Health-Care Provider Burnout

Robert Lippy, PhD, ABPP, CDR, MSC, USN

Naval Center for Combat and Operational Stress Control, San Diego, California

Presented at the 56th AmSECT International Conference, San Diego, California, May 1, 2018.

Bob Groom: I just want to say, we’re incredibly indebted to those that serve in our military like our next two speakers. Those that sacrifice and give up their time and also endure stresses and things that pale in comparison to what we encounter.

We’re able to enjoy our daily lives as free because they’re out doing the bidding of our country in our place. We’re just really grateful to them, and our next two speakers fall into that category. The stress that we experience is real, but I think that some of the stresses that they experience in service make ours just pale in comparison, but we can really learn from that.

Our next speaker is Commander Robert Lippy, who is a clinical psychologist who began his career in the Navy in 1989 as an electronics technician. After 4 years, he received an Reserve Officer Training Corps (ROTC) scholarship to Oregon State University and he obtained a bachelor of science degree in psychology. He was commissioned to serve as a surface warfare officer after his time at Oregon State.

Later on, he went to do graduate and postgraduate studies at the Uniformed Services University of Health Sciences in Bethesda, Maryland. He also went on to do postgraduate work there following that. From 2008 to 2011, he was stationed here in San Diego. In 2010, he was deployed to Afghanistan. He currently serves as the deputy director of the Naval Center for Combat and Operational Stress Control. The aim of that group is to optimize psychological readiness, so what a great speaker to come to us.

He’s received numerous awards: Meritorious Service Medal, the Navy Commendation Medal, Navy Achievement Award, and the Global War on Terrorism Awards. It’s my pleasure to invite him to come up to speak to us about health-care provider burnout.

Robert Lippy: Well, good morning everyone. Thank you for that introduction. And again, thank you AmSECT for inviting me to this conference. I’ll admit as of a few weeks ago, I didn’t really know too much about your profession, so I’ve learned quite a bit and I’m appreciative of that.

I am a Navy clinical psychologist and my current position is as the Deputy Director of the Naval Center for Combat and Operational Stress Control. We are a part of the Navy Bureau of Medicine and Surgery. Having said that, I do not speak for the Navy Surgeon General or for Navy Medicine; this presentation reflects my personal views only. I also have no financial conflicts with this presentation to disclose.

I want to start out by talking a little bit about the concept of burnout. Burnout is not a new topic. It has been studied dating back to the 1970s. However, one of the most pre-eminent contemporary researchers on this topic is a researcher by the name of Dr. Christina Maslach. She’s been studying this for quite a while, and most researchers and others use her definition of burnout.

Dr. Maslach has divided burnout into three domains. The first domain is emotional exhaustion and reflects the most conventional view of burnout, which has to do with feeling emotionally overextended and exhausted by one’s work. It is feeling taxed and fatigued with a general lack of energy for one’s work.

The second domain, depersonalization, has to do with a lack of feeling or impersonal response toward one’s clients or patients. It is a cynicism and negative attitude one develops toward one’s clients. Obviously, similar to emotional exhaustion, this is not a good thing. Dr. Maslach’s third domain is called personal achievement. In the case of burnout, this domain refers to feeling a lack of personal achievement and a general worsening self-confidence that develops.

Dr. Maslach then created a self-report questionnaire, appropriately called the Maslach Burnout Inventory or MBI, to measure these domains of burnout. The MBI is one of the most commonly used measures of burnout, and in particular within the health-care profession. This self-report scale consists of 22 questions scored from 0 to 6 measuring the three burnout domains. Some examples of items on this questionnaire include the following: “I feel emotionally drained from my work.” “I have accomplished

P5
many worthwhile things in this job” (reverse scored), and “I doubt the significance of my work.”

Next, I would like to briefly discuss how common burnout is in the general population and within the healthcare field. The study we use here tells us that about 28% of the U.S. workforce experiences burnout. I like to think of this percentage as a baseline for comparison to different groups. The study we used here found the burnout rate among physicians to be approximately 38%, which is higher than the general U.S. population figure. Now, in my field of mental health, studies have found burnout rates from 21 to 67%, a relatively wide range. If averaged out, the rate of burnout in mental health professionals would appear to also be higher than that 28% average.

