



**American Board of Psychiatry and Neurology, Inc.**

A Member Board of the American Board of Medical Specialties (ABMS)

# Crucial Issues Forum

2017

“If I told you that we had a system problem in American medicine that threatened quality of care, decreased patient satisfaction, reduced access to care, and that it was so prevalent that it potentially affected up to 50 percent of the patient encounters in the United States, you would very rapidly...respond...at all levels...We have precisely such a system problem in American medicine...that issue is physician burnout.”

— Tait Shanafelt, MD

“How to help neurologists improve and strengthen the relationships they have with one another and with other people in their lives is what we need to figure out.”

— Terrence Cascino, MD

“Physicians are in a moral crisis. We...participate in clinical care in circumstances that are often at odds with what we think is right and what we think is consistent with our values...We need to create a clinical learning environment that returns some degree of individual professional autonomy, meaning and joy for faculty as well as residents, fellows and students, and other members of the healthcare team.”

— Thomas Nasca, MD, MACP



## Psychiatry and Neurology Organizations Meet to Discuss Physician Wellness and Burnout at 2017 Crucial Issues Forum

The fourth Crucial Issues Forum, organized by the American Board of Psychiatry and Neurology (ABPN), was held on April 9-10, 2017 in Chicago. The objective of the forum was to bring together ABPN directors and senior staff, representatives of major organizations in psychiatry and neurology, select diplomates in clinical practice, and select psychiatry and neurology residents and fellows to discuss factors contributing to physician wellness and burnout and what might be done to promote physician wellness and decrease burnout by medical schools, residencies, specialty boards, and professional societies. The meeting was chaired by Dr. Kerry Levin, ABPN Chair. The forum participant list appears later in this report.

On day one of the forum, three presenters gave an overview of physician wellness and burnout. On the second day, two keynote panels examined organizational roles and strategies. On both days, participants discussed important issues in small group settings with follow-up reports provided to the entire group.

## Day One

# Keynote Address: Overview of Physician Wellness and Burnout

**Tait Shanafelt, MD**, Professor of Medicine, Hematology/Oncology and Director, Program on Physician Well-being at Mayo Clinic Department of Medicine, presented, “An Overview of Physician Wellness and Burnout: What We Know and What We Don’t Know.”

Dr. Shanafelt began by emphasizing that physician burnout is a widespread health systems issue that decreases quality of care, increases medical errors, decreases professional productivity and effort, promotes physician turnover, limits patient access to care, and erodes patient satisfaction.

Dr. Shanafelt reviewed the definition of burnout, describing it as a syndrome with three components: depersonalization (cynicism and detached feelings toward patients), emotional exhaustion, and low personal sense of accomplishment. He discussed rates of burnout by specialty among physicians, mentioning how some specialties, including neurology, have higher rates than others, and he noted that physicians have higher rates of burnout and are more dissatisfied with their work-life balance than the general population.

Dr. Shanafelt noted that in addition to the professional consequences of burnout there are tremendous personal costs as well, including broken relationships, alcohol and substance abuse, depression, and suicide.

Studies were cited linking emotional exhaustion in ICU staff with increased patient mortality, deterioration in teamwork, and decreased patient safety. Dr. Shanafelt’s own Mayo Clinic longitudinal studies were cited to demonstrate the negative effect of burnout on physician satisfaction and professional work-effort.

Dr. Shanafelt added his support to that of others who have called for a modification of the healthcare Triple Aim of enhancing patient experience, improving population health, and reducing cost of care into a Quadruple Aim through the addition of also improving the work-life balance of health care providers. He described some of the human and personal costs of burnout (loss of idealism and commitment, loss of sense that work is meaningful, feelings of guilt and unworthiness, and loss of direction and purpose) and how they may be linked to depression and suicide among physicians.

Dr. Shanafelt went on to list some of the health systems causes of burnout, including increased clinical demands, decreased staffing, decreased autonomy, increased government/



reimbursement issues, decreased time with patients, difficulty balancing personal and professional lives, inefficiency and intrusion of electronic health records, and a sense of isolation. He discussed that physicians were at increased risk for burnout because of inherent personality characteristics that are often adaptive in some professional setting (perfectionism, attention to detail) but that may become maladaptive in other contexts such as integrating personal and professional life. Ultimately, however, Dr. Shanafelt emphasized that health systems issues were the biggest culprits in physician burnout.

