

PERSPECTIVES

Physician Burnout in the United States: A Call to Action

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It is no secret how much the United States asks of physicians. Rigorous requirements include, but are not limited to university, medical school, residency, training, and professional development. The study of medicine is a lifetime commitment where financials and schedules are constantly being juggled, bombarded, and, perhaps, depleted.

There is a level of expectation above others similar public service professions. We ask firefighters to save lives, attorneys to uphold our nation's laws, and police to contain crime. But there is something different about physicians, is there not? When we are weak, downtrodden, depressed, or nauseated, we go to the physicians and entrust in them our well-being. Almost a complete stranger in some cases, no less.

Our human desire to do more than just survive moves us forward. It allows us to hand over our most treasured asset, our health, to someone else. And the physicians, the good ones, take on the challenge with their mind, and their heart. We all know the excellent physicians: Their ability to empathize is instinctive. It is inspiring.

However it begs the question: Who supports our physicians? Of course, their salaries are competitive (hopefully), they have a few plaques on the wall acknowledging their loyalty and responsibility to education and the practice of medicine, and they are perhaps recognized in their professional circles. However, who really cares for them? Do they see their most trusted colleagues when they are having a strange chest pain? Familial, mental, and financial struggles would put them in an even more complex scenario if their friends were their only confidantes.

What is clear is that physicians are tired, they are burnt out, and they are choosing to end their life. They need support. If we don't develop processes that are nationally studied and recognized, physician numbers will decrease plus patient care will suffer, and that is a scary prospect.

WHAT EXACTLY IS BURNOUT?

The ubiquitous term certainly conjures up an understanding; however, in the health care context, what does the research correlate to the word? Currently, *burnout* is defined as a syndrome of emotional exhaustion and depersonalization.¹

First and foremost, burnout is viewed as the factor most strongly related to physicians' plans to withdraw from the clinical workforce by reducing to part-time within the next

12 months (19.8%), leaving the clinical workplace within the next 2 years by retiring (9.9%), rerouting their careers into nonclinical work (2.6%), or rerouting into a different career altogether (1.9%), entering a revolving door of different practice opportunities in search of satisfaction (9.3%) or a combination of these (2.7%).²

However, just like the rest of us, physicians need to put food on the table and pay their utility bills, so some burned-out physicians don't physically leave their practice, but are psychologically out the door. This may be perceived as a lack of empathy, or lack of cognitive vigilance.³ Physicians who are burnt out may be less efficient and more costly if they are prone to reducing their pace, resisting work and bureaucratic tasks, or reluctant to engage in organizational initiatives.

Studies show that burnout also has adverse personal consequences for physicians, including contributing to broken relationships, problematic alcohol use, and suicidal ideation.

Furthermore, doctors who keep working despite signs of burnout are likely to provide lower-quality and less safe care than they did earlier in their careers. Symptoms that physicians need to take care to identify within themselves include emotional exhaustion, a loss of empathy, cynicism, feelings of detachment from patients, and a low sense of personal accomplishment.⁴

WHAT ABOUT PHYSICIAN SUICIDE?

Some of the numbers are startling—mostly because we are not conditioned to think about suicide at all, especially not from our revered physician demographic. But the numbers can potentially be skewed: Many are underreported, difficult to address, or intentionally veiled. Studies show the risk of suicide accounts for 300 to 400 physicians lost each year.²

WHAT IS THE IMPACT OF PHYSICIAN BURNOUT ON HEALTH AND THE HEALTH CARE SYSTEM?

Turnover rates are estimated to be \$800,000 per physician. And the impact on the system doesn't stop there. Some physicians deal with burnout and withdraw from clinical practice in alternate ways. For instance, they will avoid certain clinical stressors: surgeons who schedule less intense procedures, or primary care providers who deny insurance. This may help the individual but is also considered as a potentiation of the problem, as the remaining physicians will have to pick up the work.²

Frontline health care disciplines are most affected by burnout and malpractice claims and are at increased risk for substance abuse, suicide, and troubled relationships. Malpractice claims average about \$371 054 per claim,⁵ and it is noted that physician stress reduction has the potential to reduce malpractice claims by two-thirds.⁶

WHAT ARE THE CAUSATIVE FACTORS WE NEED TO ADDRESS?

Demands and Economy

Many physicians view their workload as something outside of their direct control. This passivity in such a demanding and stressful field has been seen as the “perfect storm for burnout.” The economy is a key driver here: Medical costs are currently very high; therefore, productivity has to pick up the slack. These extra hours of work are little to never recognized and are seen as a primary driver to physician burnout.⁴

Residency is also a unique factor attributing to the high burnout rate of young physicians or physicians in training. Trainees have different stressors based on the content and context of their work. They have high ideals for the profession and high expectations for themselves, which are shouldered individually. This overwhelming challenge is consoled mainly through connection with others in the medical community, especially their fellow residents. As one resident summed it up: “[The other residents] ... are really the only people who understand what is going on in a real way.” Sports and war metaphors are common, but what about the people who don’t connect best through a group setting?

There is still a rampant culture of hierarchy and competition and it isn’t common to share heavier feelings or thoughts amongst the group. And the residency experience tends to emphasize value-persistence and a “positive attitude” in the face of difficulty. Residents tend to take pride in what they have learned through prior struggles and they are encouraged to charge through. In a world that little recognizes achievements, why would difficulties be recognized? Take this comment: “The hardest part of residency is you go from 20+ years of being in school where you get a gold star, you get an A, you get these pats on the back.” In clinical work, where these rewards are not always visual, the residents can and do get discouraged.