Now shifting to a few studies of military populations, I want to highlight an army study from 2005 that took place in a deployed setting. If you recall that was around the height of the wars in Iraq and Afghanistan. As you can see from this slide, the rates of burnout were high with around 45% of providers working in a primary care setting, 33% of mental health providers, and about 15% of all provider types.

In preparation for this presentation, I searched for burnout prevalence rates that were more meaningful to this group of perfusionists. Unfortunately, I did not find any studies of perfusionists. Therefore, I tried to look at areas that may be closely related to your field. I found that some research has been conducted on anesthesiologists and found that the burnout rate was about 10 to 42%, which when averaged out would appear to be somewhat close to the general population rate of 28%. Given that perfusionists work with surgeons, I looked for studies of that particular group. The study cited here found rates of 30 to 38%, which is again higher than that baseline U.S. workforce rate, and similar to the overall rate among physicians of 38%.

One might conclude from these studies that burnout is relatively common, and since lots of folks experience it, what is the big deal? Well, these next few slides hopefully address the “so what’s the big deal?” question. So, what are the costs and consequences of burnout? Well, as you can see from this slide, burnout leads to an overall decrease in quality of care. It can also lead to an increase in medical errors, not good!

I think it makes intuitive sense how patient satisfaction can be affected when you consider a provider who has developed a cynical attitude towards one’s clients. Burnout also can affect treatment outcomes. We also know that burnout can affect health-care on a systems level. Research has found that burnout correlates with higher rates of absenteeism, job turnover, and as a result of those things, can lead to decreased access to care. Burnout has also been found to negatively correlate with overall job performance, as well as job satisfaction. The bottom line to all of these things is increased health-care costs.

If the fact that burnout can affect the care you provide your patients as well as the health-care system is not motivating, then I hope the fact that burnout can affect one on a personal level will be motivating. Listed on this slide are a few individual consequences of burnout to include higher rates of depression, anxiety, lower quality of life, lack of empathy, difficulty sleeping, substance abuse, and poor physical health. Motor vehicle crashes is an interesting and concerning correlate of burnout, as is marital problems. So, you can see that burnout can have a broad impact. It can and does impact patient care, the health-care system, and our own physical and mental health.

Now, I have some questions for the audience. I want you to think back in the past year and using the ARS live voting system answer the following question: “Have you experienced any of the following burnout symptoms?” Let’s start with first burnout domain of emotional exhaustion. Remember this domain reflects that general conception of feeling burned out, having a lack of energy or feeling fatigued as it relates to your job as a perfusionist. (Pause, waiting for the audience to vote.) Okay, please stop it there. As you can see the rates are pretty high.

Let’s move on to the next domain: depersonalization. Again, think back over the past year, “Have you experienced a sense of unfeeling, or an impersonal response toward your clients? A negativity or cynicism? A general lack of empathy?” (Another pause, waiting for the audience to vote.) Okay, it looks like the voting has mostly been completed, so we will stop it there and move on to the next question.

Again, thinking back over the past year, “How much have you felt a sense of low personal accomplishment? In other words, have you felt you were not as competent as you would like to be, maybe not as successful as a perfusionist as you might like to be?” (Another pause, waiting for the audience to vote.) Okay, it looks like we have reached a consensus there, so on to the next slide please.

Given the results of the voting we just witnessed I am curious what the audience thinks of those rates. To me, these results could be a bit surprising given what we learned in the previous presentation about perfusionists generally enjoying their work. I noticed a similarity with the previous studies about mental health providers. It would appear that although we all enjoy what we do, that work comes at a cost, which is that despite high satisfaction, we are still susceptible to burnout.

Now, I would like to switch gears and talk briefly about a couple of projects that we’ve been involved in at our Naval Center for Combat and Operational Stress Control. One is a survey of my community of navy psychologists. The second one is a staff wellness survey we conducted right here in San Diego at our Naval Medical Center, San Diego, that surveyed the entire hospital.

