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CLINICAL & RISK MANAGEMENT PERSPECTIVES

NORCAL GROUP®

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Systems Solutions to Decreasing Physician Burnout and Increasing Wellness

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By reviewing medical professional liability claims and/or emerging topics in healthcare risk management, this enduring material series will support your ability to:

- Assess your practice for risk exposures.
- Apply risk management best practices that increase patient safety and reduce medical professional liability claims.

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EDITOR

Mary-Lynn Ryan, JD
Risk Management Specialist, NORCAL Group

CONTENT ADVISORS

Sandra L. Beretta, MD
Chair, NORCAL Mutual, FD Insurance, Medicus and Preferred Physicians Medical RRG

Patricia A. Dailey, MD
Director, Preferred Physicians Medical RRG

Rebecca J. Patchin, MD
Director, NORCAL Mutual, FD Insurance and Medicus

William G. Hoffman, MD
Family Practice Content Advisor

Dustin Shaver
Vice President, Risk Management, NORCAL Group

Paula Snyder, RN, CPHRM
Regional Manager, Risk Management, NORCAL Group

Katey L. Bonderud, MHCA
Claims Specialist, NORCAL Group

Kellie N. Sorenson, JD
Sr. Counsel, NORCAL Group

PLANNER

Shirley Armenta
CME Program Lead, NORCAL Group

INTRODUCTION

"We must make both the prevention of burnout and the restoration of the joy of a career in medicine core priorities, and address this issue with the same urgent methods we would use to solve any other important business problem."[1]

Research indicates that a majority of physicians may be suffering from burnout.[2] Who or what is responsible for physician burnout is a complicated question that has prompted a great deal of research over many years. The short answer is burnout occurs when physicians cannot meet workforce demands. Various aspects of the practice of medicine have been identified as "root causes" of burnout, including:

- Electronic health records
- Loss of autonomy
- Compliance and regulatory issues
- Production pressure
- Lack of administrative resources and support
- Lack of support from physician leadership
- Reimbursement
- Meeting CME, licensure and certification requirements
- The culture of medicine
- Demanding, non-adherent and generally difficult patients with unrealistic expectations
- Unanticipated patient outcomes
- Long work hours that encroach on personal life
- Administrative actions/litigation stress

Despite burnout being a work-related condition, burnout solutions, until fairly recently, have focused on physician self-help.[3] There is no reason to doubt the benefit of physicians developing resiliency skills and seeking behavioral healthcare to manage burnout and the other stressors that affect physician well-being. But self-help does not solve the systems and administrative causes of burnout.

There is a business case to be made for burnout reduction and physician wellness.[4] Burnout can affect every aspect of healthcare delivery. For example, burned-out physicians are more likely to be involved in poor outcomes[5] and have lower patient satisfaction scores.[6] They can negatively affect workplace culture due to diminished empathy towards coworkers, disengagement from teamwork and lack of commitment to corporate values.[7] And burnout is expensive. In addition to burnout-associated loss of goodwill, reduced reimbursements and patient injury compensation, it costs $500,000 to over $1 million to replace a physician who has quit due to burnout (i.e., costs of recruitment, hiring bonuses, billing losses and search and replacement fees).[8,9] Like many issues associated with healthcare, prevention is cheaper and safer than managing the downstream consequences of full-blown burnout.[6] Physician retention is more than a financial proposition; with the anticipated physician shortage, it could become a public health issue. Organizations should, therefore, be motivated to manage the risk of physician burnout and promptly alleviate it when it occurs.

The case study in this article is based on a NORCAL Group closed claim. It highlights the ways that burnout can affect patient care and physician well-being. The risk management strategies are directed to managers, administrators and physician leaders to address organizational and cultural issues that may contribute to or cause physician burnout. Of course, there are burnout root causes under the control of parties other than healthcare administrators, including third-party payers, governmental and other oversight organizations, regulators and vendors. Addressing all of the root causes contributing to burnout is beyond the scope of this article, but various physician and healthcare organizations have been strategizing to affect changes in areas outside of their traditional areas of influence. (See, e.g., the AAFP Patients Before Paperwork Initiative, described at: ***acponline.org/advocacy/where-we-stand/patients-before-paperwork*** (accessed 9/27/2018).)

