

An Overlooked Cause of Physician Burnout

Jeffrey Walden, MD

When we cannot give patients the care they need, we all suffer. But the converse is also true.

Physician work-related stress has become a hot topic in medicine, and for good reason. A growing number of physicians are expressing frustration with their chosen profession and reporting increased levels of burnout. For example, a 2015 survey of primary care physicians found that, if given the option to restart their medical training, 68 percent of family physicians would choose a different specialty.¹ Other studies have shown anywhere from 25 percent to 60 percent of physicians from all specialties reporting symptoms of burnout.²

A recent article by Dike Drummond, MD, titled “Physician Burnout: Its Origins, Symptoms, and Five Main Causes,” *FPM*, September/October 2015 (<http://www.aafp.org/fpm/2015/0900/p42.html>), listed many of the causes of burnout, including the conditioning of our medical education, work-related stress, and a lack of work-life balance. (This article was first in a three-part series on physician burnout; see the third article in the series on page 28 in this issue.)

I would like to add one more item to the list of primary causes of physician burnout, one that often goes overlooked: the inability to achieve the highest standard of care for all patients, when they need it, regardless of their ability to pay. An increasing number of studies highlight how physician wellness affects patient care, yet few mention the converse – the stress and angst caused when we as clinicians cannot provide patients the care they need. One notable exception is a recent survey by the RAND Corporation, which found that the principal driver of physician satisfaction is not income or work-related stress

but rather the ability to provide quality care to patients.³

As a faculty physician in a community-based, academically affiliated family medicine residency, I encounter this type of stress far too often. Many of my patients are uninsured, underinsured, or on Medicaid, which amounts to underinsurance when specialists limit the number of Medicaid patients they see – or refuse to see them at all. On a daily basis, my residents and I are forced to cobble together substandard “work-arounds” for patients who cannot afford certain diagnostic tests, specialty care, or even such basic therapeutic treatments as antibiotics. This concern over inadequate patient care extends beyond our underinsured and uninsured patients. Patients with high-deductible, private insurance plans or Medicare patients without Part D coverage often face similar hardships. Many of my colleagues express frustration and disgust over such constraints to providing quality care.

What was initially hailed as a means of extending care to an increasing number of patients, the Affordable Care Act (ACA) has not provided coverage to nearly as many people as hoped.⁴ Those who did receive extended coverage through commercial payers because of the ACA often still remain woefully underinsured or face the additional burden of high copayments. Furthermore, almost a third of states, including my home state of North Carolina, refused to expand Medicaid to those truly in need, despite the availability of federal subsidies.

The growing stress of being unable to provide patients the care they need could lead increasing numbers of physicians to leave the profession, or at least leave certain practice settings. Already, we are seeing a “brain drain” occur when talented physicians flee understaffed and

About the Author

Dr. Walden is assistant professor of family medicine, University of North Carolina Department of Family Medicine, Greensboro, N.C., and is on faculty at Cone Health Family Medicine Residency. Author disclosure: no relevant financial affiliations disclosed.

WE WANT TO HEAR FROM YOU

The opinions expressed here do not necessarily represent those of *Family Practice Management* or our publisher, the American Academy of Family Physicians. We encourage you to share your views. Send comments to fpm@aaafp.org, or add your comments to the article at <http://www.aafp.org/fpm/2016/0100/p6.html>.

underfunded public institutions and move to private non-governmental organizations and institutions. This is similar to the brain drain that occurs when physicians leave lesser-developed countries to practice in Western nations. Officials often cite higher paying jobs as the main driver, but evidence reveals it is an inability to achieve high standards of care for patients, and not just better salaries, that leads physicians to seek work elsewhere.⁵

The inability to achieve high-quality care is, by definition, a patient care issue. The only way to move this subject beyond academic and practice management journals and into the “real world” of clinical care is through solidarity with patients. With little change evident in the current trajectory of health care, a course marked by increasing regulatory burdens, clinicians being forced into employment with large health systems, and only weak attempts to address another main cause of burnout – decreased time spent with the patient – it will remain important for physicians to recognize in themselves and others the signs and symptoms of work-related stress and take steps to address them. Yet we must also recognize that our patients may not understand the current challenges in health care and may have difficulty relating to our professional concerns, as their struggles are often more immediate: securing adequate transportation, enough food for their children, or a means to pay for their loved one’s treatments.

From a patient care standpoint, the emphasis on helping physicians deal with work-related stress, though important, seems insufficient. We must also address the broader issue of helping patients obtain high-quality care. This is an immense problem requiring leadership and advocacy at the national level, but there are things we can do locally as well, such as developing a list of community resources for patients, training staff to be patient advocates, and seeking peer input and best practices. Increased efforts to address our patients’ concerns would shift much of the emphasis in medicine today and go a long way toward relieving our professional anxieties as well.

When advocating for the needs of both our patients and ourselves, we should not be surprised when we find these needs often align. **FPM**

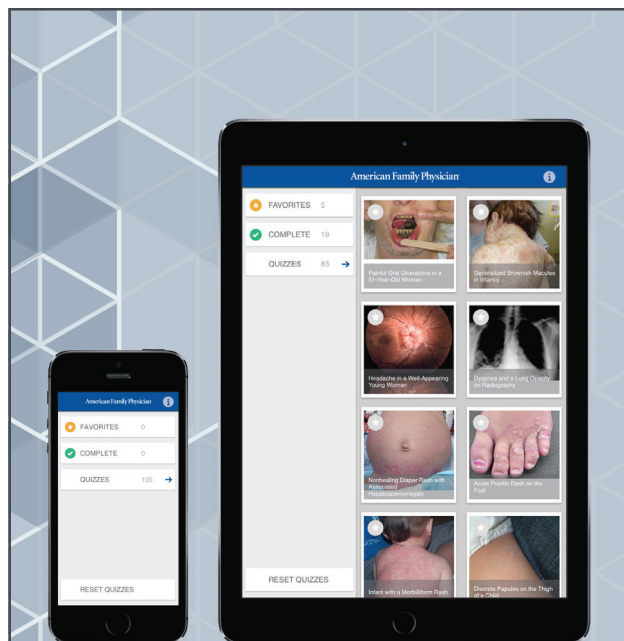
1. Peckham C. Medscape Physician Compensation Report 2015. April 21, 2015. <http://wb.md/1mcWaDh>. Accessed Dec. 10, 2015.

2. Gazelle G, Liebschutz JM, Riess H. Physician burnout: coaching a way out. *J Gen Intern Med*. 2015;30(4):508-513.

3. Friedberg MW, Chen PG, Van Busum KR, et al. *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy*. Santa Monica, Calif.: Rand Corporation; 2013. <http://bit.ly/1IWcP9F>. Accessed Dec. 10, 2015.

4. Jaffe S. USA gears up for next round of enrollment under the ACA. *Lancet*. 2015;386(10004):1613-1614.

5. Raviola G, Machoki M, Mwaikambo E, Good MJ. HIV, disease plague, demoralization, and “burnout”: resident experience of the medical profession in Nairobi, Kenya. *Cult Med Psychiatry*. 2002;26(1):55-86.



TEST your knowledge.

Download the
AFP Photo Quiz app.



AAFP

AFP