MAYO CLINIC

The Phantom Limb of the Triple Aim

William M. Spinelli, MD, MPA

For editorial comment, see page 1347

From Allina Health, Minneapolis, MN.

Recent health care improvement efforts have focused on the Institute for Healthcare Improvement's Triple Aim of improving patient care quality, decreasing total cost of care, and improving the experience of care for patients.[1] The phantom limb of this triad is the well-being of the health care workforce that is essential for acting on and implementing the necessary changes for achieving the Triple Aim.

Phantom limb pain is a condition in which patients experience a sensation of itching, twitching, or pain in a previously amputated limb or body part. The Triple Aim suffers from a similar phenomenon. Focusing only on the quality of patient care, the total cost of care, and the patient experience of care, the Triple Aim has separated the well-being of the health care workforce from system change initiatives. The separation has resulted in phantom limb pain, which is often expressed as burnout.

In 2008, Berwick et al[1] from the Institute for Healthcare Improvement proposed the Triple Aim as a model for improving health care in the United States. The Triple Aim defines a conversion from a "physician-centric" to a "patient-centric" medical system that is focused on "improving the experience of care, improving the health of populations, and reducing per capita costs of health care."[1]

Since that time, many health care systems have embraced the goals of the Triple Aim. A conscious decision to measure and understand the patient experience of care coupled with the identification of measurable outcomes of quality is transforming the work we do. We see it in different ways, ranging from honoring patients as consumers who share in decision making to physicians who use evidence-based protocols for diagnosis and treatment. Arguments persist about whether these transformations will "bend the cost curve" for health care. Nonetheless, it seems clear that the Triple Aim will continue to be a part of medicine.

Business models of employee engagement are widely used by health care systems to assess an individual's attachment to an organization, but these models fail to account for the effects of an individual's perception of his or her work experience. These effects are revealed in the increasing incidence and severity of burnout in the health care workforce.[2] The characteristics of burnout in health care workers have been well defined and extensively studied. Although there is every reason to believe that all health care workers are feeling the stress, most of the medical literature about burnout has focused on physicians.

The prevalence of burnout in US physicians as recently documented by Shanafelt et al[2] is higher than in any other professionals with advanced degrees and is twice the prevalence of burnout relative to that in the general US population (46% of the physicians report at least one symptom of burnout).

Although there is conflicting literature on the full effect of physician burnout on the quality of care,[3,4] little doubt exists about the individual effect of burnout. It leads to professional dissatisfaction,[5] elevated physician suicide rates,[6] accelerated employed physician turnover, and premature retirement. A 2012 Physicians Foundation study reported that more than 50% of the primary care physicians considered cutting back on patient care or retiring completely within 3 years; 57.9% would not recommend medicine as a career to young people.[7] With an impending shortage of primary care physicians, the premature retirement or career change of currently practicing clinicians presents a challenge to the system's capacity for accomplishing its goals.

As recently as 20 years ago, there was little acknowledgment of or attention paid to the possibility that those delivering health care were subject to the same ills as those receiving health care. Even then, many of the adverse consequences of burnout were attributed to personal inadequacy or individual variation.[8-10] Although the effect of work experience is currently recognized as the prime driver of burnout, few intentional efforts to mitigate those work conditions for clinicians are evident.[11] Treating the phantom limb of the Triple Aim and reversing the burnout trend will require applying the improvement principles that support the Triple Aim goals of improving the quality of care, improving the

Mayo Clin Proc. ■ December 2013;88(12):1356-1357 ■ http://dx.doi.org/10.1016/j.mayocp.2013.08.017
www.mayoclinicproceedings.org ■

patient experience of care, and decreasing the cost of care for patients to the structural and relational systems of care delivery that are detrimental to physician well-being.

These principles should include the following:

1. *Elevating well-being metrics to the same level of importance as financial, quality, and patient satisfaction metrics.*[12] Elevating these metrics to the organizational dashboard will focus attention on well-being in daily work and reinforce a commitment to provide a work environment that is designed with well-being in mind.
2. *Designing system and care processes that include intentional plans for physician and staff well-being.* Future innovations in health care design should attend to the effect on health care workers' well-being at the same time as attention is focused on patient outcome, patient experience, and total cost of care.[13]
3. *Adopting a robust set of self-care strategies for those experiencing burnout.* These strategies may include approaches such as wellness programs, resiliency training, reflective conversation, mentoring, and meditative practices. Because it is likely that health care workers will respond to an intervention or set of interventions that is personally unique, offering various strategies may be necessary.

To improve the outcomes of care that are articulated in the Triple Aim is not only a critical initiative for US health care but also a commitment medicine makes to patients. A healthier and more productive health care system capable of delivering this commitment will be a system that makes the same commitment to physicians and other health care workers.

Correspondence: Address to William M. Spinelli, MD, MPA, Allina Health, Division of Applied Research, 2925 Chicago Ave South, MR 10105, Minneapolis, MN 55407-1321 (william.spinelli@allina.com).

REFERENCES

1. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27(3):759-769.
2. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med*. 2012;172(18):1377-1385.
3. Shanafelt TD, Balch CM, Bechamps G, et al. Burnout and medical errors among American surgeons. *Ann Surg*. 2010;251(6):995-1000.
4. Linzer M, Manwell LB, Williams ES, et al. Working conditions in primary care: physician reactions and care quality. *Ann Intern Med*. 2009;151(1):28-36.
5. Balch CM, Shanafelt T. Combating stress and burnout in surgical practice: a review. *Adv Surg*. 2010;44:29-47.
6. Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: a consensus statement. *JAMA*. 2003;289(23):3161-3166.
7. The Physicians Foundation. A survey of America's physicians: practice patterns and perspectives. http://www.physiciansfoundation.org/healthcare-research/a-survey-of-americas-physicians-practice-patterns-and-perspectives. Accessed October 1, 2013.
8. McCranie EW, Brandsma JM. Personality antecedents of burnout among middle-aged physicians. *Behav Med*. 1988;14(1):30-36.
9. Roeske N. Stress and the physician. *Psychiatr Ann*. 1981;11:245.
10. Thomas CB, McCabe OL. Precursors of premature disease and death: habits of nervous tension. *Johns Hopkins Med J*. 1980;147(4):137-145.
11. Leiter MP, Hakanen JJ, Ahola K, Toppinen-Tanner S, Koskinen A, Väänänen A. Organizational predictors and health consequences of changes in burnout: a 12-year cohort study. *J Organ Behav*. 2013;34(7):959-973.
12. Wallace JE, Lemaire JB, Ghali WA. Physician wellness: a missing quality indicator. *Lancet*. 2009;374(9702):1714-1721.
13. Dunn PM, Arnetz BB, Christensen JF, Homer L. Meeting the imperative to improve physician well-being: assessment of an innovative program. *J Gen Intern Med*. 2007;22(11):1544-1552.