CHAPTER 1

LAYING THE FOUNDATION

"Physician burnout is not a problem to be solved. It is a dilemma to be managed."

— Dike Drummond, MD

MAKING THE CASE FOR PHYSICIAN WELLNESS

While the epidemic of physician burnout has been widely publicized, you still may need to convince your board, your members, and constituents that it is worth the time, money, and effort to begin a wellness program. You will also need data on the burnout phenomena as you approach potential sources for funding or support. Since the mid-2010s, thousands of research articles have been published on the causes and costs of physician burnout and distress, and plenty of evidence-based solutions are available.

The rising epidemic of physician burnout was first documented significantly between 2011 and 2014 by Dr. Tait Shanafelt, then at the Mayo Clinic and now head of Stanford Medicine's WellMD Initiative. While Dr. Shanafelt's studies showed an ebb and flow of burnout through the years, a mid-cycle survey in winter 2021-22 confirmed what researchers feared. After multiple surges of COVID-19 variants, physician burnout was exceeding all other years' measurements: 62.8% of respondents reported at least one symptom in 2021 compared with just 38.2% in 2020.[1]

Burnout and distress among the entire health care team became national news during the COVID-19 pandemic, especially after The New York Times covered the tragic story of Dr. Lorna Breen. A New York emergency medicine physician who served in a pandemic hotspot during the initial wave, Dr. Breen quickly became infected with the disease herself. As she recovered and returned to work, she eventually became overwhelmed by the death toll, the confusion, and the lack of resources to meet the crisis. Within a month, she took her own life,[2] admitting she was afraid of losing her medical license and reputation because she had experienced a mental health crisis.[3]

The pandemic amplified and exposed what the medical community had long known: physicians have been run over by impossible productivity and superhuman expectations. On top of that, the culture of medicine—driven by stigma over "personal weakness"—has exacerbated burnout and distress. If there was any silver lining to the pandemic, it was that more people in health care turned to each other and said, "It's OK if you take care of yourself." The culture of shame around seeking mental health care has finally cracked open like a frozen riverbed beginning to thaw in the spring. Projects like The Shame Space[4] and The Nocturnists documentary[5] are opening conversations in medicine that never would have occurred even a decade or two before.

Just as the US experienced "The Great Resignation" among the general working population in 2020 and 2021, the health care system is now experiencing its own mass exodus of physicians, nurses, and other team players. Part of this was expected, with baby boomers starting to retire in 2011 at the rate of 10,000 per day and continuing through 2030. But as the pandemic recedes, licensed medical professionals are throwing in the towel and significantly reducing hours, switching to administrative roles, or retiring altogether at increased rates. This, of course, only adds pressure to an already overworked labor pool.

The dialogue around physician burnout has shifted as well. In the mid-2010s, many administrators focused on resilience building and encouraging life and work balance. But now more conversations and research are centered around systems change, which is the underlying issue.

Dr. Shanafelt summarized what many had been feeling in his October 2021 article, "Physician Well-Being 2.0: Where Are We and Where Are We Going?"[6] Dr. Shanafelt's framework is an important shift in the conversation about well-being; readers of this tool kit will benefit by understanding it. He traces the evolution of the field of physician well-being from the "era of distress" (pre-2005) to the current state of 1.0 and imagines what it might become in its next iteration. The era of distress was characterized by a "lack of awareness, or even deliberate neglect, of physician distress."

The present stage has become characterized by knowledge and awareness of the prevalence, repercussions, and factors involved in distress. Finally, Dr. Shanafelt points to the future, where systems-based interventions address the root causes of occupational distress and result in a partnership between administrators and physicians to create practical and sustainable solutions. In this era, it has become accepted that physicians are not superhuman and have their limits just like the patients they serve.

The reason for taking time to explain this shift is to help those medical societies that begin or already manage a physician wellness program (PWP) to understand that individual support and interventions only go so far. Yes, physicians need to be resilient. Yes, physicians need better access to mental health services and can utilize them without shame. But medical societies, even at the local level, should also consider how to engage in the multifaceted battle against workplace and industry toxicity and unsustainable expectations.

BURNOUT FACTORS

Christina Maslach and Michael Leiter have spent their careers defining burnout and studying its relation to organizational work factors. In their 2022 book, The Burnout Challenge, the authors outline six generic drivers of burnout in any organization, including work overload, lack of control, and breakdown in community, among others. And while all six of the areas of work life they studied undoubtedly apply to current medical practice, particular factors drive burnout among physicians.

