

Physician Burnout: Recognize the Signs

by Michael Baron, MD, MPH

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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

Physician Burnout: What Is It and What Causes It?

By Michael Baron, MD, MPH, FASAM

Editor's Note: This is part two in a four-part series on physician burnout. Part one was published in the January 2018 edition of The SVMIC Sentinel, available [here](#). Part three in this series will be published in our July edition.

A physician touches the lives of many people, including his family, friends, colleagues, and patients. Their death affects those same people. In part one of this four-part series we saw how that was true for Dr. W. Unbeknownst to anyone, Dr. W.'s burnout evolved into a severe depression. Soon afterward, his life ended by a completed suicide. The suffering that Dr. W. quietly endured must have been considerable for him to even consider suicide, let alone complete the act. Dr. W.'s family lost a husband, father, and provider; his friends lost a confidant, and his patients lost their physician. Although burnout doesn't generally end in suicide, it does cause significant personal and professional loss for the physician.

In this second article, we will take a much closer look at physician burnout, which is associated with real suffering among physicians who are themselves dedicated to relieving suffering.

Physician burnout is associated with an increased risk for the development of substance use disorders and an even greater risk of suicidal ideation. On the professional side, physician burnout is a risk factor for an increased probability of making a medical error and being involved in a malpractice suit. Patient mortality rates in an ICU setting and healthcare-associated infections are negatively influenced by burnout symptoms, as are patient satisfaction scores and patient adherence to medical advice. A physician experiencing burnout is more likely to leave his current practice or give a reduced professional effort, resulting in loss of productivity. There is also an increase in patient referrals and the ordering of tests by physicians with burnout. The personal and professional

consequences of physician burnout lead to increased healthcare costs and decreased quality of patient care.

Burnout Defined

Burnout was first described in the 1970s as a state of fatigue or frustration resulting from professional relationships that failed to produce expected rewards (Freudenberger, 1974). A few years later that definition was expanded to be a psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment that occurs among various professionals who work with other people in challenging situations (Maslach, 1982). Christina Maslach went on to describe burnout as “an erosion of the soul caused by a deterioration of one’s values, dignity, spirit, and will.” (Maslach C, Leiter MP. *The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It*. San Francisco: Jossey-Bass; 1997.)

Physician burnout is a work-related syndrome, primarily driven by workplace stressors, consisting of three major areas: Emotional Exhaustion, Depersonalization, and Low Personal Achievement.

1. Emotional exhaustion is characterized by losing enthusiasm for work. The physician’s physical and emotional energy levels are almost depleted and are continuing to drain.
2. Depersonalization is treating people without empathy, as if they were objects. Cynicism, sarcasm, and the need to vent about your patients is evidence of this element. This is commonly called “compassion fatigue” or “caregiver syndrome.” The physician is not emotionally available to anyone, including their own significant others.
3. Having a sense that work is no longer meaningful describes low personal achievement. The physician feels like his or her work doesn’t really matter or serve a purpose. They doubt the meaning or significance of their work. They are aware that they may make an error because they don’t have the intensity to perform at their highest level.

Numerous studies that have included nearly every medical and surgical specialty show that physician burnout symptoms have reached epidemic levels – several

national studies cite a prevalence exceeding 50 percent. Unfortunately, the statistics continue to get worse as burnout rates continue to increase. As expected, physicians working in the trenches or on the front lines of medical care are among those with the highest risk. Those specialties include Emergency Medicine, Family Medicine, Internal Medicine and Neurology.

We can also view physician burnout as a metaphor: the physician was very committed to his work but then the fire or enthusiasm went out. This would infer that burnout can only happen following a high level of intensity, engagement, or interest in work. A physician cannot practice without a high level of intensity. This metaphor also insinuates that to prevent burnout, the fire must keep burning. Fires won't burn without the required resources; a fuel source in the presence of oxygen. Physician burnout occurs when resources are inadequate to feed the physician's emotional and physical fire.

Burnout Causes

The causes of physician burnout are complex. The organization and the practice environment the physician participates in plays a critical role. The drivers of burnout can be grouped into seven dimensions: workload; efficiency; flexibility/control over work; work-life integration; alignment of individual and organizational values; social support/community at work; and the degree of meaning derived from work (Mayo Clin Pro, 10:4; 1-18, 2016). Each of these drivers is influenced by individual physician factors, work unit factors, organizational factors, and national factors.

