Chapter 10
Physician Dissatisfaction, Stress, and Burnout, and Their Impact on Patient Care

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Introduction

Physicians just want to practice good medical care. Unfortunately, over the past decade there have been a number of different factors that have had a significant negative impact on their ideals, expectations, attitudes, and behaviors, which have distracted their attention away from their primary focus of providing best practice medical care. Many of these factors are based on more deep-seated internal influences molded by age, gender, culture, ethnicity, spirituality, geography, socioeconomics, and early life experiences, all of which help shape one's values, perceptions, ego, and personality. On top of these deep-seated internal factors are the contributions of more external based influences shaped by the health care training culture and experience, Health Care Reform, changing models and priorities of the workplace environment, growing complexity, and the introduction of new technologies, all of which has added a new level of distraction that has significantly increased the incidence of frustration, dissatisfaction, apathy, stress, and burnout. In combination these factors have adversely affected moods and disposition, with lower levels of tolerance, acceptance, compliance, and overall engagement. In an effort to help physicians through these distractions, we need to gain a better understanding of all of these contributing factors and how it affects their mindset and then provide the necessary guidance and support to help them better adjust to the pressures of today's health care environment.

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Contributing Factors: Internal

The first step in reducing distractions is to gain a better understanding of the factors influencing individual values, perceptions, attitudes, biases, and behaviors. Table 10.1 presents an overview of the internal and external factors which contribute to the overall makeup of thoughts and reactions that affect clinical behaviors.

Age and generational issues are based on the values and perceptions reinforced by the current existing status of the social, economic, and political environment at the time in which the individual grew up. Differences in views as to work ethic, commitment, views of authority, and work-life balance are different for each of the groups (Millenniums <1980–1995>, Generation X < 1965–1979>, Baby Boomers <1946–1964>, Veterans/Traditionalists <pre 1946>) which under stressful situations may lead to conflict in the workplace environment. Veterans and Baby Boomers whose parents were brought up during the depression and world war years are thankful to have a job, have strong loyalty to their organization, tend to stay at their job until retirement, and are willing to put in the extra effort and additional time in to get the project done. At the current time this is the majority group in today's health care workforce, and they fill most of the leadership positions. Generation X and Millenniums have been brought up during a time of economic prosperity and advanced technology. They live in a fast-paced world of information overload, feel more entitled and empowered, are more apt to question process and authority, have shorter time span job commitments, and believe in a strong work-life balance. For Baby Boomers, these preferences may lead to potential distractions and conflicts with Millenniums involving perceptions around commitment and work ethic. It's not that either group is right or wrong, it's just that they have different ideas and approaches to work responsibilities [1]. As the older workforce retires and the younger workforce moves in, the issue of how to deal with Millenniums is taking center stage [2]. Many organizations have addressed the issue by offering programs that educate staff about generational differences and provide strategies to help them reach compromises during periods of conflict or disagreement.

Gender differences may also affect the way individuals react in stressful situations. Males are typically more assertive, task oriented, and domineering and under pressure tend to dig in. Women are more socially oriented and under pressure will look for consensus opinions to support their points of view [3]. In the past these problems were exacerbated by the predominantly female nursing workforce and the

Table 10.1 Influencing factors

Internal factors	External factors
Age and generation	Training
Gender/sexual orientation	Health care reform
Culture/ethnicity/spirituality	Work environment
Geography/socioeconomics	Complexity/technology
Life experiences	Stress and burnout
►Values, personality	►Mood, disposition, engagement

predominantly male physician task force. While the percentages are changing, potential conflicts may still arise. Many organizations have addressed these issues by educating staff on sexual equality and harassment [4]. Other distractions related to gender workforce equality issues, sexual orientation, or sexual discrimination may also influence individual behaviors.

As the world situation changes, we are seeing a greater diversity in our patient and staff populations with a greater influx of foreign-born or foreign-trained nursing and medical staff with their own individual ethnic, cultural, and religious beliefs that affect values, thoughts, and beliefs as to religion and spirituality, hierarchy, authority, and communication styles. In difficult situations this can lead to distractions related to misunderstandings in purpose and intent that may negatively affect communication efficiency, expectations, and outcomes. In this regard there is a big push toward training providers on cultural competency and/or providing diversity training to help individuals better understand individual needs and values, address hidden assumptions or biases, and provide effective solutions for more effective communication [5–8].

