Physician Burnout

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Burnout, as defined by Maslach, is a psychological syndrome seen as a prolonged response to chronic emotional and interpersonal stressors on the job. These are characterized by exhaustion, cynicism, and inefficiency [1]. Compared to the general United States working population, physician burnout exceeds other professions [2]. The prevalence of physician burnout is estimated to be greater than 50% of the workforce, and costs approximately USD 7600.00 per employed doctor a year [3–5]. Factors that lead to the epidemic of physician burnout include change from private practice to an employed model, an increase in reporting requirements, loss of flexibility and autonomy, and variation in organizational and cultural values that lead to loss of meaning in work [4].

Impact and Causes of Physician Burnout

Physician burnout is associated with the following: increased rates of medical errors, turnover, risk of substance abuse, depression, relationship issues, and suicide, along with decreased quality of patient care, productivity, and patient satisfaction [4]. Factors commonly linked to burnout include a greater workload and job demand to meet productivity targets [6]. The increasing amount of documentation linked to methods of compensation and working in a team structure make it greatly difficult for physicians used to working by themselves [7]. Work–life integration with competing interests of time with family members, along with call schedules, cross coverage, weekend, and night call lead to a greater risk of burnout [4,6]. The transition toward the employed model of care comes with the loss of flexibility with regard to start and end times of clinic and vacation scheduling which, in turn, creates a loss of autonomy [4]. The use of hospitalists and other subspecialists changes the traditional patient–doctor dynamic by decreasing control over their patients health, causing a subsequent loss of job satisfaction [4,6].

Business Case to Address Burnout

The business case is multifaceted and includes costs that are incurred with turnover and lost revenue associated with loss of productivity, risk to organization with decreases in quality of care and patient satisfaction, and problems with patient safety [8]. Historical studies suggest the cost of replacing a physician is 2 to 3 times the annual salary [8]. A 2012 study estimates the hard cost of recruitment is approximately USD 88,000 dollars [8]. The losses of experiential skill sets in a senior faculty are hard to replace and difficult to quantify. Decreased productivity of 1–2% in physicians can have large impacts to an organizations bottom line. Several studies demonstrate a linkage of physician satisfaction to patient satisfaction and clinical outcomes [8].

Early Recognition of Burnout

Burnout may be recognized by several validated scales, but full-scale 22-item Maslach burnout index-human services survey (MBI-HSS) is the most used, as it measures burnout amongst human service jobs such as physicians [5]. MBI-HSS produces scores on three subscales: emotional exhaustion (range 0–54), depersonalization (range 0–30) and low personal accomplishment (range 0–48). The instrument uses Likert scale with 7 points, with 0 representing never and 6 representing an everyday occurrence [5]. Higher scores of emotional exhaustion and depersonalization with lower scores of personal accomplishment are associated with higher burnout rates [5]. MBI-general survey (MBI-GS) deemphasizes human relationships and renames subscales exhaustion, cynicism, and professional efficiency. There are other questionnaires used such as the mini Z, Modified MBI-HSS mean subscale >3, UBOS EE, but the most commonly used and validated one is MBI-HSS [5].

Interventions to prevent burnout

There are many interventions which may be of benefit to reduce physician burnout. A recent meta-analysis indicates both individual focused and structural or organizational strategies would result in clinically meaningful reductions in burnout amongst physicians [9]. No individual burnout intervention was shown to be superior to others, but both strategies are likely necessary to have impact. The most commonly studied interventions included mindfulness, stress management, and small group discussions. Duty hour reductions have only been studied in observational trials and appear to be effective. The study of organized interventions have been uncommon, but which intervention offers greatest value remains unclear [9]. Burnout is primarily a system-level problem driven by excess job demands and inadequate resources and support, not an individual problem triggered by personal limitations. Burnout tends to occur earlier in a physicians career, and interventions targeted to decrease burnout in this group would offer more impact [9]. Individual skills to foster a work–life balance include working closer to home, learning organizational skills to improve efficiency, delegation of work, and a willingness to decline added work burden beyond capacity [4,6]. Finding meaning in work with self-awareness of aspects of work that is gratifying, the ability to focus ones career to shape individual interests, and personal recognition of accomplishments, also will lead to a decrease in burnout [4]. An example of delegation includes the employment of allied health professionals to ease clerical burdens, allowing physicians to focus on physician centered issues, such as patient care. Improving control of time and scheduling with weekend call vacations, clinic start times and end times are other examples of improving physician work–life balance [4,6,8,9]. Recognizing social support structures at work with gatherings to promote community, and collegiality in the workplace increases physician satisfaction. A real example of this at play occurred at the Mayo Clinic, when reinstitution of physician gatherings in and out of the hospital led to improved communication among physician staff and productivity gains [8].

Organization-directed interventions with structural changes, fostering communication between members of the health care team, and cultivating a sense of teamwork and job control, were found to be the most effective factors in reducing burnout [9]. COVID-19 worsened the burnout epidemic, and requires urgent interventions at a personal and organizational level to improve quality of care, reduce physician turnover, and foster a culture of wellness.

Conflicts of Interest: The author declares no conflict of interest.

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