With regard to the navy psychologist survey, our community is relatively evenly split between active duty and
civilians. However, on this survey, most of the respondents were active duty. The breakdown is listed there: O-3 is a Lieutenant, O-4 a Lieutenant Commander, O-5 and O-6 are Commander and Captain, respectively. So, from these demographics, you can see that the majority of our respondents were relatively lower ranking psychologists. You can see the average time practicing psychology was approximately 6 years.

In this survey, we used the Maslach Burnout Inventory discussed earlier. We found a high percentage, 41%, on the emotional exhaustion domain. On the depersonalization subscale, we found lower rates. And on the personal achievement subscale, we find high rates, again a good thing. If we compare this to the audience survey results earlier, I think it is somewhat similar. Most perfusionists and navy psychologists tend to experience a high amount of personal achievement, low depersonalization, but a fair amount of emotional exhaustion.

The second survey here as I mentioned was conducted at our Naval Medical Center, San Diego, in 2017. This is our big hospital up on the hill here. It’s actually our largest hospital in the Navy. As you can see we again used the Maslach Burnout Inventory. I am not going to go into much detail on the demographics of the sample other than to say it was a relatively representative sample of the hospital population.

On the personal achievement subscale, the majority reported a medium to high sense of personal achievement. On the depersonalization scale, we found a low amount reported. And then on the emotional exhaustion scale, respondents reported a high amount, with 38% in the high range of the scale.

One of things that we looked at in this study was the comparison between active duty and civilians respondents. We did that because we often expect differences in these two groups. The reason this is an area of particular interest to us is because as Mr. Groom pointed out earlier, our active duty population experience some unique challenges. For example, deployments and long separations from family. Also, there is an inherent expectation for our active duty to take on a lot of collateral duties, so we wanted to look at some of those differences.

One of the things we discovered from this particular survey is that our active duty staff report that they perform best when their work is exciting, rewarding, and they have a good work–life balance. On our civilian side, we found that they perform best when they have opportunities for promotion and are satisfied with their collateral duties. Our providers perform best when they have general job satisfaction and experience minimal work–family conflict.

The main takeaways from these two studies is that there appears to be higher levels of emotional exhaustion within our navy psychologists and at Naval Medical Center, San Diego, but despite that both groups report higher levels of Personal Achievement than the general U.S. population samples. It is a bit of an interesting phenomenon that we tend to feel more burned out, but at the same time, there is a lot of satisfaction from what we do.

Now that we learned a bit about the prevalence of burnout and some of its consequence, I am going to shift gears again and discuss what we can do to try and prevent burnout. What follows are just a couple of the projects that we’ve been involved in at my place of work at the Naval Center for Combat Operational Stress Control.

The first program is called Caregiver Occupational Stress Control or CgOSC for short. This is a program that was developed about 3 or 4 years ago. It’s based on evidence informed stress management principles. The CgOSC program starts with a 4-day train-the-trainer course. My staff members at NCCOSC have trained teams at almost all of our Navy hospitals throughout the world. The process is that we teach a small cohort of health-care providers who then return to their hospitals and train their own staff. One of the important facets about this particular program is that it involves pre-clinical interventions. As a psychologist that’s something that we really stress, is that this isn’t a clinical tool. That is to say, this program is not about treating clinical disorders. The general principle is to train staff on how to recognize signs of stress and burnout within themselves and teach them some basic stress management skills and then to recognize those same signs within their peers and assist their peers in managing their stress levels.

I would like to briefly discuss some of the key components of the CgOSC program. As I mentioned one key component is learning various individual stress management skills such as deep breathing, problem solving, positive thinking, and living according to important values. We teach people how to develop personalized self-care plans. We also teach our leaders actions they can take to help mitigate stress in their subordinates, as well as how to intervene when someone is in acute crisis, as well how to bolster individual resilience in their subordinates.

We also teach staff how to conduct stress assessments of units within their organization. When units, individual departments, or clinics are experiencing high rates of burnout or stress, they can elect to have CgOSC team members come into the unit and conduct an assessment of the unit’s strengths, weaknesses, and then provide actionable recommendations on how to improve that unit’s overall morale and resilience.

