BY DAWN COLEMAN, MD; MALACHI SHEAHAN, MD; AND MICHAEL GOLDBERG, MD

Last month, we introduced the epidemic of burnout and the adverse consequences for both our vascular surgery patients and ourselves. Today we will outline a framework for addressing these issues. The foundation of this framework is informed by the social and neurosciences.

From the perspective of the social scientist: Christina Maslach, the originator of the widely used Maslach Burnout Inventory, theorized that burnout arises from a chronic mismatch between people and their work setting in some or all of the following domains: Workload (too much, wrong kind); control (lack of autonomy, or insufficient control over resources); reward (insufficient financial or social rewards commensurate with achievements); community (loss of positive connection with others); fairness (lack of perceived fairness, inequity of work, pay, or promotion); and values (conflict of personal and organizational values).

The reality of practicing medicine in today’s business milieu – of achieving service efficiencies by meeting performance targets – brings many of these mismatches into sharp focus.

From the perspective of the neuroscientist: Recent advances, including functional MRI, have demonstrated that the human brain is hard wired for compassion. Compassion is the deep feeling that arises when confronted with another’s
suffering, coupled with a strong desire to alleviate that suffering. There are at least two neural pathways: one activated during empathy, having us experience another’s pain; and the other activated during compassion, resulting in our sense of reward. Thus, burnout is thought to occur when you know what your patient needs but you are unable to deliver it. Compassionate medical care is purposeful work, which promotes a sense of reward and mitigates burnout.

Because burnout affects all caregivers (anyone who touches the patient), a successful program addressing workforce well-being must be comprehensive and organization wide, similar to successful patient safety, CPI (continuous process improvement) and LEAN (Six Sigma) initiatives. There are no shortcuts. Creating a culture of compassionate, collaborative care requires an understanding of the interrelationships between the individual provider, the unit or team, and organizational leadership.

1) The individual provider: There is evidence to support the use of programs that build personal resilience. A recently published meta-analysis by West and colleagues concluded that, while no specific physician burnout intervention has been shown to be better than other types of interventions, mindfulness, stress management, and small-group discussions can be effective approaches to reducing burnout scores. Strategies to build individual resilience, such as mindfulness and meditation, are easy to teach but place the burden for success on the individual. No amount of resilience can withstand an unsupportive or toxic workplace environment, so both individual and organizational strategies in combination are necessary.

2) The unit or team: Scheduling time for open and honest discussion of social and emotional issues that arise in caring for patients helps nourish caregiver to caregiver compassion. The Schwartz Center for Compassionate Healthcare is a national nonprofit leading the movement to bring compassion to every patient-caregiver interaction. More than 425 health care organization are Schwartz Center members and conduct Schwartz Rounds™ to bring doctors, nurses, and other caregivers together to discuss the human side of health care (www.theschwartzcenter.org). Team member to team member support is essential for navigating the stressors of practice. With having lunch in front of your computer being the norm, and the disappearance of traditional spaces for colleagues to connect (for example, nurses’ lounge, physician dining rooms), the opportunity for caregivers to have a safe place to escape, a place to have their own humanity reaffirmed, a place to offer support to their peers, has been eliminated.

3) Organizational leadership: Making compassion a core value, articulating it, and establishing metrics whereby it can be measured, is a good start. The barriers to a culture of compassion are related to our systems of care. There are burgeoning administrative and documentation tasks to be performed, and productivity expectations that turn our clinics and hospitals into assembly lines.

No, we cannot expect the EMR (electronic medical records) to be eliminated, but workforce well-being cannot be sustainable in the context of inadequate resources. A culture of compassionate collaborative care requires programs and policies that are implemented by the organization itself. Examples of organization-wide initiatives that support workforce well-being and provider engagement include screening for caregiver burnout, establishing policies for managing adverse events with an eye toward the second victim, and most importantly, supporting systems that preserve work control autonomy of physicians and nurses in clinical settings. The business sector has long recognized that workplace stress is a function of how demanding a person’s job is and how much control that person has over his or her responsibilities. The business community has also recognized that the experience of the worker (provider) drives the experience of the customer (patient). In a study of hospital compassionate practices and HCAHPS (the Hospital Consumer Assessment of Healthcare Providers and Systems), McClelland and Vogus reported that how well a hospital compassionately supports its employees and rewards compassionate acts is significantly and positively is associated with that hospital’s ratings and likelihood of patients recommending it.

How does the Society of Vascular Surgery, or any professional medical/nursing society for that matter, fit into this model?

We propose that the SVS find ways to empower their members to be agents for culture change within their own health care organizations. How might this be done:

• Teach organizational leadership skills, starting with the SVS Board of Directors, the presidential line, and the chairs of committees. Offer leadership courses at the Annual Meeting.
• Develop a community of caregivers committed to creating a compassionate collaborative culture. The SVS is a founding member of the Schwartz Center Healthcare Society Leadership Council, and you, as members of the SVS, benefit from reduced registration at the Annual Compassion in Action Healthcare Conference, June 24-27, 2017, in Boston (http://compassioninactionconference.org). This conference is designed to be highly experiential, using a hands-on “how-to-do-it” model.
• The SVS should make improving the overall wellness of its members a specific goal and find specific metrics to monitor our progress toward this goal. Members can be provided with the tools to identify, monitor, and measure burnout and compassion. Each committee and council of the SVS can reexamine their objectives through the lens of reducing burnout and improving the wellness of vascular surgeons.
• Provide members with evidence-based programs that build personal resilience. This will not be a successful initiative unless our surgeons recognize and acknowledge the symptoms of burnout, and are willing to admit vulnerability. Without doing so, it is difficult to reach out for help.
• Redesign postgraduate resident and fellowship education. Standardizing clinical care may reduce variation and promote efficiency. However, when processes such as time-limited appointment scheduling, EMR templates, and protocols that drive physician-patient interactions are embedded in Resident and Fellowship education, the result may well be inflexibility in practice, reduced face time with patients, and interactions that lack compassion, all leading to burnout. Graduate Medical Education leaders must develop programs that support the learner’s ability to connect with patients and families, cultivate and role-model skills and behaviors that strengthen compassionate interactions, and strive to develop clinical practice models that increase Resident and Fellow work control autonomy.
• The SVS should work proactively to optimize workload, fairness, and reward on a larger scale for its members as it relates to the EMR, reimbursement, and systems coverage.

While we may be relatively small in size, as leaders, we are perfectly poised to address these larger, global issues. Perhaps working within the current system (i.e., PAC and APM task force) and considering innovative solutions at a national leadership scale, the SVS can direct real change! Changing culture is not easy, nor quick, nor does it have an easy-to-follow blueprint. The first step is recognizing the need. The second is taking a leadership role. The third is thinking deeply about implementation.

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