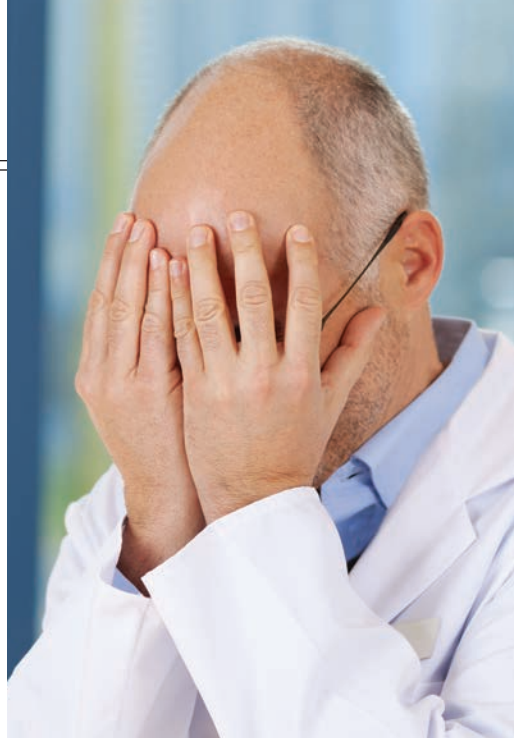
Physician Burnout: Implications for Clinical Practice Management



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It's time to take a closer look at this condition.

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Physician burnout is increasingly prevalent in clinical practice.[1] As the complexity and demands of medical practice continue to grow, contemporary research has revealed that a growing segment of the practicing physician population suffers from burnout.[2] As the incidence and prevalence of burnout expand, its impact is being felt across the spectrum of clinical models. The trickle-down effects of physician burnout are often widespread and variable. Burnout may affect patient outcomes, group practice health and sustainability, and the well-being of those physicians and other healthcare professionals who experience it. In this article, we review the nature of physician burnout, its potential implications on medical practices, and techniques to identify and manage it.

Maslach and colleagues[3] have previously described the concept of burnout, which typically is characterized by emotional exhaustion, feelings of loss of personal accomplishment or ineffectiveness, and depersonalization. The standard tool for detecting burnout is the Maslach Burnout Inventory (MBI), a 22-item questionnaire that assesses all three components of burnout.[4] Although any of these three aspects of burnout may adversely impact practitioner effectiveness, depersonalization in particular may result in the physician's loss of regard for a patient's distinct personhood. It is not well known whether, once affected by burnout, physicians will transition back to non-burnout status.[5,6] Unsurprisingly, burnout also has been reported in a variety of other healthcare professions, including nursing.[7]

Although the phenomenon of burnout has long been recognized in many industries, its escalating prevalence within the physician workforce has garnered national attention.[1,8] In a recent study, Shanafelt, et al. published their results of extensive sampling during 2014 of physicians in the United States.[8] Over 94,000 physicians were invited to participate, and 6880 of these completed a survey that assessed the three major areas of burnout. Their research revealed that more than 54% of surveyed physicians met criteria for burnout.[9]

When compared with similar physician survey data collected during 2011, they found a significant increase in the presence of burnout among physicians in the United States—54.4% in 2014 versus 48.5% in 2011 ($p < .001$).

Numerous causes for this escalation in physician burnout have been proposed. The expanded use of electronic medical records (EMRs), static physician workforce levels despite growing patient populations, declining physician reimbursement, and loss of physician autonomy in clinical practice are just a few potential catalysts of burnout.[10] In reality, these practice challenges do not exist in isolation; rather, a combination of these and other dynamic factors frequently impact practicing physicians on a daily basis. Hence, the aggregate effects of these phenomena and others may chronically affect physician performance and well-being.

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Recognition of Burnout

Recognizing those practitioners affected by burnout may pose a challenge in routine clinical practice, because burnout syndrome shares several characteristics with other entities, such as clinical depression. Despite the similarities with other clinical phenomena, practice managers should be aware of individuals at risk for developing burnout.[11,12]

Physicians who work in an environment where there are time pressures or a lack of control (over the work environment or a chaotic envi-

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ronment) are at risk of burning out. Those physicians also may exhibit anger or impatience, or lack any emotion (especially in treating patients). Likewise, they may be persistently absent from their clinical duties or unable to be away from the clinic, or they may lack energy to get to work or get started once at work. Although burnout is difficult to detect and less obvious to identify, several excellent awareness tools are available that may serve as a starting point for beginning discussions with potentially affected practitioners.[12,13]

