Physician Burnout: Cause and Prevention Strategies

Umesh Sharma¹, Shashank R Joshi², Amit Ghosh³

Abstract
Ongoing evolution in healthcare places physicians under an ever-increasing pressure to consistently perform at a higher level, leading to a significant number of physicians including those in training feeling “burnt-out”. Burnout is a result of interplay between personal characteristics and environmental factors. Unaddressed physician burnout negatively affects the individual, work environment and most importantly patient care. Individual and environmental changes are needed to assess and effectively manage burnout. Stigma and fear of professional consequences, especially among regional doctors appears to be an important barrier to access services and address burnout. There is an ever increasing need to expand the Triple Aim (enhancing patient experience, improving population health, and reducing costs) to a Quadruple Aim that goal of improving the work life of health care providers, including clinicians and staff.

Introduction
Caring for the patient is a fundamental reason why people including physicians choose to work in the healthcare profession. Healthcare has been undergoing tremendous evolution as a result of various factors like increased demand for services for an aging population, changing payer mix with reducing reimbursements, electronic medical records, newer regulations and compliance responsibilities. This places physicians under an ever-increasing pressure to consistently perform at a higher level, hence creating a demoralizing misalignment of physician’s values and need for quality patient care causing a “moral injury”. Unaddressed moral injury eventually leads to burnout. Burnout is affecting a significant number of physicians including those in training and has created an epidemic that needs to be acutely addressed.¹

It is vital to understand why physicians burn out, manage burnout and create strategies and tactics to prevent burnout to engage and retain a vital and productive workforce.

Understanding Burn Out
Maslach and Jackson in 1981 defined burnout as an occupation stress in human service professionals (teachers, doctors, nurses etc.) causing emotional exhaustion.²

Burnout can be characterized by three components which include depersonalization, emotional exhaustion and low personal accomplishment/experience of ineffectiveness. Burnout is now a well-recognized syndrome and has the potential of creating a negative reaction to one’s work, it most time comes with a feeling of dissatisfaction, hatred and complain.²

World Health Organization has now defined burn-out as a syndrome resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one’s job, or feelings of negativism or cynicism related to one’s job; and 3) reduced professional efficacy. Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life.³

Donald Berwick has stated that a clash between a new era of measurement and accountability targeting quality, errors, costs, inequities and a traditional physician autonomy lies at the root of this growing crisis.⁵

Prevalence of burnout
Although, the prevalence varies amongst different specialities, it affects clinicians from all specialities including medical students and residents. Physicians who work in the front line like emergency department, primary care, neurology etc. tend to have higher rates of burnout. A nationwide survey by Shanafelt et.al, revealed a 54.4% prevalence of at least one burnout symptom amongst 6880 US physicians from various specialties with about 7.6% decline in work-life in a 3-year period from 2011-2014.⁶ A 2018 survey of US physicians by Merritt Hawkins reported that 55% of physicians have a somewhat or very negative morale while 78% often, sometimes or always experience feeling of burnout.⁷ Emergency medicine physicians tend to suffer from some of the highest levels of burn out.⁸ Some potential reasons include: heavy work load with resultant inability of physicians to fully perform their duties to patients and not be able to give 100% attention to patients, high patient turnover, and resource limitations.⁹

High level of burn out is not only limited to Emergency medicine, but also prevalent in non-front line departments like Physical Medicine and Rehabilitation (PM&R). A national survey by Sliwa et. al, showed 50.7% of 1,536 physiatrists met the definition of burnout. Increasing regulatory demands, workload and job demands, practice inefficiency and lack of resources was again identified as top factors.¹⁰

Every one point (on a seven point scale) increase in burnout is associated
Factors causing burnout

Burnout is a result of interplay between personal characteristics and environmental factors as mentioned in Table 1. Individual factors like having no spouse, work-life imbalance and personality traits like being self-critical, compulsiveness, perfectionism, or delayed gratification can create additive stress in an otherwise already stressful workplace. Hobbies and interests can also help provide a mechanism for managing stress. Social support can help an individual obtain emotional and psychological support during time of stress and hence a lack of adequate social support can predispose one to burnout. Optimism and emotional regulation tends to influence how one perceives and manages stress. Organizational factors like physician-administration misalignment, limited interpersonal collaboration, limited career advancement opportunities, increased administrative requirements with reduced support make physicians feel a loss of autonomy over work environment, for an increasing work load expectations.6,14,15,16

