Take 3 – Practical Practice Pointers© December 24, 2018 Edition

Loneliness, Time Management, Physicians and Golf

From the Literature

1) The Epidemic of Loneliness

In the September 18, 2017 Harvard Business Review, former Surgeon General of the US Vivek Murthy, MD, wrote: *"During my years caring for patients, the most common pathology I saw was not heart disease or diabetes; it was loneliness. Loneliness and weak social connections are associated with a reduction in lifespan similar to that caused by smoking 15 cigarettes a day and even greater than that associated with obesity. Loneliness is also associated with a greater risk of cardiovascular disease, dementia, depression, and anxiety. At work, loneliness reduces task performance, limits creativity, and impairs other aspects of executive function such as reasoning and decision making. For our health and our work, it is imperative that we address the loneliness epidemic quickly."*

Research has found that loneliness is a risk factor for cognitive decline, cardiovascular disease, high blood pressure, disability and depression. This study of loneliness across adult lifespan examined its associations with sociodemographics, mental health (positive and negative psychological states and traits), subjective cognitive complaints, and physical functioning. The authors define loneliness as "subjective distress" – the discrepancy between the social relationships/connections one desires and the social relationships one has.

The authors studied 340 community-dwelling adults in San Diego, California, mean age 62 (SD = 18) years, range 27–101 years, who participated in three community-based studies. There were multiple instruments used to measure a sense of social isolation, mental health, wisdom, and overall health.

Based on the instrument used, the researchers found 76% of those studied had moderate to high levels of loneliness. It was correlated with worse mental health and inversely with positive psychological states/traits. Even moderate severity of loneliness was associated with worse mental and physical functioning.

Counter to what the authors hypothesized, there were 3 "peaks" for increased loneliness rather than having a direct association with old age: the late-20s, mid-50s, and late-80s. There were no gender differences in loneliness prevalence. There was an inverse relationship between loneliness and wisdom. "Wisdom" was determined by measuring general knowledge of life, emotion management, empathy, compassion, altruism and a sense of fairness, insight, acceptance of divergent values, and decisiveness.

My Comment:
The holidays seem to highlight this often hidden epidemic, and in talking with colleagues as well as in my recent experience with those whom I care for, this particular Holiday season is no exception.

As with professional burnout, I believe that professional loneliness is also epidemic, and intend to address that more explicitly and deliberately in 2019 (see Pointer 2 comments). In the meantime, don't hesitate to ask patients of all ages the question that is a standard part of our adolescent care: "Tell me about a best friend." Don't be surprised if a common answer is, "I don't have one." If so, that provides an opening to explore and encourage increased social connection – for improved health outcomes!

Reference:
Lee, Ellen et al. High prevalence and adverse health effects of loneliness in community-dwelling adults across the lifespan: role of wisdom as a protective factor. International Psychogeriatrics. Published online: 18 December 2018. Article

From the Literature, the "Anti-4th Aim," and the "Tongue-in-Cheek"

2) Opportunities for Improving Time Management in Clinical Practice

A widely held presumption is that primary care clinicians have too much to do and too little time. Strangely, no research has asked the obvious follow-up questions: Have they no evenings? Have they no weekends? Doctors therefore have a large, untapped reservoir of time. The central challenge of disruptive healthcare leadership, then, is to find ways of tapping into that reservoir and draining it dry.

Despite having an untapped reservoir of time, doctors never stop mewling about the time needed for shared decision making, especially for preventive care. This study was designed to satirically investigate the credibility of claims that general practitioners lack time for shared decision making and preventive care. Shared decision making is defined by the USPSTF as "a particular process of decision making by the patient and clinician in which the patient: 1) understands the risk or seriousness of the disease or condition to be prevented; 2) understands the preventive service, including the risks, benefits, alternatives, and uncertainties; 3) has weighed his or her values regarding the potential benefits and harms associated with the service; and 4) has engaged in decision making at a level at which he or she desires and feels comfortable."

