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Physician Burnout - A Threat to Quality and Integrity

2013 - 2 April - Managing Sepsis in the ICU
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The article highlights the growing concern over physician burnout and provides strategies for identifying the problem and improving performance and attitude.

Have you seen this headline from *Bloomberg Businessweek*: “The Many Dangers Posed by Burned-Out Doctors”? Maybe you saw this one in the *Wall Street Journal*: “Faulty Defibrillators and Doctor Burnout.” Or perhaps you read the *Time* article, “Is Your Doctor Burned Out?”, which reported that nearly half of U.S. physicians say they are exhausted.(1) Each item was a response to the commentary published in the *Archives of Internal Medicine* by Shanafelt et al from the Mayo Clinic. Shanafelt and colleagues surveyed 27,000 physicians and received 7,200 responses. They found that 45.8% of respondents had at least one symptom of burnout. In addition, physicians were more likely (than the general population) to have symptoms of burnout (37.9% vs. 27.8%) and to be dissatisfied with work-life balance (40.2% vs. 23.2%) ($P < .001$ for both).(2)

These numbers do not surprise most practicing physicians and are certainly familiar to those in critical care. Embriaco and colleagues found that almost 50% of critical care physicians had high levels of burnout symptoms.(3) Two survey studies demonstrated that burnout is common.(4,5) The work of Shanafelt et al is one more contribution to a large and growing body of literature that demonstrates an impending crisis. Without our attention, this crisis could compromise our patients, our families and our professional future.

What Is Burnout?

Freudenburger, a clinical psychologist, first proposed the modern concept of burnout in 1974.(6) This concept was clarified further by Maslach in her seminal work, published in 1982,(7) in which she describes burnout as emotional exhaustion, feelings of being emotionally overextended and exhausted by one’s work, depersonalization, an unfeeling and impersonal response toward recipients of one’s service, care treatment or instruction, and a reduced sense of personal accomplishment.(7)

What Does Burnout Look Like in the Intensivist?

Is burnout as obvious as an “Incredible Hulk” transformation, with yelling, screaming and throwing objects within the intensive care unit? While it can present this dramatically in some cases, most often burnout expresses itself in a far less obvious manner. Burned-out physicians may be angry, irritable or impatient.(8)

They may seem to treat patients as objects or to be simply emotionally depleted.(9) They may seem unable to leave work or may be persistently absent.(8) Burnout differs from depression; burnout is less pervasive, and its symptoms decrease when the practitioner takes time away from work.

Burnout affects many aspects of life. It affects both patients and the institutions where they seek care. It affects families and personal health. In general, physicians experience higher divorce rates and increased rates of depression and suicide compared to the general population.(10-14) They experience worse outcomes from heart disease and a higher prevalence of substance abuse, needlesticks and car crashes.(15-20)

Burnout compromises patient care as it is associated with medical errors. Along with riskier prescribing profiles, the physicians who have increases in depersonalization, emotional exhaustion, and mental scores on a burnout inventory have a 5% to 11% higher likelihood of reporting a recent major medical error.(21-24) Patients cared for by burned-out physicians are less compliant, less satisfied with their care, and even experience an increased time to full recovery.(25-28) Additionally, burnout has institutional costs, requiring \$150,000 to \$300,000 to replace a single physician who is lost to this condition.(29) In the new healthcare reimbursement climate, decreased patient satisfaction equates to lower reimbursement. Additionally, less quantifiable costs occur when the loss of a colleague disrupts care teams and work communities.

Who Is at Risk for Burnout?

Those who practice on the front line have a higher risk for burnout.2 Contrary to the belief that burnout occurs toward the end of a career, physicians younger than 55 years have an increased risk.(30,31) Family structure can contribute to the risk as well; a working domestic partner and children younger than 21 years increase risk.(30) A lack of career fit, defined by Shanafelt et al as spending <20% of work time performing tasks most meaningful to the individual, also contributes to risk.(32) Likewise, total work hours have a role, although agreement on the magnitude of this contribution is not universal.(30)

Why Does Burnout Occur?