All of these factors combined with genetics, socioeconomic factors, geographic influences, and other individual life experiences help to shape an individual's personality. Strategies for improvement should focus on introducing a variety of different training programs designed to enhance personality and relationship management. These programs might include such topics as sensitivity training, diversity management, cultural competency, mindfulness, generational gap values, personality traits, conflict management, stress management, anger management, sexual harassment training, customer satisfaction, and improving overall communication and collaboration skills. Some organizations have added a more in-depth focus by providing training in emotional intelligence to enhance staff and patient relationships [9, 10]. The process includes a four-step approach designed to [1] enable the individual to gain a better understanding of their own individual perceptions, values, biases, and trigger points; [2] raise social awareness by enabling the individual to better recognize the perceptions, needs, and values of others; [3] learn how to modify their own behaviors; and [4] be more sensitive to the cues and reactions needed to foster a positive relationship and positive outcome. Each of these programs has value, but success will depend on the specific situation, underlying organizational dynamics, culture, and leadership commitment.

All of these internal factors have a deep-seated impact on a person's mood, disposition, character, and personality and may be more difficult to address than some of the external factors to be discussed in the next section.

Contributing Factors: External

The external factors include current day circumstances that influence present state perceptions. For physicians one of the key factors starts with the training environment. Some equate this training to a fraternity/sorority hazing-type environment

where individuals are harassed to the point of losing self-esteem. In some cases this can lead to severe cases of stress, burnout, depression, and suicidal ideation [11, 12]. In response the trainees try to develop knowledge and technical competencies through exhaustive independent study. As a consequence there is no focus on developing personal skills or team collaboration mechanics which leads to a lower degree of sensitivity and emotional intelligence. This presents a definite liability in today's complex multi-spectrum health care environment so dependent on multidisciplinary collaboration. The problem is further exacerbated by the traditional hierarchal health care structure with dedicated roles and responsibilities and set boundaries between the different health care disciplines. Fortunately, there are movements in place to try and deal with these training hazards. Many medical schools are now looking for more "well-rounded" "better adjusted" students who are majoring in something other than the traditional math and science tracks [13, 14]. The MCAT (Medical College Admission Test) now includes questions on sociology and humanities [15]. Some of the more progressive medical schools are adding programs that focus on improving emotional intelligence and communication skill efficiencies, in some cases pairing medical students with nursing students, pharmacy students, and other ancillary staff members during their freshman year to learn about the different perspectives on care management responsibilities [16–19]. The overall goal is to build personal relationships and develop team competencies along with clinical expertise.

Health Care Reform has added another level of disturbance to the force. Where physicians used to pride themselves on their ability to provide best practice care with autonomy and control, the introduction of new care restrictions, utilization controls, changing incentives, and performance accountability metrics based on a series of "questionable" variables has forced many physicians to reassess their positions and change models of care. While concerns about Accountable Health Care continue to arise, at the current time the program is here to stay. The best remedy is to educate physicians on what it is and what it means to their practice and then provide the necessary resources and support to help them achieve compliance.

Technology

One of the major factors contributing to care distractions is the growing complexity of care management and the introduction of new technologies, in particular, the electronic medical record. The main frustration for physicians is the time it takes to complete all the documentation which could be better spent on face-to-face direct patient care. Given these frustrations, the main focus needs to be to convince physicians of the values of technology innovation and provide the necessary training and logistical support to help them master the system.

Table 10.2 provides an overview of the advantages and disadvantages of electronic medical records. The key advantages of the electronic medical record are the ready access to real-time information and the ability to share information with all

Table 10.2 Advantages and disadvantages of electronic medical records

Advantages	Disadvantages
Access/analysis	Training
Timeliness/efficiency/standardization	Time
Data flow/dissemination	Restrictive format
Population health	Distraction
AI/alerts and reminders	Dissatisfaction
►Value added (access/time/analysis/efficiency)	► Value depleted (expense/utilization/harm)

those who need to know. The system provides greater access to information, improved information flow, improved efficiency, and the support of best practice care through standardization, algorithms, guidelines, alerts and reminders, and other types of improved intelligence. With a focus on full-spectrum care and population health, electronic records play an important role in overall chronic disease and risk management. When done correctly, it's definitely a value add.

The problem occurs with physician acceptance, adoption, and compliance. Compulsory mandates can lead to a significant degree of physician dissatisfaction. Physician complaints about time spent on data entry, forced fields, and/or rigid requirements for documentation have all been reported as major distractions taking physicians away from direct patient care [20–24]. Recognizing this frustration organizations need to invest the appropriate amount of time, training, and customized support to help physicians better accommodate to the new electronic environment. One solution that has been particularly successful is to provide "scribes" to help physicians with data input and documentation support [25].

