The Impact of Stress and Burnout on Physician Satisfaction and Behaviors

By Alan H. Rosenstein, MD, MBA, and Michelle Mudge-Riley, DO, MHA

In this article...

With health care growing more harried and complex, stress and burnout are taking a bigger toll on physicians.

Dr. Sour is a 50-year physician who practices in a busy multispecialty group practice in a large metropolitan community. In years past he was passionate, energetic and proud of his role as a health care provider. He enjoyed participating in a number of different hospital committees and clinical projects and was happy to help out when and wherever needed.

Recently he has been noted by staff to be more angry and irritable and not the same old jovial person he used to be. He lost his smile. The staff also noted that he was showing up late, appeared stressed and fatigued, and didn't seem to take the time to interact or be as focused as he usually was, often letting things fall through the cracks.

When the staff tried to approach him he usually shied away or mumbled something like medicine isn't what it used to be. When pushed he would say that he didn't appreciate people telling him what he could and couldn't do and getting paid less for doing it. Even the patients appeared ungrateful. Being a physician isn't what it used to be.

One day during surgery he started yelling and screaming at the OR staff complaining about schedule changes, poor equipment, and nurse competency. One nurse in particular was so upset by the disrespectful berating behavior that she left the room in tears.

Later on that day when he was called about a change in a patient's condition he became extremely agitated and acted in a condescending manner to the nurse questioning her competency and how she ever got her license. It got to the point that he became so intimidating, that no one wanted to interact with him. There were several issues raised about communication responsiveness and coordination of care, but no one seemed to want to say anything to him directly as there was a general reluctance to intervene.

In the weeks following, Sour became more and more isolated. He stopped showing up at the committee meetings and rarely mingled with his peers. Friends and family didn't seem able to help. He appeared to be getting more and more depressed. A question was raised about whether or not there was an underlying problem with substance abuse.

After a series of minor disruptive events there was an incident where a nurse called Sour with a concern about a patient's condition and he appeared to be in such a distressed state that concerns were raised about patient safety. At that time the executive medical staff intervened and the physician was called in to discuss these issues.

Background

The case of Dr. Sour is a compilation of comments pieced together from a series of surveys we conducted to highlight concerns about internal and external forces affecting physician attitudes and behaviors.[1-6]

Most physicians entered the medical field believing that hard work and dedication would lead to a happy, successful and satisfying career in the practice of medicine. The sacrifices made through the added years of education and training required to develop unique skills were well worth it in the quest to deliver the best possible care to their patients.

All seemed to be going well until the mid-1980s. Growing worries about health care costs and quality, and noted variations in diagnosis, treatment, and clinical outcomes raised concerns about the appropriateness, efficiency, and effectiveness of different practice patterns and its impact on patient outcomes.

The era of external surveillance and accountability was born. The initial payer response was to change financial incentives for care by placing more financial risk on providers by shifting reimbursement models away from traditional fee-for-service system to more of a fixed-priced payment

A recent article in the *The Annals of Surgery* reported that 40 percent of surgeons reported being burned out and 30 percent screened positive for symptoms of depression.[9]

system based on per-case, per-diem, fixed contract or capitation models.

Any remaining fee-for-service payments were significantly discounted through a variety of managed care contracts. The second phase of concern occurred in early 2000 with the release of the IOM Report ("To Err Is Human") highlighting the large number of preventable medical deaths that occur each year as an unintended outcome of medical interventions.[7]

A variety of pay for better performance and no pay for poor performance initiatives were introduced to reinforce concerns about patient outcomes. Now as we move through the era of health care reform, there is an increasing emphasis on looking at medicine as a business with more external monitoring and interference telling us what we can and cannot do and paying us less for doing it.

The new legislation brings both positives and negatives to doctors in key areas such as new Medicaid patients at Medicare reimbursement rates, potential new business opportunities for primary care, funding issues and controlling expense and prevention efforts.[8]

Provider reaction

Many providers have made the necessary adjustments and begrudgingly adapted to the pressures of today's changing health care environment. But for some physicians the stress levels have reached a point where the pressures have progressed from indifference to dissatisfaction to fatigue, exhaustion and burnout—and in more serious cases to bouts of depression, substance abuse, or suicidal ideation.

