**Abstract**

Physician burnout is a growing problem with no easy solutions, and it has become a severe issue for healthcare today. In 2019, burnout was officially recognized by the World Health Organization (WHO). The WHO included burnout in the 11th Revision of the International Classification of Diseases (ICD-11), a handbook that provides a guideline for medical providers when making a diagnosis (WHO, 2019). The media these days is busy cranking out stories, highlighting research reports, and presenting editorials proclamation that physician burnout has reached a crisis level. Many of these media reports blame the advent of electronic health records (EHRs), but the real cause is more complicated than the proliferation of EHRs. The results from recent industry and research-based studies have shown that at least a quarter of all physicians across the continuum of medical care are burned-out and often physically and emotionally exhausted (Medscape, 2019). This issue not only hinders physician performance and resiliency but also threatens healthcare organizations’ ability to deliver quality care consistently and to maintain a healthy and engaged physician workforce. They need a workforce that finds joy and fulfillment in healing and treating patients (Kadrie, 2019).

This research case study will review the following: review the causes of physician burnout, explore how healthcare organizations recognize physician burnout, assess the prevalence of physician burnout in the era of value-based care and consequences of physician burnout, identify the driver of physician burnout, and assess strategies to prevent physician burnout.

**Understanding Physician Burnout**

Burnout consists of three symptoms related to emotional exhaustion, depersonalization, and inefficacy (Maslach & Jackson, 2001). Emotional exhaustion is the feeling of being overextended and detached from one’s emotional and physician resources. Recently, some researchers have begun favoring the term exhaustion alone (Dyrbe et al., 2010).

The second symptom, depersonalization, or cynicism is a negative, excessively detached, or callous response to one’s job; among physician, this symptom may present as distancing from patients. This symptom is a natural response to exhaustion. It is a coping mechanism for dealing with the sometimes-overwhelming emotional stress inherent in-service occupations (Maslach & Goldberg, 1998). According to recent research studies, detachment is a way for the worker to protect him- or herself from intense emotional distress that might interfere with work effectiveness. By controlling the degree of compassion, he or she feels for the person served and obtaining some emotional distance, the caregiver achieves a state of detached concern.” (Maslach, 2001).

The third symptoms of burnout, inefficacy, occurs as a sense of reduced personal accomplishment and achievement at work, low productivity at one’s job, and feelings of incompetence. Exhaustion and depersonalization can lead to inefficacy as these two symptoms interfere with a worker’s effectiveness at his or her job. Related research studies (Leiter, 2005; Maslach, 2011; Medscape, 2016-2019) have indicated that the sense of lower accomplishment is directly related to the other symptoms of burnout.

**How Healthcare Organization Recognize Burnout?**

Many recent studies have indicated that leaders of healthcare organizations many overlook symptoms of burnout among the physician in their organizations for several reasons. Physicians tend to mask their distress and are unlikely to seek or approach leaders, their colleagues, or the boards to request help for the problem. In these studies, a common theme revealed the last thing physicians are likely to do is openly display what they perceive to be a weakness or liability to their organizational leaders (Shin, Gani, & Herzig, 2016).

Healthcare leaders who are not aware of physician burnout in their organizations may recognize these secondary signs of the problems:

- High staff and physician turnover
- Vacant positions and difficulty recruiting physicians
- Disruptive physician behavior and angry complaints about other medical providers and nursing staff (and vice versa)
• Lack of physician engagement in strategic projects or improvement work
• Angry complaints about electronic health records, quality metrics, the challenges of implementing best practices, open-access scheduling, and yet another improvement initiative.
• Bitter protests that low patient satisfaction scores are beyond their control.

**The Prevalence of Physician Burnout in the Era of Value-Based Care**

It is not only the influential healthcare groups, such as the American Medical Association, The American College of Physicians, and the Institute of Health Improvement but and the press and other media outlets including the Wall Street Journal, New York Times, Washington Times, and others. All are presenting stories about the widespread prevalence of burnout among practicing physicians, but just how pervasive is this problem? It is, in fact, both widespread and increasing. A 2019 National Burnout Survey conducted by Medscape revealed that 44% of physicians reported feeling burnout; 11% were colloquially depressed, and 4% were clinically depressed. In other surveys, reported satisfaction with work-life balance had declined significantly for physicians and burnout was present in all 24 specialties studied.