Research indicates that addressing physician burnout requires interventions not only on a systemic/organizational level but also on an individual level.[4,9,10] There are abundant resources for physicians searching to increase their resilience to burnout and increase their overall wellness. An excellent place to start is the AMA Steps Forward module entitled: "Improving Physician Resiliency," which is available at: ***stepsforward.org/modules/improving-physician-resilience*** (accessed 9/27/2018).

Definition of Burnout

Burnout is a chronic state, characterized by a loss of enthusiasm for work, cynical feelings and a low sense of personal accomplishment.[i] There are various tools available to assess burnout. The criterion standard for measuring burnout is the Maslach Burnout Inventory (MBI). There is a specific Maslach burnout tool for medical personnel. The Maslach Burnout Toolkit for Medical Personnel combines the Areas of Worklife Survey (AWS) and Maslach Burnout Inventory — Human Services Survey for Medical Personnel. The combined assessment consists of 50 items and usually takes 25-30 minutes to complete.[ii] The Maslach Burnout Inventory — Human Services Survey for Medical Personnel assesses three main indicators of burnout:[iii]

- **Emotional Exhaustion**—feelings of emotional overextension and exhaustion by work
- **Depersonalization**—callous and impersonal reaction to patients
- **Personal Accomplishment**—Feelings of incompetence, poor achievement and low motivation

The AWS assesses how work environment may be contributing to burnout by evaluating:

- **Workload**—how much work is required in a given period
- **Control**—ability to influence how things are accomplished
- **Reward**—recognition for jobs well done, including praise, salary, perks, awards, etc.
- **Community**—quality of interactions with managers, colleagues, subordinates and patients
- **Fairness**—justness with which all workers are handled
- **Values**—match between personal values and organizational values

The National Academy of Medicine website includes a page devoted to burnout assessment tools with links to validated instruments. It is available at: ***nam.edu/valid-reliable-survey-instruments-measure-burnout-well-work-related-dimensions/#purpose*** (accessed 9/29/2018).

RESOURCES

i. Lacy BE, Chan JL. Physician Burnout: The Hidden Health Care Crisis. *Clinical Gastroenterology and Hepatology.* 2018;16(3); 311-317. Citing, Maslach C, and Jackson S. Maslach Burnout Inventory manual. Palo Alto, CA: Consulting Psychological Press; 1986.

ii. Tawfik DS, et al. Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors. *Mayo Clin Proc.* 2018;nn(n):1-10.

iii. Maslach Burnout Toolkit for Medical Personnel. Available at: ***mindgarden.com/329-maslach-burnout-toolkit-for-medical-personnel*** (accessed 9/27/2018).

NORCAL Group Professional Wellness Website

The NORCAL Group Professional Wellness website contains additional burnout prevention strategies, with additional content being added regularly. Visit the wellness website at: ***norcal-group.com/wellness***

Conditions and a Cascade of Events Result in Physician Suicide

In the following case study, an already burned-out physician was unable to rebound from an adverse patient outcome, which triggered medical staff privilege restrictions, a medical board action and a lawsuit. Consider how the hospital leadership and administration could have reduced this physician's burnout, second victim syndrome and suicide risk.

> ***Allegation: The surgeon's delay in recognizing a bladder perforation resulted in the patient's death.***

In October 2014, a surgeon who had never been involved with an adverse patient outcome perforated a patient's bladder during surgery at Hospital 1. He did not realize it until five days later. After multiple complications related to the bladder perforation, the patient died.

Shortly after the event, the chief of surgery presented the surgeon with a choice: voluntary or mandatory privilege revocation. The surgeon was able to negotiate an immediate voluntary leave of absence as an alternative to losing his privileges. (He continued to perform surgeries at Hospital 2 during the voluntary leave and thereafter.)

