Annotated Facilitator Guide

Burnout, Depression and Substance Use Disorder

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<u>Case scenario:</u>

Judy is a recent graduate from a fellowship in pediatric anesthesiology and started her job as an attending four months ago in a city and academic hospital system that are both new to her, far from her hometown. She had been looking forward to becoming an attending, hoping that her schedule and stress level would lighten from intense years of residency and fellowship training, but has been feeling overwhelmed. She has struggled to learn the ins and outs of her new practice environment and colleagues, and with her new supervisory role. She recently had some clinical acuity that she felt unequipped to manage.

The long hours away from her partner and young child have created tension in her relationship, and she and her spouse recently argued about her "spending it all at work and having nothing left for home." She used to love to cook, but now it feels like a chore. She feels guilty about not being available to them more, and she and her spouse have constant tension about expectations at home. She hasn't had much time to make new friends. Despite having been a college athlete, she now rarely has time to exercise, something that always relieved her stress in residency. Often her daughter is in bed by the time she gets home, so Judy pours a glass of wine to unwind when she sits down for the first time all day, sometimes falling asleep on the sofa after a glass or two. Despite being exhausted, she hasn't slept through the night for weeks, waking in the wee hours with racing thoughts.

Last week she discovered that she failed her subspecialty boards, the first time she's ever struggled with an exam, and recently started questioning her decision to become a physician. She feels conflicted about where her time and energy go, and last week she cut off a conversation with a patient's family abruptly during a sensitive conversation about their child's care so she could leave in time to pick her daughter up from daycare, which garnered a patient complaint to her chief.

For the first time she's feeling unsuccessful in multiple life domains and is struggling to imagine how to turn it around.

<u>Discussion questions:</u>

Is Judy burned out? If so, how? What is burnout?

- Burnout is the triad of
  - Emotional exhaustion; shows up as:
    - Feeling “used up” at the end of a workday
    - Feeling emotionally depleted, unable to
  - Depersonalization; shows up as:
    - Treating patients as objects rather than human beings
    - Callousness, insensitivity, inability to empathize
  - Decreased sense of personal accomplishment; shows up as:
    - Feelings of ineffectiveness in helping patients with their problems
    - Lack of feeling the value of results of work-related activities like patient care or professional achievements

What risk factors are present for burnout for Judy?

- As a new attending, she is “stretched” and in a constant state of learning. The stress of mitigating uncertainty in clinical decision-making and other aspects of work and home life can predispose to burnout due to chronic, sometimes unrelenting stress
- She recently experienced two “failures”—one of a board exam and another in the form of a patient complaint, which may disrupt her sense of fluency or competency. It may erode her confidence in her ability to do good work.
- Physician burnout is more common among women, particularly those in parenting roles. Judy likely feels the tension of not being the parent she ideally set out to be, and when coupled with some professional challenges this sense of failure to live up to her own expectations may be amplified.
- Burnout occurs more often in those who feel isolated or distant from supports. Judy is not only physically far from extended family and friends, she also finds herself in a novel environment in which she may not feel completely psychologically safe, which can be stressful as she gains familiarity with new roles and expectations. In addition, her relationship with her partner is in a stress state.

What are some primary drivers of physician burnout?

- Excessive workload
  - Expected to do more than personal reserve can meet
- Work inefficiency
  - Wasted time/effort
  - Lack of support at work (physicians not functioning at “the top of [their] license”
  - Regulatory compliance requirements that may be at odds with the physician’s value system
- Poor life-work integration
  - Work schedule and demands not respecting home responsibility needs
  - Work tasks unable to be completed during working hours

    - Lack of flexibility in scheduling and employment models
- Loss of autonomy
    - Physicians not engaged in establishing work requirements and structure
    - Decision-making not shared with physician leadership
- Loss of meaning from the work
    - Core values around the work not shared
    - Physician time with patients not protected
    - Physicians in isolation, not in shared/connected communities
    - Limited professional development opportunities
    - Leadership lack of awareness around physician burnout

What are the “costs” of physician burnout?

- Physician burnout is associated with disengagement and intent to leave
    - It costs approximately $500,000 to replace a physician who leaves the workforce
- Burnout is associated with increased medical errors and patient safety events
- Burnout is associated with increased cynicism, and risks emotional contagion in groups
- Burnout may have some associations with mental health issues, including depression and substance use disorder

What are some effective strategies to mitigate/address physician burnout?

- The Stanford Model suggests developing wellbeing strategies in three domains:
    - Personal resilience
    - Efficiency of practice
    - Culture of wellbeing
    - It is critical that wellbeing efforts center on creating systems change that favors engagement and sustainability, rather than focusing on redirection of physician perception.
    - It is critical that efforts to combat or prevent burnout should involve physician input, but the burden of fundamental systems change should not fall to the burned-out physicians feeling responsible for solving the problems they did not create. This would create a vicious cycle of further depletion and risks additional frustration and exhaustion.
- While nowhere near complete, proposed strategies may include:
    - Reasonable productivity targets
    - Schedules that honor life outside of work
    - Normalizing personal boundary setting
    - Appropriate distribution of the work among colleagues
    - Optimized EMRs
    - Nonphysician supports to offload clerical burden
    - Shared decision-making for policy development and reform
    - Support of flexible work options
    - Include all required work withing the expected work hours
    - Promote shared core values

    - Promote physician community and collaboration, increase belonging
    - Protect physician time with patients
    - Offer professional development activities
    - Leadership training and awareness around burnout and work stress
    - Stress management and resiliency education

Having done the self-assessments from the prework, how do you fare in terms of burnout? From the table you completed, what are some of the drivers of burnout in your workplace? From your own reflection, what factors might protect you against burnout?