Physician training – Anyone who has completed medical school and residency can testify that in the current US model of medical training, only the toughest survive. While we could debate whether that is the right or wrong way to train physicians, the body of evidence points out that the model produces mental health challenges for trainees. Medical students enter their training mentally strong if not healthier than their peers.[7] However, as their training continues:

30% of medical students suffer from depression or symptoms of depression.

- Medical students are three times more susceptible to mental health disorders than the average college student.[8]
- 30% of medical students suffer from depression or symptoms of depression.[9]
- One in 10 medical students report experiencing suicidal thoughts and are five times more susceptible to depression than the general population.[10]
- Depressive symptoms increase substantially during the internship year for men and women, but this increase is greater for women.[11]
- Financial costs of training are substantial—the median educational debt for medical school graduates was $215,000 in 2023.[12]

"[The medical education process ...] builds a workforce filled with highly driven, workaholic, obsessive-compulsive, lone ranger-type, superheroes..."

— Dike Drummond, MD

Culture of shame – The medical education process is a gauntlet of weeding out "the weak," and it builds a workforce filled with highly driven, workaholic, obsessive-compulsive, lone ranger-type superheroes, the very nature of which makes them susceptible to burnout.[13] The resultant medical industry accepts "conditioned" graduates and often punishes those who admit any sense of vulnerability (especially if it might result in malpractice litigation). Those who desperately need a lifeline are isolated, silenced, and ashamed.

- Suicidal ideation studies among US surgeons showed that one in 15 had recent suicidal thoughts, but more than 60% were afraid to seek help because of concerns it would affect their medical license.[14]
- A similar study of 2,106 female physician-parents sampled on a closed Facebook group reported that almost 50% of them believed they had met the criteria for mental illness but had not sought treatment; only 6% of those with a formal diagnosis or treatment of mental illness disclosed their state.[15]
- In states where licensure applications ask the most sweeping questions about mental illness, physicians are more reluctant to seek treatment.[16]

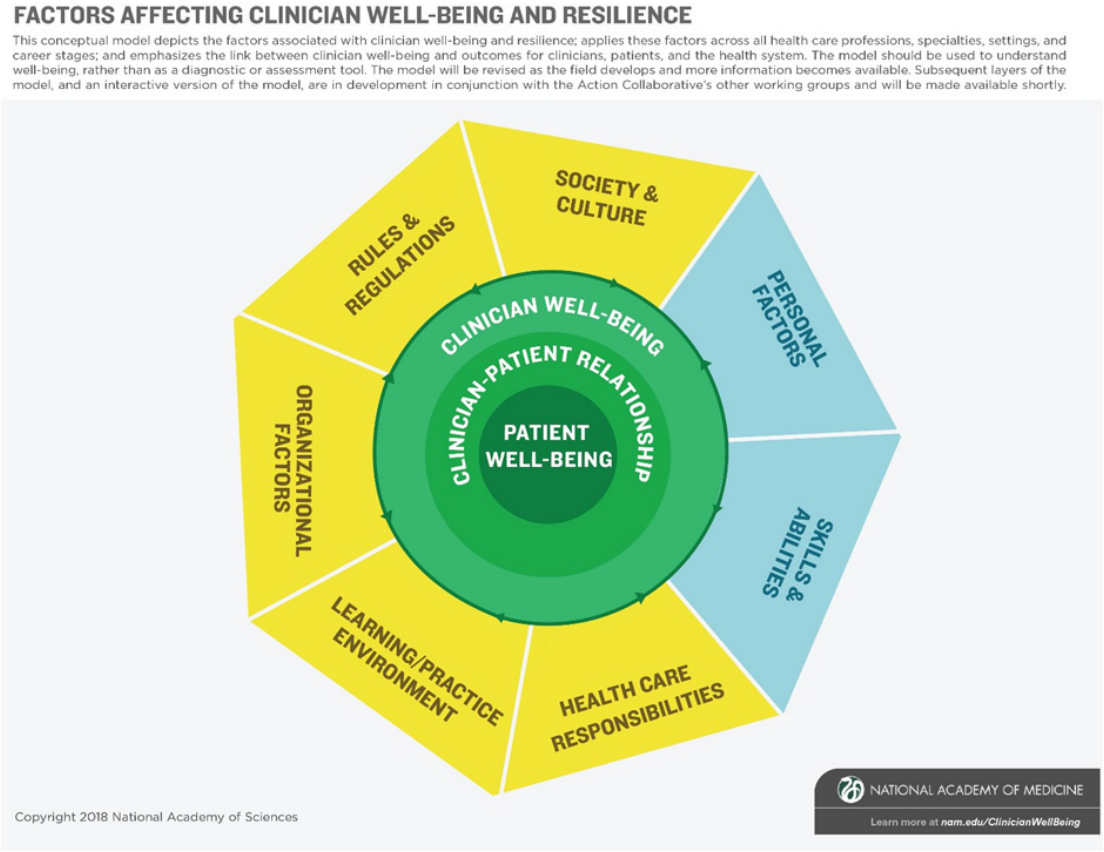
By driving these challenges underground, physicians often self-diagnose, self-medicate, or drive across state lines, using fake names and cash to procure needed services.

