Are Practice Investments to Address Physician Burnout Justified?
Understanding the Evidence

Exploratory Paper

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Introduction

Physician burnout is an escalating problem in health care. Practice managers can make a strong evidence-based justification for implementing changes that will reduce physician burnout and improve overall patient care. The objective of this paper is to highlight the expanding evidence of the problem of physician burnout and its impact on a practice, and the steps practices can take to address physician burnout in their organization.

First, the paper will present an extensive literature review highlighting the evidence, the prevalence, and the causes of physician burnout. Second, it will lay out a summary of the latest research that shows how physician burnout impacts a practice, thereby providing justification of investments made to address the problem. Finally, the paper will conclude with an outline of key steps for implementing practice improvements to address physician burnout, including how to leverage the research to build a plan for management, physicians, and other care team members to implement changes in their practice.

The paper uses the growing body of peer-reviewed literature on the prevalence, causes, impacts, and solutions related to physician dissatisfaction and burnout. Literature was accessed from PubMed, Google Scholar, and other relevant databases to create a set of pertinent articles for review, with emphasis placed on those most topically germane and recent in publication.

Background

The pace of change in health care is increasing rapidly, creating more pressure on physicians and practices. Changing government regulations, shifting payment models, higher patient expectations, expanding performance measurement, and the use of electronic health records (EHRs) and other technologies are driving physician practices to transform in order to stay current. With physicians at the center of many of these activities, the resultant pressures are affecting the entire health care team.

There is an expanding body of evidence demonstrating increasing burnout levels in the physician workforce. Practices, health systems, and medical societies are all bringing physician
burnout to the forefront. Nationally there is a call to move from the Triple Aim of better individual health care, better population health, and lower costs, to the Quadruple Aim, adding the well-being of the clinical workforce to the mix (Bodenheimer & Sinsky, 2014). The National Academy of Medicine launched an Action Collaborative on Clinician Well-Being and Resilience in 2017 with over 50 organizations to advance the knowledge of clinician well-being, increase the awareness of healthcare provider burnout, and promote evidence-based, multidisciplinary solutions (National Academy of Medicine, 2017).

While many practice managers recognize that a more satisfied physician workforce will provide more engaged and better quality care to patients, practice managers may not be implementing needed changes to enhance the satisfaction and well-being of the physician workforce. With many competing demands, practice managers need a clear business case for implementing changes that may enhance the satisfaction of the physician workforce and the entire care team. Even physicians, many of whom maybe experiencing symptoms of burnout, may not fully understand the justification for addressing this issue. How do practice managers justify making investments to address physician burnout? Are investments to improve physician satisfaction justified in an environment of limited resources and competing demands?

What is Physician Burnout?

Burnout is a condition of being emotionally exhausted, having an increased level of depersonalization, and a feeling of less personal accomplishment (Maslach & Jackson, 1981; Maslach, Jackson, & Leiter, 1996). Burnout is a workplace phenomenon leaving one unhappy about their work and dissatisfied in their work accomplishments (Maslach et al., 1996). As burnout can be caused by workplace influences, solutions in the workplace can have a positive effect on physician and staff burnout.

The awareness of increasing professional dissatisfaction in all health care providers is growing, as well as the amount of data highlighting the issue (Dyrbye et al., 2017). While burnout can be experienced in all health care professions, there are unique causes particular to physicians.
based on their unique role. Physicians have ultimate responsibility for their patients’ care, including the interactions of the care team collaborating with them to deliver that patient care. Overall, providing patient care is stressful; physicians are likely to underestimate these stresses and delay self-care (Wallace, Lemaire, & Ghali, 2009). Having been trained to care for others, to be resilient during times of stress or overburdened schedules, and to deal with the complexities of caring for sick patients, physicians may be unaware of how stress affects their own physical and mental health.

Physician burnout is extensive, with fifty-four percent of U.S. physicians experiencing at least one symptom of burnout in 2014, up from forty-six percent in 2011, while rates of burnout remained stable for U.S. workers in other fields during that time (Shanafelt, Hasan, et al., 2015). All physicians, regardless of specialty, experienced growth in symptoms of burnout during this three year period (Shanafelt, Hasan, et al., 2015). Medical students, residents, and physicians all experience more burnout than their non-medical peers despite entering medical training with better mental health than them (Brazeau et al., 2014; Dyrbye et al., 2014). Physicians experience levels of burnout nearly twice the rate compared to the general U.S. working adult population, with physicians also experiencing worse work-life balance scores (Shanafelt, Hasan, et al., 2015). Physician dissatisfaction and burnout is a national problem for physicians in all specialties, practice types, genders, and career stages.

