Defining Physician Burnout

Physician burnout is a work-related syndrome with three symptoms: physical and emotional exhaustion, depersonalization (negative or cynical attitude towards patients and healthcare staff), and a reduced sense of personal accomplishment or self-efficacy. It occurs from the build-up of stress over time.¹

According to the 2018 Medscape National Report on Physician Burnout and Depression, 42 percent of practicing physicians experience burnout, 15 percent experience some form of depression, and 14 percent experience a combination of the two.² Researchers found that before matriculation, medical students generally have lower rates of burnout and depression compared to similar-age college graduates. This trend reverses after beginning medical school as the prevalence of burnout and depression for medical students far exceeds their counterparts.³ Other studies suggest that burnout worsens over time as medical students progress in their careers.⁴

While burnout is not unique to physicians, burnout disproportionately affects physicians compared to the rest of the population.⁵ It is important to address this issue because of the widespread, adverse effects that it can have on healthcare costs and delivery.⁶ This brief highlights the causes of burnout and provides potential solutions for addressing this epidemic.
Causes of Physician Burnout

Physicians face a unique set of stresses that occur simultaneously. All of these can contribute to physician burnout:\textsuperscript{1,6,7,8}

1) Physicians work longer hours than most professions. This, in turn, can lead to a disruption in their work-life balance and an inability to maintain relationships or spend time with family.

2) Physicians encounter sick patients all the time. This can lead to emotional exhaustion as physicians must learn to cope with the realities of illness and relay bad news to their patients.

3) Physicians have a great deal of responsibility and yet, cannot control the outcomes. They are expected to completely cure their patients but illnesses are caused by a combination of genetic and environmental factors, many that are out of their control. Sometimes, the treatment simply requires patients to exercise and control their diets.

4) Physicians fear medical malpractice lawsuits. Thus, they feel the pressure to order multiple, unnecessary lab tests and prescribe medications to satisfy patient requests to be able to defend themselves in case of lawsuits.

5) Physicians must adjust and adapt to the changing electronic health records requirements. Physicians spend more than half their time inputting data and working at the computer rather than interacting with patients. These clerical duties have led to intense job-dissatisfaction and stress as some of the reporting measures can affect their payment structure.

6) Finally, some medical culture can be hierarchical and stressful. Many medical students report being treated poorly by their superiors. They are taught that medicine is stressful and it is up to them to show invincibility and strength. This puts the responsibility entirely on them to learn to deal with the external stresses and it stigmatizes seeking guidance for mental wellbeing.

Why Physician Burnout is a Problem

Physicians are central to the provision of care across all healthcare settings. Thus, poor physician well-being can result in poor healthcare delivery in the following ways:\textsuperscript{6}

- Increased risk of medical errors
- Increased risk of malpractice
- Low patient satisfaction
- Worse patient outcomes
- Higher attrition leading to shortage

Additionally, burnout can lead to depression, higher risk of alcohol abuse, and suicide.
Physician burnout is not only being recognized as an issue, but multiple institutions are beginning to turn to innovative solutions to address this public health problem.

**Stanford’s Department of Emergency Medicine “Time Banking” Program**
The Sloan Foundation invested $250,000 into a two-year program at the Emergency Department that rewarded physicians with various services (housekeeping, Blue Apron meals, help in grant-writing, movie tickets, babysitting, etc.) in exchange for their time spent in extra tasks (providing student mentorship or partaking in committees). At 1 percent of the department’s budget, the program proved to be cost-effective with post-surveys indicating increases in job satisfaction and physician wellness as well as perceived support from colleagues (an increase of 28 percentage points in two years). The grant-writing credits helped bring in $10 million of funding from 22 different proposals.\(^9,10\)

**University of Colorado Health System’s Ambulatory Process Excellence (APEX) Model**
Noting that administrative and clerical burdens occupy most of a physician’s time, the University of Colorado takes a team-based approach to delivering care in their family medicine residency. The model incorporates five extensively trained medical assistants (MAs) for every two physicians. The MAs develop individualized plans for each patient by synthesizing patient information (patient history and medications), screening for mental/behavioral health risks, and coaching patients after the physician’s visit. The MAs first brief the physicians on the patient’s history and then observe, take notes, and input information into the computers during the patient visit. The APEX model led to a drop of 40 percentage points in physician burnout scores within 6 months. Moreover, the active prevention measures such as the behavioral health screens and coaching contributed to patients’ successful health outcomes.\(^11,12\)

