Written evidence submitted by Professor Tom Bourne (WBR0079)

Evidence to the Health and Social Care Committee Inquiry into Workforce Burnout and Resilience

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I sit on the Supporting our Doctors task force at the RCOG and have published large survey studies on the impact of complaints on doctor's wellbeing and clinical practice as well as the prevalence of burnout and its association with wellbeing and defensive medicine.

Bullet point summary:

- **The level of burnout amongst hospital doctors in the UK is very high – and particularly so amongst trainees (>40%)**
- **Burnout is associated with increased defensive medical practice, medical accidents, lack of empathy and unprofessional behavior**
- **The contributors to burnout are complex and mixed. Overwork and lack of resource is a major component. However overwork if tempered by having meaning, control, supportive teams and a good supportive culture**
- **Solutions include addressing multiple organizational factors, including improved teamwork, workflow, and organizational restructuring**
- **The complaints and regulatory system contribute to the problem.**

In relation to the terms of reference – I am able to provide direct evidence on some of these points and secondary information on others. Some I have no evidence of present so will not comment on these. The repeated use of the word "resilience" in the terms of reference is concerning to me - as this is unlikely to be an answer to the problem. The contributing factors to burnout are multifactorial and require an organisational response. Making this an "individual issue" - is flawed.

1. What is the current scale of workforce burnout across NHS and social care? How does it manifest, how is it assessed, and what are its causes and contributing factors? To what extent are NHS and care staff able to balance their working and personal lives?

I have enclosed our publication on burnout, wellbeing and defensive medical practice amongst over 3000 obstetricians and gynaecologists in the UK[1]. This is the largest study using a validated instrument to examine burnout in hospital doctors carried out in the UK. It includes a large number of doctors working in obstetrics and gynaecology and has a good response rate (3102/5661 doctors completed the survey giving a 55% response rate. This is the first nationwide survey in the UK, which examines the prevalence of burnout as well as its relationship to defensive medical practice and self-reported well-being. The paper and its supplementary material is attached as appendices 1 and 2). We used the Maslach Burnout Inventory, a widely available and validated tool for measuring burnout.

In summary, 3102/5661 doctors (55%) completed the survey. 3073/3102 (99%) met the inclusion criteria (1462 consultants, 1357 trainees and 254 specialty and associate specialist doctors). 1116/3073 (36%) doctors met the burnout criteria, with levels highest amongst trainees (580/1357 (43%)). 258/1116 (23%) doctors with
burnout reported increased defensive practice compared with 142/1957 (7%) without

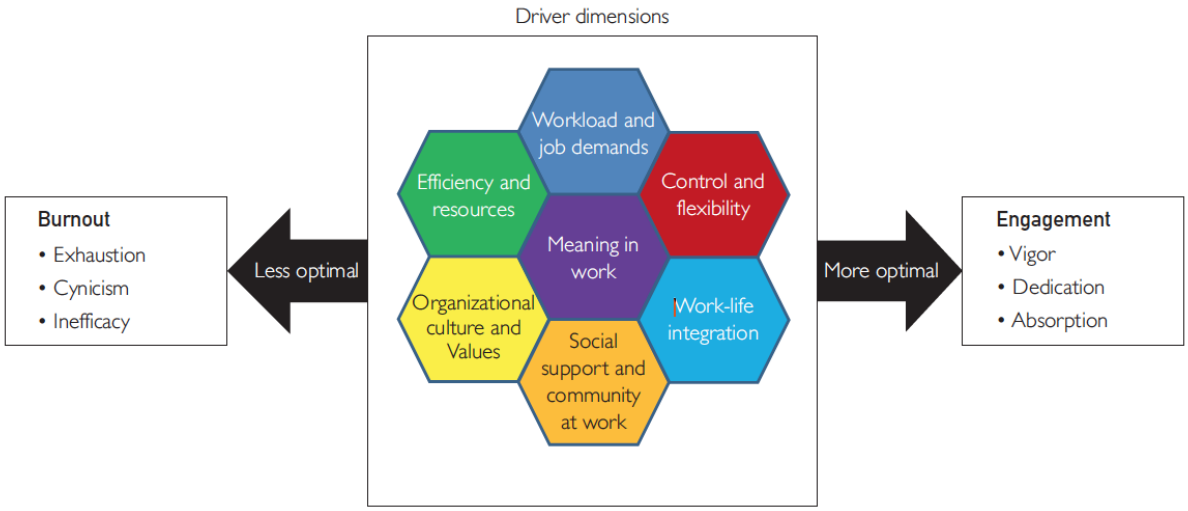
(adjusted OR 4.35, 95% CI 3.46 to 5.49). The Odds Ratio for burnout with well-being items varied between 1.38 and 6.37, and were highest for anxiety (3.59, 95% CI 3.07 to 4.21), depression (4.05, 95% CI 3.26 to 5.04) and suicidal thoughts (6.37, 95% CI 95% CI 3.95 to 10.7). In multivariable logistic regression, being of younger age, white or 'other' ethnicity, and graduating with a medical degree from the UK or Ireland had the strongest association with burnout. In other words - we have shown that just under half of trainees and a third of consultants and SAS doctors working in O&G in the UK suffer from burnout using the MBI scoring system. Furthermore, our data suggests that burnout is associated with higher levels of Defensive Medical Practice, and with poorer mental and physical well-being. The study also showed a particularly strong relationship between burnout and suicidal thoughts. A further noteworthy association in our cohort was that after controlling for other confounding variables, doctors from ethnic minorities were less likely to experience burnout. Similar findings have been reported in studies of trainees and medical students in the USA; however, the reasons for this are unknown. It has been proposed that that these differences may be explained by differences in upbringing and life stressors, which may make doctors from ethnic minorities more resilient. Consistent with this, we found that doctors who graduated in the UK or Ireland are almost twice as likely to experience burnout.