A qualitative study by Abedini et al in residents classifies burnout into 2 categories: circumstantial (self-limited environmental triggers) that occur during challenging assignments and can be easily mitigated, and existential burnout that is linked to how residents view themselves within the context of their developing role as physicians and needs intervention.17

Consequences of Burnout

Unaddressed physician burnout negatively affects the individual, work environment and most importantly patient care. Burnout can leads to an individual feeling tired, exhausted, inattentive, and depressed, leading to substance abuse, practice departures, and potentially suicidality. Physician turnover can lead to avoidable physician-replacement costs to the practice and also lead to sub-optimal interpersonal work relationships. Patient care can be adversely affected by increased medical errors, malpractice, reduced patient satisfaction, and poor patient quality and outcomes.14,18

Similarly trainees can experience professional development limitations, personal consequences including suicide, and can affect patient care adversely.12 Burnout and stress can lead to hypertension, depression, and anxiety amongst our nurse colleagues.19

A recent study estimated that the cost of physician burnout in US around $4.6 billion a year.17

This cost was attributable to physician turnover, reduced productivity, and estimated price of advertising for the vacated position, hiring and training. At the organizational level it was estimated that the annual burnout cost was estimated around $7600 per physician per year.20

Studies have shown that aside from the anxiety, depression, insomnia, emotional and physical exhaustion, and loss of cognitive focus associated with physician burnout, an estimated 300 to 400 U.S. physicians take their own lives every year. Physician suicide rates are higher than the suicide rate for the general public by 40 percent for men and 130 percent for women.21

Diagnosis

Burnout is evident when one sees a variation in performance in an otherwise good performer, leading to sub-optimal clinical interactions or interpersonal interactions. Being proactive is better than being retroactive while managing this critical issue. Many standardized surveys are available like Maslach Burnout inventory, Oldenburg Burnout Inventory, Copenhagen Burnout Inventory etc.8

Prevention and management of physician burnout

In recent years there has been substantial research and evidence on prevention and management of burnout. Organizations can support restructuring of physician workflow and provide resources to promote focus groups, wellness programs, and reduce work and administrative responsibilities. Linzer et al have recommended a 10-step approach to prevent physician burnout. These focus on individual and institutional priorities.22

Since individual characteristics like difficulty in balancing personal and professional life, paying little or no attention to wellness, work-alcoholism, and genetic factors increase an individual’s susceptibility to burnout, hence seemingly if these issues are checked, there should be a decrease in burnout.23 Emotional regulation either by self or taught or interventions like mindfulness have been reported to be beneficial for burnout management.24,25

In order to reduce the level of burnout, an individual has to be mindful about it and try to check the factors that led to it. Some suggested strategies include implementation of regulations, working space and time, and pursue opportunities that are of value to the physician. Research of academic internal medicine faculty by Shanafelt et al demonstrated an inverse relationship of time spent on meaningful work activity (> 20%) and burnout.26

Self-limited circumstantial burnout is reversed by resolving the triggering workplace challenge like conflict, nurturing personal lives, and taking time-off from work. While existential burnout that arises from uncertain professional role or loss of meaning in medicine needs the following: feeling validated, connecting with

Table 1: Factors predisposing to burnout

<table>
<thead>
<tr>
<th>Individual-related</th>
<th>Environmental-related</th>
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<tr>
<td>Personality traits: compulsiveness, perfectionism</td>
<td>Unmanageable workloads</td>
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<tr>
<td>Delayed gratification</td>
<td>Lack of autonomy and involvement in decisions affecting the practice</td>
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<tr>
<td>Social support</td>
<td>Chaotic and inefficient work environment</td>
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<tr>
<td>Hobbies and interests</td>
<td>Lack of alignment amongst physicians and executives regarding mission, values, purpose and compensation</td>
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<tr>
<td>Optimism and emotional regulation</td>
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with 30-40% increase in likelihood that physicians will reduce their workhours and professional exit in next two years.11 Burn out has even started to affect future physicians including medical students and residents because of added stress of study in addition to work.12

Medicine is a team sport that includes interaction with nursing colleagues, who unfortunately are also facing burn-out. Burnout in nursing staff tends to negatively affect their work-satisfaction, quality of care and their intent to leave their job.13