The foundation of the CgOSC program is something we call the stress continuum. The purpose of the stress continuum is to give everyone a common language for understanding and describing stress levels. I like to think of the stress continuum as a continuum of psychological health. The left far end of the continuum is the green zone and reflects the goal where we want to be. When we are in the green zone we are physically and mentally healthy, ready, nourished, getting good sleep, etc.
The reality is that we do not stay in the green zone for very long because we all inherently experience daily stressors that push us into the yellow or reacting zone. The yellow zone is likely where the majority of people spend a large amount of time, which means it is entirely normal to be in the yellow zone. Signs of being in the yellow zone include irritability, sleep problems, concentration problems, and perhaps getting into arguments. Again, remember that it is completely normal to experience yellow zone stress levels.

Moving to the right on the stress continuum, if a particular stressor persists or you experience a significant acute stressor that can actually push you into the orange/injured zone. This is where it’s starting to become more serious and individuals may begin experiencing clinical mental health symptoms like panic attacks, nightmares, shame, guilt, or blame.

On the far right of the stress continuum is the red/ill zone. If the same stressor or stressors continue to persist without intervention or an individual experiences a significant traumatic event, then that may push the individual into the red/ill zone. That’s really this clinical zone that you start to get into the realm of formal mental health treatment, which involves treatment of clinical conditions that may have developed such as post-traumatic stress disorder, which Dr. Kraft is going to talk about here shortly. But, also things like major depression, anxiety, and substance abuse.

The chart running along the bottom of the stress continuum reflects levels of responsibility for intervention. We as individuals are most responsible and in the best position for keeping ourselves in the green and yellow zones. As we start to move up the continuum, as our stress increases, then we may need the assistance of our peers or our family to help recognize our increasing stress and help intervene on our behalf to help get us back into the yellow and green zones. When we get into the orange and red zones, is when it will likely require the help of a professional caregiver to help restore our psychological health.

This slide lists some signs of burnout broken down into five domains: mind, body, spirit, social, and behavioral. Please notice the parallel of these signs with the orange and red zones of the stress continuum. Within the mind domain, you should notice some of the things we have already talked about, such as anxiety, irritability, sadness, guilt, and depression. Within the body domain, signs of burnout can include body complaints, sleep problems, and fatigue. In the spiritual domain, burnout can lead to questioning one’s faith, helpfulness, or hopelessness. Social domain signs can include withdrawing or interpersonal conflicts. ‘Presentseeism’ means zoning out in a conversation. And then, you can see lots of examples of burnout within the behavioral domain.

Now it’s time to do some more audience polling. How many of signs of burnout just listed have you experienced in the past month? Please flip back to that last slide and now as you look at the slide, think back in the last month, and now count how many of those burnout signs/symptoms that you experienced, even to a small degree. Once you have that final number, please vote. (Pause, while audience votes.) It appears just about everyone has voted. I want to say I appreciate your honesty. Although this is anonymous, it still takes some courage to admit that you may be experiencing some of these.

When I reviewed the new guidelines, I noticed that one involved ‘on call duty.’ Therefore, that was something that myself and Mr. Groom were interested in learning more about. So, please vote “Yes” if you felt like your ‘on call duty’ has contributed to burnout. (Pause, while audience votes.) Looks like we’ve reached the steady state there, so 80% of those who voted felt like being on call contributed to some burnout.

And then, the other new guideline that I read about is for 8 hours of rest for every 16-hour consecutive work period. The question is “how much do you adhere to that guideline?” Responses include “Always or most of the time,” “Some of the time,” or “Nearly none of the time.” (Pause, while audience votes.) Very interesting.

I am going to wrap up this presentation by briefly discussing some of the individual resilience topics that we teach as part of our CgOSC program that I previously discussed. Everything that we teach here is not new or novel. These are all evidence-informed principles in the field of psychological health, resilience, and stress management. Some of the more common skills that we’re teaching are basic optimism and flexible thinking. Something that we find is that many individuals just get stuck in these ruts of having very negativistic thinking, which can have negative emotional consequences.

Mindfulness is another basic, but highly effective resilience skill. Just by a show of hands, how many folks are familiar with mindfulness or have heard of it? Okay, some. That’s actually encouraging. Mindfulness is focused attention on the present moment in a non-judgmental way. It sounds very simple, but I can tell you, it’s very hard to do and actually quite complex. All of these skills here, and I’ll emphasize the word skills, are things that just like any skill can be learned. And like any other skill, the more you practice them the better you get at them. Mindfulness is one of those that takes a lot of practice.

