LTC Clinician Resiliency because you're worth it.

October 22, 2022

Ontario Long-term Care Clincians Conference

Dr. John Crosby, MD, FRCP(C), MCFP (EM)

Dr. Hugh Boyd, MD, CCFP(COE)

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Faculty/Presenter Disclosure

- **Faculty: Hugh Boyd**
- **Relationships with financial sponsors:**
  - **Grants/Research Support:** none.
  - **Speakers Bureau/Honoraria:** none.
  - **Consulting Fees:** Sienna Senior Living; St. Joseph's Villa – Dundas; St. Joseph's Health Centre Guelph; Alexander Place;
  - **Patents**: none
  - **Other:** Ontario Medical Association; Provincial Geriatrics Leadership Organization Clinical Leadership Council; McMaster Care of the Elderly Working Group; Greater Hamilton Health Network LTC Advisory Board

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Faculty/Presenter Disclosure

- **Faculty: John Crosby**
- **Relationships with financial sponsors:**
  - **Grants/Research Support:** none.
  - **Speakers Bureau/Honoraria:** none.
  - **Consulting Fees:** none.
  - **Patents**: none
  - **Other:** none.

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Disclosure of Financial Support

- **No external support. (contact us if you're interested☺)**

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Mitigating Potential Bias

- We recognize that “wellness” has appeared to have been abused by employers in the past to pressure healthcare professionals into enduring trauma exposed work without enabling meaningful change to protect clinicians or help them recover. We are both consultants for organizations who employ clinicians – some are likely in this audience. We will work hard to distinguish between factors within the control of clinicians and those that are the responsibility of organization leaders (including us) and system leaders (we’re looking at you OLTCC, NPAO & OMA).

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Correlation vs Causation

Mentimeter

- Pull out your laptops or cell phones and go to www.mentimeter.com
- When you see Menti: ####
  enter the ### code to participate anonymously
- SCREEN SHOT ON IPHONE

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Learning Objectives

1. Complete a case study on clinician resiliency on yourself.
2. Understand the influence of individual factors, culture of medicine, and health system influences on clinician health.
3. Practical Pearls to improve your resiliency on your next day back to work.

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Trigger Warning

- Burnout is prevalent.
- This discussion may unintentionally cause some to revisit their suffering.

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Scope

- Managing mental illness and injustice (racism, agism, sexism, gender-based violence, colonialism and other forms of harm) is important but beyond the scope of this presentation

- **Replace with Venn diagram**

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Case Study - you

- “I feel burnt out”

- What does that mean to you?

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Results of #____

- Word collage

Mentimeter.com #____

"Overall, based on your definition of burnout, how would you rate your level of burnout?"

1. = I Enjoy my work. I have no symptoms of Burnout
2. = Occasionally I am under stress, but I don't feel burned out
3. = I am definitely burning out and have one or more symptoms of burnout
4. = The symptoms of burnout that I'm experiencing won't go away
5. = I feel completely burned out

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Results of #____

Mentimeter.com #____

- What Individual Factors are contributing to your burnout
  1. Low collegiality
  2. Rising patient entitlement
  3. Angry patients and families
  4. TV is on during the exam

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Results of #____

Mentimeter.com #____

- What Culture of Medicine Factors are contributing to your burnout
  1. Computer & paperwork
  2. Less control over workloads
  3. Too many meetings

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Results of #____

System Factors

- What System Factors are contributing to your burnout
  1. Less prestige
  2. College complaints
  3. Clinician voice ignored
  4. Lack of a unified voice

Results of #____

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Traditional vs Novel Treatment

- Escapism vs work life balance?
- burnout results in less caring

- Correlation vs causation?

- Evidence suggests that intentionally caring more reduces burnout

Care More

- for Yourself
- for your Residents & their families
- for your colleagues & Team

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Novel treatment options

- Round more often to every unit, for a shorter time

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Novel treatment options

- Agree with clinicians to see each other's urgent patients

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Novel treatment options

- Go to every family meeting, but only for 10 minutes

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Novel treatment options

- Ensure there is a parking spot for part time clinicians

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Novel treatment options

- Learn to love paperwork

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Novel Treatment Options

- 5 C's of physician resilience:
  - **C**ontrol & Confidence
  - **C**ommitment
  - **C**aring relationships
  - **C**alming
  - **C**are of self

Mamta Gautam, MD Canadian Journal of Physician Leaders 2019 Quit Multiplying by zero to address physician burnout effectively. https://cjpl.ca/zer.html

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Novel Treatment Options for Leaders