Physicians identify physician patient relationship as the most satisfying part of medical practice, while loss of autonomy, time with patient, and EHR as the greatest source of professional dissatisfaction that negatively affects quality of care, patient interaction and efficiency.7

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colleagues and patients, finding meaning in medicine, and redefining a professional role and identity.27

Volunteering, which is supposed to improve mental health, has been postulated as a strategy to combat burnout. According to Iserson, many physicians feel like they are not fulfilling their roles like they ought to, hence short-term global medicine experiences may reinvigorate and reengage clinicians who are suffering or at high risk of persistent burnout syndrome while simultaneously befitting their roles like they ought to, hence physicians feel like they are not fulfilling burnout syndrome.27

Other organization supported strategies could include utilization of nurse practitioners or medical assistants to decrease physician workload, mitigate stresses contributing to burn-out, and reallocate more physician time to procedures.29,30 Organizations can optimize career fit and promote physician satisfaction and help to reduce attrition among academic faculty physicians.26

State Medical societies like Massachusetts can create statewide physician health programs that reach out to hospitals and physicians and provide confidential mental healthcare.31 The Federation of State Medical Boards (FSMB) has called on state medical boards to offer “safe haven” non-reporting of physicians who have received appropriate substance abuse and mental health treatment and remain in good standing.32

Innovative ways will be needed to reduce EHR burden and increase usability. Use of open health care Application Programming Interface (API) will allow third parties to develop apps to support clinical documentation and quality and regulatory compliance.33

<table>
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<tr>
<th>Table 2: Strategies to prevent and manage burnout</th>
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<tr>
<td><strong>Individual (physician wellness)</strong></td>
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<tr>
<td>Healthy lifestyle</td>
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<td>Self care skills</td>
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<td>Emotional regulation skills</td>
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<td>Resiliency training</td>
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<td>Social and family interactions</td>
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<td>Professional support (Focus group, Wellness programs)</td>
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<td>Employee assistance programs</td>
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<td>Statewide physician health programs</td>
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<td>Wellness programs with effective Chief Wellness Officers</td>
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<td><strong>Social support</strong></td>
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<td>Physical activity like sports</td>
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<td>Travel, Volunteering</td>
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<tr>
<td>Meditation</td>
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<td>Manageable workloads</td>
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<td>Effective workflows</td>
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<td>Flexibility and autonomy in job</td>
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<tr>
<td>Career development opportunities</td>
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<tr>
<td>Safe Haven non-reporting of appropriate treatment for mental health and substance abuse</td>
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<tr>
<td><strong>Hobbies and interests outside work</strong></td>
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<tr>
<td><strong>Environmental (Organization, Regulatory)</strong></td>
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<tr>
<td><strong>Improve EMR- usability</strong></td>
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<td>API to allow third parties to develop apps</td>
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<td>AI to support clinical documentation and quality and regulatory compliance</td>
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Table 2 further summarizes strategies to combat burnout.

**Barriers to implementation**

Stigma and fear of professional consequences, especially among regional doctors appears to be an important barrier to access services and address burnout.33 Although there has been increased awareness and research in psychosocial and behavioral interventions, the quality of evidence remains low.34 There is also a rising concern that efforts are focussed more on increasing resilience and wellness rather than managing the uncontrolled evolution and practice of current era medicine. Hence, we may be treating the symptom rather than the disease.35

**Conclusion**

Burnout not only affects the physicians personally but has been a factor in patient harm, hence health care organizations have an inherent responsibility to prevent and manage physician burnout. Healthcare organizations need to invest in the psychological health of their physician and other employees, since a resilient and non-burnt workforce would be able to adequately handle the physical and emotional needs of patients they care for. Hence, there is an ever increasing need to expand the Triple Aim (enhancing patient experience, improving population health, and reducing costs) to a Quadruple Aim that goal of improving the work life of health care providers, including clinicians and staff.36

Many organizations like Mayo Clinic have come up with comprehensive strategies to address burnout. Some key features include: recognizing burnout as a threat to healthcare, use common metrics and identify drivers of burnout using staff surveys, implement strategies to mitigate these factors and share best available evidence.41

**References**

8. Rothenberger DA. Physician Burnout and Well-Being. A