A recent article in the *The Annals of Surgery* reported that 40 percent of surgeons reported being burned out and 30 percent screened positive for symptoms of depression.[9] Burnout ratings were the greatest predictor of career satisfaction.

Table I Approaching Stress and Burnout	
1.	Raise awareness.
2.	Recognize impact of stress on self and others.
3.	Be willing to accept outside assistance.
4.	Address barriers to seeking support.
5.	Reach out to family, friends and peers.
6.	Identify self help strategies.
	• Life style management • Stress management • Anger management
7.	Take advantage of internal physician wellness programs.
8.	Utilize outside coaching and mentoring services.
9.	Utilize professional counselors or therapists.
10.	Career counseling
	• Re-energize • Diversify • Change practice model • Change professions • Retire

Table II Selected steps in the career evaluation process	
1.	Create a timeline to evaluate your career and what you want out of it.
	• Set milestones • Make necessary adjustments
2.	Investigate new possibilities.
	• Research areas of interest • Join appropriate healthcare/ business/ entrepreneur organizations • Utilize job/ career search engines
3.	Spread the word.
	• Update CV/ resume • Utilize social media • Establish website • Create networking opportunities • Enhance exposure
4.	Beginning a personal branding strategy.
	• Focus on experiences, strengths and interests • Perfect a 30 second elevator pitch • Enhance interview/ salesmanship skills

Several reports suggest that many of these problems may actually begin during the medical school years and residency training programs.[10-12] One study reported a 50 percent burnout rate in medical students with 10 percent experiencing suicidal thoughts.[13] Similar findings were noted in primary care physicians as well.[14,15]

A recent survey conducted by The Physician's Foundation found that 78 percent of physicians think medicine is either "no longer rewarding" or "less rewarding" and 49 percent of primary care physicians say they will reduce the number of patients they see over the next three years.[16]

Besides the toll it takes on personal life and work satisfaction, there is a growing body of literature that links practice dissatisfaction, work life stress, burnout, and fatigue with behaviors that are known to adversely affect staff relationships and performance efficiency that can seriously compromise patient safety and quality of care, increase the occurrence of adverse events and/or medical errors, and increase the likelihood of litigation.[17-20]

With the growing shortage of physicians, we need to look at physicians as being a precious resource and work with them in an effort to reduce stress, improve overall satisfaction, and help them adjust to the changing environment. What's the best way to address the problem?

Problem recognition

The first problem is to get the physician to recognize and understand that a problem even exists. Most of the time physicians don't perceive that they're working under any undue stress, and even if they do, they look at stress as being part of the job. They have been working under stress their entire career. It goes with the territory.

67% OF AMERICANS ARE OVERWEIGHT OR OBESE

MAKING WAISTLINES SMALLER HAS BECOME VERY **"BIG"** BUSINESS

BE THE SOLUTION

MEDI WEIGHTLOSS CLINICS®

The one that works!®

a physician-supervised weight loss program

- Actual average daily revenue per patient base clinic = **$3,644†**
- Actual average annual revenue per patient base clinic = **$884,570†**

1.866.551.MEDI (6334)

www.mediweightlossfranchising.com

YouTube Broadcast Yourself®

509 South Hyde Park Avenue
Tampa, FL 33606

To compound the issue, as a byproduct of medical training, many physicians become detached or desensitized to the emotional components of care and have a low level of "emotional intelligence" which dampens their perceptions of their interactions with the surrounding environment.[14]

The second problem is to get the physician to allow someone else in. Most of the time physicians feel like they can handle the pressures themselves and don't need any outside assistance. Physicians are very egocentric.

The thought and stigma of opening themselves up to outside help can be a blow to their ego or worse yet, stimulate concerns about what others might think as to their competency and capability to provide care.

All of these are real emotions, but in the end the physician must realize that the potential of non-action may lead to more severe problems resulting from burnout, depression, substance abuse and more, if issues remain unresolved.

Evaluating options

Although physician denial, acceptance and reluctance to allow someone else in to intervene are potential obstacles, there are effective ways to overcome these barriers. Physicians must remind themselves that they are not invincible, that reacting to stress is not a character weakness, and that they can take steps on their own to help adjust to the pressures of the surrounding environment.[24]

Table I provides a series of steps that can help physicians more effectively address issues related to stress and burnout.

