Why all the angst?

To avoid burnout and ensure resiliency, we need to reframe our view of competition.

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Minnesota physician Tait Shanafelt, MD, authored a landmark paper that brought national attention to the issue of burnout in our profession in 2009.[1] Shanafelt, a Mayo Clinic internist, and his coauthors described the alarming number of the nation's surgeons struggling with burnout, harmful behavior, depression, poor quality of life and suicidal thoughts. The paper was based on a 2008 American College of Surgeons cross-sectional survey completed anonymously by 7,905 surgeons across the United States. The results were shocking: 40 percent of the respondents met diagnostic criteria for burnout, 30 percent screened positive for depression and 6.3 percent had considered suicide in the previous 12 months.

A more recent report showed a consistent national physician burnout rate of 46 percent, regardless of practice setting (whether the private sector, an academic medical center or a Veterans Affairs medical center).[2] Others have noted that burnout is not confined to specific specialties; however, physicians in some specialties appear to be at higher risk than others, and generalists appear to be at a higher risk than specialists.[3,4]

Burnout contributes to drug and alcohol abuse, broken relationships, disruptive behavior at work and frequent conflicts in, or withdrawal from, social interactions—all of which result in poorer quality of life.[2] As Mark Linzer, MD, and his colleagues from Hennepin County Medical Center in Minneapolis noted, the harmful impact of burnout extends well beyond individual physicians to family members, colleagues, co-workers and patients.[5] Importantly, Linzer et al. observed that burnout leads directly to disruptive behavior, an increase in medical errors, poorer outcomes for patients, and high rates of physician and staff turnover, all of which damage the financial performance and reputation of the organizations for which they work.

Causes of burnout

The underlying causes of burnout are multifactorial, complex and not completely understood. A common theme in the literature is that major changes in society in general and in the health care delivery system in particular have created a highly stressful environment for physicians that can readily trigger a cascade of burnout.

Societal changes that have contributed to burnout include the way the role of the physician is perceived. In the past, patients were generally comfortable having their physician make treatment decisions and rarely questioned those decisions. By contrast, patients and their loved ones now participate in decisions about their care. Safety and quality are expected outcomes of care.

Similarly, oversight by hospitals and regulatory agencies was once limited. If complications arose, the general assumption was that the physicians had done their best. But today, patients and their family members and advocates expect full transparency and accountability, especially if errors occur. And the public increasingly has access to performance metrics and comparative rankings of outcomes.

Our health care delivery system has also undergone fundamental changes that affect both physicians and patients. In the past, most physicians worked in solo or small-group practices that were independent from hospitals. Their compensation was derived largely from fees charged to patients for services. Today, more and more physicians are closely aligned with, or fully employed by, large hospitals, clinics or health care organizations.

Government and private payers increasingly link incentive payments for providers and facilities to improved performance defined by quality and cost. Private health insurers and other payers expect health systems to consistently deliver "value," a term defined as safety, quality, plus patient experience divided by total cost of care

over time. Thus, physicians find themselves being held accountable not only by their patients but also by their employers and payers.

To survive, many health care organizations feel the need to grow their market share, further consolidating to form even larger systems and pressuring their employees, including physicians, to compete aggressively with other systems. Physicians are aware that large-scale strategies, far from increasing value and efficiency or improving safety and quality, often spawn divisiveness—eroding value and creating unnecessary costs. For example, some systems restrict patients' choice of providers and closely control their access to services.[6]

Physicians have been admonished to keep patients in "their" system, even if their professional opinion is that the patient may be better served by an expert in another system. If these physicians choose to discreetly provide their patient with the name of a physician who works for a competing system, they hope no one reports them for facilitating "leakage" of that patient from their system. Such a culture causes physicians to question their professionalism and to wonder whether it is moral to continue to work in such an environment.

These changes within society and health care have intensified tension within the medical profession and contributed to burnout. For the most part, we do not know how to effectively tame these stressors, responding instead with denial or anger, or by blaming "the system."