Stress, which is caused by a perception of threat, fear, uncertainty, and cognitive dissonance, causes burnout when it is excessive in magnitude or prolonged in duration. Clinicians experience this stress for personal, professional, and organizational reasons. For the most part, critical care physicians are type A personalities, obsessive and compulsive. While this may be functional or even helpful in patient care, it can be harmful to the individual. Physicians often have dysfunctional coping skills for dealing with stress. Learned in residency and persisting into careers in clinical practice, these dysfunctional tools include delayed gratification, sequestering stress, a keep-it-to-yourself mentality, a focus on what to do next and self-sacrifice.(21,33,34)

Critical care physicians work long hours, are deprived of sleep, and shoulder large workloads in jobs that are emotionally demanding. It is routine to manage complex patient interactions, guide patients and families through difficult decisions, and deal with death and dying on a daily basis. It is a rare conversation of two or more physicians that does not include themes such as the stress of litigation risk, loss of professional autonomy, decreasing reimbursement for services and increasing documentation to meet regulatory requirements.

What Can Be Done?

Awareness is the first step. Once the problem is acknowledged, one can determine where and in whom it is occurring. Screening tools effectively identify burnout. The Maslach Burnout Inventory, a 22-item questionnaire, is the most commonly used tool. The General Health Questionnaire and Self-Assessment Exercise tools are other validated measures. Once burnout is identified, the focus can shift to acute or preventative intervention.

Acute interventions are directed to those practitioners who have become compromised or disruptive to themselves, their patients or their organizations. Some organizations or practices refer their practitioners to an external agency for assistance in the management of cases of burnout. These agencies include the Professional Renewal Center, located in Kansas, and Inner Solutions for Success, based out of California. Alternatively, some organizations have their own internal programs to address the needs of their practitioners; these include the Physician Assessment and Clinical Education (PACE) Program at the

University of California at San Diego, the Faculty and Physician Wellness Program at Vanderbilt University, the Physician Well-Being Program at the Mayo Clinic in Minnesota, and the Wellness Institute at the Cleveland Clinic. Early intervention or prevention of burnout is a proactive way to address this pervasive problem.

To quote Shanafelt, “Well-being goes beyond the absence of burnout or depression and includes being challenged, thriving and achieving quality of life in mental, physical, emotional, social and spiritual domains.”(35)

Approaches to satisfaction, well-being and the prevention of burnout can be loosely categorized into personal, professional and organizational strategies. A personal or individual-centered approach helps address, develop or support personal health, values, relationships and skills for managing the stress inherent in the profession. The stress coping skills often assimilated in residency must be unlearned, deliberately substituting constructive mechanisms for work (time out, talking with colleagues, or using humor) or outside of work (exercise, quiet time, spending time with family and leaving work at the workplace).(34,36) The cultivation of spiritual or religious practice helps to develop a sense of meaning in a larger life context.(37) This is not as difficult as it may sound. The University of Rochester demonstrated that a 12-month continuing medical education course teaching mindfulness, meditation and self-awareness produced a statistically significant improvement in burnout and mood disturbances in participating primary care physicians.(38) The Mayo Clinic offers the Stress Management and Resiliency Training (SMART) program, which promotes the development of a flexible disposition through focus on five areas: forgiveness, acceptance, compassion, gratitude and meaning/purpose in life. Its 40-physician pilot program demonstrated a statistically significant improvement in resiliency, perceived stress, anxiety, and overall quality of life at eight weeks.(39)

Furthermore, Shanafelt and colleagues have developed professional strategies that promote well-being and prevent burnout. They outline a process that assists in the identification of, and reflection on, personal and professional values and priorities. The process involves ranking personal and professional values and priorities in order of importance. Areas of incompatibility between personal and professional goals are identified and determinations are made for managing these conflicts.(33,40) The exercise encourages reflection on areas of work that are most meaningful with the goals of enhancing work that is personally rewarding and reshaping practices to increase focus in areas of personal growth. Mentorship and interactions with peers can greatly enhance this process.(41,42)