Rapid, sustained, and significant change fatigue – For the past 20-30 years, physicians—and the entire health care system—have been constantly pummeled with new requirements for measuring, documenting, billing, and delivering care. The transformation of an occupation built around meeting human needs into one primarily driven by regulations, profits, and industry pressures has sucked the joy out of medicine for many.

Complex and multifactorial nature of burnout and distress

There is no single driver of physician dissatisfaction and there are no simple remedies. In October 2022, the National Academy of Medicine (NAM) released the National Plan for Health Workforce Well-Being.[17] In it, NAM outlines seven factors that affect clinician well-being and resilience. Significantly, only two of the seven factors are individual, with the remainder being the environment in which clinicians do their jobs. These factors are:

- Personal factors
- Skills and abilities
- Health care responsibilities
- Learning/Practice environment
- Organizational factors
- Rules and regulations
- Society and culture



"Human concerns will not be addressed directly until they have economic consequences."

— Maslach & Leiter

BURNOUT COSTS

Maslach and Leiter write, "In today's workplace, economic values are the primary driving force, and all else is subsidiary. Although this emphasis on economic values affects people, human concerns will not be addressed directly until they have economic consequences."[18] Never is this more true than in the current health care industry where physician productivity is measured to the minute, compliance burdens like MACRA and prior authorization consume physician energy, and pay-for-performance has emergency medicine physicians clicking an electronic health record more than 4,000 times in a single shift.[19]

- A 2016 meta-analysis of 46 studies found a correlation between moderate to high levels of burnout among health care staff and poor patient safety outcomes, such as medical errors and poor well-being.[20]
- Dr. Christine Sinsky's research for the American Medical Association linked a cost to the problem of burnout, citing data that says it costs $500,000 to $1 million to replace an existing physician.[21]
- Dr. Shanafelt released a paper making a business case for addressing physician burnout with costs associated with turnover, lost revenue, financial risks and threats, decreased patient satisfaction, and so forth. This paper provides conservative formulas for organizations to calculate costs and potential savings and shows that investment in reducing burnout is justified.[22]

Besides the economic costs, some organizations may begin to address burnout issues when they recognize the dissonance between their stated values and behaviors.

Because of the evidenced-based nature of modern medicine and administrative demands for cost containment, those who wish to implement a physician wellness program will need to become familiar with some of the basic research available and that which continues to emerge.

SUGGESTED READING

- *The Burnout Challenge: Managing People's Relationships With Their Jobs,* Christina Maslach, PhD; Michael P. Leiter, PhD, 2022
- *If I Betray These Words: Moral Injury in Medicine and Why It's So Hard for Physicians to Put Patients First,* Wendy Dean, MD, 2023
- *Preventing Physician Burnout,* Paul DeChant, MD, MBA; Dian W. Shannon, MD, MPH, 2016
- *Stop Physician Burnout: What to Do When Working Harder Isn't Working,* Dike Drummond, MD, 2014

WHAT IS A PHYSICIAN WELLNESS PROGRAM?

"The PWP is a wonderful program for physicians... who often feel overwhelmed & misunderstood."

— Anonymous Physician, PWP Client

The clear challenge in addressing physician well-being focuses on how to address what has become a toxic environment for clinicians. Nevertheless, individual support for the frontline providers of health care remains important. Physician wellness programs (PWPs) provide a limited number of confidential mental health and/or coaching services to members as a benefit of medical society membership. This is similar in design to an employee assistance program (EAP), which is often bundled with or added onto health insurance policies. An EAP provides employees the opportunity to seek a limited number of counseling sessions that are usually paid for 100% by the employer.

