



Revealing the ripples of burnout

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In the summer of 2012, the U.S. medical community still hadn't experienced its collective "aha!" moment in understanding the prevalence of physician burnout.

"People would ask me, 'Why are you studying this? Do doctors really have it worse than anyone else?'" says Lotte N. Dyrbye, MD, MHPE, professor of medicine and medical education at the Mayo Clinic Alix School of Medicine and one of the relatively few researchers looking into the phenomenon at the time. "There wasn't a good sense nationally of whether this was a problem for the profession or just a niche issue affecting a handful of less-well-adapted physicians or learners."

That moment would come in August with the publication, in *JAMA Internal Medicine*, of a study by Dr. Dyrbye and others at Mayo Clinic comparing burnout among U.S. physicians with the general population. There was already lots of data on physician burnout, but this was the first national study. It concluded that burnout was, in fact, more common among physicians than among other workers and that doctors working in specialties at the front line of access seemed to be at greatest risk. It found burnout symptoms in more than 45% of the physicians surveyed.

"After many years of feeling like we were running uphill, trying to understand whether this was a real issue, suddenly, seemingly overnight, we were getting very different questions, like, 'How do we fix this?'" Dr. Dyrbye recalls.

Since then, most interventions aimed at curbing burnout have been directed at individuals. This has given rise to an array of time-management and self-care techniques, as well as corresponding data on their effectiveness. But while resilience is an important bulwark against burnout, it is sometimes overemphasized in organizational efforts, leaving physicians and medical students with the feeling that no one is looking out for them.

"The message they're getting seems to be, 'You just need to be stronger to deal with your working environment. You're not committing yourself to those individual strategies sufficiently,'" says Colin P. West, MD, PhD, professor of medicine, medical education and biostatistics at Mayo Clinic Alix School of Medicine and co-author of the 2012 study.

The medical community has needed a second revelation, Dr. West says: that individual-directed measures are simply a first step. The real solution to burnout is changing the working and learning environments at academic and community medical centers.

The good news, for starters, is that every major accrediting and licensing organization in the United States has now meaningfully endorsed the need for culture change.



Photo courtesy Mayo Clinic

“System and organizational change are huge boulders, though, and the science is very hard,” Dr. West says. “There have been a number of efforts to try to move the organizational levers, but I don't think they are as visible to people outside of the research world because the outcomes from those interventions have been harder to come by. What I think will help people feel more comfortable that this effort is going in the right direction is to see that organizational science around culture change and system change. Again, those are really big boulders, and it's slow going to get them started in a different direction. But the people who are going to be able to effect those changes, their ears are open and they're engaged.”

Broadening the view of burnout's impact

Since 2003, Drs. Dyrbye and West have been working on longitudinal studies looking at quality of life, burnout, empathy and other markers of personal well-being among medical students and internal medicine residents.

Dr. Dyrbye, who immigrated from Denmark when she was 5 and learned English largely from watching the TV medical drama “Emergency!” had been a practicing physician but was inspired to go into research after hearing pioneering investigator Tait D. Shanafelt, MD, present a study on burnout in University of Washington residents and how it related to suboptimal patient care practices. Dr. West, who notes that he had never heard the term “physician burnout” before he became Mayo Clinic's chief

internal medicine resident, was asked to join the research team because of his background in biostatistics. Today, Drs. Dyrbye and West co-direct Mayo Clinic's Program on Physician Well-Being.

As big an issue as physician burnout has become, there still aren't many researchers studying what drives it or what works to fix it. This is mostly a function of the scant research dollars available. Drs. Dyrbye and West are considered by many to be among the Beatles of burnout research, in part because of their persistence in getting studies done on shoestring budgets.

But this lack of funding may also be due to a failure of imagination. One key to accessing resources, they note, is taking a broader view of the topic of physician well-being. Some researchers may not yet appreciate how it relates to topics they are investigating.

"We as researchers have to take some responsibility. The case could be made more strongly and in a more appealing fashion for incorporating well-being research into other investigations," Dr. West says. "If you're studying a clinical outcome, and if we've got strong evidence that physician well-being is a driver of clinical outcomes, then it makes sense to incorporate physician well-being when the overall goal of the grant is to go after improving care. Similarly, burnout researchers need be reaching out for partnerships with investigators who have other successful lines of funding, to look for areas where there could be mutual benefit."

Given that medical research is most commonly funded by large government agencies, work also needs to be done to help the general public and politicians understand the implications of physician well-being on quality and cost of care.

"What you don't want is to send the message that you have a bunch of overpaid doctors whining that their jobs are hard," Dr. Dyrbye says. "Physicians expect and want to work hard, but they need to do so in efficient systems that support, rather than hinder, their efforts."

She suggests bringing the conversation back to the triple aim: lower costs, improved quality, better access. These all rely on a healthy professional workforce, and that means solving burnout.

