Curbside Consultation

Physician Burnout and Stress While Interacting with Patients

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Case Scenario

Case #1. A 25-year-old patient presents to your clinic with viral upper respiratory tract symptoms that have been present for two days. The patient requests antibiotics based on her experience of past care at a local retail clinic. Antibiotics are not indicated; however, you oblige, recognizing that the patient may choose other health care options for future care, including retail and urgent care clinics. You also fear that the patient will give you poor patient-satisfaction ratings in the postvisit survey conducted by your hospital employer and on online physician-review sites.

Case #2. A 67-year-old patient with poorly controlled type 2 diabetes mellitus presents to your office for her quarterly follow-up appointment. Her A1C level remains high at 9.6%. The patient tells you that she is unable to afford the insulin you prescribed because she is in the Medicare Part D "doughnut hole." You empathize with the patient's dilemma, but you are inwardly concerned that her misfortune will adversely affect your quality scores and Medicare Shared Savings Program status.

Case #3. A 54-year-old patient presents for a consultation regarding ongoing fatigue and myalgias related to her fibromyalgia diagnosis. While you are typing into the electronic health record, she asks whether you are listening. She then challenges your recommendations with information from online sources, including message boards and blogs. You respond by stating that you cannot help her if she does not want your opinion or expertise. You immediately regret your words and apparent lack of compassion.

Commentary

Physicians, especially family physicians, face multiple stressors in modern medicine that can lead to disillusionment and burnout, which occur when the reality of practicing medicine does not match physicians' previous naive expectations. Physician burnout is a syndrome that includes emotional fatigue, cynicism, depersonalization, and a loss of meaning in work. Nearly 43% of American physicians, including 54% of primary care physicians, exhibit at least one symptom of burnout.[1] The emotional, mental, and physical toll associated with burnout places physicians at risk of developing mental health issues, such as depression and substance abuse.[2,3] Furthermore, ongoing emotional distress causes physicians to be at higher risk of suicide. Male physician suicide rates are currently 1.4 times that of the general population, and nearly 300 physicians annually take their own lives. Female physicians are even more vulnerable to suicide, with rates 2.3 times higher than the average for women in the general population.[4]

Burnout adversely affects the ability to provide quality care to patients, even to the point of becoming a public health crisis. One study showed that self-reported major medical errors among surgeons increased 3% to 10% as measures of burnout increased.[5] Also, the risk of losing capable physicians through attrition or dysfunction will further affect patient care and access.

Studies have shown that patients of engaged physicians are more apt to adopt their physicians' recommendations and have greater compliance with clinical treatment plans.[6] Some experts have proposed expanding the Triple Aim (enhancing patient experience, improving population health, and reducing costs) into the Quadruple Aim to include health care professionals' health and happiness as the fourth tenet.[7] This transformation could reinforce the importance of ensuring that physicians stay healthy and professionally fulfilled.

Identifying the external and internal root causes of burnout and creating actionable initiatives and strategies may be a start in improving stress and physician morale. External factors include increased electronic health record documentation requirements; perceived loss of control and autonomy; medicolegal stressors; administrative tasks, including quality reporting, payer preapproval, and billing demands; a shift from professionalism to consumerism; patient access to online medical resources and physician reviewing platforms; and patient demands and expectations of physicians.[2] Many patients regard the primary care

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to afpjournal@aafp.org. Materials are edited to retain confidentiality.

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physician as the face of American health care, resulting in transference of their frustrations with the entire system onto those front-line physicians.

Internal factors contributing to burnout stem from the erosion of core values with which physicians entered the medical field. Studies show that physicians may be vulnerable to burnout because of specific personality traits and working in a medical culture that emphasizes perfectionism, denial of personal vulnerability, and delayed gratification.[8] Exhaustion, lack of time, and a sense of demoralization have made it even more difficult for physicians to care for themselves and their patients. Primary care physicians have found themselves excluded from positions of influence, with their voices dampened by health care's move to a corporate culture, and they have lost touch with each other in the current health care system.

How can physicians develop strategies, including resiliency skills, that enable them to remain connected to the deeply rooted reasons that led them to become physicians? Early intervention could be part of the answer. A small study found that early exposure to an interactive resiliency-based intervention in family medicine residents resulted in short- and long-term decreases in burnout symptoms.[9] Such interventions suggest that physicians benefit from focusing on themselves to build resiliency as individuals and as a physician community.

