Uncovering how burnout affects physicians at different life stages with Kim Templeton, MD
Moving Medicine

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In this episode of Moving Medicine, Kim Templeton, MD, believes that more physicians will leave the field of medicine unless something is done to address burnout and the system. Dr. Templeton is an orthopedic surgeon and professor of orthopedic surgery at the University of Kansas School of Medicine and Health System and is also a past chair of the AMA Women Physicians Section and a past president of the American Medical Women’s Association.

Speakers

- **Kim Templeton, MD**, orthopedic surgeon, professor of orthopedic surgery, University of Kansas School of Medicine and Health System
- **Sara Berg**, senior AMA news writer, American Medical Association

Host

- **Todd Unger**, chief experience officer, American Medical Association

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Transcript


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**Dr. Templeton:** So, to help physicians from all backgrounds thrive in their careers, remain in their careers and address the diversity of the field, we need to better understand what they’re facing in the workplace and what the workplace can do to try to address some of those issues, improve some of those issues. And that in turn is going to increase the diversity within health care.

**Unger:** That’s Dr. Kim Templeton, orthopedic surgeon and professor of orthopedic surgery at the University of Kansas School of Medicine and Health System.

Dr. Templeton served a past president of the Ruth Jackson Orthopedic Society, the U.S. Bone and Joint Initiative, and most recently, the American Medical Women’s Association.

Having been an AMA member for years, Dr. Templeton was also past vice chair of the AMA Women Physicians Section and past chair of the Orthopedic Section Council. On this episode of Moving Medicine, Dr. Templeton will share why she believes more physicians will leave the field of medicine unless something is done to address burnout and the system level problems. Here’s AMA senior news writer Sara Berg. Hi, Sara.

**Berg:** Hey, Todd. Thanks for the introduction. I'm Sara Berg, senior AMA news writer. And I have the pleasure of speaking with Dr. Kim Templeton today. Dr. Templeton is an orthopedic surgeon and professor of orthopedic surgery at the University of Kansas School of Medicine and Health System. Welcome, Dr. Templeton.

**Dr. Templeton:** Thank you so much. I appreciate the opportunity, and I really appreciate your interest in this topic.

**Berg:** Of course. Dr. Templeton has had a number of leadership roles and advocacy accomplishments. Today, we'll hear more about her leadership experiences in physician well-being and gender equity in medicine. We're happy to have you and thanks for being with us, Dr. Templeton. Why did you get involved in physician burnout and well-being?

**Dr. Templeton:** During the course of my career, especially more recently, I've seen the issues that physicians are facing at all levels of their careers, whether it's a medical student or a resident. I'm a residency program director. So, I see the issues that they're facing.

But I also see the issues that physicians in practice are facing, primarily from two levels of involvement. One, my work on the state medical board, the Kansas State Board of Healing Arts, as well as interacting with members of AMWA.
My work with the latter, work with AMWA, led me to look further into the issues that women in particular face in terms of burnout and understanding that women may be more likely to exhibit burnout.

Some studies would say women have higher rates of burnout. Some not. It kind of depends on what metrics you use and how it's measured. But even if there aren't any differences in prevalence, their risk factors are different, which means that the interventions are different.

So, while all physicians are at risk of burnout, there are groups that do carry higher or at least different risks. And these are people that tend to be the minorities in medicine, meaning other than cis white men.

So, whether that's women, underrepresented racial minorities, LGBTQ+ physicians, those in rural communities, to some degree, those in academia. All of them may again may not have higher levels of burnout but there are very specific issues that they face that increase their risk of burnout.

And so, while we discuss specific populations—and a lot of studies talk about—when they talk about physician burnout, single out areas that or characteristics that the physicians have that then result in higher rates of burnout, whether it's age or gender or race.

My concern with that is that it does indicate the populations that may be at higher risk but it doesn't mean that those are personal characteristics that increase their risk of burnout. Those characteristics mean that those physicians are working in an environment that cannot or is not addressing their needs.