Individual Factors

The individual physician factors driving burnout are related to specialty, practice location, organizational skills, ability to say no, ability to delegate, control over career path, personal and professional values, priorities, values, and emotional support outside of work, to name a few. Positively aligned, these drivers can pull a physician toward engagement. When they skew or turn negative, they can push them in the opposite direction toward burnout.

There are other personal drivers of burnout. Physicians are not taught the art of work-life balance during training. In fact, just the opposite: physicians are taught

to ignore their physical, emotional, and spiritual needs. They are taught to work until they can't, and then to work more. The old joke, "The problem with being on call every other night is you miss half the good cases," wasn't really a joke. During the physicians' education they develop certain traits, qualities, and personas responsible for success. In an ironic twist, these same traits, qualities, and personas are the personal drivers for physician burnout. These include: perfectionist, workhorse, superman, check everything yourself, asking for help is a sign of weakness, and the patient comes first. Here's how they can go wrong:

1. Perfection is unobtainable, at least not by mere mortals. The small rise on the Y axis from excellence to perfection can utilize a great deal of time or energy on the X axis. Stated another way, a minimal gain that requires a large amount of effort is inefficiency. A physician can ill afford inefficiency in any part of their practice.
2. The workhorse and superman descriptions, like perfectionism, are not human attributes. Therefore, they, too, are not obtainable and should be replaced with better and more realistic human qualities.
3. "Check everything yourself" is not possible in today's medical office. What is possible is to set up systems and policies in your office that delegate responsibility to prevent omissions and mishaps.
4. Asking for help is a sign of strength, not weakness. It takes a healthy ego, good insight and maturity to realize that one needs help. Asking for help takes courage and is applaudable. We all need help at one time or another in our professional and personal lives.
5. "The patient comes first" dictum is problematic. If the physician has burnout or is sick in other ways, they may not be able to deliver quality care. Health care is a service industry so patient care and patient service are important, but self-care is at least equally if not more important, and should take precedence. If you have burnout or are infirmed or dead, you are not doing your patients any good.

Organizational Factors

Although individual physician factors are important drivers, the organizational factors seem to be the principal drivers for physician burnout. Organizational factors include productivity targets; method of compensation; the EHR; the

organizational culture, mission and values; scheduling and vacation policies; and the immediate supervisor. The leadership skills of the physician's immediate supervisor powerfully affect the physician's work satisfaction and stress levels. Hospitals, professional organizations, and companies like SVMIC have realized this even before the epidemic of physician burnout, and started leadership schools and leadership classes to mitigate its effects. But there is more to be done.

Physician burnout is at epidemic levels. As we have seen in part one, physician burnout can have dire consequences. If you have the symptoms or sequelae of physician burnout or know someone who does, please get help. Doing nothing is the worst thing to do. Your call to the TMF-PHP is confidential. We have resources that can help. Please contact the Physician's Health Program at 615-467-6411 or online at e-tmf.org.

The Federation of State Physician Health Programs provides a comprehensive listing of state programs [here](#).

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Physician Burnout: Prevention and Treatment

By Michael Baron, MD, MPH, FASAM

Editor's Note: This is part three in our four-part series on physician burnout. Part I was published in the [January 2018](#) edition of The SVMIC Sentinel and part II was published in the [April 2018](#) edition. Part four in our series will be published in our October edition.

On June 9 of this year, the *Wall Street Journal* published an article titled “Hospitals Address Widespread Doctor Burnout.” It was not alone – Physician Burnout Syndrome has been featured above the fold in many major national newspapers since we began this article series in the *Sentinel* in late 2017. The national attention is appropriate.

Escalating physician suicide rates have also received widespread attention. Symon Productions, an independent movie company, released the documentary *Do No Harm* in March 2018. The movie is about the impact completed suicides of medical students and residents have, not only on their families but on their patients as well. It exposes our “sick healthcare system that not only drives our brilliant young doctors to take their own lives but puts patients’ lives at risk, too.” Physician health has not only become a national topic of discussion, but is also a national concern because sick and burned-out physicians make mistakes that can harm patients, whereas healthy doctors provide better healthcare. That is not just a bumper sticker slogan; there is ample evidence to validate that statement.