- Wellness-centred physician leadership
  - Care about people always
  - Cultivate individual and team relationships
  - Inspire change

Shanafelt T, Trockel M, Rodriguez A, Logan D (2021): Wellness-Centered Leadership: Equipping Health Care Leaders to Cultivate Physician Well-Being and Professional Fulfillment. Academic Medicine 96(5): 641-651. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8078125/pdf/acm-96-641.pdf

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Additional Resources

- Precontemplation
  - Nazir A, Smalbrugge M, Moser A, Karuza J, Crecelius C, Hertogh C, Feldman S, Katz PR (2018): The Prevalence of Burnout Among Nursing Home Physicians: An International Perspective. JAMDA 19(1): 86-88
  - Gajjar J, Pullen N, Li Y, Weir, S, Wright J (2022): Impact of the COVID-19 pandemic upon self-reported physician burnout in Ontario, Canada: evidence from a repeated cross-sectional survey. BMJ Open 12(9). https://bmjopen.bmj.com/content/bmjopen/12/9/e060138.full.pdf

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Additional Resources

- Contemplation
  - Stephen Trzeciak, MD, Anthony Mazzarelli, MD (2019): Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference.

Additional Resources

- Preparation
  - Jillian Horton, MD (2021): We Are All Perfectly Fine – A memoir of Love, Medicine and Healing. Harper Collins – print, e, audio

Additional Resources

- Action
  - John Crosby, MD (2022): Avoiding Burnout in Long Term Care Doctors.

    Entire article in the handout

  - Q&A = SHARING

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Additional Resources

- Maintenance
  - Peer support from professional organizations
  - SELF-COMPASSION FOR HEALTHCARE COMMUNITIES TRAINING. https://mscnorth.com/
  - the RAFT. The online leadership program for women physicians. At the Intersection of Leadership & Wellness. https://peakmd.ca/the-raft/
  - Trade emails

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Q&A – You're the expert

Try something new for 3 months:

"On Monday I am going to …"

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Email drjohncrosby@rogers.com for free mentoring &/or e-book "Crazy Busy Doctor"

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Results of #____

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END OF PRESENTATION

- See Below for extra content

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Definitions

- "Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed" (WHO)
  - Not a medical condition.
  - Traditionally three dimensions:
    - Emotional exhaustion
    - Depersonalization
    - Reduced sense of personal accomplishment
  - Associated with depression, SI, substance use, MVC, turnover, early retirement, lower quality of care, increased medical errors.

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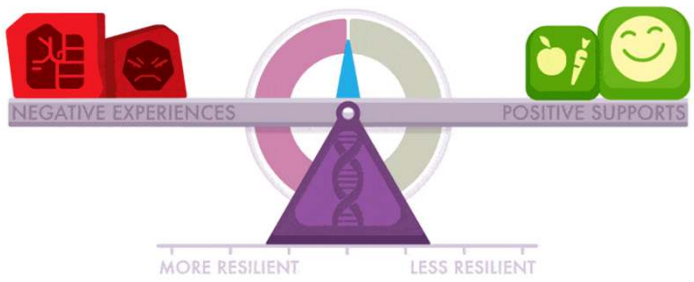
Definitions

- Resiliency = skills and abilities that develop through experience and allow us to adapt and stay healthy even in circumstances of severe stress or hardship