The first step is to raise awareness of the toll of stress on mind and body. Physicians may recognize the more obvious physical symptoms of stress such as chest pain, palpitations, headaches, muscle pains, panic/anxiety attacks, and gastrointestinal distress, but they may not recognize the more subtle symptoms such as anger, irritability, mood swings, apathy, loss of focus, sleep disturbance, isolation, and an overall sense of frustration and dissatisfaction with what they are doing. Understanding, acknowledging and accepting the fact that they are stressed and that the stress is affecting their moods and behaviors opens the door for the next steps.

Physicians must remind themselves that they are not invincible.

After acknowledgement and acceptance, we need to encourage physicians to open themselves up to outside assistance and support. This can come from family, friends, peers or a neutral third party like a coach or mentor. When outside help is offered, the parties must be aware of physician sensitivities and resistance, be respective of the physician's time and place, and make a point of trying to make the physician feel comfortable in discussing these issues by assuring confidence and trust and that they are there to help in a supportive non-threatening manner.

Interventions should include a number of different self-help strategies that focus on life style management as to the benefits of proper diet and nutrition, exercise, sleep, relaxation, meditation, and the avoidance of unnecessary drugs or stimulants. In some cases participation in specialized training programs in stress management, time management, anger management, or work-life balance techniques will often provide assistance in adjusting perspectives and priorities.

Taking advantage of a coach or mentor will help provide the needed expertise to move forward. A recent study concluded that physicians who are dissatisfied may greatly benefit from training or a personal coach or mentor to decrease the chance that the process of burnout will get out of hand.[23]

These strategies are designed to help physicians understand their surroundings and provide coaching tips that will enable them to better adjust to their surroundings, increase satisfaction and productivity, and lower the likelihood of an undesired downstream effect. Using the coaching or mentoring model, a physician can take concrete steps to improve his or her current situation while still remaining in practice.

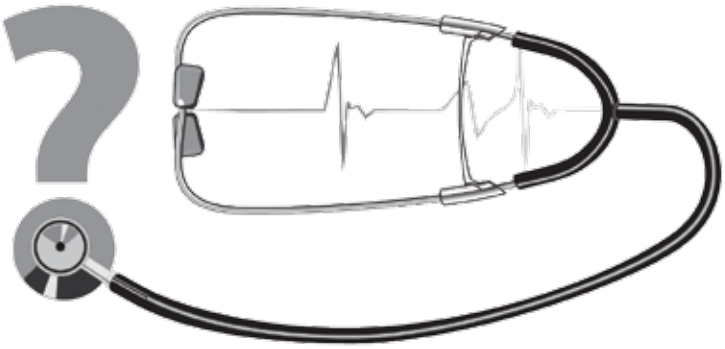
There are a number of different organizations offering these types of services either through a physician wellness or executive coaching model. In some cases more comprehensive therapy sessions will be more appropriate. Early intervention programs have a much greater potential for success than interventions occurring after an unwanted event occurs.[25]

When it becomes apparent that the status quo will no longer do, physicians need to be willing to take the next steps to move forward. Introspection is often involved and includes re-visiting the question of why one became a doctor, what the physician enjoys about the profession and what he or she could do to reenergize the passion in a medical career.[26]

This model is very important because by using it, a physician often chooses to stay in practice with a more balanced outlook and perspective. The physician may take steps to innovate and diversify his or her current model of practice.

For example, he or she can choose to switch practice models

How's Your Health?



Has Your Patient, Employee, and Community Tried The *Newest*

HowsYourHealth.org?

Over a **decade of internet R&D**, many publications, and **several hundred thousand uses** will help you, your patients and your organization attain *information management functionalities* needed for **best health and healthcare**.[1]

#1 in Value for Patient-Centered Care

A partial list of functionalities includes

- Automatically and easily customizable for all ages in different settings (such as hospital, clinic, workplace, schools, home health) and many care transitions.
- Web-tablet optimized.
- Behaviorally sophisticated to maximize user confidence with self-care.
- Immediate tailored information and predictive modeling for each user's responses.
- Automatic linkage to chronic condition, problem-solving and decision-making modules.
- A transportable, interactive personal health record and care plan for each user.
- A secure registry of users' needs and common conditions loaded by the users themselves.
- Immediate feedback to professionals of each user's responses.
- Online patient consent for follow-up, phone coaching, and research.
- A HIPAA secure registry of users' needs and common conditions loaded by the users.
- Automatic summaries and comparisons of user responses including national measures.[2]
- A brief, extensively tested practice improvement program with optional CME accreditation.