Dr. Shanafelt next described three dimensions that contribute to happiness, and that are essential for well-being and a full life: pleasure, engagement, and meaning. He also noted the importance of a sense of “flow” that results from deep concentration, intrinsic motivation, and the skills to respond to a high challenge. He noted that physicians are not always good at accurately calibrating their own distress and sense of well-being and that they often need help to focus on their most important personal and professional goals and priorities. Dr. Shanafelt cited his own study of career fit among physicians at the Mayo Clinic, emphasizing that those physicians who spent less than 20 percent of their time in what they considered to be their most meaningful activities were more likely to experience burnout. He reviewed important keys to personal resilience and strategies physicians have used to enhance their self-awareness, including mindfulness and narrative medicine.

Dr. Shanafelt pointed out that physicians are increasingly employed by organizations and that physicians in organizations face unique challenges, including sacrifice of

autonomy and flexibility, productivity requirements, and accountability to leadership. He went on to list the following specific organizational strategies to reduce physician burnout and promote physician engagement from one of his recent publications:

- Acknowledge and assess the problem
- Harness the power of leadership
- Target interventions to improve efficiency
- Cultivate community at work
- Use rewards and incentives
- Align values and culture
- Promote flexibility and work-life integration

- Promote resilience and self-care
- Employ organizational science

While he acknowledged the importance of all of the organizational strategies in reducing physician burnout and promoting physician satisfaction, Dr. Shanafelt focused special attention on the effect of leadership and interventions at the work-unit level to improve work efficiency.

Dr. Shanafelt ended by reemphasizing that distress is common among physicians, that distress influences both physicians and their patients, and that the drivers of physician burnout need to be addressed through a combination of personal and organizational strategies to promote physician well-being and engagement.

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## The ABPN Perspective on Physician Wellness and Burnout

**Kerry Levin, MD**, ABPN Board Chair and Chair of the Department of Neurology at the Cleveland Clinic, presented, “Drivers of Physician Wellness and Burnout: The Perspective of the ABPN”.

Dr. Levin reemphasized that the prevalence of burnout among physicians was greater than for the general public, that physician burnout has been increasing in recent years, and that neurology seems to be one of the medical specialties disproportionately affected by burnout and lack of work-life balance. He noted that in 2011 neurologists had a burnout rate of 55 percent compared to 45 percent for psychiatrists and that satisfaction with work-life balance was only 42 percent for neurologists compared to 60 percent for psychiatrists. By 2014, all specialties, including both neurology and psychiatry, reported more burnout and less satisfaction with work-life balance.

Dr. Levin described the Task Force on Physician Burnout established by American Academy of Neurology (AAN) president Dr. Terrence Cascino, and the results of a Task Force survey on neurologist burnout, career satisfaction, and well-being, authored by Dr. Neil Busis and colleagues and published in 2017 in *Neurology*. The paper reported that 60 percent of U.S. neurologists surveyed

met at least one criterion for burnout, mainly emotional exhaustion. Factors associated with the risk of burnout included performance of direct clerical tasks, number of hours worked per week, number of outpatients seen per week, and number of nights on call per week. Factors associated with less burnout included job autonomy, effective support staff, meaningful work, older age, and practicing the subspecialty of epilepsy. Greater career satisfaction was associated with finding meaning in one’s work, job autonomy, older age, and effective support staff, while lower career satisfaction was associated with burnout, percent time in clinical practice, and practicing the subspecialty of sleep medicine.



Dr. Levin noted that a recent American Association of Directors of Psychiatric Residency Training (AADPRT) survey of psychiatry program directors suggested that the leading factors contributing to resident burnout were personal life stressors and electronic health record-

related stressors, followed by inadequate clerical support, work compression, perfectionism and self-criticism, and high acuity clerical errors. Leading factors contributing to faculty burnout were believed to be work compression, followed by electronic health record-related stressors, inadequate clerical support, regulation hassles, inadequate time for scholarship and teaching, and lack of leadership support.

Dr. Levin announced the upcoming publication of a 2016 AAN survey of neurology residents and fellows, and recognized that prior studies have shown very high rates of burnout among trainees in many specialties.

Dr. Levin concluded that burnout is a significant threat to the current workforce of psychiatrists and neurologists, the pipeline of future physicians, and the quality of patient care. He stressed that the ABPN needs to understand the following specific aspects of burnout:

- The drivers of burnout and the policy changes needed to mitigate them.
- The MOC components that can be satisfied by practice requirements already in place at the institutional and national levels (CMS, JC, FSMB) to document physician competence.
- The changes that ABPN and ACGME need to make in curriculum and rotation requirements to improve meaning in trainee work and minimize trainee exhaustion and depersonalization.

**Joan Anzia, MD**, ABPN Director and Vice Chair for Education and Residency Training Director in the Department of Psychiatry and Behavioral Sciences at the Northwestern University's Feinberg School of Medicine, presented, "Wellness and Resilience: The Individual Physician."