https://www.albertafamilywellness.org/what-we-know/resilience-scale

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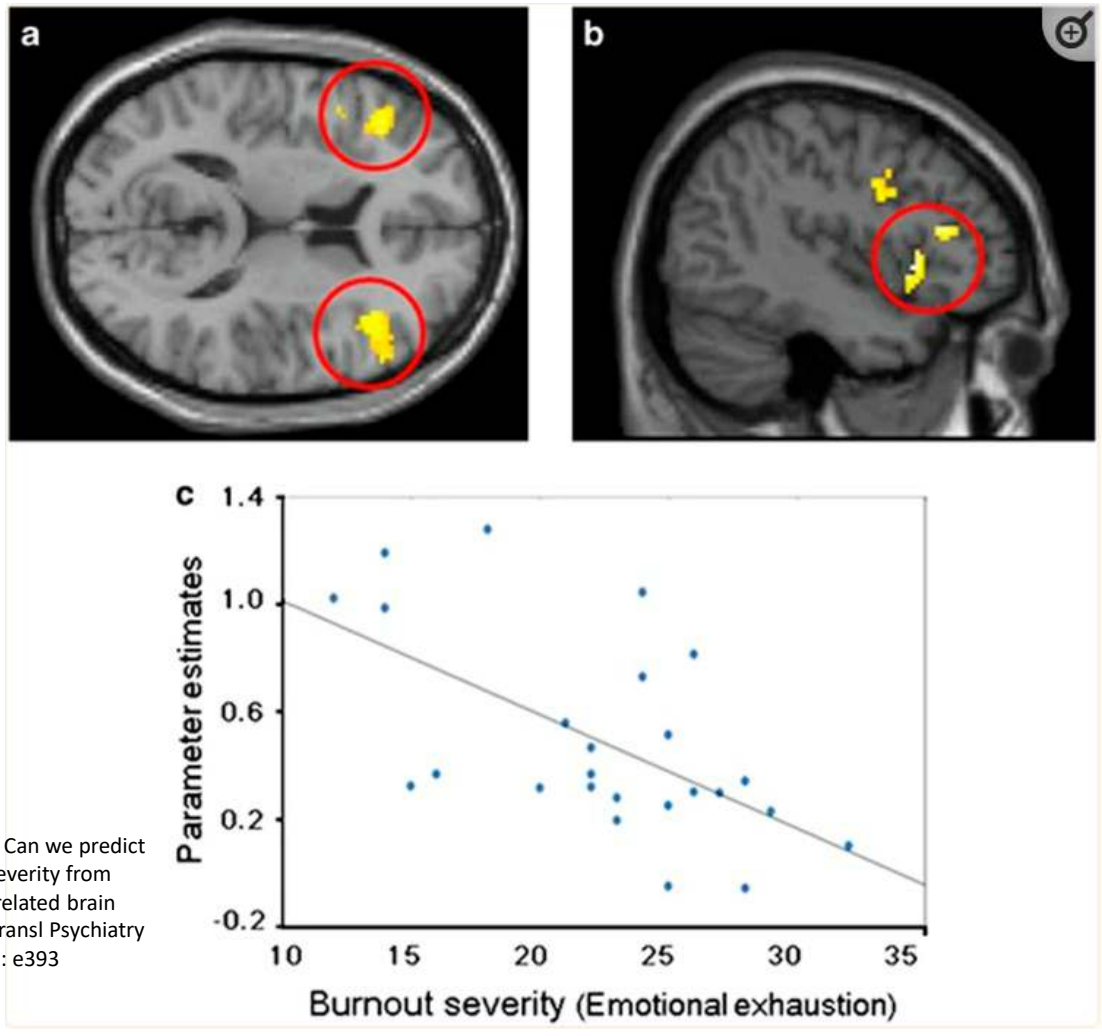

Tei S et al. Can we predict burnout severity from empathy-related brain activity? Transl Psychiatry 2014; 4(6): e393

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Compassion INVERSELY Associated with burnout

- Systematic Review – high caring / empathy associated with low burnout

  Wilkinson H, Whittington R, Perry L, Eames C. Examining the Relationship between Burnout and Empathy in Healthcare Professionals: A Systematic Review. Burnout Research 2017;6: 18-29.

- high compassion associated with lower depression symptoms, higher personal accomplishment & enhanced quality of life
  - Thomas M, Dyrbye L, Huntington J, Lawson K, Novotny P, Sloan J, Shanafelt T. How Do Distress and Well-Being Relate to Medical Student Empathy? A Multicenter Study. Journal of General Internal Medicine 2007; 22(2):177-83.

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Compassion INVERSELY Associated with burnout

- 7500 physicians – those with lowest compassion satisfaction had highest burnout, personal distress, most missed days of work, more likely to take a medical leave of absence
  - Gleichgerrcht E, Decety J. Empathy in Clinical Practice: How Individual Dispositions, Gender, and Experience Moderate Empathic Concern, Burnout, and Emotional Distress in Physicians. PLOS One 2018; 8 (4): e61526.
- 411 –multifactorial analysis showed physician's compassion INDEPENDENTLY associated with lower burnout
  - Lamothe M, Boujut E, Zenasni F, Sultan S. To Be or Not to Be Empathic: The Combined Role of Empathic Concern and Perspective Taking in Understanding Burnout in General Practice. BMC Family Practice 2014; 15: 15.