**The Fellows’ and Residents’ Health and Wellness Initiative Humanities Program at Mayo Clinic**
Nationally recognized by major medical associations, the program provides an opportunity for physicians to partake in art projects once a week. During the Wellness Fair, physicians enjoy massages and partake in yoga. The program was a result of a pilot study that concluded that art and meditation reduce physician stress and have positive effects on their wellbeing.\(^13\)

**The Physician Vitality Program at Loma Linda University Health (LLUH) Systems**
The Coalition for Physician Well-Being awarded the LLUH Physician Vitality Program the 2016 Medicus Integra award for its multifaceted-approach and achievements in ensuring physician wellbeing. The program provides education through grand rounds and lectures, debriefings and home visits for crises situations, a peer coach program, research opportunities, and an art display program after identifying existing gaps and opportunities through a needs-assessment.\(^13\)

**Other Noteworthy Practices**
Organizations such as the Accreditation Council for Graduate Medical Education (ACGME) and the Alliance of Academic Internal Medicine (AAIM) have provided grants to fund pilot programs to develop effective solutions. They have also created interdisciplinary committees to investigate and inform and have changed program requirements to give physicians more autonomy in deciding how much time to spend with their patients.\(^14\)
Recommendation

Changes will have to occur at multiple levels in order to combat physician burnout.

**Recommendations for Federal and State Policy**

Regulatory burdens cause inefficiency in the healthcare system. Moreover, in an effort to provide quality, cost-effective care the government proposes a variety of different payment incentives that change every year.\(^1\) Lawmakers must recognize the stress this places on physicians and should create policies that minimize potential hurdles.

1) Federal and state governments should invest in medical information technology systems to make them more intuitive and easy to use. Federal policies should encourage hospitals to utilize scribes and technology assistants to handle data input.

2) States should investigate the effects of expanding scope of practice laws for allied health workers.

3) The federal government should limit physician reporting requirements and consider receiving a majority vote from hospital physicians before tying the requirements to payment incentives.

The federal government should bring the issue of physician burnout to the national front and promote a culture of physician wellbeing.

**Recommendations for Hospitals and Medical Institutions**

1) Health care organizations must make physician wellbeing an institutional value. Health systems have already begun monitoring physician satisfaction using benchmarks and evaluating and disseminating the information in the form of dashboards.\(^2\)

2) Hospitals should support team-based, collaborative environments by hiring more scribes, medical assistants, and physician assistants to foster patient-centered teams. They should also provide separate authority to administrators to handle insurance company preauthorizations.

3) Continuing medical education (CME) programs should work to normalize and destigmatize seeking help. The organizations may consider creating an anonymous hotline to speak with physicians about traumatic events or potential litigation.

4) Organizations should allot scheduled breaks along with time for CME classes and support meetings for physicians during work hours.

**Recommendations for Individuals**

It is critical to understand that physician burnout is not the individual’s fault. That being said, physicians can take steps to protect themselves from its effects and should support other physicians.

1) Physicians can raise awareness, normalize asking for help, and encourage vacations.

2) Physicians can take up hobbies that relieve stress such as painting, playing an instrument, or practicing meditation. Narrative medicine is a great tool for helping physicians reconnect with their patients and provide effective care.

The development of such programs will require a change in the way that we frame the problem and its solution. For instance, we may consider changing the national dialogue from physician burnout being a problem to maintaining physician wellness as a societal goal.
The Prescription: A Cultural Shift

In conclusion, physician burnout is a widespread, work-related syndrome that leads to adverse outcomes for physicians, patients, and hospitals. As the problem has been exacerbated by regulatory burdens, such as the implementation of the electronic health record, research studies and media awareness have been bringing attention to the situation. While institutions implement pilot programs to find solutions, there are opportunities at the national, organizational, and individual level to enact policies and create a cultural change. At its core, it calls for recognizing that physicians are human beings who deserve just as much care and compassion as the patients they serve.

References