2. *What are the impacts of workforce burnout on service delivery, staff, patients and service users across the NHS and social care sectors?*

In our paper we also found that burnout is associated with increased Defensive Medical Practice supports the concern that doctor burnout impacts the quality of patient care. In 2010, Shanafelt et al[3] showed that burnout is an independent predictor of self-reported perceived major medical errors. Our study shows that gynaecology consultants in the UK with burnout are three times more likely to report both avoidance (avoiding cases or procedures) and hedging (overprescribing or over-referral) which may have significant and serious consequences on patient care. We found that Depersonalisation was one of the most commonly endorsed subscales if the Maslach. This is concerning as this is particularly associated with a lack of empathy as well as difficulties with interpersonal relationships. It is not a big step to hypothesise that a number of the recent hospital scandals may well relate to burnout – leading to lack of empathy and unprofessional behavior. I have enclosed a very good review by Maslach on colleagues[4]3on the implications of burnout and the impact this may have. The literature on burnout are generalizable to the UK. Burnout is associated with increased patient safety incidents. This is best summed up by the systematic review by Pangagioti et al[4] (a systematic review of the available evidence).

3. What further measures will be required to tackle and mitigate the causes of workforce stress and burnout, and what should be put in place to achieve parity for the social care workforce?

The figure and the table below are taken from Tate Shanafelt's paper: Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout[2].



From the above you can see the simple relationship between the driver dimensions of burnout and outcomes. In the table below you can see and analysis of factors related to burnout. This is for the US audience – however many of the factors hold true in the UK.

The contributors to burnout are complex and mixed. Overwork and lack of resource is a major component. However overwork if tempered by having meaning, control and a good supportive culture may not be associated with burnout. Organisational strategies are needed to deal with burnout. It is not an individual responsibility (i.e. to increase resilience).

The issue of resilience is not in my view the answer. Being too resilient may lead to a lack of empathy – furthermore resilience in many cases is a poor approach to dealing with an unacceptable working environment. The results of resilience training have also been disappointing.

A key issue is the creation of functional supportive teams that have control over how they carry out their work. In the fact the antithesis of how doctors in particular have been forced to work in recent years. It is perhaps hardly surprising that we found over 40% of trainees were burnt out. During the initial phases of the COVID pandemic a clinicians were able to take control with the rapid sign off of clinical changes to streamline services as well as research protocols. Furthermore at least initially there would have been a cultural lift because of the public support that existed. My perception is that this is rapidly evaporating as pressure is put on to return to pre-COVID activity, with more difficult pathways and processes once again become sclerotic – with clinicians (and in particular trainees) having little control.

