

Physician Burnout: Recognize the Signs

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Some physicians are familiar with the Tennessee Medical Foundation - Physician Health Program (TMF-PHP) - many more are not. Unfortunately, this can have dire consequences. The TMF-PHP's mission is to help the 15-20% of physicians impaired by mental and behavioral illnesses, which includes mood disorders, boundary violations, disruptive behavior, substance use disorders and burnout. This article, and three more that will follow in 2018, will focus on Physician Burnout - the causes, clinical presentations, impairments, treatments and outcomes. Physician burnout is a pervasive problem that can impair clinical competence, shorten careers, distress families and is an independent predictor of reporting a major medical error and being involved in a medical malpractice suit. SVMIC wants to educate its policyholders about burnout to prevent tragedies like the one described below.

During the steamy month of August, I met the grieving widow of Dr. W¹, who died in July from a self-inflicted shotgun blast to the chest while the family was at church. Dr. W's death was tragic, and Mrs. W. asked that his death be used as a clinical illustration so no other family, office or population of patients goes through this grief. As I sat with her and listened to her visceral grief, I recalled the articles I had reviewed about physician burnout. Years in residency training taught me to reflexively review the differential diagnosis as the signs, symptoms and demographics become known. The diagnosis became evident long before she was through describing what happened. While she talked, I recalled that doctors practicing in the trenches of primary care are at much higher risk for burnout than doctors in other specialties, as are mid-career physicians versus those in early or late careers. Dr. W. had numerous risk factors for burnout, which he developed long before he became severely depressed.

Dr. W. grew up in a small Tennessee town and met his wife

1 Names have been changed for confidentiality



while in the military. He traded years of military service for a medical education and was happy during his military obligation. After being honorably discharged, he was recruited by the hospital to a rural west Tennessee town. After fifteen years in practice, many of which were without a vacation day, he had signs of burnout. He avoided family and social activities such as church, ball games, shopping and the gym. Like many doctors, he didn't know how to say no, so he avoided having to do so. Dr. W. became frustrated, emotionally depleted and less empathic - he didn't have any more to give. He resented his patients and his office. He told his wife about 3 years ago he felt like "a robot going through the motions."

Approximately 1 year before he completed suicide, two significant events occurred. Dr. W's trusted front office clerk of 8 years, "Linda", was caught embezzling money. Apparently, Linda was stealing from the practice almost since the day she was first employed. Dr. W. hired her and trusted her; she would even babysit for his children on that rare occasion when he and his wife would go out. Mrs. W. had to call the police to have Linda arrested because Dr. W "couldn't face that conflict." The court entered a restitution order that Linda was not able to honor, creating additional conflict. The second event occurred when a for-profit private corporation purchased the county hospital and offered to buy his practice. "Freedom" he told his wife, "no more financial, office, billing or credentialing worries. And no more Linda issues." With little legal or business advice, Dr. W. quickly sold his practice. Within 4 months, he regretted it.

The new practice management group implemented changes including a time clock, 45-minute new-patient appointments, 12-minute follow-up appointments, a new electronic health record (EHR), rigid payment structures and financial targets.

Mrs. W had read about burnout in one of her husband's journals and said, "For at least 3 years he fit all the symptoms." He became depressed his last year of life. He

was afraid to reach out. He took samples of antidepressant medications. He told his wife if he were treated for depression by a psychiatrist, the licensing board would investigate. "I'll lose my license; it'll just make it worse." He became more despondent and chose the permanent resolve of suicide as his way out.

Although Dr. W had never mentioned the TMF-PHP, the hospital's new CEO referred Mrs. W to us soon after the funeral. At our first meeting at a coffee shop in Jackson, I explained our full mission, and she began to sob uncontrollably. She realized that the TMF-PHP might have been able to help her husband and prevent his death, and she asked that I use her husband's story to help prevent it from being repeated.

A physician's completed suicide impacts the village. The family loses a loved one and wage earner, the community loses a valued member and employer, and patients lose their doctor. At his wife's request and with her help, Dr. W's emotional state was examined. A root cause analysis of his professional life revealed many issues on multiple levels that are relevant to physician health.

Like most health care providers, Dr. W was co-dependent. He put the health and welfare of his patients before his own. Even when he was sick with a febrile illness, he was at the office taking care of patients who were less sick than he was. He had difficulty saying no. Co-dependence may feel like a bonanza for patients; it is certainly venom for a physician. Co-dependence can cause over-prescribing, over-working, a feeling of being used, quality of care problems, and can be a precipitator of burnout.

Burnout is currently an in vogue word that, because of its impact and severity, is being discussed at all levels of

organized medicine. The National Academy of Medicine, American Medical Association, Federation of State Medical Boards and Federation of Physician Health Programs are all collaborating with many other national and state medical groups to discuss physician burnout.

Burnout is devastating to the physician's wellbeing in the three realms of their life - work, social and home. The classic signs of burnout include emotional exhaustion, loss of the passion to practice medicine and being too drained to work effectively. Burnout includes depersonalization, loss of empathy, lack of efficacy and purpose and loss of a desire to help a patient. The prevalence of physician burnout is staggering; over 50% of practicing physicians have at least one burnout symptom. Dr. W. was very isolated and had little "community." He worked long hours with little time off and less time away. The practice management group that was to provide "freedom" removed what little control he had, further exacerbating his burnout. His burnout persisted for years before it was eventually supplanted by depression.

Depression and burnout are not the same but have related antecedents. Dr. W inappropriately and ineffectively treated himself for depression, something no physician should ever do. He was worried if he reached out for help, his medical license would be in jeopardy. The TMF-PHP has no reporting mandate in an effort to provide protection and confidentiality to physicians who reach out for help.

The following three articles in this series will discuss physician burnout, treatment and prevention in more detail. Please reach out if you need help, Mrs. W wishes her husband had.

For more information on the Tennessee Medical Foundation, see <https://e-tmf.org/> 

The QPP Portal is Open: Submit Your 2017 Data

by Elizabeth W. Woodcock, MBA, FACMPE, CPC

The Centers for Medicare & Medicaid Services (CMS) opened the reporting portal for the Quality Payment Program (QPP) on January 2. The deadline to submit your 2017 performance data is March 31, 2018. The portal provides one-stop shopping, allowing users to enter performance scores for all three categories of the Merit-based Incentive Payment System (MIPS).

The new portal offers several benefits. In addition to being comprehensive, CMS reveals real-time scoring, as