For this change to succeed, strong physician leadership is required. Professional organizations and local health care systems must play a major role in supporting these efforts, especially in reducing administrative burdens on physicians and improving practice environments. Forward-thinking health care organizations, including Stanford Health and Novant Health, have made bold investments in physician health and wellness by creating and implementing physician wellness strategies. Stanford Health, led by Tait Shanafelt, MD, created Stanford WellMD to address physician burnout. Novant Health, led by Tom Jenike, MD, offers three-day resiliency-based training to their physicians, which has shown a marked improvement in physician engagement scores.[10] By creating policies and processes that enable physicians to be physicians, they will feel more effective, appreciated, and respected within the health care system. One large, physician-owned, primary care–focused organization, Coastal Medical (located in Providence, R.I.), engaged its doctors by holding brainstorming sessions. In the work groups, physicians voiced their frustration regarding administrative burden. By mandating that their physicians perform only "doctor work," the organization's executives created processes to ensure that their physicians worked at the top of their licensure rather than being bogged down in administrative tasks (e.g., completion of prior-approval paperwork) that could be handled by other staff members.[11] Adopting a patient-centered medical home approach, including team-based documentation, allows physicians more time to focus on patient care. A pilot study at the University of Colorado found that transforming to a team-based documentation model reduced physician burnout rates from 56% to 28%.[12]

The American Medical Association's Code of Medical Ethics enjoins physicians to address their own and their colleagues' mental health and well-being.[13] It can be argued that physicians have performed poorly with this mandate. Previous approaches have relied on self-monitoring and mutual accountability. For self-care to work, processes and programs must be in place to foster and reinforce a culture of physician wellness. Rebuilding physician community and mutual accountability for wellness will not fix all of the external factors that have led to the burnout epidemic, but it will remind physicians that we are all in this together, united, and no longer left to fend for ourselves. *Table 1* lists online resources that can serve to educate and train physicians on improving their resiliency and wellness habits.

Each of the presented case scenarios underscores stressors and indicates different aspects of potential physician burnout.

Case #1 highlights the realities and competitive landscape of primary care. Patients now have a variety of options to receive health care, and physicians ▶

TABLE 1

Resiliency and Wellness Resources

American Academy of Family Physicians: Physician Health First https://www.aafp.org/membership/benefits/physician-health-first.html
American Foundation for Suicide Prevention: Healthcare Professional Burnout, Depression and Suicide Prevention https://afsp.org/our-work/education/healthcare-professional-burnout-depression-suicide-prevention/
American Medical Association: Steps Forward Online Modules https://www.stepsforward.org/
National Academy of Medicine: Action Collaborative on Clinician Well-Being and Resilience https://nam.edu/initiatives/clinician-resilience-and-well-being/
Stanford Medicine: WellMD https://wellmd.stanford.edu/

are more vulnerable to patient scrutiny and criticism. Family physicians can improve their own standing by ensuring patient access to convenient care by implementing same-day scheduling, extended hours, and virtual health to alleviate patient anxiety or resentment. The implementation of best practices can ensure that quality care remains a priority, including practice-based interventions to curb inappropriate antibiotic use.[14] At the same time, the reasons for clinical decision-making must be clearly understood and appreciated by the patient. Good communication with patients should help avoid ratings being based on convenience and personal factors rather than treatment safety and effectiveness.

Case #2 highlights the stress imposed by quality scores mandated by the Medicare Shared Savings Program and other programs. Physicians can implement team-based care processes to encourage stronger patient engagement, to motivate patients to control chronic health problems, and to communicate when barriers are encountered in implementing care plans. Local physicians can work together to pool resources and to access community services to support patients, including those with difficulty accessing medication or health services.

Case #3 demonstrates the burden placed on physicians by technological advancements. Physicians can use team-based documentation and virtual scribes to lessen the documentation burden. Virtual scribes use online medical documentation services to help complete the office visit documentation, either during or after the visit. Rather than viewing the electronic health record as an adversary, physicians can reframe the patient's perspective and optimize its use. Physicians can also create time-saving processes, such as office visit efficiency cards provided to patients when they check in. These cards engage patients by asking them to prioritize three medical issues they would like to address that day. Finally, patients have access to an array of online information, but not all of it is valid, useful, or even safe. Physicians can steer their patients to sites that provide appropriate, accurate, reliable, and useful information, including contacts with resources and reputable patient organizations. A previous article in *American Family Physician* provides guidance on how to help patients accurately understand information from online sources.[15]

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