Doing something about physician burnout

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Burnout affects more than half of practising physicians and is on the rise.[1] When burnout was seen as a crisis of wellbeing—affecting physicians' personal lives and work satisfaction—it garnered little public sympathy and could be dismissed as the whining of a privileged class. Now that evidence suggests that burnout negatively affects physicians' effectiveness and availability to patients, as well as patient safety, physicians, health-care organisations, and the public are justifiably worried about quality of patient care and the health of health-care institutions.[2,3]

According to psychologist Christina Maslach, burnout is when physicians feel emotionally exhausted, depersonalised (ie, cynical and detached), and ineffective; when they feel "an erosion in values, dignity, spirit, and will".[4] Burnout is not an expected reaction to hard work—deeply satisfying work can involve tremendous personal sacrifice. It is not the same as depression, yet severe burnout can evolve into it. Initially, burnout might coexist with empathy, satisfaction, and caring, but unrelieved work stress for months diminishes the ability to call forth and sustain those attributes. Although burnout is not new, recent increases are probably due to interactions between individual and organisational factors,[5] which contribute to a high burden of responsibility, low perceived control, discordance between individual and organisational values, unsupportive work environments, isolation, and loss of meaning.[6,7] Burnout is not an acute self-limited illness and it has an uncertain prognosis.

In *The Lancet*, Colin West and colleagues[8] report a comprehensive meta-analysis that raises fundamental questions about what clinicians and health-care organisations should be doing about burnout now. They reviewed 2617 articles, of which 15 randomised trials and 37 cohort studies were of sufficient quality; all but three were done in high-income countries. Interventions reduced overall burnout from 54% to 44%, high emotional exhaustion from 38% to 24%, and high depersonalisation from 38% to 34% among participating physicians. West and colleagues[8] note that individual (eg, mindfulness, discussion, and stress management) and organisational (eg, work environment) interventions produced similarly large improvements in burnout; while diverse, all of these programmes share the initial step of enhancement of awareness. For example, mindfulness training can help individuals be aware of burnout in its early phases—noting changes in the body (eg, headaches or muscle tension), emotions (eg, irritability or sarcasm), or thoughts (blaming self or others)—before it becomes unmanageable, name it, and accept that it is present.[9] Equally important is physicians' awareness of their ability to mitigate burnout: resilience, perspective taking, and cognitive reappraisal.[10,11] Just as individuals can be mindful of their level of burnout and wellbeing, health-care organisations can monitor these levels as quality indicators and disseminate findings to raise collective awareness and resolve.[12]

Treatment of burnout solely as a disease or failure of individual practitioners is unlikely to be effective. Rather, the individual and system drivers of burnout also need to be addressed. Physicians tend to name external causes, such as productivity pressures and loss of control, yet they should pay equal attention to psychological factors. Just as resilience has a neurocognitive fingerprint,[11] so might burnout. Cognitive rigidity, difficulty with ambiguity, setting of boundaries, and forgiving oneself seem to be risk factors that can be addressed, helping physicians manifest adaptive qualities.[9,11] To promote community and shared vision, meaningful discussions among colleagues and community building can help.

Addressing burnout on an individual level will not be enough in the current health-care environment.[13] Leaders

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at health-care institutions should take a careful look at what promotes joy, effectiveness, and engagement with clinical practice among their staff and muster the resolve to take positive action.[13] Physicians, disillusioned by the productivity orientation of administrators and absence of affirmation for the values and relationships that sustain their sense of purpose, need enlightened leaders who recognise that medicine is a human endeavour and not an assembly line. Health planners need to be aware of human limitations—physical, cognitive, and emotional—when layering increasing demands on individual physicians. Health-care organisations should move beyond a culture of endurance, which overvalues stoicism and dismisses complaints as signs of weakness, and help clinicians be better at self-care than they are at present. 21st-century patients demand more than in the past, rightfully so, calling for greater interprofessional coordination. Evidence suggests that the more physicians use electronic health records and computerised physician order entry, the more burnt out they become;[14] intelligent design of health information systems is needed. The explosion in regulatory documentation begs for re-examination and debulking. To address the sheer fatigue of completion of documentation, scribes might be an answer. Realignment of workflows and consideration of the potentially avoidable costs attributable to turnover, retraining, recruitment, malpractice, and loss of patient satisfaction can make such efforts fiscally feasible.

Although optimisation of programmes to address burnout will require further research, we should not wait for perfect understanding before acting; too much is at stake. Institutions should take the lead and address clinician burnout now that West and colleagues[8] have described effective models that have been implemented successfully.

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