In December 2014, the Hospital 1 chief of staff informed the surgeon that the medical executive committee (MEC) was conducting a focused professional practice evaluation (FPPE) that would involve evaluating all of the surgeon's cases from the past two years. Four months later, the MEC informed the surgeon that no violations of the standard of care were discovered. He was told that his privileges were reinstated; however, the FPPE would continue for an additional 12 months, during which time he was required to have a minimum of 30 cases reviewed and internally proctored. He would not be eligible for emergency department (ED) call during this time. By June 2015, the surgeon realized it would be almost impossible to complete the designated number of cases without being on call in the ED, and he resigned from the Hospital 1 medical staff.

In July 2015, the surgeon was served with a malpractice lawsuit alleging the October 2014 surgery was negligent, as was the delay in diagnosing the perforation. In August 2015, the surgeon received a notice to appear before the medical board. He was informed by the medical board that he had been reported by a colleague.

In September 2016, at Hospital 2, a patient presented with appendicitis symptoms. The surgeon removed her appendix without complication. The patient's symptoms continued, but no further workup was done to investigate the patient's symptoms, which were partially masked by post-operative pain. Two days after the surgery, the surgeon was informed by pathology that the appendix was healthy. However, he failed to communicate the finding. The patient was later diagnosed with a ruptured ectopic pregnancy. As a result of the failure to communicate the findings of the healthy appendix, which delayed the diagnosis of ectopic pregnancy, Hospital 2 revoked the surgeon's privileges. He committed suicide shortly thereafter.

Actively promoting wellness and removing the punitive culture associated with maintaining a healthy work/life balance are integral aspects of decreasing the risk of physician burnout.

DISCUSSION

Although the preceding fact pattern may not appear to involve burnout, the surgeon involved was struggling with meeting the demands of his job before the first patient injury occurred. Then he became trapped in a vicious burnout cycle. Physician burnout can increase the risk of adverse patient outcomes,[11,12] which can further increase the risk of burnout.[13] Adverse outcomes can lead to medical executive board investigations, medical board proceedings and litigation. The stress associated with these proceedings can have a significant effect on physician well-being and can exacerbate burnout.[14,15] Burnout, bullying, adverse outcomes and litigation stress can separately or in combination increase the risk of physician suicide.[6,15,16,17] This physician's chance of recovery from the cascade of events was significantly diminished due to the culture of medicine and the lack of systems/organizational strategies and programs for promoting physician wellness and reducing the risk of burnout.

The signs and circumstances of burnout are not always obvious. Consider the underlying facts of the case study.

Physician Schedule

Heavy workload[18] and interference with family life[19] are predicators of burnout. The surgeon in this case worked an average of 60 hours per week, not including the four days per week he was on call. He had privileges at two different hospitals and averaged 15-20 operations per week, not including surgeries occurring on call. He generally left for work at 5:30 a.m. and returned home around 8 p.m. He regularly devoted an hour or more per evening to completing medical record documentation. Because of his schedule, he rarely saw his two young children or spouse during the week.

EHR

Electronic health records (EHRs) are a main cause of physician burnout.[20] Hospital 1's EHR was difficult to utilize, which cut into the time the surgeon had available to spend with patients. The system did not communicate with the other hospitals' systems or medical offices from which the surgeon's patients were referred. He often operated with less patient information than he wanted.

Workplace Bullying

Workplace bullying (also referred to as "disruptive behavior," "lateral" or "horizontal violence" and, if it is subtle, "insidious intimidation") is a prevalent problem in healthcare[21,22] that contributes to burnout, depression and anxiety.[23] Bullying ranges from outrageous, aggressive behavior and "whisper campaigns" to subtle patterns of disrespect that might be so common they seem normal.[24] Not only does bullying affect the mental health and well-being of victims and bystanders, it creates a culture of disrespect in which coordination and collaboration decline,[24,25,26] and patient injury is more likely.[24,27]

The chief of surgery at Hospital 1 had a "difficult personality." His tendency to single out the defendant surgeon for unwarranted criticism and generally unpleasant comments was well known among the other surgeons and staff, who liked and respected the defendant surgeon. In addition to the blatant verbal abuse, the chief of surgery refused to return the defendant surgeon's calls or emails, which made communication impossible. When the need to communicate with the chief of surgery arose, it filled the surgeon with dread. The defendant surgeon had been told that the chief of surgery regularly and unfairly criticized his surgical skills and questioned his mental stability in front of colleagues and members of the medical executive committee. The defendant surgeon constantly worried that the chief of surgery would manufacture some reason to advocate for the removal of his staff privileges. It is likely that the chief of surgery's treatment of the defendant surgeon affected his ability to practice medicine safely.