Medscape asked 15 000 physicians from 29 specialties respondents what factors they thought contributed to their feelings of burnout. This is what they had to say: 56% cited too many bureaucratic tasks such as charting and paperwork, 39% said spending too many hours at work, 26% listed a lack of respect from colleagues and/or staff members, and 24% said increasing computerization of health care. Other factors included insufficient compensation (24%), lack of control/autonomy (21%), lack of respect from patients (16%), government regulations (16%), and emphasis on profits over patients (15%).⁷

Prestige

Beyond the external factors, is there something internally that hinders a physician themselves from getting well? It turns out there is.

Ironically, there are a broad range of issues regarding how the profession views mental health. First, mental health is seen as more long-lasting and recurrent than physical illness. This lends to a mind-body dualism and that physicians with mental illness pose a greater risk of danger to patients through mistakes in reasoning or decision making. This obvious negative implication poses a great risk to job security! The physician who didn’t make their mental health, or lack thereof, apparent, is viewed as superior.

It centers on image. Doctors admitting to a mental illness are viewed as weak and it also can undermine their “professionalism”:

Often as a doctor you have to be the person that everyone perceives as being strong, who is looking after all the other patients where you know, you are not necessarily meant to be ill yourself as well.⁸

With all this stigma and invulnerability, how can we expect physicians to help themselves?

CLINICAL PRACTICE TIED TO BURNOUT

Were things always this way? A turn out the view was a bit rosier when a physician-to-be started his or her path in medicine.

Compared with the general population, physicians enter clinical practice healthy, with a higher quality of life, lower rates of burnout and depression,⁹ and lower rates of cancer and cardiovascular disease.¹⁰

However, once in practice, things start to change. Physicians register a lower work-life satisfaction and higher rates of burnout. Plus the risk of suicide becomes 1.4 and 2.3 times higher for male and female physicians, respectively. To underscore this connection further, burnout increased across all medical specialties between 2011 and 2014, while remaining stable in the general population.¹¹

HOW CAN WE UPHOLD DOCTORS’ WELL-BEING AND SUCCESS?

As a community and a country, we have to address they ways to repair the broken health care system, and not just for our patients. We have to see physicians as an end user in of themselves. Take a look at the Mayo Clinic’s Office of Staff Services (OSS). Their proactive measures are designed for the individual physician. Services include financial and peer support. Common topics of discussion during support meetings include work-life integration, career satisfaction, self-care, and personal medical needs.

Also, we have to look at this trend as a malfunction within a larger health system. The OSS’s origins at Mayo Clinic was a financial planning center but in 2002 the office transitioned to the OSS with a mission to “help voting and consulting staff address issues of concern in their professional and personal lives.” It is a system within a system wherein a medical director and peer support panel exist to assist colleagues—whether it is a malpractice suit, patient death, demanding hours, or a changing practice environment.¹³

Hospitals, universities, and other medical institutions are very quick to emphasize the successes and advances of their leading physicians or residents. Social media blasts, highfalutin announcements and ceremonies will abound. But, when a physician jumps off the roof of their university, or there is a revolving door of turnovers in the hospital, accountability goes out the window. Does that sound very Hippocratic to you? (*Altern Ther Health Med.* 2018;25(2):8-10.)

REFERENCES

1. Maslach C, Jackson S. The measurement of experienced burnout. *J Occup Behav.* 1981;2:99-113.
2. Sinsky C, Dyrbye L, West C, Satele D, Tutty M, Shanafelt T. Professional satisfaction and career plans of US physicians. *Mayo Clin Proc.* 2017;92:1625-1635.
3. West CP, Huschka MM, Novotny PJ, et al. Association of perceived medical errors with resident distress and empathy: A prospective longitudinal study. *JAMA.* 2006;296:1071-1078.
4. Collier R. Physician burnout a major concern *CMAJ* 2017 October 2; 189: E1236-7.
5. Studdert DM, Bismark MM, Mello MM, Singh H, Spittal MJ. Prevalence and characteristics of physicians prone to malpractice claims. *N Engl J Med.* 2016;374:354-362.
6. Jones JW, Barge BN, Steffy BD, Fay LM, Kunz LK, Wuebker LJ. Stress and medical malpractice: Organizational risk assessment and intervention. *J Appl Psychol.* 1988;73:727-735
7. Peckham C. Medscape National Physician Burnout & Depression Report 2018. Medscape Web site. <https://www.medscape.com/slideshow/2018-lifestyle-burnout-depression-6009235?faf=1#26>. Published January 17, 2018. Accessed January 8, 2019.
8. Bianchi EF, Bhattacharyya MR, Meakin R. Exploring senior doctor's beliefs and attitudes regarding mental illness within the medical profession: A qualitative study. *BMJ Open.* 2016;6:e012598.
9. Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med.* 2014;89:443-451.
10. Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: A consensus statement. *JAMA.* 2003;289:3161-3166.
11. Schernhammer ES, Colditz GA. Suicide rates among physicians: A quantitative and gender assessment. *AM J Psychiatry.* 2004;161:2295-2302.
12. Shanafelt TD, Lightner DJ, Conley CR, et al. An organizational model to assist individual physicians, scientists, and senior healthcare administrators with personal and professional needs. *Mayo Clin Proc.* 2017;92:1688-1696.
13. Winkler A. Thriving in scrubs: A qualitative study of resident resilience. *Reprod Health.* 2018;15:53.