Causes of Physician Burnout

Most of the factors causing physician burnout are at the system-level rather than at the individual physician level (Panagioti, Panagopoulou, Bower, & et al., 2017). While many factors can contribute to dissatisfaction and burnout, these can fundamentally be categorized into areas related to a physician’s workload, the efficiency and organization of the practice, the control a physician has over his or her work environment and their balance with home life, the physicians’ alignment of their values with the practice’s values, the social circles and sense of community developed at work, and if they find meaning in their work (Shanafelt & Noseworthy, 2017).
One significant contributor to burnout is the burden caused by EHRs and documentation. For every one hour a physician devotes to direct patient care, they will devote nearly two additional hours doing EHR and deskwork, including one to two additional hours at home each evening (Sinsky et al., 2016). This administrative work is often perceived as lower in value and not utilizing the physician at the top of his or her license. As a result, physicians who use EHRs are frustrated with the significant amount of time and effort they must devote to clerical tasks within the EHR, resulting in an increased risk for professional burnout (Shanafelt, Dyrbye, Sinsky, et al., 2016). Physicians working in EHRs with more functions and features had greater burnout than those physicians working in EHRs with less functions (Babbott et al., 2014).

Primary care physicians are particularly vulnerable to the burdens caused by EHRs. Specifically, primary care physicians spend over half their workday (“5.9 hours of an 11.4 hour workday”) in the EHR (Arndt et al., 2017). Another study highlighted that primary care physicians spent more hours over the course of the workday in the EHR than they spent in direct patient care (Young, Burge, Kumar, Wilson, & Ortiz, 2018). Despite the increased time required for using EHRs, physicians are aware of their value, but are frustrated by poor usability and the additional time it takes to interact with them (Friedberg et al., 2013).

As burnout occurs in the workplace, leadership’s decisions to address or not address burnout will have a significant impact on physician burnout. Decisions to address burnout, and whether those actions focus on making system improvements or on providing individual coping mechanisms (e.g., mindfulness, resiliency training, wellness programs), will determine how physicians perceive leadership’s actions and whether physicians experience burnout in practice (Shanafelt & Noseworthy, 2017). Addressing burnout primarily by implementing and promoting wellness activities, such as mindfulness and yoga, can be perceived as placing the onus of fixing physician burnout on the individual, rather than modifying the underlying organizational causes of burnout. Thus, practices that implement interventions solely focused on the physician are not fully taking advantage of opportunities to create a better environment and these efforts may be
conveying the message from leadership that the physicians, rather than the practice environment, are the problem.

Many physicians and other staff members have gained their leadership roles based on tenure, but may not have had training or experience in leadership. The leadership qualities of those individuals supervising physicians have a clear influence on the satisfaction of individual physicians working under their leadership. One study highlighted that manager scores across twelve leadership dimensions are correlated with the burnout and satisfaction scores of those physicians they manage; that is “each one point increase in composite leadership score was associated with a 3.3% decrease in the likelihood of burnout and a 9.0% increase in the likelihood of satisfaction of the physicians supervised” (Shanafelt, Gorringe, et al., 2015). Proper leadership training is essential for any organization looking to create a positive work environment.

Another concern for physicians is how their personal views and values align with organizational leadership and how leadership supports a positive work environment. If physicians perceive their personal values are misaligned with management they will more likely be burned-out (Linzer et al., 2009; Linzer et al., 2016). A practice environment that supports a participatory, group culture is positively correlated with improved physician satisfaction while a practice with a hierarchical and bureaucratic culture is negatively correlated with improved physician satisfaction (Zazzali, Alexander, Shortell, & Burns, 2007). Creating an open, collaborative, and supportive team environment can go a long way in addressing physician burnout in a practice.