Burnout prevalence varies to some degree based on physician characteristics, such as specialty, years in practice, age, and gender. According to the 2019 Medscape survey, 10 specialties with the highest rate of reported burnout are:

• Urology
• Neurology
• Physical Medicine and Rehabilitation
• Internal Medicine
• Family Medicine
• Diabetes and Endocrinology
• Infectious Disease
• General Surgery
• Gastroenterology
• Ob/GYN

Many studies have documented an increased prevalence of reported burnout among female physicians. The Medscape (2019) survey shows 50% of female physicians have symptoms of burnout and are more likely to admit psychological problems and seek help and may be more likely to acknowledge burnout than male their counterparts. Also, female physicians generally acknowledge more challenges with work-life balance than do men. Women disproportionately assume children and family issues.

Despite variations among certain groups, burnout cuts across every demographic and exists in every subpopulation of physicians. Indeed, burnout is more prevalent in physicians than in the general U.S. working population. Even after adjusting for age, sex, and relationship status and hours worked per week (Shanafelt et al., 2015).

Recent studies have shown that no physician is immune to burnout—not even those who attain highly respected leadership positions in prestigious healthcare organizations.

**Consequences of Physician Burnout**

Empirical evidence from recent research studies shows that burnout exacts a substantial personal toll on affected physicians. Physicians impacted by burnout experience disillusionment, stress, and confusion as they struggle to continue caring for others while being depleted themselves. As a result of burnout, many physicians cut back on clinical practice or leave practice entirely. Recent studies and surveys have revealed that burned-out physicians are more likely than their colleagues to report an intention to leave their current position within the next 2-3 years, to decrease work hours, or to leave patient care entirely (Shanafelt et al., 2016; Rabatin et al., 2016; Medscape, 2019).

Physician distress can have dire consequences if untreated. A study of surgeons found that those who were burned out or depressed were significantly more likely to suffer from alcohol abuse or dependence (Oreskovich et al., 2012). Physicians die by suicide at a rate much higher than the general population. In a study of more than 4,000 medical students, burnout was an independent predictor of suicidal ideation over the subsequent year (Dyrbye et al., 2008). There are several possible explanations for physicians’ heightened risk for suicide, including access to lethal means (that is, medications), the hesitancy of physicians to admit to symptoms that might affect their ability to practice or register as “weakness” and the tendency of physicians to diagnose and treat themselves.

The effect of burnout on patient care cannot be underestimated. It is known that patient outcomes are affected by many factors, only some of which are influenced by physicians. For this reason, it can be challenging to show a direct relationship between physicians’ burnout and specific, objectives patient outcomes. However, the collection of available evidence makes a compelling case for the adverse effects of burnout on patient care (Shin, Gandi, & Herzig, 2016).

When we consider the three symptoms of burnout, it is logical that physicians’ burnout would have direct consequences for patient care. Increasing evidence shows that an emotionally exhausted physician may be less likely to go the extra mile to have a meaningful conversation with a patient’s family with recommended care practices. A physician experiencing depersonalization is unlikely to be as compassionate and empathic as he or she might be otherwise. A physician struggling...
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with inefficacy and during his or her performance or the meaning of the work may be unable to fully engage in change initiatives that would ultimately improve patient care.

Burnout has definitive effects on patient safety practices. A recent study from the Mayo Clinic indicates that nine percent of surgeons reported a major medical error within the prior three months, and surgeons who reported an error were significantly more likely to have symptoms of burnout (Shanafelt, 2010). Also, burnout and depression remained independent predictors of reporting a recent major medical error even after researchers controlled for other personal and professional factors. In fact, for each one-point average on the depersonalization dimension of the Maslach Burnout Inventory, the likelihood of reporting an error increased by 11 percent.

