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INSIDE THIS ISSUE

PHYSICIAN BURNOUT

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Burnout rates for physicians are astonishingly high. According to a 2012 report in the *Archives of Internal Medicine* that surveyed 7,300 physicians, almost half reported at least one symptom of burnout. Four out of 10 physicians felt emotionally exhausted, cynical, or depersonalized toward their patients. The specialties that are most prone to burnout include the ones that are involved in highly frequent patient contacts. These include emergency medicine, family medicine, and general internal medicine. Dermatologists and preventive care specialists were the least affected.

The professional burnout syndrome is characterized by loss of enthusiasm for work (emotional exhaustion), feelings of cynicism (depersonalization), and a low sense of personal accomplishment. Causes of physician burnout include excessive workloads, loss of professional autonomy, a higher patient load to make up for declining reimbursement rates, lack of time to build interpersonal relationships with patients, and the paradoxical effect of increased time with EHR documentation.

Burnout in physicians erodes professionalism by influencing the quality of care, increasing the risk for medical errors, and promoting early retirement. Burned out physicians are more likely to think about suicide and actually make medical errors. Relationships with other health care professionals and patients' families are affected as well. On a personal level, physician burnout contributes to broken relationships, maladaptive coping strategies such as problematic alcohol use, depression, and suicidal ideation.

Contributing to physician burnout are the deleterious aspects of the culture of medicine. A 2015 study revealed that physicians are notoriously prone to continue to work when they're ill, even if they have contagious infectious disease. Ninety-six percent (96%) said they would work if they had a cold, 77% said diarrhea would not keep them from coming to work, and 53% felt that vomiting would not keep them from coming to work. The rationale behind such behavior was found to be feelings of guilt if they will were absent, the physician having to ask others for coverage, their perception that their infectious disease was not really contagious, and that they really were not sick enough to stay home. Interventions that would reverse this behavior included department chiefs setting a protocol for what to do when ill, the clinic or institution sending colleagues home if they are perceived as ill, and policies that reinforced that there were no negative repercussions for taking a sick day.

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A profile of the most stressed physician included one that is female, less than 48 years of age, 100% in solo practice, having the greatest numbers of hours in direct patient care and taking the least vacation days compared to their peers. The most common stressors in physicians can be divided into external and internal stressors. The former are related to work and organizational structures and personal and family life. They include overwork and a fear of making a medical error resulting in possible lawsuits. Another common external stressor is the overload of cases in a variety of settings, including clinics, hospitals, and emergency departments. A paucity of resources to care for patients, the avalanche of new medical knowledge, and the fear of not keeping skills up-to-date are also involved. There is also great uncertainty with respect to reimbursement systems and in the past decade health care has undergone many restructurings. In addition, the management of medical information is more cumbersome due to repeated requests from insurance companies and regulatory agencies, as well as pressure to become adept and efficient using electronic medical records. Organizational and intergenerational conflicts with peers around clinical responsibilities, access to facilities such as operating rooms, and administrative roles all are also external stressors.

When they're related to family life and activities away from medical practice, external stressors include problems at home with significant others, especially criticism for being away repeatedly from home. Problems may also manifest with one or more children, caring for aging patients, financial problems, medical or mental health problems, lack of sleep, utilizing maladaptive coping strategies such as alcohol abuse or illicit drug use, and a family history of mental illness.

Internal stressors are produced by the physicians themselves including thoughts, interpretations, beliefs, and inherent prejudices about their work behavior. These include disproportionate demands on oneself, the fear of being wrongly judged by peers, and not respecting basic needs such as eating and sleeping. Physicians who are stressed often work at a pace that goes against professional principles and find themselves worrying about patients who have to wait — a conflict of loyalties between high standards for patients and respect for physicians' needs and abilities.

To combat stress physicians must know their own alarm signals. These include adhering to an adequate diet that includes never skipping meals at work as well as engaging in routine physical exercise. This is one of the first things that is dropped when the physician is overworked, even though it is a valuable tool for fighting burnout. Monitoring alcohol use, for men 2 glasses per day or no more than 14 drinks per week, and for women 2 glasses per day with no more than 9 drinks per week. It is important to abstain from drinking 48 consecutive hours per week to prevent dependency. Vacation is also essential whether taken at home or away. To combat stress, physicians must also find time to spend by themselves. In this context they have no responsibilities for anyone other than themselves. Physicians must set aside one day a month or one evening a week and schedule time that can be devoted to them.

On a personal level, physicians can prevent burnout by identifying and adhering to core values. They must engage in self-care and have a supportive partner and friends. Maintaining a spiritual outlook on life has also been found to be protective. Professionally, physicians need to adhere to a meaningful schedule, seek peer and administrative support, as well as mentorship.

On an institutional level, it is important to note that physician burnout can have a profound effect upon employment retention. Burnout is associated with physicians leaving practice or decreasing their work hours. One study found that the replacement cost for a PCP is approximately $250,000.

The most comprehensive systematic review and meta-analysis of all studies

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MARKET WATCH

2016 Survey of America's Physicians

Which of the following best describes your current practice?

(Survey of 17,236 physicians)	2016	2014	2012
I am overextended and overworked	28.2%	31.2%	22.7%
I am at full capacity	52.4%	49.8%	52.8%
I have time to see more patients and assume more duties	19.4%	18.9%	24.6%

To what extent do you have feelings of professional burnout in your medical career?