What is the relationship between burnout, mental health and substance use disorders?

- Burnout may be associated with higher rates of mental health disorders such as depression
    - Significant overlap in feelings of anhedonia and decreased personal efficacy
- Mental health disorders among physicians are remarkably prevalent and should not be stigmatized. The priority should be on getting help.
- Substance Use Disorder is often coexistent with other mental health disorders, predominantly depression.

How does substance use differ from substance abuse? From addiction?

- Use is simply that: use. Traditionally not thought to be associated with ill effects or undesirable social or health repercussions.
- Misuse is inappropriate use or use to treat something other than what is indicated. In the case of alcohol or controlled substances, this often takes the form of overuse.
- Dependency is the body’s adaptation to repeated exposure, often with the development of tolerance, or the need to have increasing doses to attain the same effect. In a state of dependency, the user will experience withdrawal in the use of the substance is stopped.
- Abuse is associated with use of a substance with the aim to elicit certain feelings. Abuse is characterized by use of alcohol or drugs in manners that are harmful to self and others. It may be characterized by changes in appetite, behavior, mood, personality, weight, or sleep patterns. It is also associated with poor emotional regulation (outbursts), and relationship tension between the user and those closest to them.
- Addiction is the compulsion to use a substance repeatedly despite negative social or physical consequences, as demonstrated by impaired work performance, DUI, deteriorating relationships, or violated social contracts. Someone who is suffering with addiction may be in a state where they are effectively no longer making their own decisions—complex brain chemical changes influence their decisions unduly. Addiction is considered a complex disease and requires careful intervention and treatment.

Prevalence of substance use disorder (SUD) is significantly higher in anesthesiology than the general population. You very likely have encountered or been personally affected by SUD and/or addiction. Do you have a story you would like to share?

What features of anesthesiologists and our practice contributes to our increased rates of substance use disorder?

- Relatively unrestricted access to and daily handling of medications of misuse/abuse/additive potential
- Sophisticated and intimate knowledge medication dosing and pharmacological affects
- We practice "in a silo"—largely independently and unchecked by others
- Most surveillance/checking systems (in-OR drug dispensing) are circumventable in the moment diversion occurs, and system notifications (discrepancy alerts to pharmacy, returned drug analysis such as spectroscopy) happens after diversion occurs
    - Many surveillance strategies (such as random drug screening) do not prevent, but rather detect, diversion/use, at which point it may be too late.

How does substance use disorder present in anesthesiologists?

- May appear on the surface like *dedication to work*
    - For the anesthesiologist with SUD, maintaining close access to the substance of preference is important
- Frequent positioning to be at work/close to the substance of use
    - Volunteering for extra call/shifts, staying late
- Preference for solitary work
    - Refusal of breaks or willingness to transition cases to another practitioner
    - Preference to sit own cases, rather than supervise
- "Sloppy" charting
- Mismatch between opiate withdrawal and waste/inventory return
- Long stays in a call room or longer than expected breaks
- Larger than anticipated opiate withdrawal
- Patients of the affected physician may have higher reported pain if medications reported to have been administered to the patient have been diverted
- Personality changes or erratic behavior, including being short-tempered or slow in thought/action/speech
- Family and home life will suffer before work will (keeping the job is important to maintain access)
    - Legal or financial problems, strained relationships with loved ones are common
- Disheveled or unkempt appearance: physical self-care becomes a lower priority
- Long sleeves to cover injection sites in the arms

If you suspect substance use disorder in a colleague, what should you do?

- Anticipate denial. Even in the face of overwhelming and irrefutable evidence, most physicians suffering with SUD will deny they have a problem.
- DO NOT approach the impaired physician first, even if it is a friend/peer. If there is suspicion, it's critical that it go through the proper pathways to protect the physician involved and prioritize their safety.
- Report first to the physician's immediate supervisor (Training Program Director, Division Chief, Practice Director, etc.) along with Human Resources. All are mandated reporters

and should take the report seriously and collaborate to ensure appropriate measures are taken for the physician.

- Evidence should be collected and presented to the physician at a meeting in the presence of institutional and departmental leadership and potentially a family member, all of whom will make clear to the impaired physician their genuine care for them and wish for their safety and rehabilitation, as a far greater priority than putative action.

What are the priorities for addressing substance use disorder in a physician?

- The top priority should be safety of the individual involved, as well as the safety of patients the impaired physician may harm if practicing under the influence of mind-altering substances
    - Immediate removal from the work environment (for the safety of both the physician and patients)
    - Physical need to prevent overdose
        - A plan for removal from the workplace where the drug is readily available should be swift, immediate, thorough and unalterable in the face of anticipated denial by the physician-patient.
        - Inpatient detoxification and rehabilitation may be necessary; there are several wonderful rehabilitation/detoxification programs designed specifically for physicians.
        - Of those anesthesiologists who complete rehabilitation but relapse, in 50% of cases the presenting symptom of that relapse is overdose/death.
    - Psychological supports to the affected individual
        - Consequences of substance use disorder in anesthesiologists may be perceived to be profound (inability to practice in the chosen field, loss of licensure, financial and job loss, etc.) which is likely to have a deep effect on the physician—potentially more than their ability to perceive the benefits of living a life unshackled from addition.
        - DO NOT dismiss the physician from work and “follow up later.” The act of dismissal from work for the impaired anesthesiologist may not only precipitate physical withdrawal but also may potentiate self-harm from a sense of despair and loss of identity. Have a continuity plan for removal from the workplace prior to dismissal the prioritizes psychological and physical safety.
- The earliest/top priority is not to report to medical licensing boards first, but rather to ensure the physical safety of the impaired physician.

When you leave this room today, what can you do to protect yourself from burnout and SUD?

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