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EDITOR'S PAGE

# Physician Burnout – Part 1

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Until recently, the term physician burnout was not one with which I was very familiar. However, over the past several years the problem of physician burnout and depression has been increasingly recognized and written about. In fact, I am almost embarrassed to write yet another essay on this problem. However, physician burnout was featured at the last meeting of the European Society of Cardiology, and will be so at the forthcoming meeting of the American College of Cardiology, attesting to the importance to which it is regarded. Therefore, I thought it would be very important to address this topic, especially since structural heart disease specialists find themselves in some of the most stressful situations in medicine. I will do so in two parts; the first discussing the issue and its causes and the second presenting potential remedies.

A variety of definitions of physician burnout have been proposed. However, one that I found particularly attractive was that burnout is a long-term stress reaction consisting of a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal efficacy. Physicians who experience burnout typically manifest anger and irritability, demonstrating absenteeism and job turnover, and exhibit decreased productivity. Other characteristics typically associated with burnout include deterioration of relations with patients and other physicians as well as diminution in the amount of the quality of care that these physicians deliver.

The prevalence of physician burnout has been reported by several sources. The most recent and best data has been recently published by Medscape in their 2018 report.[1] The Medscape survey reported that 42% of physicians indicated they were burned out, while 12% were colloquially depressed and 3% clinically depressed. The degree of physician burnout varied by specialty, ranging from 23%-48%, with cardiology in the upper half at 43% prevalence. Interestingly, the Medscape survey indicated that, of all medical specialties, cardiologists were the least happy at work, with only 21% reporting happiness with their position. Similarly, cardiologists were the least of all medical specialties to be likely to seek professional help. The prevalence of burnout was similar between physicians who were employed and those who were self-employed, but female physicians reported burnout more frequently than males (48% vs 38% respectively). Somewhat surprisingly, the incidence of physician burnout peaked in the 45–54 age bracket, reaching 50% in those physicians.

In terms of contributing factors to physician burnout, the job was the primary factor cited, and was considerably greater than other contributors. In decreasing but generally comparable order, other factors contributing to physician depression were finances, family and romantic issues, and health. In this regard, the increasing requirements for documentation as well as for dealing with the electronic medical record have clearly been recognized as major sources of stress, anxiety, and depression among physicians. Fifty-six percent of physicians indicated that there were too many bureaucratic tasks such as charting and paperwork, while 24% felt that increasing computerization of the practice was a major factor in burnout. The net effect was that physicians generally felt that they spent too many hours at work and that there was a lack of respect from administrators, employers, and even colleagues and staff. A lack of control and diminished autonomy as well as just feeling like a cog in the wheel were reported by approximately 1 in 5 physicians. Somewhat surprisingly, insufficient compensation was cited as a major contributor to burnout by only 24% of physicians, although in other reports, increased compensation was cited as a possible solution to burnout.

The Medscape survey yielded evidence that burnout and depression had a definite effect upon patient care. Although 40% of physicians indicated that depression did not affect interactions with patients, a third of physicians indicated that they had become easily exasperated and less engaged with patients and more likely to express frustration in front of patients. Of greater significance, 14% of depressed physicians indicated that they made errors that they might not ordinarily make while 5% indicated that they made errors that could potentially harm patients. The effect of depression also extended to dealing with fellow physicians or staff members. Similar to the effect upon patients, burnout in physicians led them to be less engaged, more easily exasperated and frustrated, and less friendly with peers and staff. It also resulted in errors that might not ordinarily be made and could potentially harm staff or fellow physicians.

According to the Medscape survey, physicians apply a variety of actions to cope with burnout, many of them self-destructive. Fifty percent of physicians indicated that they turn to exercise to cope with burnout, while a similar number seek to talk to family members and close friends. An increased amount of sleep or listening to music was also a calming coping mechanism. However, burnout frequently led to hurtful actions. Thus a third of physicians indicated that they ate

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more junk food, 22% drank alcohol, and a small number admitted to smoking cigarettes, using prescription drugs, or consuming marijuana products. It would seem that these inappropriate coping mechanisms might lead to a vicious cycle of burnout. Of interest, male and female physicians dealt with burnout with relatively similar actions.