(Survey of 17,236 physicians)	2016	2014	2012
No such feelings	10.7%	N/A	N/A
Rarely have these feelings	15.3%	N/A	N/A
Sometimes have these feelings	25.4%	N/A	N/A
Often have these feelings	31.4%	N/A	N/A
Always have these feelings (significant burnout)	17.2%	N/A	N/A

Source: *2016* Survey of America's Physicians, *Conducted by Physicians Foundation and Merritt Hawkins Survey of 17,236 physicians. For more information visit: www.physiciansfoundation.org*

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assessing the effect of interventions on burnout among physicians were published online in The Lancet on September 28, 2016. It summarized the results of 15 randomized controlled trials and 37 observational studies and found that many personal and institutional interventions are effective in combating physician burnout. Personal strategies include mindfulness-based approaches, stress management training, and small group discussions. Institutional methods include "duty hour requirements and locally developed modifications to clinical work processes." However, only a few studies have examined long-term burnout outcomes.

Institutions can also appreciate that technology may push more work to the physician. Hospitals and clinics can decrease their message generation and make security modifications to accommodate workflow. Technology should be improved with respect to user ability and a team-based design should be employed. Treatment teams should meet regularly and huddles should be co-located for ease of meeting. They should map their workflow and the physical and personal environment should be restructured to support trust.

The medical culture in institutions must support wellness, work-life balance, and professional job satisfaction. Satisfaction and wellness programs must be developed to engage all physicians across their developmental continuum, from students to trainees to attendings. Networks of support will prevent burning out and be the catalyst for professional fulfillment.

WHAT'S NEW AT NEJM GROUP?

NEJM CareerCenter iPhone App Update

We've updated our iPhone app to make it easier and faster for physicians to search, view, and apply for your jobs! Our latest version of the iPhone app includes:

- A fast and fluid interface
- Ability to filter and re-order results
- Cloud-based CV support (e.g., Dropbox)
- Jobs "near me" — using current location via GPS
- Physician career articles are now available in-app
- Native SMS, email, and social sharing

If you have any questions or feedback regarding the new app please feel free to email us at ad@nejmcareercenter.org.

Upcoming Recruiter Meetings and Medical Conventions

American College of Physicians (ACP)†
San Diego, CA
March 30–April 1, 2017

Association of Staff Physician Recruiters (ASPR)
San Diego, CA
April 29–May 3, 2017

Society of Hospital Medicine (SHM)†
Las Vegas, NV
May 1–4, 2017

American Society of Clinical Oncology (ASCO)†
June 2–6, 2017
Chicago, IL

†Call (800) 635-6991 or email ads@nejmcareercenter.org for more details on bonus convention distribution of your paid recruitment ad in selected NEJM issues at these physician conventions.

PROMOTIONAL NOTES/NEWS

The First Chance to Reach the Class of 2018 and New In Demand Specialties Physician Career Guide

Final-year residents and fellows start their job searches very early. This is your first opportunity to reach the class of 2018! Our *Career Guide: MD Career Path* edition is not only sent to ALL final-year residents and fellows but also their program directors who assist them in their job search. See below for more details.

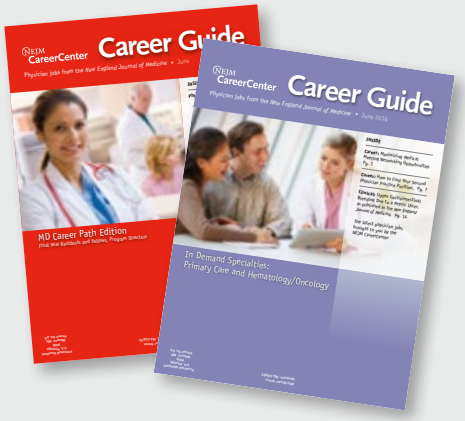
Additionally, this year we will be replacing the June *Career Guide: Primary Care* edition magazine with a new issue, the *Career Guide: In Demand Specialties* edition. This special magazine will be sent out to the most in demand specialties of that year; in 2017 it will focus on Primary Care and Psychiatry.

Here's how you can participate:

Run a paid line or display print ad (of any size) in selected NEJM issues, and in addition to reaching over 140,000 weekly recipients of NEJM, your ad will automatically be reprinted for FREE in the corresponding Career Guide magazine, mailed directly to a specific target audience of physicians. Additionally, your ad will run on NEJMCareerCenter.org, the heavily trafficked companion website of the *New England Journal of Medicine*. Our unique solution offers unmatched reach to physician passive jobseekers!

CAREER GUIDE: MD Career Path
NEJM ISSUE: June 1, 2017
CLOSING DATE: May 12, 2017
AUDIENCE: All final-year residents and fellows and over 9,000 program directors
BONUS REACH: Over 39,000*

CAREER GUIDE: In Demand Specialties, Primary Care and Psychiatry
NEJM ISSUE: June 29, 2017
CLOSING DATE: June 9, 2017
AUDIENCE: Primary Care and Psychiatry physicians currently in practice
BONUS REACH: Over 30,000*



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*Counts are estimates only and are subject to change based on data collected and approved by AMA.