In Part I of this series we were introduced to Dr. W. who completed suicide, leaving a trail of burnout symptoms and a wake of sorrow. We saw what burnout is and how it negatively impacts physicians and their patients. In Part II we took a closer look at the drivers and factors of burnout. In this segment, Part III, we will explore another case presentation and talk about prevention and treatment options for Physician Burnout Syndrome at the clinician level.

The Case of Dr. H

Dr. H. is a mid-career internist. She is one of a four-physician Internal Medicine group in a large West Tennessee town. She was raised close to the town where she now lives and has no desire or plans to leave. Her parents still live nearby and are completely independent. Dr. H.'s husband gave up his career as a journalist to become the manager of her practice, as their last three office managers were incompetent and disorganized. Her husband has a history of trying to rescue Dr. H. when she is "stressed," which only adds to her stress. Dr. H. has three high-school-aged children. She hasn't been to her children's ball games, recitals, or school events except an occasional weekend birthday party. The family joke is that she almost missed her children's births.

Dr. H. leaves for her office around 6:30 am, explaining that she can “get a lot done before the doors open.” From 6:30am to 8:00am she goes over patient emails and messages; she is not reimbursed for this but views it as an important aspect of clinical care because it “helps patients.” Office hours are from 8:00am to 5:00pm with one hour for lunch – a built-in buffer to keep her from being too late in the afternoon. However, she never uses the hour for lunch because patient visits encroach on that time. Similarly, her day rarely ends at 5:00pm – the last patient usually doesn’t leave the office until around 7:00pm. Dr. H. then goes home exhausted. Her husband and children have usually finished dinner by the time she gets home. Her pajama time is spent charting, as she seldom has time to close out charts during the day. Dr. H.’s group utilizes a very efficient Electronic Health Record (EHR), which allows her to chart from any location. However, to avoid simply copying/pasting and having each visit report look like the last, she spends many hours each night capturing and recording the subjective flavor of the day’s office visits in each note.

Dr. H.’s story is exhausting. She could not find a way off the devastating treadmill that she enthusiastically got on in residency. Like many physicians, Dr. H. needed help to make changes to the hopeless agony that became her life. Disguised as a virus, that help eventually came. Despite receiving a flu vaccine, she became ill with type B influenza. It took a high fever, chills, rigors, and cognitive clouding for Dr. H. to take time off. Her own primary care doctor, an office partner, sent her home.

Caused by a high fever, viral load, or just plain lucidity, on the fourth day of sick leave Dr. H. had a moment of clarity. She told her husband that evening that she had to make changes that may include changing careers – otherwise, she feared she would soon be dead. Her husband gave her the number of the Tennessee Medical Foundation Physician’s Health Program (TMF-PHP). She called the next day.

Dr. H. had classic symptoms of Physician Burnout Syndrome. Her practice was no longer meaningful or fulfilling. She was emotionally exhausted and received no sense of personal accomplishment from work. She treated her patients as objects and was disengaged. She also felt like a stranger to her husband and children. On

closer examination, she had developed intermittent bouts of depression and thoughts that her family would be better off if she were dead.

After a few weeks to recover and implementing strict work boundaries regarding time and clinical load, mandatory vacation, and continued therapy to address perfectionism, Dr. H. is a much happier and better physician. Her husband addressed his codependence and rescue fantasy as well. These changes were very painful and difficult but considered worth the effort by all involved.

Drivers of PBS

Although physicians are a very visible component of healthcare, they are not the primary drivers of Physician Burnout Syndrome (PBS). The organizational components of medicine that have control over and limit the autonomy of the individual physician practice are the major drivers of PBS. Those drivers include the federal and state governments, hospitals and institutions, and the C-suite executives of physician practices. Reducing PBS is the responsibility of physicians working together with those organizational components.

Drs. Shanafelt and Noseworthy go into detail discussing the “Nine Organizational Strategies to Promote Engagement and Reduce Burnout” in their 2016 article.¹ We will explore the strategies that are more physician-based, including “Promoting Flexibility and Work-Life Integration, Resilience and Self Care,” and look at Mindfulness-Based Stress Reduction in more detail as a treatment for PBS.

