

# Physician Burnout: What Is It and What Causes It?

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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

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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](http://e-tmf.org).

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

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