According to Maslach and Leiter, burnout is, at its core, an organizational problem.(43) Unfortunately, the medical profession has not developed sound organizational strategies to prevent burnout. Aside from the Joint Commission requirement that hospital staffs implement organizational processes to promote physician health and assist those suffering from burnout and impairment, there are no specific guidelines or recommendations for achieving this.(44) Based on the work of Maslach and Leiter, a framework for organizational solutions could focus strategies on the six areas of mismatch between the individual and the work at the core of the conflicts resulting in burnout: work overload, lack of control over work, lack of reward for work contributions, lack of community or positive connection with colleagues, lack of fairness, and conflict between personal principles and job requirements.(43) Some specific strategies suggested by the medical literature include: offering group meetings to elicit physician concerns, allowing scheduling templates customized to the individual practitioners, accommodating specific physician interests through work options and case-mix adjustment, optimizing perceived value to the organization, evaluation of interventions to increase physician efficiency, support interventions intended to decrease tension between personal and professional responsibilities, and the creation of relationship-building opportunities for physicians, spouses, and families.(35,42,45)

Physician burnout has been recognized by many professional organizations, including the Canadian Medical Association’s Centre for Physician Health and Well-Being, the American Medical Association’s Physician Guide to Personal Health, and the American College of Surgeons’ Governors’ Committee on Physician Competency and Health. J. Randall Curtis, MD, MPH, made the promotion of work-life balance and the prevention of burnout a main goal of his tenure as president of the American Thoracic Society. Still, a cohesive approach to burnout prevention in critical care has not been crafted.

Parting Thoughts

Physician burnout is pervasive across specialties and has the potential to compromise our lives, the care we deliver and the system within which we practice. Our obligation is to understand burnout and the stressors from which it stems. We must work on personal and professional levels to clarify career expectations and to develop coping, planning and development skills to shape our experiences to suit our individual priorities and values. As members of care organizations and the Society of Critical Care Medicine, we must prioritize the development and promotion of professional and organizational strategies to build an environment that supports practitioner well-being. As educators, we need to address well-being strategies and skills in medical education to help the next generation of care providers. We must take action to preserve the integrity of our profession and the quality of care we have worked so hard to achieve.

References

1. 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.
2. 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(18):1377-1385.
3. 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.
4. Guntupalli K, Fromm R. Burnout in the internist - intensivist. *Intensive Care Med*. 1996;22:625-630.
5. Fields A, Cuerdon T, Brasseaux C, et al. Physician burnout in pediatric critical care medicine. *Crit Care Med*. 1995;23(8):1425-1429.
6. Freudenburger H. Staff burnout. *J Soc Issues*. 1974;30(1):159-165.
7. Maslach C. *Burnout: The Cost of Caring*. Saddle River, NJ: Prentice Hall; 1982.
8. Wilters JH. Stress, burnout and physician productivity. *Med Group Manage J*. 1998;45(3):36-37.
9. Shanafelt T, Balch C. Combating stress and burnout in surgical practice: a review. *Adv Surg*. 2010;44:29-47.
10. Firth-Cozens J. Emotional distress in junior house officers. *Br Med J*. 1987;295:533-536.
11. Firth-Cozens J. Interventions to improve physicians' well-being and patient care. *Soc Sci Med*. 2001;52:215-222.
12. Myers W. The well-being of physician relationships. *West J Med*. 2000;174:30-33.
13. Center C, Davis M, Detre T. Confronting depression and suicide in physicians: a consensus statement. *JAMA*. 2003;289:3161-3166.
14. Rollman B, Mead L, Wang N, Klag M. Medical specialty and the incidence of divorce. *N Engl J Med*. 1997;336:800-803.
15. Williams E, Konrad T, Schleckler W. Understanding physicians' intentions to withdraw from practice: the role of job satisfaction, job stress mental and physician health. *Health Care Manage Rev*. 2001;26:7-19.
16. O'Connor P, Spickard A. Physician impairment by substance abuse. *Med Clin North Am*. 1997;81:1037-1052.
17. Arnetz B. Psychosocial challenges facing physicians of today. *Soc Sci Med*. 2001;52:203-213.
18. Ayas N, Barger L, Cade B. Extended work duration and the risk of self-reported percutaneous injuries in interns. *JAMA*. 2006;296:1055-1062.
19. Barger L, Cade B, Ayas N. Extended work shifts and the risk of motor vehicle crashes among interns. *JAMA*. 2005;352:125-134.
20. Baldiserri M. Impaired healthcare professional. *Crit Care Med*. 2007;35:S106-S116.
21. Shanafelt T, Bradley K, Wipf J, Back A. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med*. 2002;136:358-367.
22. Williams E, Manwell L, Konard T, Linzer M. The relationship of organizational culture, stress, satisfaction, and burnout with physician reported error and suboptimal care: results from the MEMO study. *Health Care Manage Rev*. 2007;32:203-212.
23. Melville A. Job satisfaction in general practice: implications for prescribing. *Soc Sci Med*. 1980;14A:495-499.
24. Shanafelt T, Balch C, Bechamps G, et al. Burnout and medical errors among American surgeons. *Ann Surg*. 2010;251:995-1000.
25. DiMatteo M, Sherbourne C, Hays R, et al. Physicians' characteristics influence patients' adherence to