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Mechanisms of How Caring Helps

- Helper's High = sharp spike in circulating endorphins, endogenous opiates
  - Luks A. "Doing Good: Helper's High." Psychology Today 1998; 22(10): 39-42.
- activates reward pathways
  - Shamay-Tsoory S, Lamm C. The Neuroscience of Empathy - from Past to Present and Future. Neuropsychologia 2018; 116: 1-4.
- activates parasympathetic nervous system by increasing vagus nerve activity
  - Stellar J, Cohen A, Oveis C, Keltner D. Affective and Physiological Responses to the Suffering of Others: Compassion and Vagal Activity." Journal of Personality and Social Psychology 108, no. 4 (April, 2015): 572-85.
- Giver and receiver → lower bp, improved heart rate variability & lower cortisol.
  - Cosley B, McCoy S, Saslow L, Epel E. Is Compassion for Others Stress Buffering? Consequences of Compassion and Social Support for Physiological Reactivity to Stress." Journal of Experimental Social Psychology 2010; 46(5): 816-23.

Interventions

- training reduces blood markers of systemic inflammation in response to experimental stressful event
  - Pace T, Negi LT, Adame DD, Cole SP, Sivilli TI, Brown TD, Issa MJ, Raison CL. Effect of Compassion Meditation on Neuroendocrine, Innate Immune and Behavioral Responses to Psychosocial Stress. Psychoneuroendocrinology 2009; 34(1): 87-98.
- MRI scans - augmenting compassion helped with emotion regulation.
  - Engen HG, Singer T. Compassion-Based Emotion Regulation up-Regulates Experienced Positive Affect and Associated Neural Networks. Social Cognitive and Affective Neuroscience 2015; 10 (9): 1291-301.

Interventions

- there is a minimum level of compassion that is needed to benefit from the positive aspects of professional fulfillment and QOL.
  - Gleichgerrcht E; Decety J. The Relationship between Different Facets of Empathy, Pain Perception and Compassion Fatigue among Physicians. Frontiers in Behavioral Neuroscience 2014; 8: 243.
- Loving-kindness meditation 1.7 h / month --> increased feelings of social connection & positive affect.
  - Hutcherson CA, Seppala EM, Gross JJ. Loving-Kindness Meditation Increases Social Connectedness. Emotion 2008; 8(5): 720-4.

Interventions

- 70 primary care physicians trained to be fully present and attentive over 8 weeks --> raised belief in importance of compassion & improved their self-ratings of compassion --> burnout symptoms decreased & well-being increased
  - Krasner MS, Epstein RM, Beckman H, Suchman AL, Chapman B, Mooney CJ, Quill TE. Association of an Educational Program in Mindful Communication with Burnout, Empathy, and Attitudes among Primary Care Physicians. JAMA 2009 302 (12): 1284-93.
- RCT 132 resident physicians - compassion training --> more compassion for others, decrease in depression symptoms. Benefits were greatest among those with highest level of depression at baseline.
  - Mascaro JS, Kelley S, Darcher A, Negi LT, Worthman C, Miller A, Raison C. Meditation Buffers Medical Student Compassion from the Deleterious Effects of Depression. The Journal of Positive Psychology 2018; 13 (2): 133-42.

Interventions for leaders

- practicing compassion for others among physician leaders - even though stress rated at "severe, very severe or worst possible”; burnout was much lower. 91% of CMOs stated actively caring for others reduced their stress and reduced risk for burnout.
  - Wiens K. Leading through Burnout: The Influence of Emotional Intelligence on the Ability of Executive Level Physician Leaders to Cope With Occupational Stress and Burnout. Doctoral dissertation 2016.

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Avoiding Burnout in Long Term Care Doctors.

Written by Dr. John Crosby for CanadianHealthcareNetwork.ca

I have been the medical director of two long-term care homes for 30 years. One has 55 beds, the other 190. Two other doctors and a nurse practitioner help me at the larger one. I also have a family practice of 1,200 patients, about 60% of whom are seniors.

Long-term care has changed a lot in 30 years. It used to be quite easy since the seniors were relatively well. Mass immunization against influenza, better antibiotics for urinary tract and respiratory infections, better wound care and pressure sore prevention have kept more people alive. We have better teams for behaviour problems, wound management and nutrition and better medications and diagnostics. We have X-ray and lab available the same day on weekdays.

But access is becoming a problem. Among the younger patients are those with head injuries facing 20-year waits for group homes (because the turnover isn't as high as it is at long-term care homes). Down Syndrome residents are also living longer (one of mine is 75) due to heart surgery advances. We have more psychiatric patients due to the closing of the large psych hospitals. Increasing numbers of homeless mental patients are living past 65.

Residents and their families are also becoming much more informed due to Dr. Google and are much more demanding (though we still have a 100% death rate).

We are all doing a better job, but that makes for a more intense job. LTC has become more like a chronic hospital rather than a resident's home (which it should be), and hospitals have had their beds cut in half so patients are coming back sicker and quicker. This means more complex patients like those with tube feeds, dialysis, ventilators and palliative younger cancer patients.