We also teach positive coping. We talk a little bit about control, which involves learning when and how to change things versus understanding that we can manage our stress better by accepting things that are outside our control. Again, these are just some examples of the topics that we teach that are designed to expand individual resilience skills.

We also teach people about Self-Care. Self-care is different than self-pampering, which includes things like...
eating chocolate, drinking beer, or ‘vegging out’ and watching your favorite TV show. Certainly, those things feel good and can help us control some of our stress. However, self-care represents more of a deliberate action. It’s actually developing the self-care plan that balances what you already do with a few things that are good for you that you may not be that inclined to do. What is a self-care plan? It’s a systematic approach to identifying warning signs of stress and burnout in those four self-care domains. We mentioned those earlier. To be self-aware, which is a must for self-care involves identifying your strengths and weaknesses. They’ll help you understand your reactions in specific and overall stressful situations. The idea here is not to eliminate stress but actually to help you manage stress rather than being overwhelmed by your emotions.

One of the nice things about these various resilience skills that I just mentioned is that they are all very portable. In other words, they are all skills that you can do almost anywhere, in any place, and at any time. Compared to say something like golf, which although a deliberate action that could be very relaxing to someone, still requires a certain time, place, and props to do it.

The other key to developing a self-care plan is to make a commitment to yourself. It also involves a break in the conspiracy of silence. This is something that we find we’re all susceptible to. We get stressed and we feel like we have to hold that in and not talk with others. I admit as a psychologist, I’m probably biased that talking actually is very helpful.

The second program that we developed at our Naval Center for Combat and Operational Stress Control is called Mind Body Resilience Training (MBRT). This program has a lot of overlap with our CgOSC program, but it has a few differences. Whereas the CgOSC program is designed primarily for use within our hospitals and our health-care providers, MBRT was actually designed to be used by any sailor or marine in the operational environments where they work, our assault ships here in San Diego just last year. MBRT was actually born out of the request from a Commanding Officer on one of the ships in San Diego to develop a training program to help them become more resilient. That request was a unique watershed moment for us because historically, our operational commanders focus almost exclusively on operational issues such as weapons systems and tactics and how to keep their ship materially ready. However, our line commanders are now starting to realize that without resilient sailors and marines, they cannot fully execute their mission. Therefore, from a medical/psychological perspective, it is very exciting to see our operational colleagues now really taking these principles to heart and asking for resilience programs like these.

So, I just briefly want to highlight some of the components of the MBRT program. You can see some of the overlap with our CgOSC program. But some of the unique components of MBRT include mindfulness, meditation, as well as communication skills. We talk about problem-solving, and we actually talk about values because your values can also affect your resilience level.

We also include a couple of optional modules in MBRT. One module is all about the importance of sleep and sleep hygiene. The other module is all about leadership and how effective leadership positively affects stress management. The MBRT program, like the CgOSC program, uses a train-the-trainer model. In this case, we teach members of operational units, who then go back and teach these skills to their unit members. We also encourage units to tailor MBRT based on their unique operating environments. For example, on a ship, we don’t expect them to teach the full MBRT program in a full day and teach this to everyone on the ship and then to practice this every day. That’s just not practical. So, we give them the tools we say. “Adapt this to your environment.” Our preliminary results from this are promising. We found that the sailors who have gone through MBRT like the program, understand the material, and are taking these concepts and practicing them and noticing benefits from it.

The last module is about leadership. That’s an important component. I am sure many of the audience members are leaders in your field. Leadership has a key component in preventing burnout. This topic emphasizes good leadership principles, such as being empathic and being a good communicator. It also includes valuing the people that work for you, providing them that positive feedback, and being transparent about the organization.

Well, that concludes my presentation. However, I have one last question which is “Given what I’ve talked about this afternoon, are you committed to building a self-care plan to help balance your work–life demands?” (Pause, while audience votes.) Looks like the votes are in. Thank you again very much for your time and I hope you learned something from this presentation.

Bob Groom: Thank you Commander Lippy. That was outstanding and we’ll bring you up in a little bit for discussion.