Second Victim Syndrome

"Second victims" are physicians or other caregivers who sustain psychological harm as a result of involvement in an unanticipated patient outcome.[28] The response to an adverse outcome can be physical and emotional. For

example, in the immediate aftermath of an adverse outcome, second victims can experience increases in blood pressure and heart rate, muscle tension and rapid breathing. Difficulty concentrating, appetite and sleep disturbances, flashbacks and suicidal ideation can follow. Second victims experience a range of emotions, including sadness, fear, guilt, anger, embarrassment and humiliation. Second victim syndrome symptoms can last for months or even years. Some commentators compare second victim syndrome to post-traumatic stress disorder.[28] Although second victim syndrome can develop in the absence of burnout, in this case the initial patient injury itself most likely exacerbated the defendant surgeon's burnout.

Culture of Medicine

The surgeon's wife had urged her husband to seek counseling to deal with his burnout, second victim syndrome and litigation stress, but he refused. He did not want to appear weak. He also worried that he would have to report counseling on his license renewal application. Fear of stigma, lack of confidentiality and licensing repercussions are common reasons physicians fail to obtain necessary mental health treatment.[29]

Organizational/Systems Strategies for Reducing Physician Burnout and Increasing Wellness

Actively promoting wellness and removing the punitive culture associated with maintaining a healthy work/life balance are integral aspects of decreasing the risk of physician burnout. This requires not only stating an organizational intention to value and support physician well-being, but also providing the time and funding to make it happen. It is important to involve physicians in the planning and monitoring of these programs. It is also important to have a physician leadership team in place that will model healthy behavior, foster collegiality and recognize physician achievements. Physician leaders' behavior can significantly contribute to the satisfaction and well-being of the physicians they lead.[15] Poor leadership can increase burnout.[30] The following strategies can create a culture of wellness and diminish burnout risk:[7,31,32]

- Ensure physician workload expectations are reasonable.
  - Prevent overscheduling, excessive call and sleep deprivation.
- Give physicians more control over their work schedules.
- Improve workflow.
  - Improve patient flow.
    - Ensure physicians can meet with patients for an appropriate amount of time.
  - Facilitate a team-based approach to patient care.
    - Maximize quality time physicians spend with patients.
  - Address EHR issues.
    - Analyze the necessity of various EHR alerts.
    - Restructure in-baskets to increase efficiency.
  - Improve the password process with single sign-on technology.
  - Customize the EHR interface to individual physicians or departments.
  - Give physicians choices regarding how they will accomplish data entry (e.g., scribes, virtual scribes, dictation, voice recognition or typing).
  - Spread data collection duties among patient care team members to allow physicians to work at the top of their license.
  - Provide individualized EHR training from qualified trainers, tailored to the physician's workflow and specialty.
    - Give physicians the opportunity to have an EHR specialist "shadow" them to determine how they can improve their EHR use efficiency.