Stress and Burnout

Recent studies have shown that more than 50% of physicians report a significant amount of stress and burnout that has led to increasing irritability, cynicism, apathy, fatigue, disillusionment, dissatisfaction, and in some cases more serious depression, behavioral disorders, and even suicidal ideation [26–29]. As a result there is an increasing amount of physician dissatisfaction, where many physicians have either changed practice settings, joined different groups, or moved into salaried positions. Others have either left the profession entirely or chose early retirement. Not a good situation particularly with the looming physician shortage.

So how do we deal with stress and burnout? The first issue is physician awareness. Many physicians are unware that they are working under stress and the physical and emotional toll it's taking on their livelihood. If they do admit that they are under stress, they accept it as being part of the job and rationalize that they have been working under stress all their lives. Even if they think they may need some outside help, they are reluctant to ask in fear of concerns about their competency,

confidentiality, discoverability, or a blow to their ego [30]. These are significant barriers that need to be addressed before moving forward. If physicians are reluctant to admit or receive assistance, we need to look for the organizations that they are associated with to take a more pro-active stance in trying to encourage and provide support.

Where to begin? As mentioned previously, there is a growing amount of evidence suggesting that high levels of stress, burnout, depression, and even suicidal ideation starts during the first year of medical school. This probably results from a combination of factors of having individuals driven by a strong competitive egocentric driven personality being dropped into an intensely complex bewildering hierarchal system without direction and a sense of nowhere to go. These problems are further exacerbated by a sense of physical and emotional exhaustion, stress, and fatigue, which can take a toll on physical and mental well-being. One of the major barriers is the student's reluctance to seek help from issues related to stigma and/or time. Fortunately many organizations are making a concerted effort to provide resources to help students adjust to the pressures in the academic environment [31].

Once a physician gets out into practice there are other day-to-day pressures that promote a stressful environment. As mentioned previously, many physicians are either unaware or reluctant to admit that they are under stress, and even if they do recognize it, that won't take any action. In this case we need to look for outside assistance from friends, peers, or the organizations in which the physician is associated with to help out. The most consistent approach is to provide pro-active support at the organizational level. Unfortunately, many physicians feel that their organizations don't support them. In a recent study conducted by Cejka Search and VITAL WorkLife, when asked if their organization did anything currently to help physicians deal more effectively with stress and/or burnout, 85% of the respondents said no [32]. Another study conducted by InCrowd showed similar findings reporting that 75% of surveyed physicians did not feel that their organization was doing anything to address burnout [33]. So, in an effort to better address the issue of physician stress and burnout, we need to [1] raise awareness, [2] motivate physician reactiveness, and [3] have the organizations take a more active role in providing visible support services to help physicians better adjust to the stress and pressures of today's health care environment.

Support can come from a variety of different directions. At one level the organization can provide training on stress management, time management, conflict management, business management, and other appropriate programs to teach basic skill sets on stress reduction. On a deeper level the organization can provide more personalized support services through Physician Wellness Programs, Wellness Committees, and Physician EAPs (Employee Assistance Programs) or through individualized coaching or counseling. Some physicians may require more in-depth behavioral modification programs. Organizations need to approach these programs with the idea that they understand the physician's world, that they respect and value the physician's time and what the physicians do, and that they are here to help. They need to make an effort to promote individualized support and be responsive to physician resistance, time constraints, and fears of confidentiality. To motivate physician

action, the focus needs to be on the goal of helping the physician do what they want to do, which is to practice good medical care.

One excellent case example is the approach taken by the Center for Professionalism and Peer Support at Brigham and Women's Hospital in Boston [34]. Recognizing the impact of physician burnout and the emotional stress it had on physicians and organizational culture, the hospital started its peer support program in 2008 in an effort to provide resources to support physician well-being and resilience. Through a multistep process that includes education, pro-active outreach, peer training, peer support, and individualized coaching, the organization has led the way in developing programs that are now been replicated across the country. Many other examples from the Mayo Clinic, Stanford University, and other hospital centers across the country provide a variety of different innovative approaches designed to reduce physician stress and burnout. [35, 36].

Consequences: Disruptive Behaviors

Despite all the evidence and concern about the physician behavioral turmoil, in many cases it goes unresolved. In more extreme cases, depending on the circumstances, the combination of internal and external factors can result in inappropriate actions that lead to disruptive behaviors. Unfortunately, many disruptive events either go unrecognized, go unreported, or are ignored for a variety of different reasons [37]. The problem with this personal and organizational reluctance is the potential for bad things to happen to patients and staff (see Table 10.3).

