
Physician Burnout: Prevention and Treatment

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Editor's Note: This is part three in our four-part series on physician burnout. Part I was published in the [January 2018](#) edition of The SVMIC Sentinel and part II was published in the [April 2018](#) edition. Part four in our series will be published in our October edition.

On June 9 of this year, the *Wall Street Journal* published an article titled “Hospitals Address Widespread Doctor Burnout.” It was not alone – Physician Burnout Syndrome has been featured above the fold in many major national newspapers since we began this article series in the *Sentinel* in late 2017. The national attention is appropriate.

Escalating physician suicide rates have also received widespread attention. Symon Productions, an independent movie company, released the documentary *Do No Harm* in March 2018. The movie is about the impact completed suicides of medical students and residents have, not only on their families but on their patients as well. It exposes our “sick healthcare system that not only drives our brilliant young doctors to take their own lives but puts patients’ lives at risk, too.” Physician health has not only become a national topic of discussion, but is also a national concern because sick and burned-out physicians make mistakes that can harm patients, whereas healthy doctors provide better healthcare. That is not just a bumper sticker slogan; there is ample evidence to validate that statement.

In Part I of this series we were introduced to Dr. W. who completed suicide, leaving a trail of burnout symptoms and a wake of sorrow. We saw what burnout is and how it negatively impacts physicians and their patients. In Part II we took a closer look at the drivers and factors of burnout. In this segment, Part III, we will explore another case presentation and talk about prevention and treatment options for Physician Burnout Syndrome at the clinician level.

The Case of Dr. H

Dr. H. is a mid-career internist. She is one of a four-physician Internal Medicine group in a large West Tennessee town. She was raised close to the town where she now lives and has no desire or plans to leave. Her parents still live nearby and are completely independent. Dr. H.’s husband gave up his career as a journalist to become the manager of her practice, as their last three office managers were incompetent and disorganized. Her husband has a history of trying to rescue Dr. H. when she is “stressed,” which only adds to her stress. Dr. H. has three high-school-aged children. She hasn’t been to her

children's ball games, recitals, or school events except an occasional weekend birthday party. The family joke is that she almost missed her children's births.

Dr. H. leaves for her office around 6:30 am, explaining that she can "get a lot done before the doors open." From 6:30am to 8:00am she goes over patient emails and messages; she is not reimbursed for this but views it as an important aspect of clinical care because it "helps patients." Office hours are from 8:00am to 5:00pm with one hour for lunch – a built-in buffer to keep her from being too late in the afternoon. However, she never uses the hour for lunch because patient visits encroach on that time. Similarly, her day rarely ends at 5:00pm – the last patient usually doesn't leave the office until around 7:00pm. Dr. H. then goes home exhausted. Her husband and children have usually finished dinner by the time she gets home. Her pajama time is spent charting, as she seldom has time to close out charts during the day. Dr. H.'s group utilizes a very efficient Electronic Health Record (EHR), which allows her to chart from any location. However, to avoid simply copying/pasting and having each visit report look like the last, she spends many hours each night capturing and recording the subjective flavor of the day's office visits in each note.

Dr. H's story is exhausting. She could not find a way off the devastating treadmill that she enthusiastically got on in residency. Like many physicians, Dr. H. needed help to make changes to the hopeless agony that became her life. Disguised as a virus, that help eventually came. Despite receiving a flu vaccine, she became ill with type B influenza. It took a high fever, chills, rigors, and cognitive clouding for Dr. H. to take time off. Her own primary care doctor, an office partner, sent her home.

Caused by a high fever, viral load, or just plain lucidity, on the fourth day of sick leave Dr. H. had a moment of clarity. She told her husband that evening that she had to make changes that may include changing careers – otherwise, she feared she would soon be dead. Her husband gave her the number of the Tennessee Medical Foundation Physician's Health Program (TMF-PHP). She called the next day.

Dr. H. had classic symptoms of Physician Burnout Syndrome. Her practice was no longer meaningful or fulfilling. She was emotionally exhausted and received no sense of personal accomplishment from work. She treated her patients as objects and was disengaged. She also felt like a stranger to her husband and children. On closer examination, she had developed intermittent bouts of depression and thoughts that her family would be better off if she were dead.

After a few weeks to recover and implementing strict work boundaries regarding time and clinical load, mandatory vacation, and continued therapy to address perfectionism, Dr. H. is a much happier and better physician. Her husband addressed his codependence and rescue fantasy as well. These changes were very painful and difficult but considered worth the effort by all involved.

Drivers of PBS

Although physicians are a very visible component of healthcare, they are not the primary drivers of Physician Burnout Syndrome (PBS). The organizational components of medicine that have control over and limit the autonomy of the individual physician practice are the major drivers of PBS. Those drivers include the federal and state governments, hospitals and institutions, and the C-suite executives of physician practices. Reducing PBS is the responsibility of physicians working together with those organizational components.

Drs. Shanafelt and Noseworthy go into detail discussing the “Nine Organizational Strategies to Promote Engagement and Reduce Burnout” in their 2016 article.¹ We will explore the strategies that are more physician-based, including “Promoting Flexibility and Work-Life Integration, Resilience and Self Care,” and look at Mindfulness-Based Stress Reduction in more detail as a treatment for PBS.