In addition, a physician’s work quantity, the type of work, and the perceived control a physician has over his or her work all influence the risk of burnout. Research highlights that burnout is associated with working in an organization where one has limited control of their work setting (Linzer et al., 2009; Linzer et al., 2016). A physician’s control over his or her work schedule is a significant predictor of work-life balance and level of burnout (Keeton, Fenner, Johnson, & Hayward, 2007). Physicians who reported spending more time on administrative tasks, like prior authorization and clinical documentation, had greater levels of burnout (Rao et
al., 2017). However it is not the actual number of hours a physician works that drives his or her happiness, rather it is the perceived ability to manage their workload (Eckleberry-Hunt, Kirkpatrick, Taku, Hunt, & Vasappa, 2016).

Finally, physicians are facing an overwhelming and growing administrative burden from tasks such as quality reporting and payer-required documentation (Friedberg et al., 2013; Miller, 2016). Practices that increase support staff per physician and “shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication,” can improve team function and professional satisfaction (Sinsky et al., 2013). Addressing these workplace factors, which can be improved, can be a positive step for a practice to improve physician professional satisfaction. The practice of medicine is a team-based effort; leveraging the team can create a better environment for physicians, staff, and patients alike.

Body

*Evidence of the Impacts of Physician Burnout on a Practice*

Today, practice managers may not be addressing the issue of physician burnout because they are unaware of the organizational and financial impacts of it and/or are not sure how to address it. There is evidence supporting the organizational, financial, and patient impacts of physician burnout and proven strategies that can address these issues (Shanafelt, Goh, & Sinsky, 2017). This body of evidence is growing and there is a national call to continue to build practice-based science on effective interventions that improve the delivery of care while creating a better work environment for the care team (Dyrbye et al., 2017). Understanding the impacts physician burnout can have on the whole practice, including reduced quality of patient care, decreased physician professionalism, reduced work effort by way of leaving the practice or even the profession, and reduced patient satisfaction, can help explain why investments to improve physician satisfaction are crucial in an era of limited resources.
Why Burnout Matters?

There is significant evidence that physician burnout impacts the outcomes of patients and their perceived wellness. Physician burnout and depersonalization have been linked with longer post-discharge recovery time and worse patient outcomes even after controlling for demographics and severity of illness (Halbesleben & Rathert, 2008; Wallace et al., 2009). Furthermore, physician stress is reported to increase errors and decrease patient satisfaction (Firth-Cozens, 2001). Stressed and burned-out physicians report making more errors and have more instances of providing patient care that is less than optimal (Shanafelt et al., 2010; Shanafelt, Bradley, Wipf, & Back, 2002; West et al., 2006; Williams, Manwell, Konrad, & Linzer, 2007).

Physicians who were burned-out had more troubling and poorer quality prescribing patterns (Melville, 1980). In addition, the satisfaction of a physician is a predictor of a patient’s adherence to the physician’s treatment recommendations (DiMatteo et al., 1993). There is also a correlation showing that practices with more satisfied patients will likely have more satisfied physicians within their organization (Linn et al., 1985). Moreover, higher satisfaction scores for both patients and physicians are associated with reducing patient no-show rates and more efficient use of the practice’s support staff (Linn et al., 1985). Thus improving patient and physician satisfaction has a combined effect to create positive advantages to the practice, physician and patient.

Likewise, when physicians perceive they are providing high-quality care they report better professional satisfaction (Friedberg et al., 2013). Physicians who are dissatisfied with their careers have reported having more difficulty in treating their patients (DeVoe, Fryer Jr, Hargraves, Phillips, & Green, 2002). Interestingly, emotional exhaustion was correlated with better patient communication scores, which is likely because physicians who give more to their patients in terms of time and engagement during patient visits may find themselves more emotionally depleted at the end of the day (Windover et al., 2018). Physicians want to provide
high-quality patient care but dissatisfaction is created in an environment that makes it harder to deliver that high-quality patient care.

Furthermore, when physicians feel as if they have made a medical error it can result in significant personal distress and reduce the physician’s empathy; these factors are also linked with the increased probability of future self-perceived medical errors, creating a vicious downward cycle (West et al., 2006). Research has shown that programs to reduce physician stress have the potential to decrease malpractice claims at an average of over $350,000 per claim (Jones et al., 1988; Studdert, Bismark, Mello, Singh, & Spittal, 2016). Clearly a physician experiencing burnout has negative consequences on patient care.

