

Coaching Physicians on Burnout

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4 tiers of solutions for burnout with coaching

- Self
 - Personal health: exercise, nutrition, sleep
 - Mind: emotional health, mindfulness/meditation, resilience/recovery
 - Spirit: religion, arts, hobbies
 - Communities: social/personal, learning, civic, sports
- Workplace
 - work/life boundary
 - delegation/teaming
 - efficiency

4 tiers of solutions for burnout with coaching

- Organization

- Finding one's voice as an advocate
- Political savvy
- Change management
- Creating effective teams

- Environment

- Finding leverage points
- Successful advocacy, teaming, change management

Physician Coaching: Choosing the Right Dose

Customized Coaching Solutions for Burnout

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Mini-dose: the individual doc

The mini-dose approach assumes that burnout can be addressed by improving factors primarily within the individual physician's control, such as personal resilience practices or workplace efficiency. Burnout results from incursion of workplace demands and stresses taking a toll on personal resourcefulness. This approach is designed to restore personal health practices, improve self-efficacy with workplace tasks, and balance professional and personal priorities.

INDICATIONS

For physicians able to turn in satisfactory job performance, but suffering from demoralization, as shown by expressed unhappiness with work, perceived or visible fatigue, or disengagement from colleagues

ENGAGEMENT

Up to 6 hours of 1:1 coaching with an external coach:

1. Assessment of difficulties, including standardized surveys
2. Focused goal-setting
3. Coaching sessions, in-person or remote, centering on rapidly actionable solutions
4. Concluding debrief with client

Effectiveness of Coaching for Primary Care Physicians: Preliminary Results

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Overview



- Primary Care Physicians (PCPs) are vulnerable to **burnout** and **leaving medical practice**.
- We are conducting a **coaching intervention** for PCPs based on principles of **positive psychology**.
- We will present information about the **scope** of the problem, our **approach** to the intervention, and **initial study findings**.
- We will also discuss **coaching content and process**.

Scope of the Problem

- PCPs are critical for lower cost and higher quality care (Johnson, 2013)
- Yet, we have a PCP shortage
 - Affects 60 million people in the U.S. (Primary Care Progress, 2014)
 - Projected shortfall of 20,400 PCPs by 2020 (U.S. Dept. of Health & Human Services, 2013)
- PCPs tend to leave their institutions at peak of value (Drybye et al. 2013)
 - Expensive and difficult to replace



Scope of the Problem



- PCPs are among the highest rates of burnout of medical specialties (Shanafelt et al., 2012)
- Systemic factors (changes in medical practice):
 - Electronic medical records
 - Team-based care
 - Consolidation of health care provider entities
 - Reimbursement models
 - Public performance data reporting
 - Increased administrative demands
 - Time and pressure detracts from patient care
 - Work-life conflict
 - Decreased in-person interaction with colleagues

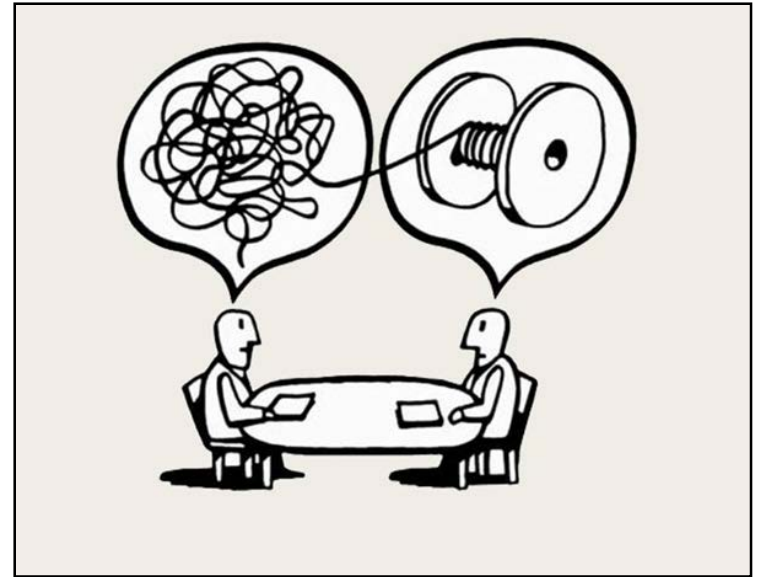
Background: Burnout



- Burnout is associated with:
 - Increased medical errors, substance abuse and other health problems (Krasner et al., 2009)
 - Turnover (Halbesleben & Buckley, 2004)
- Supports for sustainable PCP careers are necessary

Background: Coaching

- We proposed that coaching would be helpful
 - Individualized process; specific to role and workplace
 - Logistically flexible to meet the needs of a population often too busy and focused on the care of others to engage in caring for themselves



Background: Coaching

- We used theory and research from the field of positive psychology to frame our study
- Focus on well-being
 - **P**ositive emotion
 - **E**ngagement
 - **R**elationships
 - **M**eaning
 - **A**chievement