Dr. Anzia began by stressing that even though she was going to focus her presentation on the wellness and resilience of individual physicians, everyone should understand that the highest impact of burnout interventions will likely be through changes in organizations and systems. She then pointed out that the ABPN as well as physician educators should care about burnout because of the following demonstrated effects of burnout on both physicians and patients:

- Medical errors
- Impaired professionalism
- Reduced patient satisfaction
- Staff turnover and reduced work hours
- Depression and suicidal ideation
- Motor vehicle crashes and near-misses

Dr. Anzia explained that addressing burnout will require changing the longstanding culture in medicine and medical education that has traditionally undermined most of what is known to promote human resilience and wellness, including:

- Adequate sleep
- Good nutrition and hydration
- Regular exercise

- Social and emotional support
- Community connectedness
- A sense of life meaning and purpose
- A positive, active approach to mastering problems

Dr. Anzia noted that medical organizations frequently recruit for and reinforce personality characteristics often considered good in physicians but that likely increase the risk of emotional exhaustion and burnout, including perfectionism and compulsiveness, need for control, need for achievement, exaggerated sense of responsibility, need to please everyone, difficulty asking for help, excessive and unrealistic sense of guilt, suppression of feelings, and difficulty taking time for oneself.

Dr. Anzia discussed the role of stress in performance, the difference between optimal and excessive levels of stress, and the need for educators to teach students and residents how to recognize their own physiologic and emotional needs and to respond to them appropriately while also developing the identity, values, knowledge, and skills of a physician.

Dr. Anzia identified factors known to increase resilience, including recognition of personal needs, proactive self-care, supportive professional relationships, talking things out with others, hobbies, personal relationships, optimally challenging tasks, appropriate boundaries, and humor. She noted how these resilience factors are consistent with Maslow's Hierarchy of Needs and then described specific approaches that might help physicians build up their resilience through mindfulness training, cognitive behavioral therapy, communication skills training, and self-care workshops.

Dr. Anzia suggested that changes in our current education and practice environments tend to promote a sense of isolation among trainees and practicing physicians, inhibit the



establishment of networks of social and emotional supports, and undermine feelings of community connectedness that appear to be necessary to prevent burnout. For example, many medical students no longer feel the need to attend class with their colleagues and are often in competition with one another for residencies and fellowships, residents often rotate in hospitals separate from other residents, doctors' dining rooms are now a thing of the past, and the structure of modern hospitals maximize clinical space at the expense of space for physicians to gather together.

Dr. Anzia briefly reviewed selected model programs for promoting physician well-being. For example, the Balance in Life Program at Stanford University attempts to address multiple dimensions of physical, psychological, professional, and social well-being of residents, and the Peer Support Program at the Brigham and Women's Hospital provides

intensive peer support to its physicians who have experienced an adverse event.

Dr. Anzia pointed out the many difficulties physicians often face in accessing both general medical and mental health care and the importance of responding immediately when a physician colleague asks for help.

Dr. Anzia ended by posing two questions she felt must be addressed by trainees and practicing physicians alike if burnout is to be prevented:

“How do we foster and maximize our sense of meaning and purpose in our work?”

“How do we foster active mastery of knowledge and clinical skills, build 'grit' and resilience, and ensure that we don't become clinically overwhelmed and burned out?”

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## Small Group Discussions: What are the specific drivers of physician wellness and burnout?

### Ten Drivers of Burnout

1. Isolation, lack of connectedness, and lack of collegiality
2. Loss of autonomy, authority, and control
3. Lack of respect and stature
4. Lack of professional meaning and purpose
5. Lack of time and pressure to increase clinical service
6. Decreased sense of professionalism in medicine
7. Economic pressure, including student debt
8. Electronic health records and regulations without discernible value
9. Lack of leadership, empathy and understanding
10. Personal characteristics, including perfectionism and obsessiveness

### Ten Drivers of Wellness

1. Peer support and connectedness
2. Sense of autonomy and control
3. Professional culture at all levels that values and supports provider wellness
4. Availability of effective tools to assess burnout
5. Training on strategies to manage adverse events
6. Support systems, including families
7. Appropriate work-life balance
8. Longitudinal relationships with patients
9. Sense of professional life progress
10. Personal characteristics, including resilience



## Day Two

# First Keynote Panel: The Role of Medical Schools, Residencies, and Specialty Boards

The first keynote panel discussed, “The Role of Medical Schools, Residencies, and Specialty Boards in Promoting Physician Wellness and Decreasing Physician Burnout.”

