Physician Burnout
A Potential Threat to Successful Health Care Reform

Liselotte N. Dyrbye, MD, MHPE
Tait D. Shanafelt, MD

DISCUSSIONS OF BARRIERS TO SUCCESSFUL IMPLEMENTation of the Patient Protection and Affordable Care Act have largely focused on legislative, logistic, and legal hurdles. Notably absent from these discussions is how the health care reform measures may affect the emotional health of physicians.

Burnout is common among physicians in the United States, with an estimated 30% to 40% experiencing burnout.[1] Many aspects of patient care may be compromised by burnout. Physicians who have burnout are more likely to report making recent medical errors, score lower on instruments measuring empathy, and plan to retire early and have higher job dissatisfaction, which has been associated with reduced patient satisfaction with medical care and patient adherence to treatment plans.[1-4]

Burnout stems from work-related stress. Preliminary evidence suggests that excessive workloads (eg, work hours, on-call responsibilities), subsequent difficulty balancing personal and professional life, and deterioration in work control, autonomy, and meaning in work contribute to burnout in physicians.[2,3,5] Some aspects of health care reform are likely to exacerbate many of these stressors and thus may have the unintended consequence of increasing physician burnout.

Although reducing the number of patients who are uninsured is an important improvement, providing insurance to 30 million previously uninsured US residents will increase demand for care within a system already struggling with access issues due to an increasing older population, a decreased supply of physicians due to retirement, and low interest in primary care among graduating physicians.[6] With demand for care outpacing supply of physicians,[6] the workload for physicians active in practice will inevitably increase. Decreased financial margins due to cost containment provisions and higher practice costs will provide additional pressure for physicians to increase their workload. Capital costs to purchase electronic prescribing tools and computerized medical records are not fully covered by subsidies.[7] Infrastructure expenses required for compliance with new regulations, such as those expenses associated with reporting quality-based measures, will be an additional ongoing practice expense. These and other new regulations and reporting requirements (eg, requiring reporting of patient outcome data and guideline adherence for payment) will also increase the administrative burden for physicians on each patient for whom they provide care. Indeed physicians in Massachusetts report seeing more patients,[8] reducing the time they spend with each patient, dealing with greater administrative requirements, and experiencing a detrimental financial impact after implementation of the Massachusetts Health Insurance Reform Law.[9] If physicians nationally have a similar experience with health care reform, it is likely to result in increased workload that will exacerbate the challenge physicians have balancing their personal and professional life. Thus, health care reform is likely to adversely affect physicians' workload, autonomy, and work-life balance—all large contributors to burnout.

Health care reform does contain some provisions that may reduce physician stress. For example, removing insurance barriers for treatment of preexisting conditions, facilitating medication coverage, and streamlining insurance claims are all positive features of health care reform that are likely to improve patient care and reduce physician workload and stress. The introduction of a standardized claim form, as proposed in the Patient Protection and Affordable Care Act, may also improve efficiency. Although these are important steps, more can be done to help ensure that health care reform does not have the unintended negative effect of precipitating burnout and job dissatisfaction among physicians, which appears to have occurred with health care reforms in other nations. For example, in a longitudinal study of UK physicians, the prevalence of burnout increased after new health care policies were implemented.[10]

However, little is known about how best to mitigate burnout in medical practice. Policy makers, health care organizations, insurance companies, academic medical

Author Affiliations: Department of Medicine, College of Medicine, Mayo Clinic, Rochester, Minnesota.
Corresponding Author: Liselotte N. Dyrbye, MD, MHPE, Department of Medicine, College of Medicine, Mayo Clinic, 200 First St SW, Rochester, MN 55905 (dyrbye.liselotte@mayo.edu).

centers, and individual physicians share the responsibility to ensure that the implemented reforms promote accessible, affordable, and high-quality health care. Doing so in a sustainable manner will require attention to the effect of reform on physician job satisfaction and well-being. Support of provisions to expand the primary care workforce will be one essential strategy; however, given the extended time it takes to educate physicians, other strategies that can be rapidly implemented are needed to ensure that primary care can be delivered without overwhelming the existing workforce.

With current workforce constraints, a greater understanding of how to optimally use physician-extenders, provide effective chronic disease management using nurses and other staff, and practically implement medical home models of care with existing resources is needed to ensure successful implementation of reform. Policy makers and health insurance companies should work in collaboration with nurse and physician professional groups to determine optimal workloads, which should be established to promote quality of care, prevent burnout, and achieve patient safety, rather than based on financial productivity models designed to make up for shortfalls in Medicare and Medicaid reimbursement.

Tort reform, payment models that enable practices to invest in needed infrastructure (eg, replacement of the fundamentally flawed sustainable growth rate formula by a predictable, stable, and fair reimbursement schema), and incentives rather than payment reductions and penalties (eg, for failure to report quality measures or use electronic prescribing) should all be considered in light of their potential effect on physicians' practice decisions. Reform should also promote better use of the time and energy of the existing health care workforce so that nurses and physicians spend their time taking care of patients rather than on the endless stream of regulatory paperwork, insurance approvals, and reimbursement battles that characterize the current system.

Academic medical centers, medical school deans, and residency program directors also need to identify and address factors in the training process associated with burnout. The Accreditation Council for Graduate Medical Education should consider adding an explicit self-care competency, which already has been done by the Canadian Royal College of Physicians and Surgeons ("Demonstrate a commitment to physician health and sustainable practice") and the UK General Medical Council ("Demonstrate knowledge of responsibility to look after personal health, including maintaining a suitable balance between work and personal life, and knowing how to deal with personal illness to protect patients"). Doing so would lead to development of evidence-based curricula that could help trainees develop and sustain health habits needed to assess personal well-being and promote resilience throughout the course of a medical career. Once in practice, physicians have a professional responsibility to promote their own well-being. Additional studies are needed to determine the optimal way in which physician societies, medical centers, practice groups, and individual physicians can facilitate this.

Burnout is a common problem among US physicians. Because of its prevalence and effects on professionalism, access, and quality of care, the issue of physician burnout should have surfaced during the US discussion of how to effectively reform the health care system. For reform to achieve its goal of providing all residents access to high-quality medical care, efforts to identify and address the controllable factors contributing to burnout among physicians are needed. Doing so is vital for patients to receive compassionate care from committed, competent, and professional physicians.

Conflict of Interest Disclosures: Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Shanafelt reported clinical trial support and research funding from Genentech, Hospira, Celgene, GlaxoSmithKline, and Polyphenon E International, and research funding from Cephalon. Dr Dyrbye reported no disclosures.

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