Achieving Physician Well-Being:
The Best Physicians Are Well Physicians

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Numerous recent surveys reveal an alarming increase in physician burnout and stress. This is true not only for physicians on the front lines of medical care but also for specialists in medical oncology. Further, physician burnout not only is an issue for the medical profession but also has been increasingly linked to the delivery of quality care and national workforce needs.

In August 2012, a survey of 7288 US physicians revealed that 46% had at least one symptom of burnout. Compared with a control population of 3442 working adults in the United States, physicians were more likely to have symptoms of burnout (38% vs 28%) and to be dissatisfied with work-life balance (40% vs 23%; $P<.001$ for both). Even after adjustment for hours worked per week, physicians (MD or DO) remained at a higher risk for burnout compared with other working adults with Bachelor's, Master's, professional, or doctoral degrees.

In April 2014, the same group published the results of a survey of 2998 ASCO members regarding work-life satisfaction. The survey had a high rate of response (49.7%), with 37.3% of the surveyed oncologists completing detailed surveys. Only 33.4% of respondents reported satisfaction with work-life balance, ranking lower as a group than all other medical specialties in the national study. A quarter of respondents reported a moderate or higher likelihood of reducing their clinical work hours in the next 12 months, and one-third indicated a moderate or higher likelihood of leaving their current position within 24 months. Female oncologists and those who devoted greater time to patient care were less likely to be satisfied with work-life balance. Satisfaction with work-life balance and burnout were the strongest predictors of intent to reduce clinical work hours and leave one's current position. Clearly, these findings have significant implication on the future of the national oncology workforce and the looming acute shortage of oncologists by 2020.

What is burnout? Burnout can be defined as professional distress accompanied by a high level of emotional exhaustion, a loss of sense of purpose or meaning in one's work, and a feeling of depersonalization. Burnout can lead to feelings of guilt toward family, poor personal relationships, addictive behavior, and even suicidal ideation. Stress becomes distress and impairment. Physicians for many generations have been stressed by the demand of long hours required by patient care and the weight of life and death decisions they must make. What has fueled the recent increase in physician burnout has been the “perfect storm” of increasing medical regulatory and administrative burdens, the loss of autonomy for physicians as a profession, decreasing reimbursements, and the challenge of adopting systems, such as ICD-10 and new electronic medical records—sometimes several different systems in different hospitals.

Historically, efforts to prevent physician burnout have been focused on individuals in training, including in medical school. Graduate medical education programs require residents and fellows to attend to these issues. Unfortunately, programs for physicians after they have completed training are few and inconsistent. What programs exist are usually sponsored by individual hospital medical staff or state medical societies. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that medical staff must implement “a process to identify and manage matters of individual licensed independent practitioner, which is separate from actions taken for disciplinary purposes” (Joint Commission Standard, MS 11.01.01). This process must include education regarding illness and impairment recognition, confidentiality,
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appropriate referral of physicians for therapy, monitoring, and reporting to the medical executive leadership in cases of unsafe practice.

Some states go even further in the attempt to address and prevent physician impairment. California Title 22 Regulations require each hospital medical staff to include a provision in its bylaws for the assistance of “medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services.” Inclusion of a standing Well-Being Committee (WBC) in the hospital bylaws not only satisfies Title 22 Regulations and Joint Commission standards but also assures that the committee will receive the same confidentiality protections for its record. Various names have been used to describe these committees, including Practitioner Well-Being Committee, Physician Health Committee, and Committee on Physician Health.

These WBCs act as educational resources for medical staff in matters related to prevention of practitioner impairment and maintenance of health. They can provide an informal, confidential access point for anyone seeking and assistance. They also provide a source of expertise that can help medical staff identify health factors underlying a clinical performance problem for which corrective action is being considered. Referrals from concerned colleagues or medical staff leaders can be made to the WBC, leading to fair and impartial investigation, assessment, and recommendations. Committee membership should be diverse, and should include practitioners specializing in psychiatry or psychology. Because the primary charge of the committee is to focus on the well-being and needs of the physician in question, members should not serve on other medical staff committees with disciplinary functions. WBC members often have a challenging and thankless task, which they undertake with great compassion for their colleagues. All referrals are strictly confidential and privileged. However, because patient safety is also critical, these committees are obligated to report safety concerns to medical staff leadership.

In addition to issues of impairment related to burnout, illness, or life changes, the WBC can also assist physicians and hospitals with reentry issues after a period away from medicine, such as after recovering from illness or return to the workforce after child-rearing. They can also facilitate the evaluation and monitoring of aging physicians, with appropriate referral to comprehensive programs that assess, educate, and remediate physicians with clinical deficiencies, such as the PACE (Physician Assessment and Clinical Education) Program at University of California, San Diego.

Despite the benefits that WBCs can provide to individual practitioners and medical staff, they are not well-known. Physicians as a group are often reluctant to seek help, and may feel invulnerable or fear a loss of reputation. Too often, WBCs are viewed as only dealing with problems of addiction. (In fact, the incidence of addiction in physicians is similar to that in the general population, ≈10%.) An Internet search of current NCCN Member Institutions yielded information about the existence of a WBC in fewer than a third.

Physician burnout and the potential benefit of WBCs should grab the attention of all stakeholders concerned about high-quality and high-value cancer care. This includes not only medical staff, medical groups, and professional societies such as ASCO, but also health care systems, insurers, government policy-makers and regulators, and consortia like NCCN that strive for continuous quality improvement. Physicians who report a higher level of burnout also report a higher number of recent medical errors and decreased empathy for patients. Conversely, physician burnout and dissatisfaction are associated with poorer patient adherence to treatment plans. This fact has led some to declare that physician wellness, like rates of venous
thromboembolism or compliance with treatment guidelines, is a quality indicator that is currently missing and should be measured by health systems. Others have gone as far as saying that physician burnout is a potential threat to the implementation of successful health care reform and inclusion of 30 million new patients in the Patient Protection and Affordable Care Act, because physicians who report a higher level of burnout also plan to retire earlier.8 From a purely financial aspect, replacing a physician may cost as much as $200,000. Hence, returning even 5 physicians to the safe and full practice of medicine can save $1 million.9

Few data exist on how to address the problem of physician burnout. Outreach efforts to the physician community, such as those made by groups like Vanderbilt University and University of California, San Diego, should be applauded. We need rigorous methodology to study the problem, such as the randomized intervention trial to reduce physician burnout and promote engagement that is currently underway at the Mayo Clinic. The quote, “The best physicians are well physicians,” comes from that trial. Institutions must define physician wellness and build a culture of wellness—one that celebrates accomplishments, demonstrates appreciation, and shows compassion for and loyalty to physicians. Physicians themselves must be aware of their own needs. The need for work-life balance and professional satisfaction, far from being a selfish desire, is now linked to professional competence.

In the end, physicians have a moral obligation not only to their patients but also to their colleagues and themselves to optimize each others’ wellness. The same compassion we hold for our patients should extend to our colleagues and ourselves.

References