Not what we signed up for

Leaders need to understand what’s driving physician burnout in order to address and prevent it.

BY LAURIE C. DRILL-MELLUM, MD, MPH

You may remember the grainy photo of the grieving ER doc doubled over outside a Southern California hospital that made the rounds on social media last year. The physician had just “lost” a 19-year-old patient and was later quoted by a friend as saying: "I worked on him until he died, and then I went outside and got down and cried, and then I got up and went back inside and tried to feel better so I can make other people feel better."

This photo poignantly captured the extremes of emotion and devotion that characterize medicine on the front lines. What it couldn’t convey was that the ever-expanding list of demands on today’s physicians—filling out paperwork, signing forms, documenting care in the EHR, for example—makes timeouts like this increasingly rare. These ever-increasing burdens on an already-overtaxed physician workforce pose a public health threat, as they are the root of a burnout problem that is driving people out of the profession and compromising patient care. Medical practice today doesn’t feel like what we physicians thought we were signing up for oh so long ago.

The burnout phenomenon

Physician burnout appears to have reached epidemic proportions. The prevalence rate is 55 percent, according to Mayo Clinic researcher Tait Shanafelt, MD.¹ One cannot go more than a few days without seeing a piece about burnout among physicians in either the mainstream media or the medical press.²,³

Physician burnout is believed to be an accelerant for the predicted shortage of physicians, which is expected to reach 90,000 by 2025, according to the American Medical Association. It also poses both clinical and economic risks. Although the issue is rightly engendering attention from medical leaders, administrators and the public, there is no “magic bullet” to fix it, as the causes of burnout are multifactorial—training that is punishing, workflow challenges exacerbated by the mandated/imposed use of EHRs, decreasing time allotted for patient care, increasing workload for decreasing pay, work-life imbalance.

In his book A Hidden Wholeness, Parker Palmer discusses what he calls the “tragic gap.” It’s the place between “what is” and “what is possible,” and it’s where many of us in medicine find ourselves standing. It is the gap between what feels like a beat-up version of our mission to heal and serve and what we truly want—to help others using our expertise, our hearts and our presence.

The physician mindset

Burnout is real, and in order to address it, leaders first need to understand what’s driving it. It’s helpful to look at what we know about what human beings need. Daniel Pink, in his book Drive, says it’s quite simple: People need a sense of purpose, the opportunity to develop and demonstrate mastery, and control over their work or environment.⁴ Edward Deci, PhD, developed a “self-determination theory” based on years of research around motivation and performance.⁵ He, too, discovered that competence and autonomy were required for motivation. He also found that a sense of “relatedness” or being a part of something bigger than oneself was a key factor in motivation. A number of years ago, Harry Harlow, PhD, who conducted research on infant rhesus monkeys at the University of Wisconsin, found that connection is more important than food,⁶ and Abraham Maslow, PhD, asserted that we have physiological, safety, social and esteem-developing needs.⁷

It’s also helpful to understand that physicians tend to have certain personal-
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. 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. 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. 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. 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. 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 improving 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. 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 (wwwstepsforward.org). Its website has research, tools, protocols and resources to aid any medical organization committed to this work. (continued on next page)
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Conclusion

Physician burnout is a significant and growing phenomenon that needs to be addressed at the leadership level. The problem will not be solved by benign neglect; we must, as leaders, act now to effect important changes in the way we treat those charged with caring for all of us—our physician workforce. It will not be easy or simple, but we must try. MM

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REFERENCES


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help we can get. And if we screw up and we don’t do a good job, it’s not somebody’s fault. It’s our fault.”

Conclusion

I believe that reframing our view of competition—by fostering professional collaboration, both within and among institutions, and by widely sharing information for the benefit of physicians and patients everywhere—will help contain the burnout epidemic that threatens our profession. Despite countless stressors, medicine remains extremely rewarding. But what motivates most physicians, including surgeons, is not ruthless competition, not regal salaries, not relentless regulations. As Daniel Pink asserts in his book Drive, truly healthy motivation is not about money, power or prestige. Instead, it’s about autonomy, creativity and purpose.

Our profession still offers the opportunity for a relatively autonomous, creative and purpose-filled career, but only if it doesn’t overwhelm us first! MM

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REFERENCES