Martin Seligman

<https://positivepsychologyprogram.com/perma-model/>

Background: Coaching

- Broaden and build theory (Frederickson, 2001)
 - Positive emotions **broaden** how an individual thinks and identifies actionable opportunities.
 - These thought-action patterns **build** personal resources and contribute to resilience and well being
- Self-determination theory (Deci & Ryan, 2000)
 - Meeting these three needs leads to intrinsic motivation:
 - Autonomy
 - Relatedness
 - Competence



EVIDENCE FOR THE EFFECTIVENESS OF COACHING FOR PHYSICIANS

- There is a small but growing body of evidence that physicians can learn skills to counter burnout through learning techniques of mindfulness or stress reduction through training or coaching^{1,2,3}

¹ Fortney et al (2013)

² Schneider, Kingsolver, & Rosdahl (2014)

³ Sood et al (2011)

SUCCESSFUL COACHING APPROACHES FOR PHYSICIANS

- Coaching: elevated physician resilience by improving their ability to (a) set boundaries more effectively, (b) be more self-compassionate which, in turn, informed better self-care, and (c) be more self-aware.¹
- Coaching model to remediate inadequate communication skills: all participants rated the consultation in the moderate to high satisfaction range, and all supervisors rated the consultation in good to high satisfaction range.²

¹Schneider et al (2014)

²Egener (2008)

Study Hypotheses

Following participation in a coaching program

- PCPs will report decreased levels of . . .



- Burnout
- Stress
- Intentions to drop out of medical practice

- and increased levels of . . .



- Psychological capital (hope, resilience, self-efficacy, optimism)
- Compassion
- Work engagement

- compared to a control group.

Coaching Structure

- Six sessions over a three-month period
 - One every two weeks
- Session 1: 60-minutes long (in-person)
 - Focused on creating the coaching alliance, assessing character strengths, reviewing the results of Workplace PERMA Profiler, and setting client-centered goals
- Sessions 2-6: 30 minutes long (by phone)
 - Focused on specific topics and tools, based on a client-centered action plan created in the first session
 - Pre-work completed prior to each session

Coaching Process and Content

- Selection of coaching tools
 - Based on fit with the pillars of the PERMA model and research validating their effectiveness in enhancing well-being (e.g., Bolier et al., 2013; Seligman et al., 2005; Sin & Lyubomirsky, 2009)
 - Take into consideration varied learning styles and time horizons in order to provide flexibility to match participant learning preferences (Kolb, 1984)
- Intervention consistency across the team
 - Worksheets were developed for each tool to guide the coaching conversation between coach and study participant
 - Coaching protocol included discussion of PERMA values at Session #1 and character strengths (viacharacter.org) at Session #2
 - Ongoing discussion between coaches as needed

Coaching Tools

Tool	Learning Style	Time Horizon
Workplace PERMA Profiler	All learning styles	Past, present, future
Mindfulness Reflections	Reflective observation	Present
Social Flow	Active experimentation	Present, future
Best Self	Abstract conceptualization Concrete thinking	Future (past and present for examples)
Mindfulness Reflections	Reflective observation	Past
Using Strengths in New Ways	Active experimentation Concrete thinking	Future

Study Method

- Enroll 60 PCPs from local medical groups
- PI (Les Schwab, MD) conducted phone screenings
- Inclusion criteria:
 - Early to mid-career PCP's (< 20 years' experience)
 - Currently working at least half-time

Study Method

- Randomized control trial (RCT)
- After screening, participants were randomly assigned to a primary coaching group (one of 5 coaches) or a waitlisted control group
- Participants completed online surveys at:
 - Baseline
 - Baseline + 3 months
 - Baseline + 6 months
 - Baseline + 9 months
 - Baseline + 12 months
 - Baseline + 15 months

Study Method: Measures

Variable	Measure (Authors)	Coeff. Alpha
Burnout	MBI (Maslach, Jackson, & Leiter, 1996)	.86
Stress	Stress in General Scale (Stanton, et al., 2001)	.88
Intent to Turnover	Turnover Intentions Scale (Cammann et al., 1983)	.84
Psychological Capital	Psychological Capital Questionnaire (Luthans et al., 2007)	.94
Compassion	Santa Clara Brief Compassion Scale (Hwang et al., 2008)	.86
Engagement	Job Engagement Scale (Rich, LePine, & Crawford, 2010)	.93

Participants

- Study is ongoing; these are preliminary results
- Primary Group:
 - Time 1 (baseline): $N = 26$
 - Time 2 (post-coaching): $N = 15$
- Waitlisted Group:
 - Time 1: $N = 24$
 - Time 2: $N = 14$
- Overall Demographics:
 - 39 female (78%); 11 male (22%)
 - Average age = 42.72 (SD = 8.33)
 - 64% have children under 18
 - 24% are caring for dependent adults
 - 52% have 5 years of tenure or less with their organizations

Baseline Comparisons

- Compared demographics and study variables at baseline by group (primary vs. control)
- Chi square tests and t-tests used
- No differences observed
- Successful randomization!