Flexibility

Almost half of all physicians work more than 60 hours per week, neglecting their own personal and family needs. It’s estimated that almost half of that time is devoted to non-clinical activity. Work-Life Integration provides opportunities for meeting family and personal needs. Creating flexibility in physician scheduling is one option that provides the physician with an element of control. Scheduling work days that begin or end earlier or later allows time to meet personal or family responsibilities. This can easily be accommodated in an equitable manner without a decrease in total work hours. Other industries have been utilizing flexible hours with good results and without the scheduling chaos that office managers often predict. Flexible hours may seem unworkable in the single physician office; however, flexible hours can be utilized by planning and blocking needed time off for family or personal obligations. A multiple physician or provider office allows for increased flexibility in scheduling. The physician and scheduler need to work together to accomplish this task.

Another viable option is to allow physicians to schedule reduced hours with a commensurate reduction in reimbursement. This can be especially appealing to double income families so at least one parent is available for after-school functions or activities. Missing a child’s game, graduation, or school play can be anything from a faux pas to an unforgivable act, whereas attending a child’s event will provide great satisfaction to both parent and child. Flexible scheduling and compensation can be used to promote a healthy balance of family, work, and personal time. The concept of Work-Life Integration promotes a healthier physician, and a healthier physician provides better care.

Physician Resilience

“Timeo Danaos et dona ferentes,” or “I fear the *Greeks*, even those *bearing gifts*.”

Improving physician resilience has been touted as a tool to treat PBS. Dr. D. Drummond makes an eloquent analogy to the contrary that physicians are the canary in the coal mine

of medicine, and states that the epidemic of PBS is an indictment of the conditions of the coal mine, not the resilience of the canary.² Thus, he argues, making a stronger more resilient canary is not the answer. Dr. Drummond defines resilience training as “the acquisition of any burnout prevention tool the physician puts to their own individual use. The tool increases the physician’s resilience in the face of the stresses of their practice and workplace systems.”²

When resilience training is instituted by a hospital or other healthcare organization it is met with caution and skepticism. Resilience training elicits a similar visceral response as “I’m from the government and I’m here to help.” It is generally viewed as one more thing to do, increasing the stress load on an already stressed physician population.

Resilience training can also imply to the physician that they are the problem, as with the metaphor of a sick canary vs. a sick environment or culture. Sometimes resilience training is interpreted as a sinister attempt by the organization to get more output from the physician.

For these reasons, it is important that when resilience training is offered, it is presented as a small part of a much larger strategy; the healthcare organization needs to show it is addressing PBS as a systems problem, not a physician problem.

Mindfulness-Based Stress Reduction

Mindfulness-Based Stress Reduction (MBSR) is an effective tool to decrease stress and prevent PBS. Again, the argument can be made that promoting an individually-obtained remedy gives a message that it is the physician who is broken and not the system. By now, we can all agree it is a systems problem. MBSR is a healthy way to deal with the system, to prevent PBS.

Developed in the late 1970’s at the University of Massachusetts Medical Center, MBSR is a mixture of science, medicine, and psychology with Dharma, or Buddhist, meditative traditions, teachings, and practices. It is used to help treat numerous conditions including anxiety disorders, mood disorders, substance abuse disorders, eating disorders, chronic pain conditions, insomnia, ADHD, and burnout syndrome.

MBSR promotes mind and body awareness to reduce the physiological effects of stress, pain, or illness. It emphasizes non-judgmental awareness in daily life while promoting serenity and clarity in each moment so one can experience a more joyful life and access inner resources for healing and stress management. There are education centers dedicated to mindfulness that have proliferated around Tennessee and the country that are open to the public.

MBSR is a powerful tool in the toolbox that physicians can utilize on a daily basis to promote wellbeing and joy in life, even if one has not been or is not yet impacted by PBS.

Summary

Physician Burnout Syndrome is characterized by exhaustion, cynicism, and loss of accomplishment. PBS is an organization and systems issue that is shown to influence quality of care, patient safety, and physician turnover, and can lead to depression and even suicide. An engaged physician workforce is critical for healthcare organizations to provide quality care and achieve fiscal goals.

Most organizations operate under the belief that it is the responsibility of individual physicians to heal themselves. While there are some meaningful actions a physician can take to prevent and treat PBS, most factors driving burnout are beyond the physician level, and some are even more systemic than the organizational level. However, organizational level efforts can greatly influence physician well-being. We all have heard about the proverbial “ounce of prevention.” That sage advice not only applies to clinical care, it is very applicable to physician health and the epidemic of PBS. The ounce of prevention in this case includes organization and systems changes, as well as strategies that involve the individual physician.

1. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. *Mayo Clin Proc.* 2017 Jan;92(1):129-146.
2. Eight Ways to Manage Practice Stress and Get Home Sooner. *Fam Pract Manag.* 2015 Nov-Dec;22(6):13-18.

See the Tennessee Medical Foundation's website [here](#).

The Federation of State Physician Health Programs provides a comprehensive listing of state programs [here](#).

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