So again, being a woman doesn't mean you're inherently at higher risk of having burnout. Being an underrepresented racial minority in medicine doesn't mean you're inherently at higher risk of developing burnout.

But it may indicate that you're in a work environment or potentially a home environment that's not seeing or addressing your needs. And so, you're constantly at odds and trying to prove yourself or overcome the barriers within your work or sometimes your home environment.

In my mind, burnout arises when physicians don't feel seen, heard or valued in their workplace. This then could put them at odds with their employers or with their colleagues.

Women also then face the additional challenges of societal gendered expectations outside of work. These two can be addressed by better understanding of the demands faced by women when they're in the workplace.


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So, understanding that if you have a woman at work, she’s still doing 70% plus of the work at home. And so, what accommodations do you need to make in the workplace so that a woman physician isn't in a position that no matter where she is, she thinks she needs to be somewhere else doing something else because that in and of itself can be a driver of burnout.

And we’ve seen that become more significant during the pandemic when schools were closed, and women were the ones primarily responsible for childcare or teaching their children. Well, what happens if you’re a full-time employed woman physician? There's only so much time and there's only so much you can do during that period of time.

And so, as we talk about burnout, there are obviously a lot of individual interventions that have been discussed. Those can help with the symptoms of burnout but it doesn’t address the causes of burnout.

And so, if we’re going to address the causes, that’s systemic change. And so, as we’re looking at the different causes and what different people in different areas face, if we want to affect real change, it’s really addressing the systemic drivers of burnout.

**Berg:** Okay, how does your work also impact gender in medicine?

**Dr. Templeton:** Hopefully, as we better identify the drivers of burnout, we can better understand what impacts physicians who are minorities in medicine in general. So, women, but also older physicians, underrepresented racial minorities in medicine, as well as LGBTQ+ physicians.

Again, it gets back to feeling seen, heard and valued. But to do that, health care systems really need to ask physicians, especially those in these minority groups, what impacts them and what solutions would work rather than assuming something is going to be beneficial.

For example, I think we need to continue to improve parental leave and available childcare. However, that doesn't completely solve the issues for women who are again dealing with societal-gendered expectations of their roles outside of the workplace.

In our study of senior women physicians that, again, would not have happened without the awesome work of the AMA Senior Physician Section; we found that 20% of women physicians over the age of 60 were still a caretaker for someone in their family. So, it was no longer the small children when they were earlier in their career but it's grandchildren, it's aging parents, it's aging spouses.

And so, as women progress through their career, I think there's this concept that there's this golden period of, “I get my career started, the kids are in school and that's going to be great.” And I hate to burst their bubble, the responsibilities may not be the same but they’re still there. They just change a little bit.
But this means that rather than having only parental leave, we need to expand this to career-long family leave so that we can support women throughout the entirety of their career. And this would go for men too that have responsibilities outside of the workplace.

So hopefully with this kind of change and engaging physicians in identifying the problem and designing solutions, we can keep and hopefully continue to attract more women and more people who are otherwise underrepresented in medicine into medical careers.

In our senior physicians study, we also found that senior women physicians were still the subjects of harassment. But it wasn't just based on gender. It was also based on age. And so, they're facing the dual impact of both age and gender.

Other studies, especially those by Dr. Gabriella Ode, have shown the biases and harassment that Black orthopedic surgeons, especially women, face. We need to better understand the issues that LGBTQ+ physicians face in terms of bias and harassment.

We know that biases and harassment are factors that can impact well-being. But as we continue to look at well-being, we need to understand, have better information in terms of how these biases and harassment impact the well-being of all of these minority groups within medicine, and especially look at issues with intersectionality.

So, to help physicians from all backgrounds thrive in their careers, remain in their careers and address the diversity of the field, we need to better understand what they're facing in the workplace and what the workplace can do to try to address some of those issues, improve some of those issues. And that in turn is going to increase the diversity within health care.

**Berg:** You worked on two resolutions around burnout that were adopted at the June AMA Annual Meeting. What were those resolutions?

