

Take 3 – Practical Practice Pointers[®] March 25, 2019 Edition

Physician Burnout, PERMAH Wellbeing, 1^o Prevention of CVD

From the 4th Aim – Caring For Those Who Provide the Care

1) New Data on Physician Burnout and Depression

Clinician distress, a multidimensional construct that includes burnout, depression, stress, work-life integration (WLI), professional satisfaction, and fatigue as well as other domains, has been a growing concern in clinical practice. These dimensions of distress have both shared and distinct drivers and do not always move in the same direction. Over the past 3 years, the particular concern over physician professional burnout has gained more attention locally, regionally, and nationally.

A study was recently published evaluating the prevalence of burnout and satisfaction with work-life integration among physicians and other US workers in 2017 compared with 2011 and 2014. This is an ongoing national effort to both quantify and track over time physician distress and burnout in a more structured and scientific fashion than other similar surveys, such as the MedScape yearly physician wellbeing survey.

In this study, burnout, depression, and work-life integration were measured using standard tools, including the Maslach Burnout Inventory (MBI), the 2-item Primary Care Evaluation of Mental Disorders (PRIME-MD), a standardized/validated assessment tool for depression screening, and questions regarding satisfaction with WL integration.

The response rate to the survey was 18% of over 30,000 physicians surveyed. Results indicated that in 2017, 44% of physicians were experiencing at least one symptom of high burnout, compared with 54% in 2014 and 46% in 2011. For Family Medicine, the rate dropped from 63% in 2014 to 51%, and for General Internal Medicine, from 59% to 48%. The estimated baseline burnout rate for the US population is 28% based on this study. Additionally, 42% of physicians screened positive for depression, an increase from 40% in 2014. It is estimated that approximately 25% of those who screen positive will have a positive score on a more comprehensive screening instrument.

The authors concluded that burnout and satisfaction with work-life integration among US physicians improved between 2014 and 2017, with burnout currently near 2011 levels, but that physicians remain at increased risk for burnout relative to workers in other fields.

My Comment:

Many Take 3 readers know that the topic of clinician and healthcare team wellbeing is a professional (and personal) focus of mine. While the trend of this data is encouraging, to be “happy” about a physician burnout rate across specialties of over 40% would be disturbing at best. Even worse, it is tragic to think that the odds of a patient being seen by a physician on the front lines of primary healthcare who is experiencing significant emotional distress is a coin flip, and this going on 8+ years (and likely much longer, since we don’t have similar national data prior to 2011).

Why the improvement at all? Certainly, just the fact that what is being described by some as a “public health crisis” is actually being talked about is a relief to many who

have been struggling for years. Being taken seriously when one is in distress certainly has therapeutic value in its own right. In our own department, we've been focusing on some of the major "pain points" of clinical practice, including the inefficiencies and challenges of the electronic health record and other frustrating and time-consuming administrative tasks. This has started to have an impact based on internal surveys as well as clinician testimonials.

Having said that, we have a long way to go. As a leader, the thought that even one of my colleagues is practicing while experiencing this level of emotional distress is one too many. We'll never get even close to zero burnout (or even to the national baseline) unless we as a profession (and a nation) decide that is the goal we aspire to. Otherwise, it becomes comical to believe we can consistently provide 5/5 care on patient surveys when we know "going into the test" that almost half of the clinicians are operating at a 1-2/5 level of functioning. That math simply doesn't add up

Reference:

Shanafelt T, et al. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2017. Mayo Clin Proc. PAP February 2019. [Article](#)

Another From the 4th Aim – Caring For Those Who Provide the Care

2) Reflecting on Your Personal Wellbeing – The PERMAH Model

The field of positive psychology has grown tremendously over the past decade. What is positive psychology? It's a scientific and professional movement that brings together the latest research in neuroscience, mindfulness, contemplative studies, and whole-person medicine. In 2011 Professor Martin Seligman, PhD, published the book Flourish, in which he proposed a model for the "building blocks of wellbeing" that he called the PERMA model. Seligman believes that strength in each of PERMA's areas can help individuals find lives of happiness, fulfillment, and meaning. PERMA has also been used to develop programs that help individuals develop new cognitive and emotional tools. PERMA stands for:

- **Positive Emotion** – right balance of heartfelt positivity, valence and intensity; not without negative emotions, to help improve resilience.
- **Engagement** – regular development of our strengths (things we're good at and enjoy doing), "flow," fully immersed, focused, concentration, and emotional dedication.
- **Relationships** – creation of authentic, energizing connections across domains (work, play, home).
- **Meaning** – sense of connection to something bigger than ourselves; "I matter" "I'm heading in the right direction."
- **Accomplishment** – belief and ability to do things that matter most to us; sense of mastery and pride.

Two of Dr. Seligman's students, Peggy Kern, PhD and Michelle McQuaid, MAPP, proposed an additional building block, **Health** (eating well, moving regularly, sleeping deeply) and proposed the PERMAH model of wellbeing.