A reframed view of competition

Fortunately, the growing awareness of burnout and its far-reaching sequelae is motivating the health care community to formulate strategies for preventing and alleviating the problem. Strategies include offering wellness programs, resiliency training, self-awareness workshops and leadership training aimed at helping the individual as well as implementing organizational efforts to improve workplace culture and operational efficiency and workflow.

Such strategies are well-intentioned and commendable—and they appear to be at least partially effective in alleviating the excessive stress arising from the many changes in our environment. But are they enough?

My hypothesis is that they are not. The burnout epidemic reflects our struggle to stay aligned with our profession's overarching commitment to do what's best for each patient while, at the same time, grappling with the need to think more globally about costs and populations, the altered expectations of the public, and the demands of our corporate and government leaders. Everyone of good will wants to build a sustainable, more equitable health care system for all, but physicians and their patients are at the crossroads of innumerable conflicting priorities.

I believe the current strategies by individuals and organizations to prevent or at least alleviate burnout may fail unless we simultaneously reframe our view of competition. We must address the insidious aspects of a fundamental shift in how physicians are being motivated to do their work. Reframing the competition model that is currently promoted by many executives could help physicians maintain a sense of purpose, thereby preventing burnout.

We must resist and reject the call, both covert and overt, from our corporate leaders to make our colleagues in other systems our enemies. A collegial mindset is much more befitting of the caring, patient-centered essence of our calling as physicians. Bill George, the former CEO of Medtronic, highlights in his book *Discover Your True North* the importance of grounding ourselves by looking inward to define, clarify and reaffirm our core values as a person and as a professional.[7] He implores each of us to set aside a few minutes each day to clear our mind, assess the alignment of our life and our values, accept our own unique frailties and imperfections, accept that much in the world is beyond our control, accept our role in the current "mess," and step up to incrementally change the environment in which we work and live.

The call from our corporate leaders to ruthlessly compete with our colleagues in other health care systems is not our call. Instead of allowing ourselves to be forced into a "fight to the death" competition, we need to think differently.

For the vast majority of physicians, the changes in operating and financing our health care system are outside of our interests and influence. Yet as conscientious professionals, we can push for a model in which we collaboratively compete. We can still work independently, within our own institutions and areas of expertise, to be the first to find better ways to manage processes of care or assess outcomes, develop new techniques and devices to improve care, conduct research that leads to new understandings of the mechanisms of disease and therapies, and more effectively educate and train the next generation of physicians. We then need to share that information with our colleagues through the medical literature, at professional meetings and in direct consultations, so they, too, can fine-tune their care of patients. That is the essence of professionalism. We do not need to pursue the all-too-common corporate model of competition that defaults to zero-sum strategies, which, in the long run, often prove to be ineffective and costly. Instead, we can purposefully add value to the medical world through collaborative competition that privileges the sharing of information.

The late Steve Jobs, one of the fiercest and most successful competitors in the world, experienced—but recovered from—burnout. At the 1997 Macworld Expo announcing Microsoft's $150 million investment in Apple, Jobs provided a great example of moving away from zero-sum strategies when he said, "If we want to move forward and see Apple healthy and prospering again, we have to let go of a few things here. We have to let go of this notion that for Apple to win, Microsoft has to lose. We have to embrace a notion that for Apple to win, Apple has to do a really good job. And if others are going to help us, that's great because we need all the

ity traits that might predispose them to feelings of dissatisfaction with the current health care environment. Lee Lipsenthal, MD, author of *Finding Balance in a Medical Life*, wrote that physicians tend to be competitive, have obsessive-compulsive behavior patterns, tend toward introversion and social isolation, and have high needs for control and autonomy.[9] Psychiatrist Sara Charles, MD, also notes that physicians exhibit obsessive-compulsive personality features including perfectionism, preoccupation with order, control and excessive devotion to work and productivity.[10] In addition, Glen Gabbard, MD, describes how physicians' compulsiveness—in the form of doubt, feelings of guilt and an exaggerated sense of responsibility—may manifest in both adaptive and maladaptive ways.[11] That is, some of these traits serve physicians and their patients well, while others lead to increased self-criticism, anxiety and depression.