Means by Group

(preliminary data – not for distribution)

		Waitlist		Primary		
Time	Variable	N	Mean	N	Mean	
T1	Burnout	24	2.41	26	2.40	↓
T2	Burnout	14	2.44	15	2.13	↓
T1	Turnover Intentions	24	1.94	26	2.12	↓
T2	Turnover Intentions	14	1.67	15	1.73	↓
T1	Job Stress	24	2.18	26	2.06	↓
T2	Job Stress	14	2.04	15	1.87	↓
T1	Psychological Capital	24	4.27	26	4.10	↑
T2	Psychological Capital	14	4.35	15	4.68	↑
T1	Compassion	24	5.58	26	5.41	↑
T2	Compassion	14	5.61	15	5.80	↑
T1	Engagement	24	5.85	26	5.74	↑
T2	Engagement	14	5.75	15	6.13	↑

Implications

- Results trending in expected directions
- Coaching appears to be helpful for PCP's in improving personal resources and mitigating strain
- Next steps:
 - continued follow-up/tests of statistical significance
 - Modification for specialty group in Maine – 10 entrants in similar brief intervention

Maxi-dose: the physician and the workplace

The maxi-dose approach addresses burnout progressing to impaired performance at work and/or impaired personal wellbeing. It assumes that burdensome workplace factors combined with individual factors which made the physician vulnerable to being overwhelmed and unable to be proactive. It includes sponsored workplace engagement and supports both problem resolution at the workplace level and restoring problem-solving capability to the individual.

INDICATIONS

For physicians suffering from demoralization and impaired performance and/or impaired personal wellbeing, as indicated by performance decrements (e.g. impaired professionalism, not completing work, etc) or indicators of demoralization (e.g. expressed unhappiness with work, general unhappiness or detachment apparent to others, etc.)

ENGAGEMENT

10-20 hours of 1:1 coaching with an external coach, in collaboration with the workplace:

1. Assessment of difficulties and precipitants, in collaboration with workplace.
2. Goal-setting focused on improving morale and performance, in collaboration with workplace.
3. Coaching sessions, in-person or remote, with workplace observations and advocacy as needed
4. Concluding debrief, in collaboration with workplace

CASE HISTORY

- 35 y.o. primary care physician at end of first year in practice
- self-referred for demoralization/overwhelmed feelings and lagging chart completion, creating anxiety when “off duty”
 - coaching process:
 - allied with client’s need to be conscientious
 - raised contrast between conscientiousness and perfectionism
 - developed prioritization process for charting
 - outcome: record keeping more caught up; private life less incurred upon by work worries

CASE HISTORY

60 y.o. academic specialist:

- referred for overbearing behavior, perceived as hostile; job at risk
- coaching process:
 - allied with client's need to be "right"
 - raised awareness of unintended consequences of personal style
 - developed self-check for provocations
 - developed alternative repertoire of responses
- outcome: job preserved

CASE HISTORY

43 y.o. academic surgeon:

- self-referred for career malaise, work/life imbalance
- coaching process:
 - allied with client's entitlement to workable supports
 - raised awareness of hesitant self-advocacy
 - experimented with negotiation for resources
- outcome: given preferred OR time and staffing, saving several hours a week; asserted presence in hospital for career development

Multi-modal/multi-dose: the organizational level

The multi-dose approach assumes that burnout can best be addressed by intervening at the system level which may indeed secondarily require individual coaching. Burnout factors that arise directly from excessive systemic stresses ordinarily require executive leadership that is committed to organizational change, e.g., for needed process improvements and infrastructure supports.

ENGAGEMENT

Widely variable as required by the needs of the institution. Generally begins with some form of needs assessment, followed by stakeholder approved and sponsored design of organizational change initiatives. Those initiatives can be implemented via leadership coaching, retreats, workshops, and other forums, all focusing on enhancing organizational effectiveness to provide a workplace with higher job satisfaction.

INDICATIONS

For systems that have high levels of burnout, whether in particular departments or divisions or throughout the institution.

Physician Leader's Coaching Style Makes a 2:1 Difference in Burnout

Items Evaluating Physician Opinion of the Leadership Qualities of Their Immediate Physician Supervisor:

- Holds career development conversations with me
- Inspires me to do my best
- Empowers me to do my job
- Is interested in my opinion
- Encourages employees to suggest ideas for improvement
- Treats me with respect and dignity
- Provides helpful feedback and coaching on my performance
- Recognizes me for a job well done
- Keeps me informed about changes taking place at Mayo Clinic
- Encourages me to develop my talents and skills

- Shanafelt et al, JAMA 2015

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