A physician experiencing burnout creates stress that may negatively impact the entire care team (Welp, Meier, & Manser, 2016). More troubling is that physicians who have higher levels of burnout are less likely to recognize their career as a calling. This diminished sense of calling can have negative consequences across the practice as physicians become “less intrinsically and prosocially motivated” (Jager, Tutty, & Kao, 2017). On the extreme end of burnout, some physicians turn to chemical dependence or abuse alcohol (Oreskovich et al., 2015) and can become depressed, including having thoughts of suicide (Shanafelt et al., 2011).

As a coping mechanism to being burned out and stressed, physicians will likely decrease their clinical schedule or leave the practice altogether. Physicians who are highly stressed or experiencing burnout are more likely to decrease the number of hours worked, leave their practice, or leave the profession of medicine (Shanafelt, Dyrbye, West, & Sinsky, 2016; Shanafelt et al., 2014; Sinsky, Dyrbye, et al., 2017; Williams et al., 2010). In the U.S., because of burnout, about 1 in 5 physicians intend to decrease their clinical schedule, while about 1 in 50 intend to leave the profession (Sinsky, Dyrbye, et al., 2017).

When physicians reduce their work schedule it leaves the practice less physician time available for patients, creating potential patient access problems; about twenty percent of physicians will reduce their work schedule due to burnout (Sinsky, Dyrbye, et al., 2017).
Physicians who are compensated by a productivity based model are more likely to reduce their schedules than those physicians in salaried compensation plans (Sinsky, Dyrbye, et al., 2017). While evidence reveals reducing work effort will reduce burnout for the physician, it does result in reduced practice capacity (Shanafelt, Dyrbye, West, et al., 2016). This reduction in capacity creates stress for the remainder of the care team who must pick up the extra work left by the physician reducing his or her schedule (Helfrich et al., 2017). Thus this reduction in work effort by a physician reduces the capacity of the practice, limits patient access, and increases burdens on those physicians and staff that remain.

Beyond reducing his or her work effort, there is significant evidence that when physicians are experiencing burnout, they will leave the organization (Buchbinder, Wilson, Melick, & Powe, 2001). Evidence highlights dissatisfied physicians leave at two to three times the rate of satisfied physicians (Landon, Reschovsky, Pham, & Blumenthal, 2006). Furthermore, physicians experiencing emotional exhaustion will also cause them to leave the organization (Windover et al., 2018). In addition, there are indications that physicians who report in a survey that they will leave practice, they follow through on their intentions to leave (Hann, Reeves, & Sibbald, 2011; Rittenhouse, Mertz, Keane, & Grumbach, 2004). Losing a physician from a practice results in lost revenues, increased recruiting costs, and increased training costs to orient a new physician, all of which negatively impact the bottom line (Atkinson, Misra-Hebert, & Stoller, 2006; Buchbinder, Wilson, Melick, & Powe, 1999). Practices report the cost of recruiting a replacement physician when one physician leaves the practice is between $500,000 and $1,000,000 (Noseworthy et al., 2017). These costs do not take into account the increased workload and stress for the staff that remain. A short-handed team, turnover among any member of the team and too many patients all increase burnout; thus teams not fully staffed and over capacity will lead to burnout for those staff that remain when a physician leaves (Helfrich et al., 2017). Therefore, one physician departure can have negative ripple effects for the remaining physicians and staff. This can begin a vicious downward cycle for a practice as physicians reduce work effort or leave the practice creating
more work for those that remain which can result in more burned out physicians and staff who then may also reduce their effort or leave the practice.

Finally, physicians who are dissatisfied have lower patient satisfaction scores, impacting the scores for the practice (Anagnostopoulos et al., 2012; Haas et al., 2000). Specifically, patients of primary care physicians who reported an increased amount of depersonalization and exhaustion had significantly lower patient satisfaction scores (Anagnostopoulos et al., 2012). As patient satisfaction scores are an important indicator used by the practice and outside entities, these decreased scores can have meaningful negative impacts on the practice.

*Implementing an Improvement Plan and Making Changes*

A physician practice can make a positive change in their environment to address physician burnout, increase satisfaction for the entire care team, and improve patient outcomes and satisfaction. A practice manager can create a simple plan by building consensus, measuring physician satisfaction, engaging practice leadership, creating a wellness team, implementing interventions, and then reassessing, adjusting and continuing their efforts.

