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Two Sides of the Physician Coin: Burnout and Well-being

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Editor's Note: *The problem of physician burnout has been illuminated by a number of recent studies, including Medscape's 2015 Physician Lifestyle Report, which surveyed approximately 20,000 physicians and asked about severity of burnout, factors contributing to burnout, and its association with a range of other issues, including happiness outside of work, alcohol and marijuana use, and financial status. Burnout is not a new problem, but an emphasis on burnout prevention and physician wellness is a relatively new response. What are the strategies that are protective against burnout? Medscape spoke with Tait D. Shanafelt, MD, a nationally recognized researcher on this topic and program director of the Physician Well-Being program at Mayo Clinic, about prevention, recognition, and interventions for physicians exhibiting signs of burnout.*

Is Burnout Really on the Rise?

Medscape: In our recent survey, we found a 16% increase in the incidence of self-reported burnout in just 2 years. Just under half of the approximately 20,000 physicians who completed our survey indicated that they were experiencing some degree of burnout. That rose to over half of physicians in primary care, emergency medicine, and critical care. How do these results compare with your own research?

Dr Shanafelt: The trend that you are reporting is consistent with what we are seeing in national studies. When assessed using validated, full-length, gold-standard tools, the rates of burnout in primary care, family medicine, and emergency medicine were well above 50% when we reported the national data in 2011.[1] Those rates all increased in the 2014 reassessment that we will soon be reporting.

Extensive evidence published over the past decade illustrates that burnout not only is a problem for the individual physician and his or her family, but also has profound effects on quality of care.[2,3] When you consider the rates of burnout that you observed and that we are seeing nationally, I think it indicates that burnout among physicians and nurses is one of the most prevalent and insidious problems undermining the quality of the US healthcare delivery system.

Medscape: A recent series of articles we posted about physician suicide garnered hundreds of comments from the tens of thousands of physicians who read it, many noting that they had experienced the suicide of a friend or colleague. Many pointed the finger at factors inherent in physician training, including high levels of competitiveness and punishing work schedules, factors that you also identified in a recently published study of matriculating medical students.[4] A minority, less sympathetic, argued that physicians who succumbed to these pressures probably shouldn't have been in medical school to begin with. Are there medical students who are inherently at higher risk for burnout?

Dr Shanafelt: That is a question that I am asked frequently. I think it is misguided to imply that when there is a suicide or a physician leaves the profession, "they were just never cut out for this in the first place."

We know that those who are at greatest risk for burnout are those who are the most dedicated and committed to their work. Those are the professionals that are at greatest risk to be consumed by their job and have difficulty drawing healthy boundaries or recognizing work overload.

Physician suicide is a substantial and underappreciated problem in both physicians in general and the general public. Physicians' risk for death by suicide is markedly higher than for age- and sex-matched professionals in other fields. In one national study of approximately 8000 surgeons, we found that over 6% of US surgeons had thought of killing themselves in the past 12 months.[5] On a practical level, that means that 1 of every 16 of my colleagues that I interact with from day to day has thought of killing themselves in the past year.

In that study of US surgeons, we found that burnout, as well as medical errors, were independent predictors of suicidal ideation after adjusting for depression. The issue of physician suicide is not limited to an "inherently weak" subset of physicians. In fact, most physicians would consider our colleagues who have chosen to pursue surgical disciplines as having signed up for a particularly demanding area of the profession relative to what have been coined "lifestyle specialties" with more contained work hours. No physician is immune to the risk for burnout and its potential repercussions.

Medscape: What is the role of screening tools[6] to identify physicians in distress or be used to identify applicants to medical school at higher risk for burnout? Are these tools for use throughout a physician's professional career?

Dr Shanafelt: I do believe that self-assessment tools for physicians that can provide individualized feedback, as well as comparison to national benchmarks for context, can be helpful. Our research team at Mayo Clinic has spent the last 7 years developing and validating precisely such instruments in national samples of physicians.[6,7] The ability of physicians to perform self-calibration in a confidential or anonymous manner, with links to resources at the time they are needed, would be a useful approach.

The hope is that such tools will allow physicians to monitor themselves at regular intervals throughout the course of their careers.