In other words, a perfect storm has developed in LTC.

How I cope

I found 20 years ago I could not manage with rounding once a week. I was getting phone calls from the nurses and pharmacists all the time. I was seeing huge numbers and no one was happy. I changed. Now, I go four times a week.

Patients love it. I think I am giving better care. I have had only one college complaint that was trivial (a son couldn't reach me due to the clerk forgetting to notify me, it was dismissed over the phone).

I found 20 years ago I could not manage with rounding once a week. I changed. Now, I go four times a week.

Our transfers to ER are the lowest in Canada, having dropped from 15 to 5 per month at the big home and from five to one per month at the 55-bed home. We have low drug usage, seven per resident versus the provincial average of 12 because I have time to talk to the substitute decision makers about deprescribing.

I break up my day so I don't end up in the office listening to people complain for eight hours. I am at the homes every morning and my office every afternoon. This helps me avoid burnout.

Staff love it. They don't have to phone me, they know I will be there in 24 hours if it can wait.

The substitute decision makers (SDM) love it. Especially with palliative patients because we can tell them an MD or nurse practitioner will round every weekday. It gives me time to get to family meetings. I am on for 10 minutes and then leave.

I love it. It takes me less time because I am ahead of the problem. A cough is prevented from becoming pneumonia. I am never faced with a ton of patients to see. If I am off on a long weekend Monday I catch up on the Tuesday.

Small bites, not a huge indigestible chunk of food.

Downsides

I can rarely have one or two patients perching at their doorways wanting to see me every time I come. I handle this by telling them they have to go through the nurse, just like I do when I see my doctor.

In winter you end up putting on and taking off your gloves, boots and coat a lot. There is also more driving. I talked to our CEO at the big home into giving us a 24-hour reserved doctor parking spot.

The nurses still try to dump everything on me on Monday so I have to triage the patients. For example, if they want two physical exams on Monday I write "I will see Tuesday" on one of them to spread out the work. I also spread out mediciation reviews into the other 3 days.

As medical director, I have house doctors sign a contract saying they will round at a specific time twice a week, not during meal times. For example, I go Monday, Tuesday and Thursday at 10 a.m. and the other house docs go Wednesday and Friday so we have an MD in-house daily. We see each other's urgent patients. My nurse practitioner goes Friday and covers my holiday and educational leave.

Our on-call is one in 30 because all the FPs in town in one giant call group. I did this by combining all the little call groups 29 years ago. They get paid $125 per night plus the usual visit billing fee. This money is pooled from the on call money from eight homes.

After 11 p.m. they are not called due to protocols for blood sugar and INRs. Pronouncement of death is by the RN. The house doctor signs the death certificate at 7 a.m. For obvious transfers to the ER, for example lacerations or fractures, the on-call MD is not woken up as they would have nothing to contribute and would delay care and burn them out

Tips for learning to love paperwork:

- Do it at a scheduled time every weekday morning like 8 to 9 a.m. or noon if you have young kids or like to sleep in. Avoid after 5 p.m. or weekends so you can be off totally.
- Charge your provincial medical association administrative fees for private paper work like lawyer's letters and the disability tax credit forms.
- Delegate some parts (demographics) to the nurse or physio or your secretary and make sure it is correct.
- Come back early from vacations to get caught up.
- Start a Fun Fund and contribute money for travel or something you want like charity, a spa day, a concert, sporting event, live theatre, book, or fancy restaurant.

Reduction of antipsychotics.

We went from 40% to 20% by having a scheduled meeting. It is on Thursday at 11 a.m. when I have caught up on ward work for the week. I meet twice a year with the nurse and pharmacist. We lock the door because when anyone sees us they have work for us. We are like Bloody Ceasars, if you see one you want one. We discuss each patient on antipsychotics and plan how to wean off as many as are feasible. With some we fail but with many we get off them. Its like spring-cleaning.

Time managed meetings

As medical directors we are paid an honorarium, which is modest but mounts over the year. 36 cents per patient per day sounds like chicken feed untill you do the math. Think of it when you are in a boring meeting. Put it in your fun fund. Ask for meetings to be scheduled to not infringe on your office time such as 8 a.m. or lunchtime. Ask for an agenda and stick to it. Start on time and end early. Do phone or Zoom meetings to avoid travel time. Ask: "Do we need this meeting?"

In summary if you do the above you can render better care and have a better life and avoid burnout.

Dr. John Crosby is a family physician in Cambridge, Ont., and an assistant professor of medicine at the University of Toronto and family medicine at McMaster and Queens universities.

email him at drjohncrosby@rogers.com