Disruptive behaviors are a serious issue which not only provide a distraction, they can also negatively affect outcomes of patient care [38–41]. Many individuals who act "disruptively" aren't aware that they are acting in an inappropriate nonprofessional manner. This is particularly true for physicians who are used to taking control and "giving orders." Under times of stress they may yell and intimidate others and not even realize they are doing it. Even if they are aware they justify their behaviors as being necessary to direct patient care. The problem is that they are oblivious to the downstream negative consequences this may cause on care relationships, communication efficiency, task accountability, and patient outcomes.

Table 10.3 Reluctance and ramifications

Organizational reluctance	Risk of non-action
Awareness/accountability/tolerance	Staff retention/recruitment/patient satisfaction
Financial	Staff/patient satisfaction
Hierarchy/boundaries/sacred saints	Quality/patient safety
MD autonomy	Medical errors/care efficiency
Code of silence/fear of reporting	Joint Commission accreditation standard
Conflicts of interest	Liability/litigation/fines/penalties
Structure?/skill set?/solutions?	Reputation/social media

A second big concern is the issue of organizational tolerance. Many of the events involve very prominent physicians who bring a large number of patients and revenue into the organization. Many organizations are reluctant to address the issue in fear of antagonizing a physician to the point where they worry that the physician won't bring their patients into the facility. This is particularly true for smaller organizations where there may be a shortage in supply of certain specialties. There is also the concern about crossing boundaries. Physicians work autonomously, and in many organizational cultures physicians are viewed as "sacred saints" impeding the willingness to intervene. There is also a hidden "code of silence" where health care workers are reluctant to report disruptive behaviors [42]. This lack of reporting is accentuated by potential conflicts of interest, concerns about lack of confidentiality, and/or fears of retaliation. Many who do report are frustrated by the lack of administrative support and the fact that despite reporting, the perception is that nothing ever changes, so why bother.

And lastly is the structure and skill set to deal with behavioral problems. Organizations have policies and procedures in place to address clinical competency but may not be well equipped to deal with behavioral problems. They need to have the right structure in place supported by individuals skilled in facilitation and negotiation techniques. Turning matters over to the Chief or Chairman of the Department may not lead to an effective resolution.

The Risks of Inaction

The risk of inaction can lead to downstream consequences that affect moral, culture, and workplace atmosphere and/or lead to medical mishaps that have significant direct or indirect financial penalties [43] (Table 10.4).

On one level disruptive behaviors have been shown to have a significant negative impact on nurse satisfaction and retention [44]. Replacing a nurse can cost the organization anywhere from $60,000 to $100,000 for recruitment, training, and secondary opportunity costs [45]. When it occurs in a public arena, disruptive events can also lead to patient dissatisfaction which can negatively impact HCAHPS scores and other patient satisfaction pay for performance initiatives which can have a negative effect on reimbursement. Then there is the spillover effect on hospital reputation which may impact market share and contract negotiations.

From a patient care perspective, the biggest concern is the occurrence of preventable medical errors or adverse events [39, 46, 47]. In addition to waste, duplication, and inefficiencies in management, lack of communication and collaboration can lead to task failures that result in medication errors, infections, delays in treatment, and other serious medical conditions which can increase lengths of stay and accrue significant non-reimbursable costs of care. The Joint Commission states that more than 50% of adverse sentinel events can be traced back to human factor issues and/or failures in communication [48, 49]. In response to the concerns about the impact of disruptive behaviors on patient safety in 2010, the Joint Commission added a new

Table 10.4 Economic consequences

I. Recruitment and retention RN: $60,000–100,000/ additional opportunity costs
II. Patient satisfaction/HCAHPS/reputation, market share implications ($?)
III. Adverse events ("No pay" for adverse event initiatives)
Medication error: $2000 to $5800 per case/> LOS 2.2–4.6 days
Hospital-acquired infection: $20,000 to $38,500
Deep vein thrombosis: $36,000/> LOS 4.2 days
Pressure ulcer: $22,000/> LOS 4.1 days
Ventilator-associated pneumonia: 49,000/> LOS 5.3 days
IV. Joint Commission standard
V. Compliance issues ($?)
Impact on documentation and coding
Impact on utilization efficiency (LOS/resource efficiency/DC planning)
Impact on quality
Impact on productivity and efficiency (down time/waste/ delays)
Communication inefficiencies ($4 million 500 bed hospitals)
VI. Risk management/malpractice: $521,560/lawsuits/ fines: $25,000–$100,000

leadership standard requiring hospitals to have a disruptive behavior policy in place and to supply support for its intent as part of the leadership accreditation standards [50]. In order for hospitals to receive Medicare reimbursements, they need to pass the accreditation survey requirements [51].