**Dr. Templeton:** Both resolutions focused on physician well-being from the perspective of intrusive health questions that physicians are frequently asked. There are significant stigma about physicians seeking help, especially for conditions such as depression and anxiety. We as physicians are supposed to be the healers, not the patients.

But a lot of the stigma around seeking help centers around potential career consequences if someone finds out that a physician has a health condition and has sought help for that condition.

I think these questions were initially well-intentioned. They were included because there was some thought that physicians who needed help could be identified. And that this was a way for hospitals and especially state medical boards to fulfill their missions to protect the public.
However, we now know that these questions actually have the opposite effect in most cases. In states in which medical boards ask about prior health history or prior treatment, physicians in those states are significantly less likely to seek help usually because they're afraid of what the consequences are going to be to their licensure status and to their careers.

This led the Federation of State Medical Boards to recommend that state licensure questions be changed to no longer ask about health conditions, to no longer ask about treatment that physicians have sought, and at most, to ask about current impairment.

Other groups, including the American Medical Women's Association, are also working to raise awareness and to effect change in this area. And the AMA has been crucial in this work, and I'm happy to help lead the American Medical Women's Association in these efforts.

However, state medical boards are not the only entities or groups that ask physicians questions about their health history. These questions are also included on most hospital credentialing forms and board certification applications.

The Federation of State Medical Boards in their report on physician well-being recommended that hospitals in addition to state medical boards look at their applications in an effort to support physician well-being by encouraging physicians to seek the help that they need by not then having to answer these questions.

I worked with the state medical board in Kansas in 2019 to change language so that we now only focus on current impairment rather than health history. The University of Kansas Health System has changed their language on credentialing forms last year to reflect what's going on at a state level, and other hospitals are doing the same.

However, the intent of one of the resolutions on which I worked for the AMA was to help standardize the process. One of the resolutions, and this one is the one that came from the American Medical Women's Association, asks that physician well-being be considered as part of hospital certification by the Joint Commission, CMS and other hospital credentialing bodies.

As noted in the resolutions, the goals of the accrediting bodies are to set standards that improve care through assuring patient and staff safety. And the physician reluctance to seek care can impact the well-being and that of their patients.

And so, what this resolution requested was that our AMA work with CMS, the Joint Commission and other hospital accrediting bodies to assure that physician well-being be a component of standards for hospital certification. And that part of this focus on well-being include removal of intrusive questions regarding clinician physical or mental health or related treatments on renewal or initial hospital credentialing applications.
So, the goal of this is for hospitals to continue to focus on physician and other clinician well-being but to have this also demonstrated very concretely at least in part by the removal of intrusive questions about health or health history on credentialing applications to serve as a motivation for physicians to seek help or at least to remove a barrier similar to what has been done again with state medical board applications.

The other resolution that I appreciate the help of the OMSS in working through this and getting this to the House of Delegates was focusing on a similar issue but through the American Board of Medical Specialties.

That resolution noted that the goal of the ABMS is to assess and certify doctors. And this is a quote from their website. "To demonstrate the clinical judgment skills and attitudes essential for the delivery of excellent patient care."

Well, physician reluctance to seek care doesn't only impact their well-being but can also negatively impact what the ABMS said they're trying to support, the delivery of excellent patient care and patient outcomes.

And so, this resolution asks that our AMA work with the ABMS and its constituent boards to assure that physician well-being is a primary concern of the ABMS and their boards. And that the ABMS and boards focus on physician well-being, again, through a concrete demonstration by removal of intrusive questions regarding physician physical or mental health or related treatments and board certification applications.

I took this through the OMSS and work with the OMSS because more and more hospitals are requiring board certification as a requirement to work at a given hospital. And so, if a physician has a health history and they're afraid to seek care because they might need to answer those questions on a board certification application, this gets down to whether or not a physician could be credentialed at a given hospital.