1. **Building Consensus for Addressing Physician Burnout: Using the Evidence**

Cumulatively, there is clear evidence physician burnout leads to increased risk of medical errors and poorer health outcomes, diminished quality of care, decreased professionalism and compassion, increased costs of care, and decreased physician work effort by reduction in clinical time or departure. Presenting this robust body of evidence and explaining it to physicians, staff, and leadership provides a compelling case for addressing physician burnout. A presentation of the frequency, causes, and impacts of physician burnout in the practice to leadership, physicians, and staff can be a persuasive call to action.

Furthermore, for those physicians, staff or management looking for the financial impact of burnout, research can be assembled to present a financial justification for addressing this issue (Shanafelt, Goh, et al., 2017). When a physician leaves there are costs required to recruit and credential a new physician, and time required to build his or her panel. An average of $500,000
per physician for replacement costs and lost revenue is a reasonable estimate when considering physician turnover costs (Shanafelt, Goh, et al., 2017). There is considerable savings if a practice needed to replace just one less physician per year.

However, just using the financial impact of physician turnover underestimates the full burden on the practice; the calculation does not account for lost revenue for those physicians who reduce their schedule as a coping mechanism, nor does it consider the positive benefits of reducing burnout on patient satisfaction scores, the quality and safety of care delivered at the practice, and reductions in the risk of litigation (Shanafelt, Goh, et al., 2017). Furthermore, when a physician does leave a practice, those physicians and staff that remain have increased burdens and are more likely to see their levels of dissatisfaction and burnout increase (Helfrich et al., 2017).

The American Medical Association (AMA) offers an online calculator to estimate the organizational cost of physician burnout by inputting the number of physicians in a practice, rate of burnout of physicians, current turnover rate per year, and cost of turnover per physician (Sinsky, Shanafelt, et al., 2017). The AMA also offers a tool to calculate the return on investment for interventions made in the practice to reduce burnout (Sinsky, Shanafelt, et al., 2017). These simple calculators help put the impact of physician burnout into financial information useful for planning and decision making. As burnout can be contagious, as was noted, none of these financial calculations fully address the savings attributable to the quality of patient care, patient satisfaction, and other team members not being burned out or leaving the practice (Shanafelt, Goh, et al., 2017).

Physicians are scientifically trained; presenting evidence-based data on the prevalence, costs, and impacts of physician burnout can help build organizational consensus to take action on addressing the issues that cause physician burnout. In addition there is a small, but expanding amount of research on successful solutions that address physician burnout showing that investment and action can have positive outcomes. Putting together the research, calculating the
financial impacts, and providing evidence-based solutions creates a compelling case for a practice to address the issues that cause physician burnout.

2. Measure Physician Satisfaction

Understanding and setting a baseline is essential to begin to address physician burnout. After building consensus, measure the levels of burnout of the practice’s physicians. Practice managers must recognize the impacts of physician burnout on the viability of their practice and measure the engagement, satisfaction and burnout levels of their physician workforce similar to any other quality benchmark (Shanafelt, Dyrbye, & West, 2017). As physician burnout does impact patient care, measuring burnout provides another important quality measure for a practice to assess their organization (Wallace et al., 2009). Any practice that does not continuously measure and identify opportunities to optimize their practice for physician and staff wellbeing and sustainability is at risk of burning out their physicians and staff with the resulting negative impacts (Linzer et al., 2014).

Organizations should commit to measuring their workforce satisfaction at all levels. While many practices may utilize a general employee satisfaction survey, using one developed for physicians can be useful as the questions are more likely to be specific to the unique issues physicians face in their role. There are numerous reputable surveys available. Organizations would be well served by using a validated survey instrument with national benchmarks (Shanafelt & Noseworthy, 2017). Some of these survey tools include the Maslach Burnout Inventory, the Mini-Z, the Mayo Well-being Index and the Oldenburg Burnout Inventory. These can be utilized through one of numerous vendors, the American Medical Association, or through an organization’s human resource department.