Given the extent and potential implications of physician burnout in clinical practice, interventions have been designed to reduce its severity. Krasner, et al.[14] reported on the utility of a mindfulness CME program that targets physicians with MBI scores consistent with burnout. Using a four-pronged approach, these investigators enrolled physicians in a long-term structured program designed to promote their self-awareness via an array of mindfulness techniques. At 15 months of follow-up, a statistically significant reduction in all three components of the MBI (mental exhaustion, depersonalization, and personal accomplishment) was seen as compared with baseline. These authors comment that programs designed to enhance physicians' introspection and self-awareness as practiced on a regular basis may have a favorable effect on the extent of burnout.

Contemporary medical practices often feature physician leaders who have both clinical and administrative responsibilities. The potential for developing burnout or job dissatisfaction in this physician population may be elevated. Maza, et al.[15] recently reported on the benefits of physician awareness programs in a population of physicians who serve as clinical outpatient practice managers, and West, et al.[16] recently published a systematic review and meta-analysis examining interventions that prevent and diminish physician burnout. Their research reviewed 15 randomized controlled trials (RCTs) that included a total of 716 physicians and 37 cohort studies that included 2914 physicians. When considering the endpoint of overall reduction in burnout as assessed by the MBI, a total of five RCTs and nine cohort studies were analyzed. In these studies, interventions either at the organizational level or involving structural changes were associated with significant reductions in overall burnout as compared with interventions focusing on the individual practitioner alone.

Physician Burnout and Clinical Performance

Dewa, et al.[17] recently performed a systematic review of burnout in practicing physicians and identified five studies in which burnout data and clinical practice variables were readily identifiable. Clinical productivity endpoints included in their analysis are listed in Table 1.

TABLE 1:

Physician Productivity Measures Affected by Burnout

- Increased utilization of sick leave
- Increased desire to change jobs
- Decreased intent to continue practicing medicine
- Decreased self-perceived capacity to manage expected workload

Adapted from Dewa, et al.[17]

Many of these indices remain difficult to track or quantify. Nevertheless, the overarching theme within these analyses reveals concerning trends from an international sampling of physicians. Numerous other studies have revealed that MBI-defined burnout has been associated with:

- Increased utilization of physician sick leave;
- A higher self-reported desire to change jobs;
- A reduced desire to continue practicing medicine within their specialty; and
- A reduced capacity to manage their expected workload.

Although seemingly intuitive, there are relatively few data addressing the interrelationship between physician burnout and objective measures of clinical performance. Shanafelt, et al.[18] examined the relationship between burnout and medical errors in a cohort of U.S. surgeons. Using a survey tool that assessed for burnout and major medical errors, these authors were able to assess responses from 7,905 surgeons. They found that 8.9% of surgeons reported committing a major medical error within the prior three months.

Burnout was defined using the typical criteria encompassed within the MBI. Multivariate modeling determined the presence of burnout and depression to be both strongly and adversely correlated with commission of major medical errors (OR 2.016, $p < .0001$). Intriguingly, more conventional variables such as number of hours worked or frequency of overnight call were not correlated with major medical errors. The authors concluded that burnout was significantly associated with committing major medical errors, and safeguards should be put in place to support surgeons exhibiting signs of burnout.

The effects of burnout on clinical performance are not exclusive to physician practices. Aiken, et al.[19] reported on the association between nursing workload and burnout as defined by patient-to-nurse ratio. Their analysis detected a significant association between increased nurse workload and the presence of nurse burnout. In addition, surgical patients hospitalized in centers with higher patient-to-nurse ratios demonstrated a higher risk-adjusted 30-day mortality.

In the modern era of healthcare reform, physician and hospital reimbursement are increasingly being linked to quality-based outcomes measures.[20] Although data examining the direct impact of physician burnout

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on health economics are limited, we suggest this as fertile ground for further investigation given the well-documented effects of burnout on physicians' clinical performance.[21]

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Practice Implications

Burnout is a growing problem among physicians practicing in the United States. Beyond the damaging personal effects associated with burnout, practice leadership should be aware of the emerging reports linking physician burnout with increases in medical errors, worsened patient outcomes, and patient dissatisfaction. Early recognition of burnout is important and should be considered in circumstances of altered practitioner behavior. Basic techniques that may help physicians avoid burnout include the following:

- Take time for yourself (e.g., exercise, time with family, vacation time, sleep).
- Set appropriate limits with work (e.g., establish work–life balance).
- Develop support systems (personal as well as professional).
- Start (or join) a wellness group.