    - Provide physicians with EHR efficiency reports, and then help them create templates for the issues they consistently and repetitively document.
    - Provide training on software upgrades and encourage physicians to take advantage of new EHR features.
- Nurture a collegial, positive practice environment.
    - Facilitate the formation of a Balint Group, which is dedicated to improving the therapeutic relationships between healing professionals and their patients. (See, ***americanbalintsociety.org*** (accessed 9/26/2018))
    - Institute team huddles at the beginning of each day to strategize about potential workflow problems and celebrate the previous day's successes.
    - Schedule regular social activities that involve families.
    - Make the physician lounge inviting.
- Show physicians respect.
    - Give physicians an appropriate level of autonomy and control to accomplish the outcomes that are expected of them.
    - Value input from physicians regarding improving patient care.
    - Thank and acknowledge physicians for meeting or exceeding performance standards.
    - Compensate physicians appropriately.
    - Compensate physicians for leadership and citizenship activities.
    - Encourage and reward integrity and ethical practices.
- Implement a burnout prevention, identification and management program.
    - Facilitate the operation of physician peer support programs to help physicians effectively manage job stress.
    - Schedule regular meetings for physicians to discuss stressful situations, difficult patients and challenging diagnoses.
    - Create specific programs that support physicians who are suffering from burnout.
    - Promptly address issues that increase burnout risk.
    - Regularly monitor physicians for burnout.
- Implement a wellness promotion program.
    - Build time into schedules for stress-relieving activities.
    - Schedule retreats that focus on team building and self-awareness.
    - Create mentor programs for junior physicians.
    - Offer sabbaticals.
    - Provide continuing medical education (CME) programs devoted to physician burnout, wellness and healthy work/life balance.
    - Designate a physician who successfully balances work and personal obligations as a point person; provide leadership skills training to that physician.
    - Create a physician wellness committee that has the same stature as other key committees.
    - Use staff and physician experience surveys to measure successes and failures of the wellness/burnout prevention program.
        - Make adjustments to the program based on the results.
- Establish physician leadership that values and promotes burnout prevention and wellness.
    - Train physician leaders and physician liaisons to be more effective in managing the risk of physician burnout and promoting wellness.
    - Encourage medical executive committees to seek support from administrators to facilitate leadership skill development.

Systems Strategies for Reducing Bullying and Intimidation

Managing bullying requires a multi-modal approach. Although holding bullies and disruptive physicians appropriately accountable for their behavior is paramount to the success of an anti-bullying policy, administrators and physician leaders must establish and enforce anti-bullying policies and procedures to create an environment in which bullying is less likely to occur, where the response to bullying is swift and effective and where the workforce has the resilience to withstand the damaging effects of bullying before patients suffer harm.[33] Incivility and bullying can arise due to compensation and marketplace forces that create bias. Medical staffs need to be aware of competing issues and not be naïve about intent. Many medical staffs do not know another department's pressure points and miss this type of bullying. Bullying prevention can be built into a physician burnout prevention and wellness promotion program. Consider the following recommendations:[25,34,35,38]

- Establish anti-bullying policies and procedures that include:
  - A definition of bullying behavior that provides enough clarity for individuals to know what behavior is prohibited or reportable. Examples of bullying behavior can be found in the following documents:
    - "Bullying Has No Place in Health Care." Available at: ***jointcommission.org/assets/1/23/Quick_Safety_Issue_24_June_2016.pdf*** (accessed 10/2/2018)
    - "Prevalence of Horizontal Violence Among Emergency Attending Physicians, Residents, and Physician Assistants." Available at: ***ncbi.nlm.nih.gov/pmc/articles/PMC5305126/*** (accessed 10/2/2018)
    - "Workplace Intimidation: The Underestimated Threat to Patient Safety" Available at: ***ashrm.org/pubs/files/white_papers/Thought_Leader_Forum_Workplace_Intimidation2011.pdf*** (accessed 10/2/2018)
  - Administrator, clinician, and staff roles and responsibilities
  - Strategies for responding to bullying
  - Clear and confidential grievance, investigation and disciplinary procedures
  - Process documentation requirements
  - Protections for individuals who report bullying or cooperate in investigatory processes (i.e., non-retaliation clauses)
    - Consider a whistleblower process.
- Enforce a "zero tolerance" bullying policy, without exemptions for well-connected or powerful members of the workforce.
  - Appropriately investigate every report of bullying.
- Provide training for physicians and staff in recognizing bullying and complying with the bullying policy.
  - Stress the risks of bullying and the specific detrimental effects bullying has on victims, bystanders and patients.
- Establish a confidential bullying reporting system.
  - Encourage patients to report bullying among members of the healthcare team; this serves as an additional source of quality improvement information.
  - Provide different ways individuals can report bullying. For example, do not require victims and witnesses to only report bullying through their supervisors.
- Ensure victims of bullying are adequately supported.
- Focus on bullying prevention and a culture change instead of relying on reactionary processes. For example:
  - Evaluate and reward reasonable and competent interpersonal behavior.
  - Encourage and support a team mentality.
  - Clearly delineate culture change goals.
  - Ensure physicians and staff understand ways in which their contribution helps achieve the culture change goals.
  - Give continuous feedback.
- Perform root cause analyses to uncover systemic problems.
  - Review bullying incidents and determine whether overwork, stress, lack of control or input, or other work processes may be contributing to bullying, and make changes based on investigation findings.