The concept of applying a screening tool among applicants to medical school to "weed out" those at high risk for burnout is fraught with problems. First, we have found that matriculating medical students have lower degrees of burnout and better mental health–related quality of life than college graduates going into other professions.[4] Once medical school begins, however, their mental health in these dimensions deteriorates and falls below that of their peers in other fields. The available research suggests that medical students with narcissistic personality traits are at lower risk for burnout. Similarly, individuals with those qualities—those who are more callous and less empathetic—may be at lower risk for burnout. Neither of these traits are the qualities we are trying to enrich in the medical profession. When we have an issue that is affecting approximately 50% of US physicians and which may disproportionally affect the most dedicated and committed physicians, it suggests that we need to look at the process of training and the practice environment. The notion of trying to "filter out those at risk" is a fundamentally flawed concept.

Is Organizational Change Part of the Solution?

Medscape: While medical school and residency have been found to be peak periods of distress, your research has illustrated that the increased incidence of burnout, depression, and suicide persists into early career years.[8]

Dr Shanafelt: Burnout—and at the other end of the spectrum, physician well-being—are multifaceted and complex constructs. The five drivers of burnout and well-being in physicians center around workload, work efficiency, work-life integration, autonomy/flexibility/control, and meaning in the work. It is important to note that there are both individual and organizational factors that contribute to each of these drivers.

Strategies focused on the individual, while important, are going to get us only so far in addressing this problem. Unfortunately, the environmental and institutional factors have been largely neglected which is likely why we see the rates of burnout increasing over the past 5 years. The physicians in these studies are largely the same individuals. They haven't changed so much over the past several years as has the practice environment, the workload expectations, and the efficiency of the environment.

Medscape: What are some of the strategies you have instituted at Mayo that can help to mitigate burnout and depression for these early-career physicians?

Dr Shanafelt: At Mayo Clinic, we have tried to take a very comprehensive approach to this problem, framed around

the belief that addressing this issue is the shared responsibility of both the individual physician and the organization. At the organizational level, while there are a few general principles that can be broadly beneficial (eg, improving efficiency, giving individuals flexibility/control over work to the extent possible), many of the challenges and solutions are unique to each department or work unit. What a radiologist specifically needs to improve the work environment is very different from what would be helpful to a family physician or a general surgeon. At the organizational level, it is important not to oversimplify the problem by trying to come up with a "one size fits all" panacea for all departments. That approach often misses the critical changes necessary to improve the practice environment in a given department. This fact underscores the importance of local leadership to address this issue.

On an individual level, our research team has spent a lot of time studying how physicians can identify and cultivate meaning in their work life.[9,10] We have also evaluated the benefits of regular structured meetings with a group of colleagues to discuss the challenges and virtues of physicianhood. In randomized controlled trials,[11] we have found that these groups can help restore physicians' sense of meaning and passion for their work as well as reduce burnout. Other investigators at Mayo Clinic have been pioneers in evaluating the benefits of mindfulness-based stress reduction training for physicians and other healthcare workers, which can be a helpful approach for many. Ultimately, I think it will be important for us to create a menu of effective approaches for individual physicians to cultivate well-being, because one size will not fit all.

Organizations must also embrace the larger challenge of redesigning the practice environment. While many organizations have engaged in practice redesign with a focus on enhancing productivity, few have engaged in redesign with the goal of creating a sustainable and fulfilling work environment for their physicians, nurses, and other allied health personnel. These goals do not have to be mutually exclusive. Creating an environment where physicians and nurses are empowered to provide high-quality and efficient patient care, and also to derive professional satisfaction, is important for the long-term health of the healthcare organizations and the patients they care for.

Medscape: What about physicians not affiliated with larger medical centers—those clinicians in solo or small practices—without resources like the physician well-being program that you head? Are practitioners in these environments at the same risk for burnout? And what are the strategies for prevention that can be implemented in these settings?

Dr Shanafelt: Physicians in solo or small group practice are at risk for burnout, and in many ways they have to be even more proactive to manage this risk. It begins by recognizing that burnout is a threat to their professional health and prioritizing self-care, cultivating sustainable work habits, and building in time for renewal in their work. If they recognize that this is important and make it a priority, there are resources to help them succeed. There are a number of conferences that are focused on the theme of self-care, renewal, addressing burnout, and promoting resilience. Our research team at Mayo Clinic is also trying to build Web-based tools and resources accessible to physicians in their local environment or online.