Quality of care is another manifestation of physician burnout. In addition to adverse effects on patient safety, burnout has demonstrable negative consequences on care quality. Recent studies have shown that burnout is associated with reduced standards of care. The 2019 Medscape survey showed that burnout among medical students was associated with self-reported unprofessional conduct and less altruistic professional values. Researchers (Dyrbye et al., 2010; Gallardo, 2016; Shanafelt, 2015) found that burnout was associated with a higher rate of the self-reported likelihood of error and suboptimal patient care.

Burnout also impacts patient experience as it hinders a physician’s ability to effectively use the skills that are critical to the optimal patient experience. In contrast, physician engagement, which is unlikely to be present in burned-out physicians, correlates with positive patient experience. Research on patient and physician satisfaction supports this assertion. Patient satisfaction with care closely correlates with physician career satisfaction within a given geographic region (Dyrbye et al., 2010). A survey of more than 2000 patients found that those whose physicians were very or extremely satisfied with their career satisfaction within a given geographic region (Dyrbye et al., 2010) reported higher overall satisfaction with their health care.

The effects of physician burnout on healthcare organizations are well documented. Given the demonstrated effects of physician burnout on patient safety, care quality, and patient experience, an obvious conclusion is that the performance of healthcare organizations is at risk of their physicians are suffering from burnout. In addition to a damaging effect on the organization’s quality and safety metrics, burnout is likely to affect its culture, finance, and overall performance and organizational resilience (Shanafelt, 2010).

The effects of physician burnout on the Healthcare System cannot be underestimated. The effect of physician’s burnout on the broader healthcare delivery system (employers, public and commercial healthcare payers, society at large) is markedly affected by the growing tide of physician’s dissatisfaction and burnout. To effectively prevent the consequences of physician burnout, we need to understand and address its root causes.

Identifying the Drivers of Physician Burnout

Physician burnout is multifactorial as there is no single explanation for burnout in an individual physician or the drastic uptick across all specialties in recent years. Recent studies have indicated that understanding the variety of factors that are responsible for physician burnout should help highlight critical leverage solutions for prevention (Koven, 2016). The key drivers of physicians’ burnout are segmented to these drivers:

(1) Physicians Factors: there are physician’s related factors that increase the risk of burnout, and they fall into five categories. They are stress inherent to the practice of medicine, common traits and characteristics of physicians, the mental health of physicians, prevailing culture in medical training and the profession at large, and other individual factors. As Trait Shanafelt of the Mayo Clinic and his co-authors commented in their 2012 study, “the fact that almost one in two U.S. physicians has symptoms of burnout implies that the origins of this problem are rooted in the care environment and delivery system rather than in the personal characteristics of a few susceptible individuals.” (Shanafelt, 2012).

(2) Workplace Drivers: a single issue does not cause burnout; it is multifactorial. Studies have shown that a substantial portion of the risk stems from factors in the workplace. Research supports this premise. Many research studies (Koven, 2016; Linzer, 2001; Linzer 2009; Shanafelt, 2016) have revealed that six workplace causes of physician burnout. These are the following: work overload, inefficiencies related to an undue clerical burden, loss of control, work-life imbalance, loss of meaning in work, and conflicting values.

A 2015 study of primary care physicians identified various workplace factors as being physician workload, degree of physicians control, and congruence between the physician’s values and those of the administration. Practice factors are responsible for about 50 percent of the risk of burnout (Gregory & Mesner, 2015). The fact that burnout affects more than half of physicians today suggests the presence of drivers outside the individual. What has changed in the environment in which physicians practice that explains this massive uptick in burnout?

Physicians are productive and efficient. They see the numerous gaps, barriers, and inefficiencies in their organizations that hamper better care to their patients. They find workarounds when they can, or they work harder. They do their best to function in a workplace that is too often fundamentally broken or inefficient (Koven, 2016). Trying so hard in an environment plagued with inefficient processes, confounding policies, and frequent communication gaps is a recipe for burnout.