- medical treatment: results from the Medical Outcomes Study. *Health Psychol.* 1993;12:93-102.
26. Firth-Cozens J, Greenhalgh J. Doctors' perceptions of the links between stress and lowered clinical care. *Soc Sci Med.* 1997;44:1017-1022.
 27. Linn L, Brook R, Clark V, Davies A, Fink A, Kosecoff J. Physician and patient satisfaction as factors related to the organization of internal medicine group practices. *Med Care.* 1985;23:1171-1178.
 28. Haas J, Cook E, Puopolo A, Burstin H, Cleary P, Brennan T. Is the professional satisfaction of general internist associated with patient satisfaction? *J Gen Intern Med.* 2000;15:122-128.
 29. Shi L. *Managing Human Resources in Healthcare Organizations.* Sudbury, MA: Jones and Bartlett; 2006.
 30. Shanafelt T, Balch C, Bechamps G, et al. Burnout and career satisfaction among american surgeons. *Ann Surg.* 2009;250(3):463-471.
 31. Campbell DA, Sonnad SS, Eckhauser FE, Campbell KK, Greenfield LJ. Burnout among American surgeons. *Surgery.* 2001; 130(4):696-702.
 32. Shanafelt T, West C, Sloan J, et al. Career fit and burnout among academic faculty. *Arch Intern Med.* 2009;169(10):990-995.
 33. Shanafelt T. A career in surgical oncology: finding meaning, balance, and personal satisfaction. *Ann Surg Oncol.* 2008; 15(2):400-406.
 34. Lemire J, Wallace J. Not all coping strategies are created equal: a mixed methods study exploring physicians' self reported coping strategies. *BMC Health Serv Res.* 2010;10:208.
 35. Shanafelt T, Sloan J, Habermann T. The well-being of physicians. *Am J Med.* 2003;114:513-519.
 36. Shanafelt T, Novotny P, Johnson M, et al. The well-being and personal wellness promotion strategies of medical oncologists in the North Central Cancer Treatment Group. *Oncology.* 2005;68:23-32.
 37. Weiner E, Swain G, Wolf B, Gottlieb M. A qualitative study of physicians' own wellness promotion practices. *West J Med.* 2001;174:19-23.
 38. 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(12):1284-1293.
 39. 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(8):858-861.
 40. Shanafelt T, Chung H, White H, Lyckholm L. Shaping your career to maximize personal satisfaction in the practice of oncology. *J Clin Oncol.* 2006;24:4020-4026.
 41. Kuerer H, Breslin T, Shanafelt T, Baile W, Crawford W, Balch C. A road map for maintaining career satisfaction and balance in surgical oncology. *J Am Coll Surg.* 2008;207(3):435-442.
 42. Cohn K, Bethancort B, Simington M. The lifelong iterative process of physician retention. *J Healthc Manag.* 2009;54(4):220-226.
 43. Maslach C, Leiter M. *The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It.* 1st ed. San Francisco, CA: Jossey-Bass Inc.; 1997.
 44. Joint Commission on the Accreditation of Healthcare Organizations. medical staff revisions reflect current practices in the field. *Jt Comm Perspect.* 2000;20:9-13.
 45. 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(11):1544-1552.