Before an organization begins to measure physician satisfaction, it must be committed to evaluating the findings and implementing solutions as needed. Physicians and staff do not want to be surveyed if they feel the results will not help improve their organization. Therefore, building consensus and organizational commitment to address burnout is an important first step before
physician or employee satisfaction surveys are implemented. If the organization is not ready to take action, be cautious about surveying physicians and staff, and be clear about how the information will be used by the practice. Survey results should be used in the aggregate to identify opportunities for improvement and not to identify or call-out or penalize any one physician who may be experiencing burnout. Survey results should only be reported and shared so that identities cannot be known (e.g. no small cell sizes). Finally, practices may consider allowing survey respondents the option to ask for personal contact in follow-up to the survey for those who may be experiencing burnout and seek help.

3. **Engage Practice Leadership**

Executive leadership support of efforts to improve physician burnout is essential (Shanafelt & Noseworthy, 2017). Management buy-in is the key to ensure changes are supported and sustained. Efforts to address physician burnout must be perceived by physicians and staff as legitimate solutions to the problems at hand. Without leadership buy-in, true practice transformation is unlikely to be implemented or sustained. Some organizations include physician satisfaction as one of their key organizational metrics, tracked on their data dashboard. Similarly, some CEOs have asked their boards of directors to hold them accountable for the physician satisfaction scores of their physicians, and in turn, hold their executive leadership teams accountable for these scores (Sinsky, Shanafelt, et al., 2017).

Leadership and physicians must work together in identifying and implementing solutions. The qualities and the skills of leadership have a correlation to physician burnout and the ability of the organization to address the problem; leadership must be trained in leading highly trained, evidence-driven, detail-oriented, and independent-minded physicians (Shanafelt, Gorringe, et al., 2015). The relationship between physicians and management should shift from a traditional definition of roles to one of dyad leadership where each brings their unique expertise to help solve the problem (Oostra, 2016). Working together, practice leadership and physicians can achieve positive, sustainable, and impactful change within their practice.
4. **Create a Wellness Team**

Create a wellness team whose focus is on improving the practice to ease burdens on physicians and staff. The higher the level of leadership on this team, the greater the chance of success. Some organizations have established a Chief Wellness Officer, who serves on the executive leadership team and reports directly to the CEO. The wellness team should comprise a diverse set of stakeholders who are willing and empowered to identify opportunities to improve the practice. The wellness team can identify quality improvement activities that provide meaningful feedback to physicians, make workplace improvements in workflow or communication, or implement quality improvement projects that address physician and staff concerns. Evidence shows these types of changes can improve care and reduce physician burnout (Linzer et al., 2015). By implementing these changes as part of a team formed to address the work environment, promoting a more positive organizational culture and improving communication, the practice will have positive outcomes on physician satisfaction (Linzer et al., 2017).

Even if the wellness team is not successful in every one of its suggested practice changes, there are benefits of physicians and staff getting together to discuss problems, share ideas, and build comradery. Evidence indicates that when physicians come together and share experiences and reflect with their colleagues, it can have lasting impact on increasing engagement and reducing depersonalization in the practice (West et al., 2014).

Wellness teams should be made up of physicians and staff from the various departments that are part of the improvement program and should be empowered to make change. A wellness team leader should be established to set the agenda, keep the group focused, and move the group forward. Caution should be taken that the group meetings do not turn into gripe sessions, but focus on positive improvements that can be made within the practice. Working together, a wellness team can create a sense of community that works collaboratively toward an improved practice.
5. **Implement Interventions**

Practice interventions can be categorized into two types: organizational interventions and individual interventions. Organizational interventions are changes in how the practice operates such as staffing and role changes, process changes, or other operational interventions. Individual interventions are targeted at the individual physician, such as wellness programs that may include mindfulness, meditation, yoga, and other self-care interventions.

For the practice, the evidence is clear that burnout is a system issue and organizational interventions will have more of an impact than interventions solely targeting the physician (e.g. wellness or mindfulness programs) (Panagioti et al., 2017). Evidence shows that dedicated and focused commitment by an organization can and will make a difference on physician burnout rates (Shanafelt & Noseworthy, 2017).

Practices that have difficult working conditions will be perceived negatively by physicians; thus practice redesign projects to create a better work environment can improve physician satisfaction (Linzer et al., 2009). One key way to change the practice is to move away from the traditional care delivery model with the physician at the center of all activities to a team-based model of care delivery with robust collaboration to create a high functioning practice (Sinsky et al., 2013). Practice managers should review how their practice is organized, how work is distributed, and what processes are in place. Looking at all these organizational processes with a fresh set of eyes can identify numerous opportunities for improvement.