- **Darrell Kirch, MD**, President and CEO, Association of American Medical Colleges (AAMC)
- **Thomas Nasca, MD, MACP**, Chief Executive Officer, Accreditation Council for Graduate Medical Education (ACGME)
- **Mira Irons, MD**, Senior Vice President for Academic Affairs, American Board of Medical Specialties (ABMS)

**Darrell Kirch, MD**, presented, “The Role of Medical Schools in Promoting Physician Wellness.”

Dr. Kirch first reviewed data from the National Academy of Medicine’s Action Collaborative on Clinician Well-Being and Resilience, revealing that about 400 physicians commit suicide each year, which is twice the rate of the general population.

Dr. Kirch listed the three somewhat overlapping domains that influence clinician well-being:

- Work environment
- Learning environment
- Personal and professional factors

For each domain, Dr. Kirch described forces that might impact clinician well-being in a negative manner as well as interventions that might have a positive effect. He noted that the many negative factors affecting each domain along the entire medical education continuum from medical school through residency and fellowships to practice will require a portfolio of solutions and initiatives.

Dr. Kirch discussed the premedical selection process and current techniques designed to identify potential medical students with sufficient resilience. He mentioned specific strategies used by some medical schools to promote cohesive



and supportive student communities, optimize curriculum structure through pass/fail grading systems and increased clinical time, and support students to develop better mind-body balance.

From the perspective of accreditation, Dr. Kirch noted that the LCME has implemented specific standards mandating that medical students have access to personal counseling and well-being programs as well as needed health care services. He stressed that accreditation standards will have little effect, however, without an institutional culture that is supportive of student well-being.

Dr. Kirch concluded that many medical organizations are still in the early stages of awareness about the issue of trainee and physician burnout, but that fortunately most organizations are past the point of denial. A tremendous amount of work still remains to be done, but emerging tools are available. He called for all medical specialty boards to partner with the National Academy of Medicine to focus attention on the negative effect of physician burnout on medical education and the quality of patient care.

**Thomas Nasca, MD**, presented, “Physician Burnout, Depression, and Suicide: Graduate Medical Education.”

Dr. Nasca began by summarizing the preliminary results from a study of the causes of death among residents enrolled in ACGME accredited programs from 2000 through 2014. The most frequently reported cause of death among residents is neoplastic disease, followed by suicide, other medical and surgical diseases, accidents, and other causes. The most frequently reported cause of death among female residents is neoplastic disease while among male residents it is suicide.

Dr. Nasca reported that suicides are most frequent in PGY-1, and that they are also most frequent during the first quarter of each residency year. He suggested that this



data provides support for focused interventions, especially at the beginning of each residency year.

Dr. Nasca pointed out that resident suicide was likely just the tip of a complex and poorly understood iceberg of clinical depression, other illnesses, and various complex factors contributing to physician burnout, including the structure and function of the modern clinical environment. He agreed with others who have advocated for modifying the Triple Aim of population health, experience of care, and per capita cost to a Quadruple Aim that also includes provider well-being.

Dr. Nasca stated that he believed medicine to be in somewhat of a “moral crisis” in which physicians are being asked to participate in clinical care in a manner that is often at odds with their core values. Pressure to increase clinical volume, inadequate staffing, unclear motivation of leadership, lack of meaning and purpose in one’s activities, patients and trainees being viewed as mainly a means (or a barrier) to an economic end, and lack of influence over one’s activities all have contributed to undermine physician satisfaction and joy of caring for others in their time of need, inquiry to improve care, and mentoring of junior colleagues.

Dr. Nasca identified a number of corrective strategies for residency programs and their sponsoring institutions:

- State clearly that physician and trainee burnout is primarily a systems issue and not the result of problem physicians with inadequate resilience.
- Create a clinical learning environment that returns some degree of individual professional autonomy, meaning, and joy for faculty, trainees, and other members of the health care team.
- Remove the stigma from those seeking assistance, provide support services, and promote a culture of mutual support.
- Demonstrate that system leadership values the educational mission and well-being of its faculty and staff.

Dr. Nasca acknowledged that while specific solutions to the burnout problem will be local, they will all share some common characteristics:

- Attention must be paid not just to outcomes (economic, clinical, educational), but also to the processes of clinical care and education.
- Faculty must be able to model professional and personal behaviors, as well as teach technical skills and information.
- Trainees must be integrated effectively into team-based care.
- Social support systems must be rebuilt in the post-modern context of care delivery and medical education.
- Medical culture must evolve to recognize and support individual clinician needs.