Your Next Step?

Simply try HowsYourHealth for *up to 75 users without obligation* by either:

Choosing www.**HowsYourHealth.org**/try or

Going through these trusted partners

planetree.org	stlbhc.org	ihi.org	idealmedicalpractices.org	VtOxford.org
for hospitals	for employers	for quality improvement	for small practices	for neonatal ICU

Questions? (603) 653-8139

1.Practice Based Population Health: Agency for HealthCare Quality and Research. June 2010 2. Consumer Assessment of Health Plans (CAHPS)

and, for example, become a salaried employee. A recent article in the *New York Times* discussed the transformation in how medical care is delivered in the U.S. due to more doctors giving up private practices.[27]

There is also a subset of physicians who change locations from large city to small town or join another practice. Some physicians choose to practice part time and pursue higher learning in a field that is complementary to their current field and interests such as informational technology, public health, genomics, or aging. Still others pursue more of an administrative role as a medical director.

In more severe cases, the physician may find he or she suffers so deeply with stress, burnout and frustration that he or she gets to the point where practicing clinical medicine is no longer a viable option. These physicians can either retire or seek out a non-clinical career.

Again, the help of a coach or mentor who specializes in working with physicians in this situation can be helpful and speed up the process while helping the physician avoid pitfalls.

In this case there are several possible alternatives to consider. Some of the options for a physician who wants to use his or her medical knowledge and skills to do more than practice direct clinical care include medical communications and writing, consulting, teaching, starting a business, working in the medical device or pharmaceutical industry, the wellness and health promotion industry, marketing and sales, business development, finance or grant writing.

A physician is uniquely qualified to pursue any of these options but he or she must take specific steps to move from the clinical to the non-clinical realm. Although physicians make excellent managers, organizational leaders or entrepreneurs, for a physician to step out of the clinical world into any other job requires a shift in focus and some new skills.[28]

Table II lists some of those steps. In addition, all of these options carry a particular set of job and lifestyle considerations—for example, what is the salary? Are there opportunities to move up the career ladder? What is lifestyle like? Will travel be involved?

Final considerations

Physicians are a precious resource and they can use our help and guidance. We need to understand physician needs and priorities, respond appropriately to their concerns, and help them adjust to the changing world of medicine.

Many of these considerations need to be addressed at the medical school and residency training levels. We need to take a proactive supportive approach in dealing with physician stress and burnout and provide support early in the process in a positive, empathetic, supportive, confidential, collegial manner.

Early intervention through friends, family, colleagues, or a coaching/mentoring program is preferred. Identifying those at risk and working with them early on in the process will increase the chances of success.

Alan H. Rosenstein, MD, MBA, is a practicing internist in San Francisco and medical director for Physician Wellness Services, Minneapolis, Minn.

alan.rosenstein@WorkplaceBehavioralSolutions.com

Michelle Mudge-Riley, DO, MHA is a physician coach and mentor who works as a consultant in the wellness and health promotion industry with large employers. She is president of Physicians Helping Physicians.

mudgeriley@yahoo.com

References:

1. Rosenstein A. "The Impact of Nurse-Physician Relationships on Nurse Satisfaction and Retention." *American Journal of Nursing*, Vol.102 No.6, June 2002, p. 26-34.
2. Rosenstein A, Lauve R, Russell H. "Disruptive Physician Behavior Contributes to Nursing Shortage." *The Physician Executive*, November-December 2002, p. 8-11.
3. Rosenstein A, O'Daniel M. "Disruptive Behavior and Clinical Outcomes: Perceptions of Nurses and Physicians." *American Journal of Nursing* Vol. 105 No.1 January 2005 p.54-64.
4. Rosenstein A, O'Daniel M. "A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety." *Joint Commission Journal on Quality and Patient Safety* Vol.34 No.8 August 2008, p.464-471.
5. Rosenstein A, O'Daniel M. "Impact and Implications of Disruptive Behavior in the Peri-operative Arena" *Journal of American College of Surgery* Vol.203 No.1, p.96-105 July 2006.