Dan Ariely, PhD, and William Lanier, PhD, in a companion piece to a recent study of burnout and satisfaction with work-life balance by Shanafelt, discuss three factors affecting those in contemporary medical practice.[12] First, physicians are working in an environment of asymmetrical rewards. In many cases, a good treatment outcome is presumed, so there may be no real acknowledgement or expression of appreciation for the physician's training, expertise and experience. Yet when something goes wrong, a physician may experience the collective wrath of patients, families, employers, insurance companies and, even worse, their colleagues. Second, Ariely and Lanier discuss the loss of autonomy in medical practice, which leads physicians to feel defeated when they are trying to put their minds, hearts and souls into their practice. Third is the cognitive scarcity in medical practice. Ariely and Lanier note that we've turned medicine into a production-line-like endeavor, when it really should be a research and development activity.

Reinventing practice
In order to change medicine to make it more sustainable for the long haul, we need to take a high-level view of how we got to where we are and where we need to go. Don Berwick, MD, founder of the Institute for Healthcare Improvement (IHI), gave a keynote talk at the IHI forum in December 2015, during which he proposed that it's time to enter a new era in medicine.[13] He described the first era as focused on professionalism, trust and the prerogative of physicians. It was about noble intent, a sense of duty and beneficence. Physicians held special knowledge and privileges and were self-regulating. But those early days of medicine were synonymous with enormous variation in practice, outcomes and cost; there also were many errors and much waste. Autonomy didn't always mean that patients were getting the best available care, as there were no reliable checks and balances. This resulted in the development of patient safety and quality efforts, including the creation of physician-owned malpractice insurance companies, with efforts to "get our arms around" risk management and patient safety.

Berwick described the second era as the time when medicine became focused on money and metrics, rather than trust. It was about accountability, scrutiny, inspection and control of physicians. Measurement became rampant, and a "carrots and sticks" approach to the management of physician behavior evolved. The protocol-centered practice that grew out of this doesn't feel good to physicians. In fact, it's demeaning and demotivating. Given our understanding of what people need when it comes to motivation and meaning, it is certainly a factor in the current burnout epidemic.

Berwick believes we need to move into what he calls the "moral era" of medicine. He advocates stopping excessive measurement, abandoning complex incentives and decreasing the focus on finance. He encourages recommitting to improvement science, embracing transparency, protecting civility, listening—really listening—to patients and rejecting greed. He notes that we need to focus on the foundation of medical care—the relationship between the one who seeks it and the one who provides it.

I agree that we need to move to a system that is people-focused and team-centered. William Osler, MD, one of the founders of Johns Hopkins Hospital, stated that: "It is much more important to know what sort of patient has a disease than what sort of a disease a patient has." I would add that it's also important knowing something about the personalities and needs of physicians.

For leaders in health care, it is imperative to understand something not only about the current reality with respect to physician burnout, but also about the basic needs of people and of physicians in particular. Organizations need to monitor physician burnout and post results where they can be seen, such as on a dashboard for organizational health. There needs to be leadership in the C-suites of medical organizations along with physician champions to address this crisis. Physicians on the front line of care need to be engaged and to have their "pain points" addressed. Mayo Clinic's Stephen Swensen, MD, has developed a "Listen-Act-Develop" model for engaging physicians in this work.[14] It includes listening to identify and understand specific drivers of burnout; empowering physicians to address the top drivers of burnout in their particular work setting; developing and supporting physicians in this work; and repeating this process as an ongoing improvement cycle.

Organizations also can address the challenges created by EHRs; create options for flexible scheduling or coverage; create space physically and metaphorically to discuss errors as well as the challenges and joys of medicine; and provide space and equipment for exercise, relaxation and connection with colleagues.

One resource for organizations wishing to address physician burnout is the AMA STEPS Forward program (www.stepsforward.org). Its website has research, tools, protocols and resources to aid any medical organization committed to this work.

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