Just like muscle groups, or areas of fitness, these domains of wellbeing can be tested, targeted and developed through the intentional practice of ongoing “Positive Interventions”. The PERMAH Wellbeing Survey was created as a tool to explore these attributes of wellbeing and includes more than 200 (and growing) positive interventions you can try. Finding the practices that are the best fit can give one a sense of mastery and control over their ability to be resilient when life doesn’t go as planned. And noticing the positive changes that building more PERMAH can make in one’s life gives them the confidence to continue being in charge of their own well-being. Created by well-being practitioners and researchers around the globe, these practices include exercises like keeping a gratitude journal, breaking the grip on rumination, developing strengths, and finding meaning in small tasks and overcoming self-doubt.

My Comment:

When during your medical training did you learn how to take care of yourself in the process of caring for others, often in the midst of extreme or substantially stressful circumstances? Anything that can help create personal empowerment regarding wellbeing is in my opinion worth exploring. In collaboration with one of my residency faculty colleagues, Laura Daniels, PhD, we have used this model as a foundation for improving wellbeing for our residents and faculty as well as in workshops for both the Virginia Academy of Family Physicians and the Uniformed Services Academy of Family Physicians and have found it quite useful. The survey (at the link below) not only provides some insights regarding your present state of wellbeing (at least for the PERMAH domains) but also provides suggestions for tools you might consider using to improve your well-being. Sure seems like a worthwhile investment of a small amount of your time! Why not give it a try?!

Reference:

PERMAH Survey: <https://permahsurvey.com/>

From the Guidelines and the ACC/AHA

3) Primary Prevention of Cardiovascular Disease (CVD)

Although there has been substantial improvement in atherosclerotic cardiovascular disease (ASCVD) outcomes in recent decades, ASCVD remains the leading cause of morbidity and mortality globally and the leading cause of death for most racial/ethnic groups in the US. It is estimated that up to 80% of all CVD could be prevented through lifestyle choices and modifications. To that end, the ACC/AHA Task Force on Clinical Practice Guidelines has commissioned this guideline to consolidate existing recommendations and various recent scientific statements, expert consensus documents, and clinical practice guidelines into a single guidance document focused on the primary prevention of ASCVD.

Top 10 Take-Home Messages for the Primary Prevention of CVD:

- The most important way to prevent atherosclerotic vascular disease, heart failure, and atrial fibrillation is to promote a healthy lifestyle throughout life.
- A team-based care approach is an effective strategy for the prevention of cardiovascular disease. Clinicians should evaluate the social determinants of health that affect individuals to inform treatment decisions.

- Adults who are 40 to 75 years of age and are being evaluated for CVD prevention should undergo 10 -year ASCVD risk estimation and have a clinician–patient risk discussion before starting on pharmacologic a therapy, such as antihypertensive therapy, a statin, or aspirin. In addition, assessing for other risk-enhancing factors can help guide decisions about preventive interventions in select individuals, as can coronary artery calcium scanning.
- All adults should consume a healthy diet that emphasizes the intake of vegetables, fruits, nuts, whole grains, lean vegetable or animal protein, and fish and minimizes the intake of trans fats, processed meats, refined carbohydrates, and sweetened beverages. For adults with overweight and obesity, counseling and caloric restriction are recommended for achieving and maintaining weight loss.
- Adults should engage in at least 150 minutes/ week of accumulated moderate-intensity physical activity or 75 minutes/ week of vigorous -intensity physical activity.
- For adults with type 2 diabetes mellitus, lifestyle changes, such as improving dietary habits and achieving exercise recommendations, are crucial. If medication is indicated, metformin is first-line therapy, followed by consideration of a sodium - glucose cotransporter 2 inhibitor or a glucagon-like peptide-1 receptor agonist.
- All adults should be assessed at every healthcare visit for tobacco use, and those who use tobacco should be strongly advised and assisted to quit.
- Aspirin should be used infrequently in the routine primary prevention of ASCVD because of lack of net benefit.
- Statin therapy is first-line treatment for primary prevention of ASCVD in patients with elevated low-density lipoprotein cholesterol levels (≥ 190 mg/dL), those with diabetes mellitus, who are 40 to 75 years of age, and those determined to be at sufficient ASCVD risk after a clinician–patient risk discussion.
- Nonpharmacological interventions are recommended for all adults with elevated blood pressure or hypertension. For those requiring pharmacological therapy, the target blood pressure should generally be $< 130/80$ mm Hg.

My Comment:

Hopefully, most of the above is not “news” to you, but rather a good reminder. At the same time, it’s nice to see our cardiology colleagues starting to give more than lip service to lifestyle interventions as the primary means of preventing CVD. Note that the blood pressure target advocated in the last bullet is not consistent with the accepted standard by either the AAFP or the ACP. This has been covered extensively in other editions of Take 3.

Reference:

Arnett D, et al. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease. Circulation PAP March 17, 2019. [Guideline](#) ; [Executive Summary](#)

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

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