From a compliance perspective, noncompliant behaviors that adversely impact coding and documentation requirements, nonadherence to utilization protocols, and/or not following best practice guidelines, policies, and procedures can all have a significant negative economic and quality impact on patient care outcomes. It is estimated that the average yearly cost for a midsize hospital due to communication deficiencies is $400,000 [52].

From a risk management perspective, issues can arise from not only the occurrence of medical errors or adverse events, but other issues can be related to poor compliance, poor communication and collaboration, impeded information transfer, neglect, failure to respond, and/or poor patient satisfaction. More egregious cases can lead to litigation. Time, preparation, and malpractice awards can result in significant dollar amounts with average malpractice settlements averaging above a half a million dollars [53–56]. In California there is the additional penalty of hospital fines (ranging from 25,000 to 100,000) for the occurrence of significant adverse events [57].

Addressing Disruptive Behaviors

Recognizing the multidimensional cause, nature, and extent of disruptive behaviors, it is clear that there is no one solution to resolve the problem. The ultimate objective is to prevent disruptive behaviors from occurring. If they do occur the organization and staff need to take immediate action to lessen the likelihood of any adverse event on staff or patient care. Depending on the nature and frequency of events, further interventions may be required to prevent repeated incidents. Table 10.5 provides a list of recommended strategies. In addition to reducing the incidence of disruptive behaviors, this approach can also improve organizational culture, staff relationships, team collaboration, communication efficiency, physician engagement, physician well-being, and overall physician satisfaction.

One of the earliest steps is to improve the process and criteria for medical school selection. As discussed earlier, many medical schools are looking for more "well-rounded" medical school applicants who majored something other than pure science and mathematics. The new MCAT (Medical College Admission Test) is now introducing more questions on humanities and social sciences. The goal is to look for individuals with more highly developed personal rather than technical skill sets. Many of the more progressive medical schools, supported by large grants from The AMA and Robert Wood Johnson Foundation, are in the process of revising their curriculum to focus more on the importance of developing strong individual communication and team collaboration skills [58, 59].

From an organizational perspective, hiring and retaining the right people is key to success. Many organizations are recognizing the importance of the right "cultural fit" and are using more selective interviewing techniques to assure that new hires will work well with the mission and operational needs of the work environment [60]. Once hired, there should be a comprehensive on-boarding process to first welcome the physician and then explain organizational priorities and incentives working under the complexities of today's health care environment and the support available to help physicians negotiate through the maze of medical requirements [61, 62]. Recognizing administrative concerns for financial viability, and clinical staff concerns about quality and safety, there needs to be a mutually agreed upon rallying point and alignment around best patient care.

Organizational culture sets the tone. Strong and supportive organizational cultures have been shown to significantly enhance staff morale, satisfaction, motivation, and engagement which leads to behaviors that result in best patient outcomes of care [63]. Having a strong, committed, and respectful leadership, an effective structure and process in place manned by skilled individuals, and a willingness to address and respond to individual concerns and barriers that pose a potential disturbance in the force; establishing priorities; and enlisting the help of key individuals who act as champions and catalysts to help promote a positive work environment are the key ingredients to a successful culture. In today's multitasking pressure-filled-here's-what-you-need-to-do world, always remember to take a step back and take time to thank and recognize physicians and staff for their efforts and a job well done.

Table 10.5 Recommended strategies

1. Training redesign
Applications/MCAT testing
Revised curriculum
2. Organizational culture/work environment
Hiring/on boarding
Mutual alignment
Leadership commitment/structure and process
Encourage motivation/address barriers/set priorities
Engage champions/catalysts/role models
Recognition and rewards/
3. Education
Awareness/responsibility/accountability
The business of health care
Expectations vs. reality
4. Relationship training
Address factor influences: generation/gender/culture/ethnicity
Diversity management/cultural competency/sensitivity training
Personality profiling
Customer satisfaction
Stress/conflict/anger management
Emotional intelligence
5. Communication skills/team collaboration training
6. Behavioral policies and procedures
Definition/accountability/incident reporting and review
Risk management
7. Intervention
Prevention
Tiered approach: informal/formal/disciplinary
8. Staff support
Administrative/clinical/behavioral (EAP/Wellness Committees/coaching/counseling)
Behavioral modification programs
Career guidance
9. Physician well-being
Awareness/reflection/motivation
Self-care/relaxation
Stress reduction/setting limits
Quadruple Aim
Mindfulness
Resilience
10. Physician engagement
Input/empathy/responsiveness/alignment
Recognition/respect

Another crucial step is to make an effort to educate staff about what's going on, what **we** need to do in response, and how it might impact individual roles and responsibilities. Providing educational sessions on the evolving health care environment, value-based care, system redesign, performance-based accountabilities, and the business implications of clinical practice will help set realistic expectations by giving physicians a better understanding of what's happening and how it might affect their individual practice.