But all of these efforts are to work together in concert to remove stigmatizing questions from state medical board applications, hospital credentialing applications and board certification applications. Because if we remove these questions from one area, that still leaves physicians concerned about the impact of seeking needed medical care and having to report this to another body.

So again, there's been a lot of work throughout states in removing this language and changing this to a focus on current impairment, which is crucial. But if you can then get a license, but then you can't get a—or you can't get a job at a hospital because you're afraid or have to report that you've had a significant health issue in the past and have sought treatment for that, then your license really doesn't do you a lot of good.
Or, if you can't get board certification because of needing to report past health history, then again likely you may not get a job at a given hospital. Or, again, worst case scenario, physicians don't seek help because they want to get their board certification, or they want to get hospital credentialing or they want to get licensure that actually puts themselves, their patients and the public in a worse position.

So the thought is if we can work in concert and remove all of these stigmatizing questions, let physicians know what that means, that should ideally encourage physicians to seek help. And I think what we're seeing during the pandemic with increasing rates of burnout, decreasing physician well-being, if we're going to change, now is the time to affect that change.

Berg: What's next for those resolutions?

Dr. Templeton: Well, I'm waiting until these become official policy of our AMA. Once this occurs, I'd like to make those within AMWA and the OMSS and any other interested groups aware that they're now official policy.

And then try to get as many people engaged in discussing this as possible to make sure that these actually come to fruition to add in another piece in the discussion of physician well-being. And then eventually follow up to see how these have been implemented and then where we stand in the process of implementation.

We keep talking about burnout but it's not going away. With the ramifications of the pandemic, may be getting worse. And I think it's broadening the discussion so that people can see that it's not an issue with an individual physician but it does have the potential for ramifications throughout healthcare.

For example, we continue to face a physician shortage. That's likely to continue to get worse as a result of the pandemic and increase physician attrition. There's discussion of getting the country back to where we were prior to the pandemic. However, at least for medicine, the status quo really isn't sufficient.

However, all of this work on burnout is obviously not something I'm doing alone. There are a lot of people, a lot of organizations that are focused on this. The AMA has obviously done amazing work. Other organizations such as Federation of State Medical Board, the Lorna Breen Heroes' Foundation, the Institute for Healthcare Improvement, et cetera are all groups that are focusing on this.

So, I think what I'm trying to do is discuss well-being and burnout and showing how it impacts a lot of other areas in medicine that may not be a direct link but there are some interrelationships. And I think as other groups and other people continue to do that, that will help continue the conversation.
Berg: You are also a past president of the American Medical Women's Association. And one of the initiatives you started there is physician well-being and re-entry. What does this involve, and how does it help address the physician shortage we continue to face as the result of the pandemic?

Dr. Templeton: The well-being worked through AMWA was initially focused on raising awareness of the issues with state licensure applications. We developed a project that's called Humans Before Heroes and then, more recently, transitioned into similar work on hospital credentialing forms. The well-being effort in AMWA is also now working on discussing issues faced by residents. So, residents and fellows in training, especially the red flags that help you identify that residents having an issue and then some of the interventions that are available.

Hopefully addressing systemic issues in the health care system will improve the lives of current physicians and keep them from leaving the field, as well as allowing them to be there to help mentor and be role models for the next generation of physicians and to encourage students to enter medicine.

Re-entry is another way to try to address the physician shortage, in addition to improving physician well-being. And I appreciate all of the work that our AMA has done in the area of re-entry. Re-entry is a process that occurs when a physician voluntarily leaves the active practice of medicine. So not one who is politely asked to leave or take some time away but someone who voluntarily takes time away.

The length of time out of practice varies state by state. But the average is a little over two years such that if you're out of practice a little over two years in most states, you likely will need some additional evaluation or intervention before you're given an active license.

However, the process to re-enter can be somewhat obscure. This is something that I started working on through AMWA because I see this to some degree as a woman physician issue, as a lot of physicians who leave are young women who take time off to have children and raise their families. And then once the children are in school, they want to come back to work.