According to the 2023 SHRM Employee Benefit Survey, 81% of surveyed employers offered an EAP.[23] The general utilization rate of EAPs nationwide by employees is usually cited at 4-8%.[24] It is widely recognized that in the medical profession there is great stigma around personal weaknesses and intense scrutiny by boards of medicine and credentialing entities of mental health issues that might cause impairment. Thus, it is no surprise that when you query large employers or hospitals about how many physicians access their EAP, they respond, "Very few."

In his 2022 study of the use of EAPs in the workplace, Mark Attridge writes:

> Historically, about 5 out every 100 employees with access to the EAP benefit use it for personal counseling in a year. But more recently since the pandemic this clinical use rate has doubled. A clinical case utilization rate was obtained from a recent national survey of 96 EAPs – split between external vendors and internal programs (with similar findings for both types). The results found that an average of 7.6 people per every 100 covered employees used the EAP for counseling in year 2019 and this rose to 9.7 during the pandemic in 2021. Other results revealed the average number of sessions of counseling per case rose from 3.9 in 2019 to 5.3 sessions in 2021. Thus, both the number of total cases and the number of sessions of counseling used per case increased during the pandemic.[25]

By providing a PWP outside of employment, a medical society offers a way for members to find the same types of counseling or coaching services without the inherent fear that their employer, practice partners, or health insurance will find out that they've accessed these services.

In our surveys, county-society managed PWPs have seen similar utilization rates as EAPs, ranging from 4-8% of their members using the benefit. The key here is that these are members who otherwise might not have used their own EAP program, and for us that has been enough to call them unqualified successes.

Although you may start your efforts around physician wellness with a physician wellness program, you may also want to emphasize other aspects of wellness such as training for personal resilience, group retreats, and effecting change at the system level that provides for a more sustainable workforce. In this edition of the toolkit, we have profiled several medical societies who have done just that.

It should be noted here that PWPs are distinct in design from what are commonly known as physician health programs (PHPs). The latter emerged in the 1980s, often run by state medical associations or state boards of medicine, as an answer to the challenge of physician impairment primarily due to alcohol or drug addiction. They typically offer a legislatively protected place for recovery shielded from the loss of medical license so long as the enrolled physician meets program requirements. PHPs are discussed in more detail and how they might interact with PWPs at the end of Chapter 6.

CREATING YOUR PROGRAM

GETTING STARTED

This tool kit contains most of the resources you will need to get your physician wellness program up and running. However, the amount of material contained in this package can be a little daunting. The best way to proceed is to follow a few key decision points that will help take some of the guesswork out of the process.

The following pages should be used as a roadmap as you begin creating your program. Along the way, you will need to make key decisions that can determine its success. The process from start to execution will be slightly different for each medical society, but following these guidelines will give you the necessary framework to get started.

DECISION #1 – WHAT ENTITY WILL ADMINISTER OUR PROGRAM?

Physician wellness programs help physicians and their families, employers, business partners, and most importantly, patients. The decision to begin a program should not be taken lightly, and that decision starts with a seemingly simple question: Who will administer your program?

No one is better suited to know the ability of your organization than you. This first decision is one that will shape everything about your program from the approval process to the fiscal management and reporting.

Investigate and decide which model is most appropriate for your physicians.

There are at least three different models for PWP program administration. The first is for the program to be administered by the medical society itself. The second is for the society's foundation to run the program. The third is to create a separate 501(c)(3) organization to run the program.

Each management model has its own pros and cons, some of which are outlined below. Before creating a PWP, you should investigate each and decide which model is right for your physicians.

Medical society – An easy way to reach your members is for your medical society to simply create the program as a member benefit that you can seamlessly integrate into your membership marketing materials.

Foundation – If your medical society has a foundation, this is a potential option. This model allows for the program to receive tax-deductible donations, which can be attractive to potential donors. Consider whether the foundation has enough staff to manage the program and whether it has access to the society membership data. Managing the PWP also needs to be consistent with the foundation's stated mission and goals.

New, charitable nonprofit organization – This model has the same tax benefits as the foundation model but creates its own leadership structure associated with the program. As with the foundation model, careful consideration should be given to the ability to access membership data. This model has the benefit of having its own budget and carries less financial risk to the partner medical society. Conversely, this model does come with the regulatory requirements of a 501(c)(3), so this should only be considered by groups with proper staffing capacity.