Providing training to enhance relationship management is crucial. Under an umbrella of increasing complexity and accountability, more segmentation between specialty and discipline-specific tasks and responsibilities, and a greater focus on care responsibilities that extend across the entire spectrum of care, it is crucial for all members of the health care team to work well together to provide best patient outcomes. In order to accomplish this, we need to gain a better understanding of the factors affecting individual values, perceptions, and behaviors.

Earlier I discussed the implications of a number of different internal and external factors influencing one's personality, mood, and demeanor. Providing specific training programs to address some of these specific factors is beneficial in gaining a better understanding of contributing circumstances and how individuals can deal more effectively with complicated issues. These programs might include training in diversity management, cultural competency, sensitivity training, generational values, personality assessments, and customer satisfaction. Additional programs on conflict management, anger management, and stress management may also be of value. As mentioned earlier, there is now a growing focus on using emotional intelligence training as a way to improve behavioral and relationship management techniques [64]. Several organizations have had notable success after implementing these types of programs.

Communication, Team Collaboration, Work Relationship Skills Training

Beyond addressing disruptive behaviors is the need to improve overall communication and team collaboration skills. Physicians are typically not the best communicators. There are many barriers that get in the way [65]. First, they look at patient management as a one-way dictatorial process. They're trained to work autonomously, to take control, and to give orders. Communication gaps are further accentuated by time constraints; a bureaucratic health care hierarchy; a teaching focus on gaining knowledge and technical competency rather than personal skill development; segmented, siloed, and discipline-specific priorities which focus more on the organ or disease rather than the patient; and an overriding strong ego that resists outside advise, interference, or involvement. In today's complex health care world, improving communication skill sets should be a number one priority.

There are many different types of communication skills training programs available. At one level is the SBAR (Situation, Background, Assessment, Recommendation) script available to help nurses more effectively organize their thoughts in presenting patient information to the physician. At a deeper level are the basic communication techniques taught by a number of different programs such as the AIDET, Bayer, or STARS programs. The focus is getting the physician in synch with effective two-way communication. Crucial points emphasized include a proper introduction and acknowledgment; making time and patience; exhibiting positive body language and verbal tone; enabling trust; avoiding distractions or conflict; reflective listening; being sensitive to the other's values, needs, and desires; providing clarification and understanding; and setting appropriate expectations. In a demanding hectic environment, taking the time to listen, understand, respond, and explain is the key to gaining compliance and a successful interaction and outcome [66, 67].

A further extension of communication is to teach team collaboration. One of the most effective programs in health care is the TeamSTEPPS program based on the Crew Resource Management techniques used in the aviation industry [68]. The focus of the training program is to teach team members how to [1] anticipate and assist; [2] build trust, respect, and commitment; [3] understand your role and roles of others; [4] reinforce accountability and task responsibilities; [5] avoid/manage conflict or confusion; [6] be assertive; [7] follow up discussions; and [8] thank for a job well done. Assertiveness training is a crucial part of the process reinforcing the need to speak up when there is a question of patient safety. In addition to the Team STEPPS program is the training offered through VitalSmarts Crucial Conversations [69].

Policy, Process, and Procedure

In order to hold individuals accountable for their behaviors, the organization needs to have a code of conduct policy in place that outlines nonprofessional behaviors and the ramifications of noncompliance [70, 71]. The policy must be backed by an effective incident reporting system where each complaint is evaluated on its individual merits and recommendations given for appropriate follow-up action. In order for the program to be effective, individuals need to be willing to report. Barriers to reporting include fear of whistleblower retaliation, a double standard of reluctance to apply consistent reprimands when it involves physicians, and the sense that they report and report and nothing ever changes. On the incident evaluation side, determinations need to be made by trained individuals functioning without personal bias or conflicts of interest with recommendations passed on to an individual or committee who has the appropriate facilitation skills to foster accountability and resolution. When patient quality or safety is of concern, many of these issues fall under a risk management protocol.

When it comes to intervention the first intervention is prevention. As discussed previously, taking a pro-active approach in trying to get a better understanding of behavioral characteristics and teaching basic principles about behavioral management can certainly reduce the predilection for behavioral problems. For recurring issues early intervention has a much greater potential for success than waiting until a bad incident occurs where the interaction takes on more of a remedial tone [72].