Dr. Nasca summarized the ACGME’s commitment to addressing physician wellness and burnout through several specific programs and initiatives:

- Sponsorship of a yearly Physician Well-Being Conference
- Support for an ACGME Board-designated Task Force on Physician Well Being
- Partnership with the AAMC, the Coalition for Physician Accountability, and the National Coalition for Improvement in the Clinical Learning Environment
- Focus on physician well-being at ACGME’s Annual Educational Conference
- Publish an IRB-approved study in *Academic Medicine* on Cause of Death During Residency and Fellowship Training
- Co-sponsor with the AAMC of the National Academy of Medicine Learning Collaborative on Caregiver Well-Being and Resiliency
- Revise the Common Program Requirements (underway)

Dr. Nasca concluded that while the necessary resources exist to address problems in physician wellness and burnout, it is culture change that matters most and that will only happen through local interest and local drive. He stated, “I do believe that we have the capacity to solve this problem and it would be a disservice to the public and the profession if we failed.”

**Mira Irons, MD** presented, “The Role of Specialty Boards in Promoting Physician Wellness and Preventing Physician Burnout.”

Dr. Irons said first that medicine is a community under stress. A substantial number of physicians appear to be disappointed with their career choice and some are encouraging young students to

reconsider going to medical school. Concerns have been raised about physician burnout, early retirement, and suicide.

Dr. Irons listed possible determinants of physician satisfaction and dissatisfaction, focusing special attention on three issues affecting physicians she believes the specialty boards might be able to influence: the experience of collegiality, fairness, and respect; time constraints; and the quality of patient care.

Dr. Irons also identified satisfaction and dissatisfaction factors more specific to academic medicine, including decreased



“academic time” for writing, professional committees, seminars and conferences, teaching, and clinical research. She raised the question, “How do the many requirements of our organizations contribute to the problem by competing for physicians’ time?”

Dr. Irons stressed that patients deserve to know that their physicians are keeping up with new knowledge and skills in their specialty and that physicians want to be able to do the same. The questions are, “How can physicians keep up with so many competing obligations,” and “Can continuing certification be viewed and valued as a means to support these efforts?”

Dr. Irons discussed possible roles for specialty boards in promoting physician wellness and preventing burnout. Specific strategies suggested included improving relationships with diplomates through more communication and feedback; better customer service; more attention to issues of relevance, burden, and cost; expanding advocacy and education efforts on behalf of diplomates; and increasing board understanding of the needs of current and future diplomates.

Dr. Irons suggested that continuing certification might help alleviate some of the burden that physicians are currently experiencing, especially if MOC requirements are simplified, made more relevant, and their burden and cost are reduced; MOC credit is given for improvement activities diplomates already perform as part of their daily work; and the range of acceptable MOC activities is increased.

In the area of assessment of knowledge, judgment, and skills (MOC Part III), Dr. Irons said that it will be especially important to consider strategies to make MOC examinations more practice relevant, formative, and less burdensome and still

allow the boards to make an external assessment. New ways need to be found to incorporate assessment of knowledge and judgment in a manner that is consistent with adult learning theories and emerging technologies. Along those lines, Dr. Irons noted that 12 member boards are currently collaborating with ABMS to pilot new web-based approaches to their recertification examinations in a manner that customizes the examinations to diplomate practices, supports a flexible approach to the time and place of the examinations, and provides diplomates with immediate feedback and performance dashboards.

Dr. Irons recommended that member boards should consider expanding options for improvement in medical practice (MOC Part IV), including providing diplomates with credit for their current quality improvement, educational, research, and administrative activities; integrating more closely with the federal Quality Payment Program (QPP) and professional registries; and encouraging organizational participation in the ABMS Multi-Specialty Portfolio Program.

Dr. Irons concluded her presentation by asking and answering the question, “What’s the value of continuing certification and how can we be part of the solution?”. She expressed the opinion that continuing certification protects the profession of medicine, ensures that physicians have a credible credential that is separate from their employment, and supports physicians in their efforts to practice at “the top of their specialty.” In the process, continuing certification provides physicians with a means to identify their knowledge and practice gaps so as to direct their learning, demonstrates to patients and colleagues that the specialist is up-to-date, supports local quality improvement efforts, and satisfies federal and other assessment requirements.



# Small Group Discussions: What should medical schools, residencies, and specialty boards do to promote physician wellness and decrease physician burnout?

## Ten Medical School Strategies

1. Emphasize life experiences in student selection.
2. Assess and improve the medical school culture concerning student wellness.
3. Foster a sense of peer support and community among students.
4. Encourage student self-awareness and recognition of strengths and limitations.
5. Implement student and faculty wellness programs.
6. Mentor students with faculty and residents.
7. Minimize competition among students for grades and Step 1 scores.
8. Increase meaningful student involvement with patients.
9. Provide students with “boot camps” to prepare for residencies.
10. Provide faculty with adequate time for student teaching.