Many practices have already identified interventions that improve the organization and efficiency of a practice. Some practices have added staff to perform administrative functions which results in less physician time dedicated to administrative tasks and higher patient satisfaction (Reuben, Knudsen, Senelick, Glazier, & Koretz, 2014). Other practices have advanced team-based care with an enhanced role for medical assistants or nurses that increases patient-physician face-to-face time (Misra-Hebert, Rabovsky, Yan, Hu, & Rothberg, 2015). These
organizational steps can improve physician satisfaction, as well as increase patient satisfaction and quality of care delivered at the practice.

Thus organizations can improve the practice environment and address burnout by initiating efforts that address workflow and communication issues (Linzer et al., 2015). There are numerous practice change options a wellness team can choose to improve workflow, patient care, and increase physician and staff satisfaction. A number of resources can be obtained from the Medical Group Management Association (www.mgma.com) and the AMA’s STEPS Forward™ program (www.stepsforward.org). Education modules on topics such as panel management, implementing a daily team huddle, creating a strong team culture, pre-visit planning, and team documentation are offered with simple step-by-step instructions for implementation. The key to success is not to overanalyze which practice improvement effort to start with, but to get started with something, to engage the physicians and care team, and start creating small successes. These small successes will energize the team and new ideas for improvement will be generated.

It is important to note, any practice changes must provide physicians with control over their environment. Evidence reveals that high work demands can be mitigated when one has control of their work (Eckleberry-Hunt et al., 2016). While a practice may look to standardize activities, this standardization must allow physicians some ability to customize their schedules, workspace, and other activities to their practice style and preferences (Linzer et al., 2014).

In the end there are four essential elements that will likely increase the chances of creating successful changes in the practice: leadership, teamwork, communication, and metrics (Bagley, 2015). Thus, getting leadership support, involving the entire care team in the practice improvement effort, and measuring and communicating progress are integral to successful practice changes. Practice managers may be surprised by the positive outcomes created by physicians and other care team members implementing practice improvement ideas.

For the individual physician, professionalism should include self-care; as an unhealthy physician cannot optimally care for patients (Linzer et al., 2014). The Code of Medical Ethics for
physicians states “physicians have a responsibility to maintain their health and wellness” including following a healthy lifestyle, having his or her own physician, and seeking appropriate help as needed (AMA Council on Ethical and Judicial Affairs, 2017).

Physicians need support and resources to stay healthy; as physicians who do not live a healthy lifestyle are less likely to recommend healthy habits to their patients (Lobelo, Duperly, & Frank, 2009; Wells, Lewis, Leake, & Ware, 1984). Programs that promote healthy living can help a practices’ physicians and their entire staff. In addition, mindfulness and resiliency training can be provided. There is evidence mindfulness programs provide benefit to participants (Grepmair et al., 2007). These programs may be in-house, through partnerships, or with community providers.

Many physicians benefit from opportunities to contribute to the practice beyond their role in direct patient care. Opportunities to provide leadership, formal and informal, are important. Practice managers can develop opportunities for physicians to take on leadership roles and other opportunities to provide input on the way the organization is run. In addition, practice managers would be well served to support various career opportunities, as well as part-time schedules, including job-sharing (Linzer et al., 2014). Overall, for physicians to thrive, they need some degree of control over their environment, comradery with their peers and staff, and an opportunity to contribute to something meaningful to the organization and their patients (Swensen, Kabcenell, & Shanafelt, 2016). Individual interventions, such as mindfulness or wellness programs, can be considered an adjunct to organizational interventions (Shanafelt & Noseworthy, 2017).

6. **Reassess, Adjust, and Continue**

Implementing practice changes to address physician burnout is not a onetime activity. Measuring physician wellness should be done yearly, as well as soliciting open feedback on the success or failure of tactics to address physician burnout. Through measurement and reassessment, programs and interventions can be adjusted to continuously improve the practice for physicians and the broader care team. Practices that pay attention to work conditions within their organization will increase their success at recruiting and retaining physicians, while likely
providing better quality patient care (Linzer et al., 2009). After assessment, continuing to adjust and moving forward is important. Celebrating small wins or other progress milestones will keep the team motivated to continually identify and implement opportunities for improvement. Practice managers that support these ongoing efforts will likely see numerous beneficial improvements in their practice.

