Opinion

# Physician Burnout: A Recovery Story

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**Every leader in health care should be asking "How can we better support physicians?"**

I was a poster child for physician burnout. After working as a family physician for 25 years, I left medicine in late 2021 because I felt I had nothing left to give patients. I had wanted to be a doctor since I broke my leg when I was 7 years old. I still remember sitting in the emergency department's orthopedics room, looking at all the stuff on the wall and thinking, "I want to know how to use all this." My entire educational and professional career had been geared toward becoming and then being a physician. As I walked out of my office in late 2021, I remember feeling empty. I wasn't happy to be leaving. I wasn't sad. I was just numb.

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My burnout experience was not unique and highlights many of the issues practicing physicians face today. A recent article noted that more than 60% of physicians surveyed two years into the COVID-19 pandemic reported at least one symptom of burnout.[1] While I was fortunate to find a way back to primary care, too many of our colleagues leave permanently and patients suffer due to decreased access.

## BURNOUT'S MANY CAUSES

Why physicians burn out is a complex process with multiple contributing causes. For me, the combination of documentation demands, value-based payment pressures, pandemic factors, and personal stressors left me feeling emotionally disconnected and often angry at patients for wanting my help.

When I became a medical director for population health in 2017, I enthusiastically supported the promise that value-based reimbursement offered. Why pay for more care when you can pay for better care? However, I quickly saw how participation can become a numbers game, with some health systems preferentially reporting on quality metrics where they already do well. In poorly designed programs, quality may not necessarily improve, and at-risk populations may be worse off as dollars shift "away from patients, providers, and communities with fewer resources and toward those with more."[2]

Being a typical physician perfectionist and overachiever, I wanted my system to perform well, and I felt singularly responsible for our success. So I started focusing more and more on care gaps during patient visits. It seems hard to believe in retrospect, but I found myself increasingly frustrated when patients wanted to talk about their complaints as I attempted to pivot the conversation to address unrelated quality metrics so I could check boxes.

As I struggled to balance my patients' needs with my system's needs, the COVID-19 pandemic was in full swing. People were demanding unproven treatments, and once a vaccine became available, everyone

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was suddenly an expert in immunology. More than one visit ended with an argument about the merits of mRNA vaccines.

Around the same time, I became a caregiver for my father who was suffering from metastatic prostate cancer and progressive dementia. I would like to say that I handled my adult caregiver role with empathy and compassion, but by the end I was pretty worn out.

Weighed down by the stress, I became progressively detached and short-tempered, as well as increasingly disappointed with myself for feeling and acting poorly. In late 2021, I decided to leave primary care practice and accepted a medical director position for a subsidiary of a large insurance company. Although I wouldn't be a practicing physician, I felt I could still improve patient care.

I soon realized I had made a terrible mistake. During a team-building session at my new organization, we watched the Cleveland Clinic video "Empathy: the Human Connection to Patient Care" (https://www.youtube.com/watch?v=cDDWvj_q-o8). It is a short but powerful video that addresses the human dimension of medicine. Watching it reminded me how much I had lost when I stopped seeing patients. Despite all the difficulties that came with practicing medicine, I still wanted and needed to help people in the way that only a clinician can. I quit my job the next week and returned to my former practice.

## HOW CAN WE BETTER SUPPORT PHYSICIANS?

Recovering from burnout has been a winding road and is still ongoing. While I wish it had been less painful, I am grateful for the process. It has made me a better doctor and a healthier person.

Since coming back, several of my colleagues have shared their own personal struggles. Some of them are overwhelmed by documentation demands and patient volumes. Others are dealing with health issues or caring for family members. Listening to their experiences has led me to ask "How can we better support physicians?"

The short answer is that there is no easy answer. Burnout is multifactorial and individual, and no single intervention will be sufficient. In my former role, I would often tell my team, "There is a patient at the end of every metric." It was meant to remind everyone that the numbers represent real people with families, jobs, and life experiences that contribute to their overall health. The same is true when it comes to physician burnout.

**To health care administrators**, I would say that you must address burnout on multiple levels on an ongoing basis. Survey your physicians and staff. Find out what is dragging them down. Then act on that information. Interventions may require additional money and resources, but so does replacing your workforce. Not addressing the problem will lead to higher burnout and turnover, placing even more stress on the remaining physicians. This vicious cycle can be devastating.

One issue health systems must address is the added burden of value-based reimbursement. While these programs can reduce expenses and improve quality, they can also unintentionally interfere with care by taking attention away from what the patient needs to what the system needs (e.g., cataloguing diagnoses and documenting care to increase compensation). A recent study showed that physicians who participate in value-based payment programs spend an additional 26 minutes per day documenting outside office hours compared with colleagues who do not participate.[3] Since the average doctor already spends 1.84 hours per day documenting outside office hours,[3] adding to this burden is not healthy or sustainable.

Just as organizations are measuring their level of quality to support value-based compensation, they should also be measuring their level of burnout to support physician well-being. The Surgeon General recently called for a National Health Care Workforce Commission to look at ways to include burnout measures in health care system evaluations.[4] This is great place to start. A healthier workforce can only improve patient care.

**To the struggling physician**, I would say that burnout is real and you don't have to face it alone. Ask for help. The best decision I made when I returned to primary care practice was to start seeing a therapist. It wasn't easy to admit I needed help, but I would not have succeeded without it. Before I left practice, I had forgotten the human element of medicine in my efforts to document and provide efficient, high-quality care. Now, I try to focus on connecting with patients and working with them as individuals to be cared for, rather than problems to be fixed in a 15-minute window. Metrics and documentation tasks have not disappeared, but they take a back seat to my relationship with my patients and how I can help them be healthier. Both my patients and I are happier for this change.

If you are suffering from burnout, know that there is a path back to enjoying patient care. It won't necessarily be easy, but little worthwhile is. FPM

*Editor's note:* The AAFP Guiding Principles for Value-Based Payment call for programs that do not add administrative burden to primary care; see the related *FPM* Opinion piece at https://www.aafp.org/pubs/fpm/issues/2023/0100/from-volume-to-value.html.

1. Shanafelt TD, West CP, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life integration in physicians over the first two years of the COVID-19 pandemic. *Mayo Clin Proc*. 2022;97(12):2248-2258.

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