"There are probably some chief financial officers who still need convincing too," Dr. Dyrbye says. "It's easy to say that if you increase the number of patients a physician sees, revenue's going to go up. But that's a huge assumption because ultimately if you burn out that doctor, quality of care is going to go down, cost of care is going to go up, and that physician will be more likely to cut back on hours or leave, which could cost you a lot of money. If there are medical errors or malpractice suits, those also could cost you a lot of money. So, you might do better financially if you change the work expectations of your physicians and invest in other members of the health care team and practice improvement initiatives"

Being at this new frontier of awareness also means the medical community is now in a better position to contemplate the fullness of the burnout experience, including the impact of bullying, discrimination and the hidden curriculum.

Harassment, for example, is known to drive depression and burnout in medical students, but not much is known about how it affects physicians in practice. Moreover, the effectiveness of a burnout solution could be impacted if it is implemented in an environment struggling with systemic biases.

The drivers of burnout may transcend the practice and organizational environments too, so identifying them requires novel measurements. For example, how do payment models and financial incentives affect physician well-being? What about malpractice liability and tort reform? How do performance feedback reports to physicians affect their well-being?

“There also hasn’t been much work in the U.S. looking at how to help people recover from burnout,” Dr. Dyrbye says. “What is the natural course of it? How many people recover on their own? What kind of strategies facilitate more expedited recovery, other than cutting back on work hours? Is there an optimal return to work process, so to speak?”

The challenge of changing culture

Despite the many questions facing researchers, some answers are readily available at the organization level. For example, most organizations have quality improvement activities aimed at a wide variety of outcomes, from improving diabetes control measures to reducing length of stay.

“There are a ton of these going on all the time. We implement process changes and then measure outcomes,” Dr. Dyrbye says. “What we fail to do is measure the impact on the workforce. How did it affect their cognitive load or their clerical burden? Did it change their connection to colleagues? Are they now more isolated? Do they get more or less meaning in work? Did it increase or decrease flexibility and autonomy?”

The electronic health record, despite its notorious role in driving burnout, is also a place to look for answers. Imagine, for example, if 60% of physicians’ orders are teed up in gastroenterology, but only 20% are teed up in pulmonary. Such a disparity could point to areas where care teams could be operating more efficiently, giving physicians more time to work at the top of their licenses, but much of this data is not yet mined. Many organizations simply don’t know how differences in their staffing by practice and workflows may be contributing to burnout.

System-level change isn’t unprecedented, by the way. A 1999 report from the U.S. Institute of Medicine (IOM), “To Err Is Human: Building a Safer Health System,” initiated sweeping changes to the

health care system to improve quality and patient safety.

“Rather than getting paralyzed by, ‘Oh my goodness, how do we change culture?’ we can go back to what we learned from that process over the last two decades,” Dr. West says. “How can we implement analogous strategies for well-being? And ideally, how can we learn from areas where the safety and quality missions have hit bumps in the road so that we can steer around those and make progress even more quickly than the safety and quality efforts have been able to achieve?”

If you go back to the years before the IOM report, Dr. West notes, few health care organizations had a patient safety officer or a formal focus on quality outcomes. Safety and quality had always been important in a general sense, but they weren’t formalized in the structure of a health care organization. The IOM report changed that, and now every organization has a safety and quality officer.

“Something that the IOM report made so evident was that our approach to fixing errors in our health care system required us to acknowledge that our system needed to change to promote safety,” he says. “I think the analogy is quite clear when we talk about well-being issues: The system is what needs to change so we can promote thriving and well-being for our health care professionals.”

A charter for the profession

It’s easy to get caught up in the blitz of burnout statistics—which specialities are hit the hardest, which ones the least, whether the overall percentage of affected physicians is ticking up or down—and those numbers do count, after all. But such a narrow view could lead one to think that little has changed in the last seven years, when, really, the environment is altogether different simply for the medical community’s awareness of the issue and its commitment at the highest levels to solving it.

Last year, *JAMA* published the “[Charter on Physician Well-Being](#),” a document conceived during a meeting shortly before of leaders from organizations spanning the medical profession at the Accreditation Council of Graduate Medical Education’s headquarters, in Chicago. Dr. West attended from Mayo Clinic.

“In informal conversations, almost everyone agrees that we need to promote well-being—it’s good for everybody—but how do you systematize that?” Dr. West says. “The idea of the meeting was to come together around a framework of expectations for the entire profession.”

Based loosely on the Physician Charter developed by the ABIM Foundation in 2002—which identified the primacy of patient welfare, patient autonomy and social justice—this charter features four guiding principles and eight key commitments focused on well-being.

“It does acknowledge that we have an individual responsibility as physicians for self-care, but that is housed among seven other commitments that go up the ladder of responsibility from local leadership to the health care system as a whole,” Dr. West says.

The hope is that the charter will serve as a reference point around well-being issues for practices, organizations and policymakers when implementing reforms—including when, say, the AMA is in conversations with the Centers for Medicare and Medicaid Services about payment models, or when the American Association of Medical Colleges is working with medical schools on redesigning learning environments.

“I think the most compelling piece of all of that for me was how resonant the content was. We got about 25 thought leaders together, and in a day and a half, they came to consensus,” Dr. West says. “That was remarkable, and it speaks to how together we are as a profession around these issues.”