But I saw this as a real issue during my time in the Kansas State Board of Healing Arts because we would have women that had taken off four or five years. Their children, young children, were now in school and they wanted to go back to practice and didn't realize that they had to do more than just come to their state medical board and ask for a license. There actually was a process to do so but it's something that isn't really discussed all that much.

So, a couple of things that I've done in this area is I worked with our board in Kansas to develop a re-entry to practice licensure category. So that's somewhat different and something that I've spoken about at our AMA. And hopefully other states can start adopting something similar.

Through AMWA, we're trying to raise awareness of re-entry as being an issue because most training students and physicians don't realize that they can't just leave practice and come back.

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So, our message through AMWA is plan ahead. If you're going to take time off, unless it's for an acute illness or injury that leads to an extended time off, then plan ahead for your return to practice as carefully as you planned for that time off. You may not plan on ever coming back to medicine but you don't want to shut that door.

So, trying to get the message out, especially through our AMWA GME task force, to let those younger in practice or in training to understand this and to learn what's needed and hopefully they can start planning ahead. AMWA was also collaborating with other groups and some national initiatives in this area.

So, the hope is if we can improve physician well-being, reduce physician attrition, have physicians to encourage the next generation of physicians. But then if they want to take time off, have a way for them to come back through all of these hopefully and other efforts we can hopefully address the physician shortage issue.

**Berg:** What's your advice to women physicians experiencing burnout?

**Dr. Templeton:** I would say let people know, talk with others, seek help. People talk about some of the ramifications of burnout, such as depression, anxiety, substance abuse, et cetera. The last is actually specifically important for women surgeons. And even the risk of suicide.

Suicidal ideation is significant issue among physicians. In a paper published recently, demonstrated it was much higher among women orthopedic surgeons than men orthopedic surgeons. So, the first thing I would do is recommend talking with someone. But to whom you talk and what kind of help you ask for depends on what the issue is. So again, you can have these mental health ramifications of burnout, but not everyone who is depressed or who has a substance abuse issue is burned out and not everyone who is burned out has a mental health issue.

And so, I think those two areas need to be very separate. So, if you're burned out and the burnout has gotten to the point that you are suffering from mental health issues, please seek help. Even if your hospital or your state medical board still asks questions about seeking help, there are ways of working through that. So, get the help that you need for that.

But when we're looking at just the burnout component, it's understanding that it's not a personal failing. It's not something that you did wrong in your career. It's something that is pervasive in medicine. And that's one of the concerns that I have with studies that look at the people that are most at risk.

I think having that data helps so we know the people that we maybe need to target more and have a better understanding of what's causing their burnout. But those risk factors should not be used again as an indication that they're somehow inherently at higher risk of burnout.

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And so, dealing from the burnout component, I would talk with other people in your department. I
would talk with other women in your institution to see if they’re facing something similar.

And if so, what are the ways to effect change? And what are some of the issues that can be
addressed? Is it that you’re having issues with work-home and home-work conflict, in that, again, no
matter where you are, you feel like you need to be somewhere else?

Well, then are there ways you can work with your institution to get the time off that you need to be able
to take care of the duties that you have at home? Because the societal gendered expectations on
women to take care of everything at home, those aren’t going to go away at least not in the near
future. So, work really needs to accommodate for that.

We did a study on senior women physicians that, again, I appreciate the help of the Senior Physician
Section of our AMA to make that come to fruition. In our study—this is the first to really look in depth at
what women physicians over the age of 60 face.

And they discussed issues with work-home and home-work conflict and noted that most of the time
they gave up or found other ways to accommodate their work at home to do their work in the
workplace. And I just worry whether or not that's a sustainable model.

So, if you’re burned out, talk with others in your institution. Is it a work-home, home-work conflict
issue? If so, are there ways that you and others can affect change? Are there things such as control
over scheduling?

Women tend to take more time with patients. There can be this mother transference where we're
spending more emotional energy on taking care of patients, which has been described as good for
patients but not necessarily good for women physicians.