Interventions can occur at several different levels. In all cases it's crucial to intervene at the appropriate time and place with the intervention conducted by someone skilled in the arts of facilitation and conflict management.

The first intervention is real time. If somebody is acting inappropriately, the recipient needs to be assertive in addressing their concerns in a respectful professional manner. Assertiveness and Crucial Conversations training can help reinforce these capabilities.

The next series of interventions are post-event interactions. Hickson and his group at Vanderbilt University have come up with a four-phase process for intervention that includes informal, awareness, authority, and disciplinary actions [73]. The informal interaction is often described as the "cup of coffee" approach where you take the physician aside, describe the series of events, and ask for their opinion. The usual response is that they weren't aware of any problem and question how someone could think that they were acting in a disruptive manner. Their next thought is justification as the need to take control during a period of uncertainty or crisis. Their next thought is rationalization and passing blame onto someone or something else for their behavior and not take any responsibility for their actions. A good facilitator will listen to what the physician has to say, ask if they thought that their action was appropriate, address their concerns but bring the focus back to their behaviors, reframe the issue to bring it into context, ask them to think about the impact it had on the other person(s) involved, and what they could have done differently to ease the angst of the situation. When the situation is addressed under the guise of raised awareness, most physicians will self-correct.

For repeat offenders or when the incident is of a serious nature, there needs to be a more formal intervention. The physician needs to recognize the ramifications of noncompliance with the code of behavioral standards, and the organization needs to reinforce the importance of a zero tolerance policy with the potential of disciplinary action. In some cases the recommendations may be made for anger management, conflict management, or diversity training and in more serious cases the need for individualized counseling. Always keep in mind the underlying possibility of drug or alcohol abuse. Depending on the nature of the problem, some physicians may be required to attend an outside behavioral modification program offered through state-sponsored Physician Health Programs (PHPs), or proprietary programs offered through the University of California San Diego PACE program, the Vanderbilt University Disruptive Behavior Program, and the University of Florida Program, or other state-sponsored or private outside resources [74].

In the more extreme cases where physicians are resistant to follow recommended actions, the only recourse may be sanctions or termination of privileges. Having served as an expert witness on both sides of the picture (representing hospitals,

representing individual physicians), termination cases stir up a lot of legal entanglement and organizational aggravation [75]. Most physicians will fight and appeal termination decisions based on failure of the hospital to follow due process, breach of contract, anti-trust issues, bad faith, malice or discrimination, defamation of character, or on the basis of undue harassment and retaliation. In their defense hospitals need to have a clear line of documentation as to the issues, to follow due process, to adhere to the bylaws and HCQIA requirements, to be consistent with similar types of cases, to document follow-up discussions, to comply with the rights of the physician to be heard, to provide specific recommendations designed to resolve problems, and to state the ability to reapply once the issues are addressed and resolved. Hospitals wind up winning more than 80% of the appeals.

When possible the focus of any intervention should be on trying to help the physician better adjust to the situation by offering assistance and career guidance rather than punishment. The primary focus should be on positive physician support.

As mentioned previously physicians are overwhelmed by administrative requirements and time constraints and are being asked to take on more and more responsibilities that take them away from direct patient care. There are several ways in which the organization can help. From an administrative and logistical perspective, having the organization be more sensitive to on-call schedules, productivity requirements, and meeting or committee attendance will help reduce some of their administrative load. Offering administrative assistance by providing more help with documentation and compliance with electronic medical records through additional training, staff support staff, or "scribes" will help ease physician frustrations in this area.

From a clinical perspective using physician assistants, nurse practitioners, or case coordinators to help cover some basic medical necessities will free the physician up to concentrate on more complex patient management issues.

From a behavioral perspective, providing services to help the physician better adjust to the pressures of medical practice, organizations can offer services through Wellness Committees, Employee Assistance Programs, individualized coaching and counseling sessions, or other services offered though human resources, medical staff services, or outside referral services.

As mentioned previously stress and burnout are a major problem affecting physician satisfaction and overall well-being [76, 77]. As much as we try to support physicians, it ultimately rests in the physician's hands to make the commitment. Unfortunately, there is often a significant gap between intentions and action, and we need to motivate physicians to move forward [78].