A recent study reported that doctors spent an average of only 59 seconds on shared decision making for lung cancer screening, despite it being known by experts that five minutes is the absolute minimum. Even without shared decision making, doctors still grouse about a lack of time to deliver basic preventive care. Yet, few studies have examined the basis for these whimpering protestations. One study estimated that to deliver all recommended preventive services to a typical patient panel, doctors need an average of 7.4 hours each workday. This average seems large, but one working day is a tiny slice of a doctor's time on the planet. Careful review of what is known about the daily lives of doctors is the only way to tell whether these "time-deprived" grievances lack credence. So, following in the long tradition of data driven management, the authors carried out a microsimulation study to examine their time management and how this affects shared decision making for highly recommended preventive interventions.

The authors found that across a variety of patient panel sizes and annual hours worked, primary care clinicians could remedy their time deficit for completing shared decision-making for highly recommended preventive services by working only an addition 30 additional hours a week. This time could be easily reallocated from time spent in

grooming and self-care, leisure and vacation time, or unnecessary sleep. The cost of such a solution is reasonable, leading to only 17 additional early retirements for every 100 doctors. Owing to lack of data and interest, the authors did not assess the effect on mood, relationships, and quality of care.

They also concluded that future research should explore opportunities for reallocation of doctors' time to other new clinical initiatives. For instance, tapping into doctors' "relaxing and thinking" time (0.32 hours of the average day) or "reading for personal interest" time (0.29 hours) would allow increased direct access to doctors on demand (eg, through telehealth, email, and Facebook).

My Comment:
Nothing like some tongue-in-cheek humor to help point out the ridiculousness of some of the demands placed on our work, many by persons who have no clue what it is like to try and actually carry out these demands ("how hard can it be ...?"). Regular Take 3 readers know that I am quite skeptical regarding the "reality" of being able to regularly practice shared decision making.

Caring for those who provide the care (aka the "4th Aim") is a topic I take quite seriously, and it is my hope that Take 3 can serve as one platform to help advance this important and vital work. And we certainly have a long way to go!

I'm intending to introduce a new program regarding this in the New Year. Stay tuned!

Reference:
Caverty Tanner et al. Much to do with nothing: microsimulation study on time management in primary care. BMJ 2018; 363 (December 13): Article

From the Literature and the 4th Aim (Caring for the Caregivers)

3) Golf Habits Among Physicians

It has long been a stereotype of the US medical profession that physicians spend much of their leisure time on the golf course, including the long held belief that physicians spend Wednesday afternoons on the golf course. The validity of these beliefs, however, has never been determined empirically. The purpose of this observational study, using the US Golfing Association database, is to examine patterns of golfing among physicians: the proportion who regularly play golf, differences in golf practices across specialties, the specialties with the best golfers, and differences in golf practices between male and female physicians.

During the study period, 4% of physicians logged golf scores in the US Golfing Association amateur golfer database. Men accounted for 89.5% of physician golfers, and among male physicians overall, 5.5% played golf compared with 1.3% among female physicians. Rates of golfing varied substantially across physician specialties. The highest proportions of physician golfers were in orthopedic surgery (8.8%), urology (8.1%), plastic surgery (7.5%), and otolaryngology (7.1%), whereas the lowest proportions were in internal medicine and infectious disease (<3.0%). In Family Medicine, 3.6% of physicians golf.

The authors conclude that golfing is common among US male physicians, particularly those in the surgical subspecialties. The association between golfing and patient outcomes, costs of care, and physician wellbeing remain unknown.

My Comment:
Along with Pointer 2, this is another "tongue-in-cheek" study coming out of the British Medical Journal, which devotes the last issue of each calendar year to studies that that are a bit "off beat."

Stereotypes exists for a purpose, but are not always as accurate as they might first appear. Not being a golfer myself, I can't comment on the draw of this particular sport/pastime. However, the importance of all clinicians (everyone really) having a constructive outlet for their stressors as well as a place/space for reflection and renewal cannot be underestimated!

So let me take this time to challenge you to reflect as to your own "outlet," and if you don't have a constructive one, perhaps the transition to 2019 is a good time to consider starting. And perhaps golf would be just the thing for you! It appears you'll be able to find some surgery colleagues to partner with!

Reference:
Koplewitz G et al. Golf habits among physicians and surgeons: observational cohort study. BMJ 2018;363:k4859. Article

Feel free to forward Take 3 to your colleagues. Glad to add them to the distribution list.

Mark

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