Physician, Heal Thyself: What About Individual Strategies?

Medscape: One study in Spain concluded that physicians were more likely to seek help in programs designed specifically for physicians and perceived to be nonpunitive.[12] In your experience, is self-referral more common than referral by colleagues?

Dr Shanafelt: The simple answer is that physicians do not always accurately calibrate their level of distress. In one study[7] we conducted in collaboration with the American College of Surgeons, we began by asking physicians to rate their well-being relative to physicians nationally. On the next screen, physicians completed a validated well-being assessment with national benchmarks after which they received immediate feedback.

Prior to the objective assessment, everybody thought their well-being was at or above average—even those objectively benchmarked to be at the bottom end of the well-being continuum relative to national samples of physicians.

It is easy for physicians to assume that "these are challenging times; all my colleagues are stressed out too." That narrative can be a barrier to recognizing when your level of burnout or distress is starting to become an outlier, relative to the general physician population. It is often not until a physician hits rock bottom that they seek help. Sometimes they are facing personal life issues and broken relationships, or they recognize that they have lost the joy in their work and are thinking about leaving practice or pursuing early retirement. Regardless, self-referral is often a late event.

Unfortunately, most of the resources and referral strategies currently available focus on "physicians at the extreme," who are dealing with anger management issues or substance abuse or dependence. They are thus relevant to only the 1% or 2% of physicians dealing with those issues rather than the nearly 50% of US physicians dealing with at least some degree of burnout or other dimensions of distress.

Medscape: What are your suggestions for physicians, family, and friends who are witnessing burnout in a colleague or family member? At what point do you recommend referring a colleague or family member to a counseling or mental health program?

Dr Shanafelt: I wish I had a simple answer. Although there are a number of efforts in this area, most of them are in relatively preliminary stages. It is fairly common for physicians early in their career to get swept up in their practice and wake up 10 years later to realize they don't like what they are doing anymore. Family members and colleagues sometimes see this before the individual physician recognizes or acknowledges it. It is important for individual physicians facing burnout to take a step back and truly assess what their priorities and values are, both professionally and personally. They then need to consider whether they are structuring their life and practice in a way that is congruent with those personal and professional values, and what life and practice would look like if it better aligned with what they care about. Often, small adjustments, either addressing how much they work or increasing or decreasing a specific aspect of work, can bring back the joy they derive from practice.

Mindfulness-based stress reduction programs have also been developed around the country and are a well-established approach for physicians to acquire skills that can help them better navigate the stress of practice. These approaches are probably best employed for prevention, however; professional help or counseling is typically needed for physicians experiencing severe burnout.

It is certainly preferable to be proactive and cultivate resilience before burnout occurs. Where we would like to see things go, where we have been trying to go, is to incorporate self-renewal activities,[9,13] foster community at work,[11] and help individuals shape their practice to enhance meaning[10,14] as continual activities that every physician is engaged in at all times throughout their career. We need progress along that line if we are going to make true inroads into this problem that affects half of US physicians.

Medscape: Are there other key messages that you would like to share with our readers?

Dr Shanafelt: There is a tremendous need for additional research in this area. Many healthcare organizations recognize the problem and its potential repercussions for quality of care, recruitment and retention, and patient satisfaction. They struggle, however, with how best to respond in a time of limited resources. They need evidence regarding the cost and efficacy of interventions to reduce burnout and promote well-being in their physicians, nurses, and allied health staff so that they can be confident that the resources they invest will make a difference and not be wasted.

Until we develop that evidence, we are going to be left with a lot of workshops for individual physicians that tell them to "fix themselves" by sleeping and exercising more, taking more vacations, and "reducing their stress." That approach is just not going to make a serious or substantive impact on such a pervasive problem that has many of its roots in the practice environment. A continuing focus on conducting research that provides evidence of how we can address this issue at the organization and system level is where we need to go.

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Cite this article: Two Sides of the Physician Coin: Burnout and Well-being. *Medscape*. Feb 09, 2015.