Drivers of burnout and engagement in physicians	Individual factors	Work unit factors	Organization factors	National factors
Workload and job demands	• Specialty • Practice location • Decision to increase work to increase income	• Productivity expectations • Team structure • Efficiency • Use of allied health professionals	• Productivity targets • Method of compensation - Salary - Productivity based • Payer mix	• Structure reimbursement - Medicare/Medicaid - Bundled payments - Documentation requirements
Efficiency and resources	• Experience • Ability to prioritize • Personal efficiency • Organizational skills • Willingness to delegate • Ability to say "no"	• Availability of support staff and their experience • Patient check-in efficiency/process • Use of scribes • Team huddles • Use of allied health professionals	• Integration of care • Use of patient portal • Institutional efficiency: - EHR - Appointment system - Ordering systems • How regulations interpreted and applied	• Integration of care • Requirements for: - Electronic prescribing - Medication reconciliation - Meaningful use of EHR • Certification agency facility regulations (JCAHO) • Precertifications for tests/treatments
Meaning in work	• Self-awareness of most personally meaningful aspect of work • Ability to shape career to focus on interests • Doctor–patient relationships • Personal recognition of positive events at work	• Match of work to talents and interests of individuals • Opportunities for involvement - Education - Research - Leadership	• Organizational culture • Practice environment • Opportunities for professional development	• Evolving supervisory role of physicians (potentially less direct patient contact) • Reduced funding - Research - Education • Regulations that increase clerical work
Culture and values	• Personal values • Professional values • Level of altruism • Moral compass/ethics • Commitment to organization	• Behavior of work unit leader • Work unit norms and expectations • Equity/fairness	• Organization's mission - Service/quality vs profit • Organization's values • Behavior of senior leaders • Communication/ messaging • Organizational norms and expectations • Just culture	• System of coverage for uninsured • Structure reimbursement - What is rewarded • Regulations
Control and flexibility	• Personality • Assertiveness • Intentionality	• Degree of flexibility: - Control of physician calendars - Clinic start/end times - Vacation scheduling - Call schedule	• Scheduling system • Policies • Affiliations that restrict referrals • Rigid application practice guidelines	• Precertifications for tests/ treatments • Insurance networks that restrict referrals • Practice guidelines
Social support and community at work	• Personality traits • Length of service • Relationship-building skills	• Collegiality in practice environment • Physical configuration of work unit space • Social gatherings to promote community • Team structure	• Collegiality across the organization • Physician lounge • Strategies to build community • Social gatherings	• Support and community created by Medical/specialty societies
Work-life integration	• Priorities and values • Personal characteristics - Spouse/partner - Children/dependents - Health issues	• Call schedule • Structure night/weekend coverage • Cross-coverage for time away • Expectations/role models	• Vacation policies • Sick/medical leave • Policies - Part-time work - Flexible scheduling • Expectations/role models	• Requirements for: - Maintenance certification - Licensing • Regulations that increase clerical work

FIGURE 3. Drivers of burnout and engagement with examples of individual, work unit, organization, and national factors that influence each driver. EHR = electronic health record; JCAHO = Joint Commission on the Accreditation of Healthcare Organizations. Adapted from *Mayo Clin Proc.*[39]

Also in this context see the GMC report by West and Coia[5] discussed below that outlines a clear plan to improve the wellbeing of the workforce.

4. What long term projections for the future health and social care workforce are available, and how many more staff are required so that burnout and pressure on the

frontline are reduced? To what extent are staff establishments in line with current and future resilience requirements?

Yes – workload is a contributing factor. However please understand that the drivers for burnout are multifactorial and workload is but one of them. See the report by Michael West and Denise Coia for the GMC[5] which outlined a number of very important factors that need to be considered. Of these – my view is that working in functional teams is vital for wellbeing as the report says the following are key issues:

- **AUTONOMY AND CONTROL**
- **BELONGING (INCLUDING TEAM SUPPORT AND CULTURE)**
- **WORKLOAD**

So this is not just a question of more numbers of staff or "resilience training". The issues outlined above need to be addressed in a systematic way, this requires an organisational approach. .

5. What further measures will be required to tackle and mitigate the causes of workforce stress and burnout, and what should be put in place to achieve parity for the social care workforce

On a highly related issue – amongst doctors a major contributor to the feeling of unfairness and stress is complaints and disciplinary processes. This relates to culture. I include this as culture and teamwork are an essential component of preventing burnout. A system relating to complaints that creates fear and a sense that there is a lack of natural justice contributes significantly to the poor culture that exists. Doctors involved in complaints processes have high levels of depression, anxiety and suicidal ideation – which is disproportionate. Furthermore those involved in complaints are more likely to practice defensively which has very significant implications for patients care. I enclose 3 papers we have written in relation to this that I think are relevant (that are based on a survey study of almost 8000 doctors in the UK [6,7,8].

Please also see reference 9. This is a further systematic review by Panagioti and colleagues – where they have looked at all the available literature – published very recently on August 18th 2020. The result of this review results support the need for organizational interventions, which is in line with previous reviews. Most studies that evaluated interventions to reduce burnout have focused on physician directed interventions, such as mindfulness and building self-confidence. Studies that have tested organizational interventions tend to focus mostly on modifying shift patterns and workload, but few studies have incorporated interventions that try to address multiple organizational factors, including improved teamwork, workflow, and organizational restructuring, which may be more useful in reducing burnout.

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