(3) The Impact of Leadership Drivers: burnout researchers have demonstrated a connection between destructive leadership behaviors and burnout (Breevaart, 2014). For example, abusive leadership, characterized by such behaviors as breaking promises or expressing anger at subordinates for things they did not do,
is correlated with higher levels of emotional exhaustion (Aryee, Sun, Chen, & Debrah, 2008). Recent research has quantified the effect of leadership on physician burnout (Shanafelt, 2015). This research revealed that a higher score of the unit or division leader on 12 dimensions of leadership had a strong negative correlation with the burnout scores of individual physicians and a strong positive correlation with satisfaction. In fact, for each one-point increase in the overall leadership score, there was a three percent decrease in the likelihood of burnout.

One key role of health care leaders is to support the frontline clinicians as they pursue the work of caring for patients. When physicians perceive that their leaders are not committed to helping by providing needed support, they become frustrated. When leaders perceive that the physicians are pursuing their self-interest over the interests of the patient, they find it hard to support such physicians. A better way is needed that is based deeply in the principle of respect for people that offers a framework that builds respect and collaboration into the management approach.

(4) The impact of the Electronic Health Record (EHR): The EHR represents one of the most significant examples of disruptive innovation catalyzing a sweeping change across the industry. A majority of hospitals and physician practices now have a patient portal into the EHR where patients can send messages, check lab results, make appointments, and pay their bills. Although EHR solves many problems of the pre-digital age, it has also created many problems. These primarily include an uptick in the time devoted to non-clinical tasks, less efficient workflow, adverse effects on interpersonal relationships, and negative effects on the quality of care. Improved design of EHR systems should be a top priority for healthcare organizations to ensure improved usability and improve interoperability and reduce physician burnout (Sinsky et al., 2016).

Preventing Physicians Burnout
An increasing body of evidence has revealed that preventing burnout requires attention to the three levels at which drivers exist: the individual physician, the workplace, and the environment external to the workplace. All three levels must be addressed to create optimal patient-physician interactions and build sustainable careers for physicians (Koven, 2016). Many healthcare organizations, systems, and hospitals are invested in prevention strategies that focus primarily on building the resilience of the physicians to stress (Sinsky et al., 2016). The emphasis on these programs may reflect the erroneous belief that the individual susceptibility causes burnout. Alternatively, it may reflect the fact that it is easier to launch a wellness program than it is to identify and address the problems of the underlying system.

Leading change in patient care workflows, management systems redesign, and organizational culture is challenging and demanding work that requires the ability to guide the technical and the emotional aspects of change. The focus on wellness programs may also reflect a sincere desire on the part of healthcare leaders to provide hope and solace to physicians in the short term while searching for more definitive solutions.

Although individual strategies are essential to ensure that the physician is at his or her best when providing patient care, in the long run, these strategies cannot prevent the effects of continuous exposure to chaotic, inefficient, and stressful work environments. The evidence base regarding the prevalence of risk factors for burnout is established, but the empirical data about effective interventions for burnout are much less robust.

Addressing burnout includes treatment for acute symptoms and strategies for prevention. Some of the individual strategies for treating acute burnout and building resiliency to help prevent burnout. Some of the approaches to preventing burnout are time away from work, professional assistance, counseling, coaching, work-life balance, peer support, and wellness programs. Focus on strategies to fix the root cause of burnout in the workplace, support effective leadership presence for creating a workplace and organizational culture in which health care providers can thrive (Shin, Gandi, & Herzig, 2016).

An increasing number of healthcare organizations have taken proactive steps to address the problems in the workplace that drive physician’s burnout. Some of these steps include improved physician engagement in the decision-making process, strategy development, and engaged leadership, redesigning health care by focusing on lean principles, eliminating daily frustrations in the primary care setting, prioritizing physician well-being, enabling physicians-led vision, and fostering improved work-life balance (Koven, 2016).

In conclusion, burnout threatens the sustainability of our healthcare delivery system, the well-being and engagement of healthcare professionals, and the quality and safety of the care that patients receive. The most effective way to prevent physician burnout is to change the organizational structure and processes that lead to burnout. The target state for addressing physician burnout is strategic long-term commitment. It is a commitment in which the workplace is efficient, stable, and reliable; caregivers and patients treat each other with respect, frontline clinicians and managers solve problems rapidly; all stakeholders are aligned around caring for the patient and striving to achieve optimal quality, cost, and services, and where physicians are engaged in all aspects of work redesign and continuous improvement.

References