Flexibility

Almost half of all physicians work more than 60 hours per week, neglecting their own personal and family needs. It’s estimated that almost half of that time is devoted to non-clinical activity. Work-Life Integration provides opportunities for meeting family and personal needs. Creating flexibility in physician scheduling is one option that provides the physician with an element of control. Scheduling work days that begin or end earlier or later allows time to meet personal or family responsibilities. This can easily be accommodated in an equitable manner without a decrease in total work hours. Other industries have been utilizing flexible hours with good results and without the scheduling chaos that office managers often predict. Flexible hours may seem unworkable in the single

physician office; however, flexible hours can be utilized by planning and blocking needed time off for family or personal obligations. A multiple physician or provider office allows for increased flexibility in scheduling. The physician and scheduler need to work together to accomplish this task.

Another viable option is to allow physicians to schedule reduced hours with a commensurate reduction in reimbursement. This can be especially appealing to double income families so at least one parent is available for after-school functions or activities. Missing a child's game, graduation, or school play can be anything from a faux pas to an unforgivable act, whereas attending a child's event will provide great satisfaction to both parent and child. Flexible scheduling and compensation can be used to promote a healthy balance of family, work, and personal time. The concept of Work-Life Integration promotes a healthier physician, and a healthier physician provides better care.

Physician Resilience

"Timeo Danaos et dona ferentes," or "I fear the Greeks, even those bearing gifts."

Improving physician resilience has been touted as a tool to treat PBS. Dr. D. Drummond makes an eloquent analogy to the contrary that physicians are the canary in the coal mine of medicine, and states that the epidemic of PBS is an indictment of the conditions of the coal mine, not the resilience of the canary.² Thus, he argues, making a stronger more resilient canary is not the answer. Dr. Drummond defines resilience training as "the acquisition of any burnout prevention tool the physician puts to their own individual use. The tool increases the physician's resilience in the face of the stresses of their practice and workplace systems."²

When resilience training is instituted by a hospital or other healthcare organization it is met with caution and skepticism. Resilience training elicits a similar visceral response as "I'm from the government and I'm here to help." It is generally viewed as one more thing to do, increasing the stress load on an already stressed physician population.

Resilience training can also imply to the physician that they are the problem, as with the metaphor of a sick canary vs. a sick environment or culture. Sometimes

resilience training is interpreted as a sinister attempt by the organization to get more output from the physician.

For these reasons, it is important that when resilience training is offered, it is presented as a small part of a much larger strategy; the healthcare organization needs to show it is addressing PBS as a systems problem, not a physician problem.

Mindfulness-Based Stress Reduction

Mindfulness-Based Stress Reduction (MBSR) is an effective tool to decrease stress and prevent PBS. Again, the argument can be made that promoting an individually-obtained remedy gives a message that it is the physician who is broken and not the system. By now, we can all agree it is a systems problem. MBSR is a healthy way to deal with the system, to prevent PBS.

Developed in the late 1970's at the University of Massachusetts Medical Center, MBSR is a mixture of science, medicine, and psychology with Dharma, or Buddhist, meditative traditions, teachings, and practices. It is used to help treat numerous conditions including anxiety disorders, mood disorders, substance abuse disorders, eating disorders, chronic pain conditions, insomnia, ADHD, and burnout syndrome.

MBSR promotes mind and body awareness to reduce the physiological effects of stress, pain, or illness. It emphasizes non-judgmental awareness in daily life while promoting serenity and clarity in each moment so one can experience a more joyful life and access inner resources for healing and stress management. There are education centers dedicated to mindfulness that have proliferated around Tennessee and the country that are open to the public.

MBSR is a powerful tool in the toolbox that physicians can utilize on a daily basis to promote wellbeing and joy in life, even if one has not been or is not yet impacted by PBS.

Summary

Physician Burnout Syndrome is characterized by exhaustion, cynicism, and loss of accomplishment. PBS is an organization and systems issue that is shown to

influence quality of care, patient safety, and physician turnover, and can lead to depression and even suicide. An engaged physician workforce is critical for healthcare organizations to provide quality care and achieve fiscal goals.