Systems Strategies for Identifying and Addressing Second Victim Syndrome

Surveys indicate that second victim syndrome has been experienced by nearly half of all healthcare providers.[12] One study found that 90% of physicians interviewed felt that healthcare organizations failed to provide sufficient assistance when dealing with second victim syndrome, despite the fact that 82% desired that kind of support.[36] Strongly consider providing second victim support as a predictable and required part of the healthcare operational response to near misses and unanticipated outcomes. It is important to structure this program in a way that any discussions of facts or event analysis are protected from legal discovery to the greatest extent possible. Consultation with a healthcare attorney for the design of any second victim support is highly recommended. Trained first responders (even when the trained responders are fellow physicians) can help protect the confidentiality of unanticipated outcome facts and analysis by focusing discussions on the second victim's emotional response to the event. Consider the following strategies:[14,12,37]

- Develop a comprehensive plan and provide accessible, effective support for all clinicians experiencing second victim syndrome.
  - Start providing support immediately and continue it for as long as necessary.
  - Establish the idea that seeking support after near misses or adverse events is not a sign of weakness; encourage physician leaders to share how they have coped after near misses.
  - Widely disseminate information so clinicians know what support is available, what can be expected, and how to access help when they experience an unanticipated outcome.
  - Build flexibility into support services.
    - Offer in-person or telephone counseling with therapists or other physicians who have coped with patient-care errors.
    - Provide services during and outside of work hours.
  - Encourage clinicians to discuss feelings about an adverse outcome with family, friends and colleagues.
    - Discussion of feelings should be distinguished from discussion of the facts of the patient's care and any event analyses, which are confidential.
    - Reinforce confidentiality protections in support programs and educate physicians about the programs.
  - Establish peer support initiatives.
    - Train peer counselors in listening and supportive skills.
    - Ensure the focus of peer counseling is the victim's emotional response and not the details of the event.
- Nurture a non-punitive culture surrounding unanticipated outcomes.
  - Focus quality assurance and risk management conferences on learning from errors instead of assigning blame.
  - Educate all parties that an unanticipated outcome does not equate to the need for privilege investigation, especially in the absence of a pattern of patient harm.
- Obtain buy-in from physician leadership and monitor leadership engagement in second victim activities.

Litigation Stress Management

Following the patient's death, the surgeon became progressively stressed as he tried to see patients and deal with various repercussions from the death. Already suffering from burnout and second victim syndrome, the additional stress of an MEC assessment, medical board investigation and lawsuit was disastrous. Although the case would be defended ultimately (perforation was a known complication of the procedure occurring in the absence of negligence and the failure to recognize it was mostly due to systems failures and inaction by other members of the patient's care team), the fact remained that the surgeon would be involved in a protracted litigation process.

Physicians need to recognize their vulnerability to medical board action and litigation stress and actively seek the support they need. Administrators should also be sensitive to exacerbating burnout, second victim syndrome and litigation stress symptoms when instigating actions against physician privileges that are prompted by an unanticipated outcome.

Litigation Stress Resources

NORCAL Group Litigation Support for Healthcare Professionals
A series of articles addressing:

1. How to Prepare for Your Initial Meeting
2. Understanding the Litigation Process
3. How to Prepare for Your Deposition
4. How to Prepare for Your Trial
5. How to Prepare for Your Deposition (Non-Defendant Witness)

NORCAL Group insureds can access these materials through the NORCAL Group website (***norcal-group.com***), by signing on to MyACCOUNT, clicking the "Claims" link, and then the "Litigation Support" link.

Physician Litigation Stress Resource Center
The Physician Litigation Stress Resource Center is a central clearinghouse and resource for physicians and other healthcare professionals.