DECISION #2 – CAN WE DO THIS?

Now that you know which organization will manage your program, it's time to gain support and approval from your board.

The first step is to discuss the program with your president and key physician leaders. This can help foster dialogue with your board as you move toward approval. Be sure to share the physician burnout data outlined on pages 5-9.

If there is interest, present the program to your board for approval. If approved, identify a physician champion who can lead a program committee or task force that is then appointed by the president.

Try to gain support from a physician(s) with expertise in well-being or a psychiatrist. This will help you when you begin vetting potential mental health providers (MHPs) for your program.

> "You ***must*** have a physician champions team to help start this program, promote it, and oversee it."
>
> — Steven Reames
> Ada County
> Medical Society

DECISION #3 – PROGRAM DESIGN: SO MANY DECISIONS!

Now that you have a program committee or task force, it is time to make a series of small but important decisions that will customize your program to be the right fit for your society. A few of these decisions should be made early in your program design phase. Others are equally important but can be tackled in whatever order is most appropriate.

Using non-psychiatrists eliminates the potential conflict of a member providing service to another member.

Tackle These First!

1. **Who will provide your service?** The majority of existing physician wellness programs use psychologists or licensed clinical social workers as their MHPs (very few programs use psychiatrists). The reasons for this decision are myriad, but in general, using non-psychiatrists eliminates the potential conflict of a member providing service to another member as well as avoiding a medical diagnosis that could become part of a physician's health record. Using these professionals could also be less expensive. Using psychologists, counselors, and social workers also increases access to care for your members since psychiatrists in many states are in high demand.
2. **How will you protect confidentiality?** Ensuring client confidentiality may well be the most critical aspect of your program. Confidentiality is covered more fully in Chapter 2.
3. **What MHP engagement model will you use?** While the first couple of PWPs provided services on site at the county medical society office, this model has since been abandoned. Most medical society programs contract with MHPs who provide the services in their own offices or online. This creates a stronger "firewall" of confidentiality so that even medical society staff are not aware of who uses the program, and it does not require the added cost to keep a counseling space.

- **Group practice model.** This is a key decision that will mold the rest of your program design. Factors to consider when identifying MHPs include location, infrastructure, and availability. Working with a mental health group may be a much quicker way to get a program up and running. You may be able to contract with one or two large MHP groups with convenient locations.

Pros: Simplified billing, ease of contracting, streamlined reporting, and potentially a dedicated phone answering service.

Cons: Limited location options, lack of therapist variety, and potential confidentiality concerns (common waiting areas).

- **Individual model.** If your area is too large or you can't find a single group to serve all your members, you may decide to contract individually with multiple MHPs.

Pros: Wider range of locations, availability, and therapeutic methods.

Cons: More administrative work. Too many choices may cause indecision for an already stressed member.

4. **What client intake model will you use?** After you have decided where the MHPs will provide services, the decision about who will receive the phone calls will probably become obvious. There are three or more ways to do this:

    - **Internal model.** This intake model places the burden of fielding the calls to the PWP wellness line on a small number of society staff members.

Pros: Relatively low overhead and a simple process for confirming membership status of potential clients who call.

Cons: Phone must be monitored, which for many programs is 24/7/365, and confidentiality concerns if a staff member is the one to answer the phone. Some societies who have employed this model have created a staff code of conduct agreement to protect confidentiality.

    - **Outsourced model**. This model involves hiring an answering service to field the client calls to the wellness line. Societies who use this model should have a simple system for the answering service to verify client membership. Additionally, there should be a clear process for reporting number of calls and non-identifying demographic information to the society staff.

Pros: Complete confidentiality from staff while removing the stress and burden from staff who would be monitoring the phone line at all times.

Cons: Additional cost and lack of control over the intake process.

- **Group practice model.** If you work exclusively with one MHP group, you may be able to outsource your telephone intake process to its answering service.

Pros: Streamlined intake and connection between the initial call and the first session with the therapist.

Cons: Need for additional level of confidentiality documentation to ensure that callers are processed in accordance with PWP guidelines; lack of a third party for validating the number of calls and therapy sessions.

5. **Who is eligible?** Many societies have made their PWP a member benefit, available only to society members. Some societies open the program to all physicians in their area. Other models include member spouses, family members, and physician extenders. Others limit eligibility to certain classifications of membership, such as active members. The ultimate decision on whom to cover (and how many sessions to cover per client) is a philosophical and financial one and should be made only after careful consideration of all available options.