## Ten Residency Strategies

1. Assess and improve the institutional culture concerning resident wellness.
2. Foster a sense of peer support and community among residents and faculty.
3. Implement a resident curriculum on burnout prevention and recognition.
4. Establish a “buddy system” for new residents.
5. Encourage resident self-awareness and recognition of strengths and limitations.
6. Implement resident and faculty wellness programs.
7. Mentor residents with faculty and senior residents.
8. Encourage resident involvement in committees and teaching.
9. Provide back-up for resident personal health and life event needs.
10. Provide faculty with adequate time for resident teaching and supervision.

## Ten Specialty Board Strategies

1. Provide MOC credit for faculty education, teaching, and mentoring.
2. Provide MOC credit for current activities of diplomates.
3. Provide MOC credit for diplomate self-assessment of burnout.
4. Provide MOC credit for diplomate wellness activities.
5. Increase opportunities for professional involvement in Board activities.
6. Increase the relevance of MOC requirements.
7. Minimize the burden and cost of MOC requirements.
8. Simplify the process of MOC.
9. Support research on physician resilience and burnout.
10. Support the development of a “tool kit” for burnout assessment and management.

“The ABPN needs to understand the causes of burnout and direct positive changes to mitigate these factors.”

— Kerry Levin, MD

# Second Keynote Panel: The Role of Professional Societies

The second keynote panel discussed, “The Role of Professional Societies in Promoting Physician Wellness and Decreasing Physician Burnout.”

- **Anita Everett, MD**, President, American Psychiatric Association (APA)
- **Terrence Cascino, MD, FAAN**, President, American Academy of Neurology (AAN)
- **Patrice Harris, MD, MA**, Board Chair, American Medical Association (AMA)

**Anita Everett, MD**, presented, “Physician Wellbeing and Burnout: American Psychiatric Association.”

Dr. Everett began with an overview of the APA Board of Trustees’ 2016 Work Group on Physician Burnout. The Work

Group’s charter is to gather data on the scope of burnout affecting the APA membership and to begin to address the problem through a series

of products on resources and planning, education, website references, and communication. Dr. Everett noted the importance of clarifying certain language conventions like wellness, well-being, burnout, compassion fatigue, and exhaustion; distinguishing between what might be a normal variant compared to a pathological problem; identifying burnout co-morbidities like depression and substance use disorders; encouraging physician self-care; and identifying physicians at most at risk of burnout.

Dr. Everett concluded that her 2017-2018 priorities as APA President will include reinforcing APA efforts to enhance psychiatric practice by improving patient access to treatment, supporting psychiatrists throughout their career, promoting physician wellness, and addressing the problem of physician burnout.



**Terrence Cascino, MD**, presented, “Neurologist Well-Being and Burnout: AAN Approach.”

Dr. Cascino first acknowledged that what neurologists really want is for the leadership of the AAN to be understanding and passionate enough about burnout to at least try to help solve the problem. He believes the most important thing is to first recognize that many physicians are now feeling lost and overwhelmed.

Dr. Cascino next reviewed some of the unintended consequences of our current health care system, including the lack of physician well-being, poor physician work-life balance, and the physician burnout symptoms of emotional exhaustion, depersonalization, and a sense of low personal accomplishment.

Dr. Cascino reemphasized the work of Dr. Shanafelt, illustrating that neurologists are among those specialists with the highest levels of burnout and the lowest levels of satisfaction in their work-life balance. Partly because of these troublesome findings, in 2015 the AAN established a task force to study burnout prevalence and its primary drivers among practicing U.S. neurologists, residents, and fellows and to mitigate burnout by identifying and offering a variety of resources.

Dr. Cascino reported that in 2016 the AAN task force sent a survey to 5,000 AAN members, about 40 percent of whom responded. As noted earlier by Dr. Levin, Dr. Neil Busis and co-authors published the results of the survey in *Neurology* in 2017. Survey respondents had a mean age of 51 years, 65 percent were men, worked an average of 56 hours per week, and spent an average of 76 percent of their time in clinical care. The large majority (84 percent) of survey respondents indicated that the AAN should attempt to reduce burnout among neurologists. Almost two-thirds (60 percent) of survey respondents indicated that they were experiencing at least one symptom of burnout, and only 32 percent reported that their work schedule left enough time for their own personal



and family life. Despite the high prevalence of burnout symptoms among survey respondents, 61 percent indicated that they would choose to be a physician again, 67 percent would choose to be a neurologist again, 67 percent were satisfied with their job, 60 percent said they had significant work autonomy, and 88 percent said their work is meaningful to them.