Discussion

Physician burnout is a real and growing problem. There is an expanding body of evidence highlighting the causes and growth of burnout, and steps to address the issue. Practice managers that recognize the problem of physician dissatisfaction and burnout, measure the pervasiveness of the problem, and implement changes will position their practices to be better places to work for physicians and other care team members, and will likely be able to provide better quality care and see improved patient satisfaction.

The issues that drive physician dissatisfaction and lead to burnout are numerous and multifaceted. The ability of the practice to make the needed changes is not always easy. However, a practice that creates a culture of wellness and inclusiveness, and is open to make changes to its operations to enhance the satisfaction of the care team, puts itself at an advantageous position compared to its peers. While the problems may be hard, the benefits of addressing them for physicians, staff, and patients are great.

Challenges to Implementation

While both individual or practice interventions can be beneficial, it is likely that both are needed to have maximum effect (West, Dyrbye, Erwin, & Shanafelt, 2016). Practice transformation is difficult; practices should be aware that not all changes will be received positively and some may feel negative about the process. While there is extensive literature on organizational development, applying these principles in practice takes effort and commitment. No practice should embark on this effort without the organizational leadership’s support and the willingness to make changes identified to improve the practice. In addition, more evidence-based
solutions are needed; further research on optimal practice design, staffing, workflow, and use of technology is required.

Furthermore, many of the frustrations physicians experience are beyond the control of the practice. These include burdensome prior authorization requirements, which seventy-five percent of physicians describe as a high or extremely high burden (American Medical Association, 2016). Government regulation, the usability of EHRs, burdensome quality reporting requirements, and confusing new payment models all are additional causes of physician dissatisfaction (Friedberg et al., 2013). While practice managers can create some workarounds to offset these larger U.S. health system burdens, they will also benefit by staying informed and being involved in larger health policy discussions. Practice managers can be informed and have a voice by joining the MGMA, joining their practice with the American Medical Group Association (AMGA), and supporting their physicians’ involvement in the AMA, state, and specialty medical societies.

Limitations of Analysis

This paper is based on the current available evidence published at the time of the writing. While the ideas are generally applicable to all practice types, some ideas may not be feasible or appropriate depending on specialty, practice type, payer mix, or specific practice demographic. Each practice must determine the specific frustrations and burdens their physicians face and identify the unique solutions their practice can implement.

Despite a deep body of research documenting the problem, causes, and potential impacts of physician burnout, the body of research on effective interventions remains limited. Most intervention research is case studies in a limited number of practice types using convenience samples with varying measurement instruments (Dyrbye et al., 2017). There is very limited methodologically rigorous research on appropriate practice interventions to address physician burnout. While there continues to be significant research on the rate, causes, and impacts of physician burnout, the field would be better served by additional methodologically rigorous
research on which practice changes create a better work environment for physicians and staff, while improving patient outcomes.

Significance of Findings

While wellness efforts for all team members are important, physicians have a number of responsibilities unique to their roles that require distinct solutions (Shanafelt, Goh, et al., 2017). Practice managers need to understand the impacts of physician burnout on the practice and the role-specific interventions that can create a better practice environment. This exploratory research paper highlights the expanding body of research that can be pulled together to create an evidence-based justification for making investments to address physician burnout that can drive organizational buy-in to address the issue. By increasing awareness of the problem of physician burnout and making a commitment to addressing it within a practice, meaningful changes can happen that will improve the environment for physicians, staff, and patients. Practice managers who address the frustrations and burdens that lead to physician burnout will create a better environment within their practice that can have positive outcomes on physician and staff retention, patient satisfaction scores, the practice’s finances, and on the quality of care provided by the practice.

Conclusion

Physician burnout is a bona fide and growing problem with real impacts on the individual physician, the care team, the practice and patients. Evidence is available to justify investments in addressing physician burnout. When this body of evidence is compiled, a compelling case can be made for implementing evidence-based, actionable solutions to addressing the problem of physician burnout. When practice managers address physician burnout, physicians, other care team members, the practice as a whole and the patients benefit.
Bibliography