If we're taking more time with patients, then that frequently means that we're also sent the patients
that are thought to be more challenging or more difficult that are inherently going to take more time.
But are you then working in a clinical environment where that's not accommodated or it's not
recognized? Meaning you're not given more time with some of the patients.

If you are being compensated on an RVU basis, if you're taking more time with individual patients,
you're seeing fewer patients in the course of a given clinic. Well, if you're paid based on how many
patients you see, that then is discounting the value that you're bringing to the workplace.

So, if people value you as a woman physician because you spend more time and you're willing to take
on more challenging patients, but, oh, by the way, you're not going to be paid as much as the men
who see fewer patients or see more patients, then that's a bit of a problem. And that, again, gets back
to the crux of the issue of, are you seen and valued in the workplace? And do people understand what
you need?

In talking with other women who may be burned out, are part of the issues bias and harassment? We know that gender biases and sexual harassment can increase the risk of developing burnout, as well as depression and anxiety.

Because again, you're constantly faced with this issue that I work in a workplace that doesn't value me because bias and harassment occur and nobody's doing anything about it. And so, can that be addressed?

Only about 15% of episodes of harassment are ever reported. Most people who report actually report to family and friends who are not in the workplace. So, they can't really do anything about it.

But when you ask why women don't report, it's because they think nothing would be done or that there could be a negative impact on their career. Well, if you don't think anything's going to be done or if you do report there's a negative impact, then why would you bother to report?

And so, all of this gets back to, if a woman is burned out, if it's leading to mental health or physical health issues, because those can happen for burnout too, please seek individual care for those.

But from the burnout component, it's letting people know; it's talking to others in the workplace and figuring out what's leading to your burnout. Because if you're burned out, you're probably not the only woman in your institution who is burned out. So, find out their experiences.

There also is a lot—developing that kind of report and support is also helpful. Medicine has been described as one of the loneliness professions. I worry that that's gotten worse during the pandemic.

I also worry what that means for women physicians because we are frequently a minority in the workplace. We go home and take care of the work at home. Where is their time to develop the networks outside of home? So, can we find a way to develop more networking for women in the workplace? And discussing issues that lead to burnout that can be addressed is one way of developing some networking.

But as these discussions progress, as you talk with other women in the workplace, you find out what some of the issues are, it's crucial then to engage leadership in health care in trying to address these changes. There has been some mention by a variety of people that we just need more women in medical leadership and everything that's leading to women's burnout is going to get better.

It's an interesting concept. We need more women in medical leadership. That's definitely true. But the problem is if there are things inherent in the health care workplace that lead to women being burned out, or biases or lack of sponsorship that keep women from achieving leadership positions, we're...
never going to have enough women in leadership to change all of the systemic issues that keep having a negative impact on women.

And so, as we find out what these issues are, it’s crucial to engage the men in leadership to try to effect change. And I think part of the message to them too that it’s the women that are being affected by some of these issues, but it’s not just women.

Men also can be impacted by some of the issues with scheduling or lack of control of their schedule, or issues with the EHR or lack of accommodation for the responsibilities outside of the workplace. So, as we identify these issues, it helps everyone. Can be started from a women’s perspective but eventually can help men too.

Berg: Is there anything else you would like to highlight or emphasize about well-being and the work you continue to do?

Dr. Templeton: I would just emphasize what I mentioned earlier that a lot of my career is focused on physician well-being and addressing burnout. But it’s not just me. There are a lot of people and a lot of organizations that are doing similar work. I’ve learned from all of them.

And this needs to continue to be a collaborative effort as we move forward because there are a lot of areas to address. I think we’re affecting change but there are a lot of other areas that need to be addressed. And we’re only going to be able to affect that level of systemic change working together as a community on this.

Berg: Dr. Templeton, it was a pleasure talking with you today. Thank you for joining me on AMA Moving Medicine.

Dr. Templeton: Thank you so much for your interest. I appreciate your time and I appreciate people listening to this.

Berg: Of course. I’m Sara Berg. Thanks for listening. And until next time, please be well.

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