Dr. Cascino compared survey responses by academic neurologists with those neurologists predominantly in clinical practice. The number one factor associated with burnout among academic neurologists was lack of job autonomy, followed by number of hours worked per week and percent time spent in clinical activities. By comparison, the number one factor associated with burnout among neurologists in clinical practice was also lack of job autonomy, followed by older age, absence of effective support staff, lack of meaningful work, unreasonable amounts of direct clerical tasks, the number of outpatients seen per week, and the subspecialty of epilepsy.

Dr. Cascino reported that the next steps for the AAN task force will be to use the obtained survey data to inform AAN efforts to help reduce neurologist burnout and promote their engagement. He also noted that three more publications are in preparation, focusing on burnout among residents and fellows, a qualitative analysis of the free text comments from the survey, and the effects of gender and age on burnout. Future projects under consideration include a deeper analysis into the effect on burnout of issues such as family responsibilities and maintenance of certification (MOC). Follow-up surveys are also planned to assess changes in burnout rate and career satisfaction over time as well the effects of efforts to mitigate burnout.

Dr. Cascino pointed out that efforts to mitigate burnout will need to focus simultaneously on both factors internal to individual neurologists as well as external factors such as regulatory hassles, excessive workload, lack of autonomy, clerical burden, and inadequate support staff. He stated that the AAN has attempted to identify burnout best practices and has adopted specific strategies to help ameliorate burnout in individual, work unit, organization, and national domains.

Dr. Cascino concluded that it was his opinion that the best overall strategy to mitigate burnout was to foster professional and personal connections and stated, “How to help neurologists improve and strengthen the relationships they have with one another and with other people in their lives is what we need to figure out.”



**Patrice Harris, MD** presented, “The Role of Professional Societies in Promoting Physician Wellness and Decreasing Burnout.”

Dr. Harris began by stating that “physicians have entrusted the AMA to work on their behalf.” She noted that the AMA includes 190 state, specialty, and subspecialty societies representing physicians at every stage of their careers and in every practice setting, and that “no other organization is better positioned to advocate for and unify physicians, the profession and our patients.”

Like other forum presenters, Dr. Harris acknowledged that physician dissatisfaction and burnout are extensive and growing. She too listed some of the negative

effects of physician dissatisfaction and burnout, including increased risk of medical errors, diminished quality of care, decreased professionalism and compassion, decreased patient compliance, reduced physician cognitive function and poor decision-making skills, increased cost of care and decreased reimbursement, and decreased physician capacity.

Dr. Harris reviewed an AMA/Rand Report documenting the negative effects on physician satisfaction of barriers to providing high quality care, including electronic health records that do not work properly and excessive governmental regulations. For example, a 2016 *Annals of Internal Medicine* study by Christine Sinsky, et al found that during a typical clinic day, physicians spend nearly two hours on electronic health records and desk work for every hour spent in direct clinical face time with patients. In an AMA survey, 75 percent of responding physicians also indicated that the burden of prior authorization requirements was “high or extremely high” and that 90 percent of responding physicians stated that prior authorization requirements “sometimes or often” delayed access to care.

Dr. Harris reviewed advocacy work done by the AMA in an effort to make federal regulations such as MACRA more reasonable and to reform prior authorization requirements. She also presented an overview of the various tools the AMA has developed to help physicians better manage their practices, improve quality of patient care, increase reimbursement, and advance professional development.

Dr. Harris concluded by reinforcing the commitment of the AMA to continue to work on many levels to promote physician wellness and to address physician burnout.

# Small Group Discussions: What should professional societies do to promote physician wellness and decrease physician burnout?

## Ten Specialty Society Strategies

1. Collaborate with other medical organizations and advocacy groups to increase recognition of the importance of physician well-being and the dangers of burnout.
2. Disseminate information on best practices for promoting physician wellness and preventing burnout.
3. Disseminate information on best practices for practice management and electronic health records.
4. Advocate for reasonable governmental regulations and reimbursement for physicians.
5. Provide opportunities for physician professional engagement.
6. Conduct and support research on physician resilience and wellness and on strategies to identify and mitigate physician burnout.
7. Advocate with the FSMB to minimize the effect of physician help seeking on medical licensure.
8. Provide on-line resources for wellness education and sources of help for physicians.
9. Advocate for the destigmatization of physician help seeking.
10. Provide leadership training on issues related to physician wellness and burnout.



“In terms of what the boards can do to...impact this question (of burnout), I think we should focus on collegiality, fairness and respect; effective time constraints; and the quality of care being provided.”

