again to maintain a connection. • "No obligation to respond but I am thinking of you. I'm here for you if you need me."

Trainee wellness

ESTABLISH SUPPORT FROM INSTITUTIONAL AND DIVISIONAL LEADERSHIP

CREATE A WELLNESS COMMITTEE

PERFORM A NEEDS ASSESSMENT

ASSESS TRAINEE WELLNESS AND BURNOUT

PERFORM TARGETED INTERVENTIONS

ROUTINELY REASSESS TRAINEE WELLNESS AND BURNOUT

Clinical Consultation

- Offering advice or consultation on complex medical cases
- Discussing treatment options
- Interpreting test results
- Providing guidance on challenging diagnoses

Mentorship

- Providing guidance and support to less experienced colleagues, including medical students, residents, or junior physicians.
- Sharing clinical knowledge, career advice, or insights into navigating the healthcare system.

Professional Development

- Assisting with professional development by sharing resources
- Recommending continuing education opportunities
- Providing feedback on presentations or research projects

Emotional Support

Offering a listening ear and emotional support during challenging times

such as when dealing with difficult patients, making tough decisions, or coping with personal stressors.

Collaboration

- Working together on research projects
- Quality improvement initiatives
- Other collaborative efforts aimed at advancing medical knowledge and improving patient care

Peer Review

- Providing constructive feedback on research manuscripts
- Clinical guidelines
- Other professional documents

Advocacy

- Advocating for the well-being of colleagues
- By speaking up about concerns regarding workload
- Workplace safety
- Other issues impacting their professional lives

Networking

- Introducing peers to valuable professional contacts
- Connecting them with potential collaborators or mentors
- Helping them navigate professional organizations and societies