Materials can be accessed at: ***physicianlitigationstress.org*** (accessed 9/27/2018).

Successful Litigation Stress Coaching (SLSC)
Provided by the Winning Focus company upon referral by a NORCAL Group insured's defense counsel, SLSC provides tools to physicians involved in litigation that empower them as physician-defendants to meet the challenges associated with a medical malpractice lawsuit. During litigation stress coaching, the facts of the case are not discussed; instead, the focus is on what the healthcare professional is feeling and on relieving litigation stress. If you feel you would benefit from litigation stress coaching, please contact your NORCAL Mutual Claims Specialist or attorney. It is NORCAL's goal to provide our insureds with the necessary information and resources to help with stress as a result of being named in a malpractice lawsuit.

Suicide Prevention

By the time the surgeon was involved in his second adverse outcome (failure to act on the pathology report indicating the appendix was healthy at Hospital 2), he had become increasingly despondent. Losing this second job would exacerbate his family's financial difficulties. He could not envision a way to continue in his career. Feeling there were no other options, he took his own life.

Physician suicide rates (which are likely underreported) are higher than suicide rates in the general population.[39]

If you, a colleague, an employee or contractor are experiencing suicidal thoughts, confidential resources are available.

Suicide Prevention Resources

National Suicide Prevention Lifeline
suicidepreventionlifeline.org
Online chat or 1-800-273-8255
Free and confidential support, 24 hours a day, seven days a week, for people in suicidal crisis or distress, or for those who are helping a person in crisis.

United States Substance Abuse and Mental Health (SAMHSA) National Helpline
samhsa.gov/find-help/national-helpline
1-800-662-HELP (4357)
Free and confidential support, 24 hours a day, seven days a week; referral and information service for individuals and families facing mental and/or substance use disorders.

NORCAL Webinar: "What We Have Learned About Physician Suicides and Responsive Measures"
NORCAL Group insureds can access this webinar through the NORCAL Group website (*norcal-group.com*), by signing on to MyACCOUNT, clicking the "Risk" link, and then the "MyCME" link. Public access is available on the NORCAL Group Professional Wellness website at: *norcal-group.com/wellness* and directly at: *youtube.com/watch?v=fBzJVJrr2zc&feature=youtu.be&list=PLMofftADNJ80BUkgasPjTAOqSSlMY1e6p* (accessed 10/30/2018).

AMA STEPS Forward™ Toolkit: "Preventing Physician Distress and Suicide"
Available at: *stepsforward.org/modules/preventing-physician-suicide*
Downloadable tools to help physicians and healthcare organizations prevent physician distress and reduce the risk of suicide.

CONCLUSION

Healthcare organizations bear a heavy burden in reducing burnout among their physicians because the organization has the power to reduce many of the workplace stressors causing burnout. Without intervention, burnout harms physicians, creates a negative workplace culture, threatens patient safety and increases medical liability risk exposure. Retaining physicians in the workforce who would otherwise be lost to burnout benefits the organization's bottom line and protects the public from physician shortages. Prevention of, rather than reaction to, burnout is a more effective and efficient approach to eliminating burnout and improving physician wellness. Although burnout can exist without causing adverse patient outcomes, they are more likely among burned-out physicians. When adverse outcomes occur, second victim programs should also be in place. Having these programs in place can start to break the cycle of burnout and increase wellness support on a systems/organizational level. Finally, physicians are unlikely to seek help for the burnout, stress, depression, anxiety and even suicidal thoughts that can be associated with medical practice. Administrators and physician leaders can play a major role in removing the stigma of seeking help and removing the fear of reprisal for admitting distress.

ENDNOTES

The NORCAL documents referenced in this article, along with many other Risk Management Resource documents and past editions of the *Claims Rx*, are available in the Risk Solutions area of MyACCOUNT, or by policyholder request at 855.882.3412.

1. Noseworthy J, et al. Physician Burnout Is A Public Health Crisis: A Message To Our Fellow Health Care CEOs. Health Affairs Blog. Available at: ***healthaffairs.org/do/10.1377/hblog20170328.059397/full/*** (accessed 9/27/2018).
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