— Mira Irons, MD

## Crucial Issues Forum Attendees

**Ike Ahmed, MD**  
American Association for  
Geriatric Psychiatry

**Zubair Ahmed, MD**  
American Board of  
Psychiatry and Neurology

**Imran Ali, MD**  
American Board of  
Psychiatry and Neurology

**Joan Anzia, MD**  
American Board of  
Psychiatry and Neurology

**Valerie Arnold, MD**  
American Board of  
Psychiatry and Neurology

**J. Robert Batterson, MD**  
American Board of  
Psychiatry and Neurology

**Lama Bazzi, MD**  
American Board of  
Psychiatry and Neurology

**Carol Bernstein, MD**  
American Psychiatric  
Association

**John Bodensteiner, MD**  
American Board of  
Psychiatry and Neurology

**Robert Boland, MD**  
Academy of  
Psychosomatic Medicine

**Allison Brashear, MD, MBA**  
American Board of  
Psychiatry and Neurology

**Robin Brey, MD**  
Association of University  
Professors of Neurology

**Robin Callen**  
American Board of  
Psychiatry and Neurology

**Terrence Cascino, MD**  
American Academy of  
Neurology

**Joseph Cheong, MD**  
American Association of  
Geriatric Psychiatry

**Julie Chilton, MD**  
American Psychiatric  
Association

**Alexis Cohen-Oram, MD**  
American Board of  
Psychiatry and Neurology

**Sandra DeJong, MD**  
American Association of  
Directors of Psychiatric  
Residency Training

**Marc Ettensohn, MD**  
American Board of  
Psychiatry and Neurology

**Anita Everett, MD**  
American Psychiatric  
Association

**Saul Farris, MD**  
American Board of  
Psychiatry and Neurology

**Larry Faulkner, MD**  
American Board of  
Psychiatry and Neurology

**Anthony Fine, MD**  
American Board of  
Psychiatry and Neurology

**Richard Frierson, MD**  
American Academy of  
Psychiatry and the Law

**Ondria Gleason, MD**  
American Association of  
Chairs of Departments of  
Psychiatry

**Robert Golden, MD**  
American Board of  
Psychiatry and Neurology

**J. Clay Goodman, MD**  
American Board of  
Psychiatry and Neurology

**Tristan Gorrindo, MD**  
American Psychiatric  
Association

**Gregory Hanes, MD**  
American Board of  
Psychiatry and Neurology

**Patrice Harris, MD**  
American Medical  
Association

**David Homan**  
American Board of  
Psychiatry and Neurology

**Saskia Hostetler Lippy, MD**  
American Board of  
Psychiatry and Neurology

**Mira Irons, MD**  
American Board of Medical  
Specialties

**Pat Janda**  
American Board of  
Psychiatry and Neurology

**Paramjit Joshi, MD**  
American Board of  
Psychiatry and Neurology

**Dorthea Juul, PhD**  
American Board of  
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**Meena Kannan, MD**  
American Academy of  
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**George Keepers, MD**  
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Program Directors (AAN)

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Neurology Residency  
Review Committee

**Darrell Kirch, MD**  
Association of American  
Medical Colleges

**Kerry Levin, MD**  
American Board of  
Psychiatry and Neurology

**Steven Lewis, MD**  
American Board of  
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**Sam Libeu, MD**  
American Psychiatric  
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**David Lott, MD**  
American Academy of  
Addiction Psychiatry

**Tim Lotze, MD**  
Professors of Child  
Neurology

**Jeffrey Lyness, MD**  
American Board of  
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**Jonathan Mink, MD**  
Child Neurology Society

**Eli Mizrahi, MD**  
American Epilepsy Society

**Thomas Nasca, MD**  
Accreditation Council  
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**Warren Ng, MD**  
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**Micaela Owusu, MD, MSc**  
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**L. Russell Pet, MD**  
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**Michael Rosenbloom, MD**  
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**Stephan Schuele, MD, MPH**  
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**Tait Shanafelt, MD**  
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**Kailie Shaw, MD**  
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**Heather Vestal, MD, MSc**  
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**Patti Vondrak**  
American Board of  
Psychiatry and Neurology

**Paul Whittington**  
American Board of  
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**Shahnour Yaylayan, MD**  
American Board of  
Psychiatry and Neurology

## Our Mission

The mission of the ABPN is to develop and provide valid and reliable procedures for certification and maintenance of certification in psychiatry and neurology by:

- Developing the best testing methods to evaluate candidate and diplomate competencies;
- Applying the best technologies and information available to collect and analyze pertinent data;
- Communicating and collaborating effectively with training programs, residents, candidates, diplomates, professional and health care organizations, and the public; and
- Operating programs and services effectively and efficiently.



**American Board of Psychiatry and Neurology, Inc.**

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