"This program effectively removes a great deal of barriers for physicians to access the counseling they need. This is a great resource!"

— Anonymous Physician, PWP Client

All the Rest

Once these fundamental decisions have been made, your committee will be able to tackle several other decisions that will shape your program.

Demographic data collection – Collecting data is important for successful programs. While the program must be confidential to be successful, the MHP can ask for some information during intake. For more information see Chapter 4.

Program hours – Physician schedules create special challenges for fitting in mental health appointments. Be sure to ask your prospective MHPs if they can offer early morning, evening, or weekend hours. You may also find it helpful to contract with MHPs in different time zones to offer telehealth services. Be sure you list the MHPs' hours of availability in the time zone your physicians are in. If physicians find your available hours inconvenient, the program will be underutilized.

Make sure you consider your capacity and your members' needs so you can secure MHPs who will be able to meet member expectations.

Response time – How quickly will you respond to calls? What requirements will you place on the MHPs about their availability to members? This element varies greatly from society to society. Some promise a session within 24 hours of the first call. Others have a process to decide the urgency of the call and have timelines based on urgency. Be sure you can meet whatever promise you've marketed.

Number of appointments – The number of appointments you agree to cover will have the biggest impact on your budget and financial ability to sustain the program. Current programs provide four to eight sessions per client, per 12-month period. A program cost estimator is provided in Chapter 2.

One medical society shifted to half-hour billing slots instead of one-hour appointments. "We had contracted psychologists request this to offer the opportunity for evaluations which could take longer than one hour. For example, some EMDR sessions require more than an hour to be effective, and we had no mechanism in our contract for billing that way," says Steven Reames of Ada County Medical Society. Shifting this way requires contractual and marketing language changes and is a little more complex to track if also counting total number of appointments along with total hours.

We have created the name and brand LifeBridge for any medical society to freely use.

Program name – What will your program be called? Just like you carefully manage the brand of your medical society, you will promote and market your PWP by the name you select for it. We have created the name and brand LifeBridge for any medical society to use. By using LifeBridge as your brand, you will save time and money by not having to create a name that has clear and unambiguous meaning, is not already registered to another entity when paired with the tagline Physician Wellness Program, and accommodates a logo design that is appealing to your members, staff, and potential donors. Branding information can be found in Chapter 3.

Ensure program participation is not reportable – A key to the success of your PWP will be creating a program that does not create a medical record and will not have a negative impact on the physician and their licensure. How to ensure this varies from state to state. For details see Chapter 2, under confidentiality.

Program evaluation – You may find it important to evaluate the program's effectiveness and rely strictly on use rates. If you do request program evaluations from clients who have used the PWP, they must remain anonymous. The questions you ask and the method for requesting these evaluations may vary. This is discussed more in Chapter 4.

Financing – No matter how big or small your program is, you must have a plan for how you will fund it and track the expenses. There are many ways to fund your program including endowments from your foundation, private donations, membership dues, and sponsorships. For more on fundraising and budgeting for your program, see Chapter 2.

PROGRAM APPROVAL

Once you and your leadership team have answered these first questions, you are likely ready to present your program to your board for final approval.

PROGRAM LAUNCH

Congratulations!

Once you've gained approval from your board, the real fun begins. Now is the time to complete all your legal documentation and agreements while starting to implement your plan. There are three critical stages to the successful execution of your well-designed plan.

Marketing – What good is your program if no one knows about it? What plans do you have to make your program known to eligible members? We have compiled an extensive list of marketing ideas and suggestions for getting your program off the ground that can be found in Chapter 3.

Execution – Maybe this is obvious, but it's critical that you do what you say you are going to do. It is imperative to be vigilant with your client intake and your MHP referrals and that you meet the promises delivered to your members. Consider a "secret-shopper" model to ensure that the system is being effectively handled from beginning to end, perhaps by asking a board member to make and keep an appointment.

Measure – Your program will only be sustainable if you effectively measure your results and use them to plan. We recommend you create a program dashboard to report program data back to your board. This information not only will keep the board informed about use and effectiveness but also will help forecast PWP usage for future years, allowing you to budget appropriately. More information about this is provided in Chapter 4.

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SAMPLES

GETTING STARTED

Board Presentation (Generic)

Staff Code of Conduct