6. Rosenstein A, O'Daniel M. "Impact of Disruptive Behaviors on Clinical Outcomes of Care." *Journal of Neurology* Vol.70 No.17 April 24, 2008, p.1564-1570.
7. *To Err is Human: Building a Safer Health Care System.* Institute of Medicine National Academies Press, Washington, DC 2000.
8. Kane L. "What Does the Healthcare Reform Bill Really Mean for Doctors?" *Medscape Business of Medicine,* March 23, 2010
9. Shanafelt T, Balch M, Bechamps G, Russell T, and others. "Burnout and Career Satisfaction Among American Surgeons," *Annals of Surgery* Vol.250 No.3, September 2009, p.463-471.
10. Yeo H, Viola K, Berg D, Lin Z, and others. "Attitudes, Training Experiences, and Professional Expectations of US General Surgery Residents," *Journal of the American Medical Association* Vol.302 No.12, September 23.30 2009, p.1301-1308.
11. Goebert D, Thompson D, Takeshita J, Beach C, and others. "Depressive Symptoms in Medical Students and Residents: A Multischool Study," *Academic Medicine* Vol.84. No. 2, February 2009, p.236-241.
12. Tarkan L. "Arrogant, Abusive and Disruptive – and a Doctor." *New York Times,* December 2, 2008.
13. Dyrbye L, Thomas M, Massie S, Power D, and others. "Burnout and Suicidal Ideation Among Medical Students." *Annals of Internal Medicine* Vol.149 No. 5, September 2, 2008, p. 334-331.
14. Krasner M, Epstein R, Beckman H, Suchman L, and others. "Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians," *Journal of the American Medical Association* Vol.302 No.12, September 23.30, 2009, p.1294-1300
15. Linzer M, Manwell L, Williams E, Bobula A, and others. "Working Conditions in Primary Care: Physician Reactions and Care Quality," *Annals of Internal Medicine* Vol.151 No.1 July 2009, p.28-36.
16. Commins J. "Unhappy Docs Provide Roadmap for Recruiting, Retention." *HealthLeaders Media,* December 2008.
17. Quinn M, Wilcox A, Orav J, Bates D, and others. "The Relationship Between Perceived Practice Quality and Quality Improvement Activities and Physician Practice Dissatisfaction, Professional Isolation, and Work-Life Stress." *Medical Care* Vol.47 No.8, August 2009, p.924-928
18. Wetzel C, Kneebone R, Woloshynowych M, Nestel D, and others. "The Effects of Stress on Surgical Performance." *American Journal of Surgery* Vol.191 no.1, January 2006 p.5-10
19. Rosenstein A., O'Daniel M. "Impact and Implications of Disruptive Behavior in the Peri-Operative Arena." *Journal of American College of Surgery* Vol.203 No.1 p.96-105, July 2006.
20. Fullam F. "The Link Between patient Satisfaction and Malpractice Risk." *Press Ganey Insights* 2009, Press Ganey Associates.
21. Spickard A, Gabbe S, Christensen J. "Mid-Career Burnout in Generalist and Specialist Physicians." *Journal of the American Medical Association* Vol.288 No. 12, p.1447-1450.
22. Hickson G, Entman S. "Physician practice behavior and litigation risk: evidence and opportunity." *Clin Obstet Gynecol.* Vol.51 No.4, December 2008, p. 688-699.
23. Zantinge E, Verhaak P, Bakker D, and others. "Does Burnout among Doctors Affect their Involvement I Patients' Mental Health Problems?" *British Medical Journal Family Practice* Vol 10 No 60, 2009
24. Miller M, Mcgowen R, Quillen J. "The Painful Truth: Physicians are not Invincible." *Southern Medical Journal* Vol.93 No.10 October 2000, p. 966-973.
25. Rosenstein A. "Early intervention Can Help Prevent Disruptive Behavior." *Physician Executive Journal,* Nov/ Dec 2009, p.14-15.
26. Shanafelt T. "Enhancing Meaning in Work: A Prescription for Preventing Physician Burnout and Prompting Patient Centered Care." *Journal of the American Medical Association* Vol.302 No.12, September 23.30, 2009, p.1338-1340.
27. Harris G. "More Doctors Giving Up Private Practices." *New York Times,* March 25, 2010.
28. Bakhtiari E. "Physician Hat Tricks." *HealthLeaders Media,* May 15, 2008.