Most organizations operate under the belief that it is the responsibility of individual physicians to heal themselves. While there are some meaningful actions a physician can take to prevent and treat PBS, most factors driving burnout are beyond the physician level, and some are even more systemic than the organizational level. However, organizational level efforts can greatly influence physician well-being. We all have heard about the proverbial “ounce of prevention.” That sage advice not only applies to clinical care, it is very applicable to physician health and the epidemic of PBS. The ounce of prevention in this case includes organization and systems changes, as well as strategies that involve the individual physician.

1. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. *Mayo Clin Proc.* 2017 Jan;92(1):129-146.
2. Eight Ways to Manage Practice Stress and Get Home Sooner. *Fam Pract Manag.* 2015 Nov-Dec;22(6):13-18.

See the Tennessee Medical Foundation's website [here](#).

The Federation of State Physician Health Programs provides a comprehensive listing of state programs [here](#).

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Physician Burnout: Other Viewpoints

By Michael Baron, MD, MPH, FASAM

October, 2018

Editor's Note: This is part four in our four-part series on physician burnout.

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(</resources/newsletters/147/physician-burnout-prevention-and-treatment>).

Physician burnout syndrome 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. This will be the fourth and final article in this series about Physician Burnout Syndrome (PBS). The first article discussed the signs and symptoms of PBS using a tragic clinical case for illustration. The second article in this series looked at the causes of PBS and described the three aspects that make up PBS as first described by Christina Maslach in the 1970s: Emotional Exhaustion, Depersonalization, and Low Personal Achievement. The third and most recent article in this series discussed prevention and treatment of PBS.

In this fourth and last article, we will look at burnout from a different viewpoint. Dr. Dike Drummond has written extensively on this subject. I mentioned Dr. Drummond in Part 3 when discussing prevention of PBS by improving physician resilience. His thoughts are that *"physicians are the canary in the coal mine of medicine."* PBS is a reflection on the condition of the practice and business of medicine. Improving the conditions of medicine is much more appropriate than improving the resilience of the physician. It's not the canary that needs help, it's the canary's environment. Likewise, the problem is not the resilience of the physician, but the environment in which the physician is practicing.

Like many syndromes, PBS has many consequences. As we've seen, these consequences include quality of care issues, decreased patient satisfaction, decreased patient compliance, increased medical errors leading to increased malpractice risk, increased use of alcohol and illicit drug use, and increased

number of suicide attempts and suicide completions. PBS can be especially lethal if not acknowledged or treated. Physicians are masters at denying their own problems, something that we encounter every day at the Tennessee Medical Foundation Physician's Health Program (TMF-PHP). Their focus is never on their own health, which is why physicians seldom ask for help. They are generally forced to get help by a peer, spouse, or superior in the workplace. However, the leaders of organized medicine, including the National Academy of Medicine, American Medical Association, Federation of State Medical Boards, and other national groups, are taking aim at PBS to find effective prevention and treatment that doesn't focus on fixing the canary.

PBS is a low-energy state analogous to functioning with a depleted energy store - not the type of energy manufactured from glucose and carried around in ATPs; this energy source is better described as transcendent or spiritual. Dr. Drummond makes the analogy of an energy that is more like "The Force" in the *Star Wars* movies than anything measurable with units of energy.¹ Drummond describes an energy account, much like a bank account where deposits and withdrawals are made. Rest, relaxation, and rewarding relationships are positive deposits in the energy account. Withdrawals of energy are made by life activities that are not rewarding or pleasant such as illness, unpleasant or difficult relationships, or unrewarding types of work. For example, being named in a malpractice lawsuit or making a medical error are quick ways to drain one's energy account. Having little to no autonomy or control over your work environment also depletes this type of energy but at a slower rate. Burnout is likely to occur when an energy account remains depleted or in the negative over a period of weeks to months.