Motivation and Engagement

Motivation for physician well-being needs to be linked with the physician's primary goal and aspirations to provide best practice care. They need to recognize, understand, and accept the fact that emotional and physical well-being affects their levels of energy and the joy of being a physician. Many recent studies have

documented that emotional and physical wellness is a strong contributor to physician satisfaction, improved care relationships, and improved patient outcomes of care [79, 80]. This all starts by getting the physician to understand the importance of good health and the negative consequences of ill-health on performance that impacts family, friends, colleagues, staff, and ultimately patients. They need to understand the importance of relaxation and recreation, adequate sleep, regular exercise, and good nutrition. They need to try and avoid stressful situations, be able to set limits, and be comfortable in saying no. They also need to be willing to accept outside advice. One of the most important components is to teach them techniques to support self-reflection, self-preservation, and the importance of time off and relaxation to achieve inner peace. For most physicians the recognition is there, but it becomes a secondary priority to the daily grind. We need to aggressively promote and support the importance of physician well-being and help them commit to make it happen [81, 82].

There are now a growing number of different initiatives being introduced to support this point. From a health care policy perspective, the IHI (Institute for Healthcare Improvement) and other health care societies are promoting the extension of the concepts of the Triple Aim (enhancing the patient experience, improving population health, reducing costs) to the Quadruple Aim adding to the goals the importance of improving the work life of health care providers [83, 84]. Many organizations are introducing the concepts of mindfulness and mediation training programs for physicians as a way to promote self-refection, purpose, and fulfillment [85, 86]. Mindfulness activities help to reinforce purpose and meaning by focusing on the benefits of the current activity or task. It incorporates many of the ideals of meditation and relaxation techniques with the goal of providing a more productive and fulfilling interaction. Many organizations have successfully used these techniques to improve overall physician satisfaction, well-being, and engagement [87]. The term resilience is used to describe the capacity to "bounce back" and respond to stressful situations in a successful manner [88, 89]. Many of the attributes of resilience lie in positive organizational support, mindfulness, relaxation, self-preservation, and the ability to set limits.

The final phase is to enhance physician engagement. The key steps include establishing an underlying culture of positive support for physician livelihood, giving physicians an opportunity for input and discussion, and responding to their needs and concerns [90–94].

Think about this. Physicians are a precious resource. All they really want to do is to practice good medical care. But growing frustrations arise from outside intrusions and someone else unidirectionally telling them what they need to do. Part of their frustration is the lack of physician input. Physicians want to have a voice particularly when it involves issues revolving around patient care. Input can be gathered from several different sources. These include surveys, discussions at town hall or department meetings, specialized task forces, or, better yet, one-on-one conversations with administrative and clinical leaders. Allowing input diffuses some of the frustrations particularly if there are expressions of empathy and understanding of

the physician world. Input must be followed by responsiveness. It's not that you'll be able to solve every problem, but at least you can provide an explanation and coordinate next steps on achieving mutually aligned objectives. There is a strong correlation between physician engagement, physician alignment, physician well-being, physician satisfaction, physician motivation, improved relationships, and improved outcomes of care. And always remember to visibly show respect and thank physicians for what they do.

Conclusion

Increasing complexities in today's health care environment have introduced a number of different factors distracting physicians from their primary goal to provide best practice care. At times the resulting levels of frustration, dissatisfaction, stress, and burnout can affect their attitudes and behaviors to a point where they can negatively impact relationships that adversely affect patient outcomes of care. With this in mind, we need to do what we can to help them better adjust to the pressures of medical practice. In order to do this we must first get a better understanding of the impact of contributing factors, give them an opportunity to discuss their concerns, and then provide pro-active support to help them thrive. This will require a multi-step process that includes education, advanced training to enhance work relationship, communication, time, and conflict management skills and by providing the necessary logistical, clinical, and behavioral support to help them deal with the day-to-day distractions. In some cases more in-depth support needs to be provided to help reduce the effects of stress and burnout. We need to support physician health and well-being by encouraging and supporting rest, relaxation, and teaching coping skills for resilience. More comprehensive behavioral support can come from coaching, counseling, or services provided through a Physician Wellness Committee or Physician EAP. When more serious behavioral problems occur, the organization needs to take the necessary steps to address the issue head on before it comes to the point where it can compromise care. They need to have the right policies and procedures in place, provide the necessary interaction steps to hold the physician accountable for their actions, and implement the appropriate recommendations for improvement. To better motivate and engage physicians we need to address the barriers, resistance, or the reluctance from "what's in it for me." We need to provide a supportive culture that makes an effort to better understand their world, enhance their engagement by allowing them an opportunity for input and discussion, motivate their inner passion by reminding them of the pride and joy of who they are and what they do, show respect, and thank them for a job well done. The reason that it's a "we" is that physicians won't take the necessary action on their own. We need to look at physicians as an overextended precious resource and take a pro-active stance in helping them to succeed.

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