Physicians were questioned as to what changes they felt would reduce burnout. As stated earlier, increased compensation was the answer most frequently given by 35% of responders. Prominently mentioned changes that would reduce burnout included decreased government regulations, increased autonomy and greater respect from administrators, employers and colleagues, or more reasonable patient loads and work schedule, and an environmental emphasis upon patients over profits. Only 5% of physicians indicated that a more supportive spousal partner would be of value in overcoming physician burnout.

Physician burnout is having a major effect on the overall healthcare enterprise. In 2016, 13.5% of physicians indicated that they were planning to look for a nonclinical job in healthcare in the next 1–3 years.[2] This exit of physicians would be a major contributor to the shortfall of physicians which is projected to increase to the year 2030. Physician burnout also has major financial implications. Stanford University estimated that physician burnout cost their organization at least 7.75 million dollars a year.[3] Burnout related turnover across all US physicians was estimated to be costing as much as 17 billion dollars a year by the National Task Force for Humanity and Health Care. It was estimated that it cost the healthcare system approximately 1.5 million dollars for every physician who left the practice and needed to be replaced.

The most devastating manifestation of physician burnout and depression is suicide. Of all professions, physicians have the highest incidence of suicide, being approximately 1.87 times more frequent in the medical community than in society overall.[4] Approximately 300–400 suicides occur among physicians annually, roughly the equivalent of four graduating school classes. The rate of physician suicide is also likely under reported, since physician colleagues are less likely to report such events. A number of factors predispose to physician suicide. As physicians, we have knowledge of and access to lethal methods, and we are typically reluctant to come forward with psychological problems as they may not only indicate weakness but also cast doubt on our medical practice. As physicians we are in a stressful profession as we deal with the most important factor in anyone's life, that is their health. Our practice is expected to be errorless, a situation sometimes referred to as the tyranny of perfection. The increased incidence of suicide among physicians has been a major factor in shining light on the problem of burnout.

From my perspective, it is impossible to overemphasize the effect that increased documentation requirements and the use of electronic medical record (EMR) have had upon physician burnout. A nearly universal cry among doctors is the fact that they now spend more time with the computer and medical records than they do with the patient. Much of the documentation required is often felt to be extraneous to the care of the patient, and requiring it to be done in the unfriendly environment of a computer program only adds to the frustration. It has been pointed out that the requirement for an electronic medical record was imposed upon the medical community prior to any documentation of efficacy. Rarely if ever is a major intervention made mandatory in medicine without absolute documentation of efficacy, as was done with the EMR. Moreover, in requiring that all physicians utilize an electronic medical record, the government ensured a captive customer base for the vendors of these programs, therefore limiting some of the incentive to improve their usability. It would appear that the government has recognized the unintended consequences of its action as manifested by the exploding prevalence of physician burnout and depression. The recent decision by CMS to reduce the requirements of documentation are clearly a step in the right direction. Although medical scribes represent another alternative, there are associated downsides including possible interruption of the patient-physician relationship.

Depression and burnout are not limited to practicing physicians, but are also prevalent among medical students and residents, thus, the systematic review of the literature led to the estimate of the prevalence of depression or depressive symptoms among medical students of 27%, and of suicidal ideation of 11%.[5] Twenty percent of residents indicated that they had fallen asleep while driving because of work-related fatigue. Most house staff training programs must now incorporate a healthy work life program in their curriculum for accreditation. Indeed, one article listed 20 nonclinical career options for physicians seeking to leave clinical medicine. A study in *JAMA* followed doctors in training over the course of 6 years and found 45% of them reported symptoms of burnout and 14% regretted their choice of profession.[6]

A variety of approaches to reduce physician burnout and depression have been proposed and/or implemented. These measures will be discussed in Part 2 of this Editor's Page. While the optimal remedy to prevent physician burnout remains to be defined and put into practice, it is undeniable that the problem of physician burnout is increasing, and has major effects upon both the healthcare enterprise in general, and the delivery of individual patient care.

## Disclosure statement

The author has no conflicts of interest to disclose.

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