Using the energy analogy described above, Dr. Drummond describes the five main causes of burnout he sees most:

1. The practice of clinical medicine is a difficult task that utilizes a lot of energy. However, this can be very rewarding to physicians and can be a net gain of positive energy. After all, we attended medical school to join the healing arts, but at some level dealing with sickness and death can erode that positive energy.
2. On a more basic level, the personal aspects of a practice situation such as specialty, call rotation, compensation, office personalities, location, and the type of practice can all influence the type of energy - positive or negative - that is produced.
3. The lack of work-life balance. This balance is necessary to recharge your energy. Work-life balance was not taught in medical school or residency. Actually, the opposite was reinforced, that is, to disregard your home life, your emotions, your spiritual connections, or anything that keeps you out of the hospital and gets in the way of your education. The old joke, "The problem with every-other-night call is that you miss half the good cases," isn't funny because it is or was the mindset of our medical education system. A home life that is healthy and nurturing is important to have and to use to help replete this type of energy. Unfortunately, some types of home life can cause energy depletions, such as illness, conflicts with spouse or children, and financial problems. When looking for causes of PBS, it is important to include the home as a potential etiology.
4. Dr. Drummond describes four character traits that create good physicians but leave them vulnerable to burnout and other mental health disorders: the

workaholic, the superhero, the perfectionist, and the lone ranger. The *workaholic* uses work and more work to overcome any difficulty. The *superhero* faces every challenge alone, not needing or asking for help. The *perfectionist* can't make a mistake and demands the same from everyone else. The *lone ranger* is unable to delegate responsibility and is a micromanager. In 1985, Dr. G. Gabbard described three characteristics that physicians have - doubt, guilt feelings, and an exaggerated sense of responsibility - that he called the "triad of compulsiveness."² This triad can easily lead to PBS or negative energy. These characteristics are present in most physicians but they do come with a cost.

5. One of the most direct causes of PBS is the leadership skill set of the physician's immediate supervisor. Unfortunately, most physicians either do not receive or innately have good or effective leadership qualities. In the medical education world, the immediate supervisor is the person with one more year of experience. Thus, the medical student answers to the intern, who answers to the resident, who answers to the chief resident, to the junior attending, to the department chair, up the chain of command to the Dean. Research and attracting grant money are the usual prerequisite for promotion, so the top dog may produce Nobel-winning research but have terrible leadership skills, making everyone in the department miserable, which results in mass resignations.

Physician Burnout Syndrome is a real and potentially lethal problem that is increasing in prevalence. When a physician becomes burned out, it is noticeable as they proceed from happy to indifferent, from engaged to apathetic, from a high-energy state to a depleted state. The repercussion of burnout can be devastating to the physician and to their patients. Quality of care suffers, as does patient satisfaction. Everyone suffers.

As mentioned, there are changes being discussed by the leadership of our national organizations to reverse this trend. However, those changes are not occurring overnight. If you are struggling or know someone who is struggling with burnout, please give the TMF-PHP a call, or encourage them to call. 615-467-6411) All calls are strictly confidential; getting help does not mean getting reported. We have the expertise to identify causative problems and initiate changes to help remedy the situation. Please think of the TMF as a resource, not a punishment. Asking for help is a sign of strength.

The Tennessee Medical Foundation (<https://e-tmf.org/>) can be contacted at 615-467-6411.

The Federation of State Physician Health Programs provides a comprehensive listing of state programs here (<https://www.fsphp.org/state-programs>).

1. Drummond D. Physician Burnout: Its Origin, Symptoms, and Five Main Causes, *Fam Pract Manag*. 2015 Sep-Oct;22(5):42-47.

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About the Author

Dr. Michael Baron attained his Medical Degree, Masters in Public Health, and completed an internal medicine internship at Tulane University, School of Medicine. He completed his first residency in anesthesiology at Washington University School of Medicine, and his Psychiatry training at Vanderbilt University School of Medicine. He has maintained Board Certification in Anesthesiology, Psychiatry and Addiction Medicine. He has practiced in the Nashville area since 1998 in a variety of settings including private practice, teaching hospitals and residential treatment centers. Dr. Baron was appointed to the Tennessee Board of Medical Examiners (BME) in 2010 and served as Chair of the Controlled Substance Monitoring Database committee. He resigned from these positions in January 2017 to become the Medical Director of the Tennessee Medical Foundation - Physician Health Program. As well, he is the psychiatrist of record at the Davidson County Drug Court- DC4.

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