However, for clinical leaders, there may be alternative ways to assist with physician burnout beyond individual interventions. That is, there may be system or organizational changes that could reduce the number, the severity, and the frequency of burnouts. Such approaches include team-based care, where physicians are engaged in the process of designing a system to deliver care. Likewise, more communication within the practice can lead to a better understanding of the stressors that could lead to burnout. This could also lead to practice-specific changes that are more effective at reducing the number and severity of burnouts.

Finally, the impact of physician burnout on healthcare delivery systems has been poorly described. The benefits of managing and reducing physician burnout could increase physician retention rates, reduce medical errors, increase patient satisfaction, and improve overall quality. As patient populations increase in both size and complexity, careful attention to the recognition and treatment of physician burnout appears to be a necessary focus for practice management teams. **PM**

References

[1] Shanafelt T, 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;172:1377-1385.

[2] Sifferlin A. Is your doctor burned out? Nearly half of U.S. physicians say they're exhausted. Time. August 21, 2012. http://healthland.time.com/2012/08/21/is-your-doctor-burned-out-nearly-half-of-u-s-physicians-say-theyre-exhausted. Accessed January 25, 2013.

[3] Maslach C, Leiter M. The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It. San Francisco: Jossey-Bass Inc.; 1997.

[4] Maslach C. Burnout: The Cost of Caring. Saddle River, NJ: Prentice-Hall; 1982.

[5] Shanafelt T, Sloan J, Habermann T. The well-being of physicians. Am J Med. 2003;114:513-519.

[6] Shanafelt T, West C, Sloan J, et al. Career fit and burnout among academic faculty. Arch Intern Med. 2009;169:990-995.

[7] Embriaco N, Azoulay E, Barrau K, et al. High level of burnout in intensivists: prevalence and associated factors. Am J Respir Crit Care Med. 2007;175:686-692.

[8] Shanafelt T, Hasan O, Dyrbye L et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc. 2015; 90:1600-13.

[9] Arnetz B. Psychosocial challenges facing physicians of today. Soc Sci Med. 2001;52:203-213.

[10] Dunn P, Arnetz B, Christensen J, Homer L. Meeting the imperative to improve physician well-being: an assessment of an innovative program. J Gen Intern Med. 2007;22:1544-1552.

[11] Sood A, Prasad K, Schroeder D, Varkey P. Stress management and resilience training among department of medicine faculty: a pilot randomized clinical trial. J Gen Intern Med. 2001;26:858-861.

[12] Weiner E, Swain G, Wolf B, Gottlieb M. A qualitative study of physicians' own wellness promotion practices. West J Med. 2001;174:19-23.

[13] Lyndon A. Burnout among health professionals and its effect on patient safety. PSNet. February 2016. https://psnet.ahrq.gov/perspectives/perspective/190/burnout-among-health-professionals-and-its-effect-on-patient-safety. Accessed January 11, 2017.

[14] Krasner M, Epstein R, Beckman H, et al. Association of an educational program in mindful communication with burnout, empathy and attitudes among primary care physicians. JAMA. 2009;302:1284-1293.

[15] Maza Y, Shechter E, Eizenberg N, et al. Physician empowerment programme: A unique workshop for physician-managers of community clinics. BMC Medical Education. 2016;16:269.

[16] West CP, Dyrbye LN, Erwin PJ, et al. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet. 2016;388:2272-2281.

[17] Dewa CS, Loong D, Bonato S, Thanh NX, Jacobs P. How does burnout affect physician productivity? A systematic literature review. BMC Health Serv Res. 2014;14:325-35.

[18] Shanafelt T, Balch C, Bechamps G, et al. Burnout and medical errors among American surgeons. Ann Surg. 2010;251:995-1000.

[19] Aiken LH, Clarke SP, Sloane DM, et al. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. JAMA. 2002;288:1987-1993.

[20] Center for Medicare and Medicaid Services. Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. CMS.gov. January 26, 2015. www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html. Accessed January 17, 2017.

[21] Wilters JH. Stress, burnout and physician productivity. Med Group Manage J. 1998;45(3):36-37.

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