Patients are harmed by physician burnout

James L. Bernat, MD, and Neil A. Busis, MD

Neurology: Clinical Practice August 2018 vol. 8 no. 4 279-280 doi:10.1212/CPJ.0000000000000483

Correspondence

Dr. Bernat

bernat@dartmouth.edu

The growing prevalence of physician burnout and its grave harms are now recurring headlines. Among specialists, neurologists have a particularly high risk of burnout.¹ In recognition of the seriousness of this problem to American neurology, the American Academy of Neurology (AAN) empaneled a task force to study the problem in all its dimensions, including career satisfaction, work–life balance, and well-being. Their recent reports on the prevalence, causes, consequences, and mitigation of the epidemic of neurologist burnout and the possible strategies to enhance career satisfaction should be studied carefully by all neurologists.^{2–4}

Most of the literature on physician burnout addresses the symptoms, causes, and adverse effects of burnout. Burnout is a progressive dysfunctional syndrome comprising emotional and physical exhaustion, depersonalization, extreme cynicism, loss of empathy, career dissatisfaction, a sense of meaninglessness of professional work, and low personal esteem and accomplishment.^{5,6} Unchecked, it leads physicians to abandon the medical profession and to higher rates of depression, substance abuse, and suicide.^{5,6}

Burned out physicians who remain in the workforce provide suboptimal care for their patients due to their poor judgment, treatment of patients as objects, and increased medical errors, all of which lead to poorer patient outcomes.⁵ Burned out physicians' lack of empathy exerts a particularly destructive effect on the patient–physician relationship and thereby on patient welfare.⁷ How can a physician sustain a caring relationship with a patient when the physician no longer cares?

In this issue of *Neurology® Clinical Practice*, former AAN President Stephen Sergay⁸ poignantly illustrates how patients have their own form of burnout when treated by burned out physicians. Sergay is a dedicated clinical neurologist devoted to his patients and who is respected and beloved by them. When they tell him during office visits that they detect a problem in their medical care, he knows they are correct. As the American physician–novelist Walker Percy fittingly observed, “If you listen carefully to your patients, they will tell you not only what is wrong with them, but also what is wrong with you.”⁹

Several factors endemic to contemporary medical practice can damage the patient–physician relationship. The unintended but ubiquitous interference caused by the electronic health record (EHR) has been described in detail¹⁰ and quantified in studies.¹¹ Completion of EHR data entry during office visits disturbs the patient–physician relationship by diverting physician eye contact and attention away from the patient. Completion of the EHR outside of the visit markedly adds clerical time to already overburdened physicians, further aggravating work–life imbalance.¹¹ Physicians' awareness that the usurpation of patient visit time by mandated but unproductive EHR documentation compounds their sense that work is meaningless and increases their dissatisfaction with practice. Patients ultimately become harmed as a result.

EHRs were mainly designed for primary care physicians. Successfully practicing neurology depends on a more thorough history and physical examination than many other specialties.⁵ It is difficult to enter a complete and accurate neurologic history and examination into an EHR and to review electronic records from colleagues. Thus, it is not surprising that neurology is

RELATED ARTICLE

The burnout patient

Page 346

Department of Neurology and Medicine (JLB), Geisel School of Medicine at Dartmouth, Hanover, NH; and Department of Neurology (NAB), University of Pittsburgh School of Medicine, PA.

Funding information and disclosures are provided at the end of the article. Full disclosure form information provided by the authors is available with the full text of this article at Neurology.org/cp.

among the specialties with the lowest rate of satisfaction with the characteristics of today's electronic health care environment.¹¹

Current medical insurance reimbursement policies and regulations, intended to compensate clinicians fairly for their work, unintentionally but perversely dictate the content of clinical visits. Led by the Center for Medicare and Medicaid Services, these Evaluation and Management regulations stipulate the elements of history, physical examination, and medical decision-making that clinicians must record to justify an appropriate billing code. As a consequence, medical practices strive to complete these elements regardless of their appropriateness to a clinical situation or their benefit to the patient. The EHR abets this change by providing macros, templates, and other shortcuts that facilitate fulfilling coding documentation requirements. It is no exaggeration to state that these regulations have catalyzed a transformation of American medical practice in which the EHR has become a billing tool rather than a record of a clinical encounter. This perversion of appropriate medical practice to satisfy billing regulations aggravates physician burnout and harms patients.¹²

A growing cause of burnout that harms patients is the deprofessionalization of medicine, one aspect of which is physicians' loss of control over their medical practices.^{4,12} In many practice settings, administrative supervisory personnel design daily patient schedules. Administrators lack physicians' Hippocratic obligations to place patients' interests first. To increase patient throughput, they may allot insufficient visit time for neurologists to complete a thorough history, examination, and discussion with the patient. Neurologists' dissatisfaction from taking shortcuts and doing substandard work leads to burnout, and patients suffer when they do not receive proper neurologic care.¹² As is true in nearly every instance, factors that aggravate physician burnout also ultimately harm patients.

There are no simple solutions for the problem of burnout because most causes arise from factors outside of the practice of medicine. Experts have proposed and assessed strategies to prevent and mitigate physician burnout.¹³ Currently, the AAN is implementing programs to disseminate evidence-based resources to members that identify and prevent burnout and strive to increase physician resilience.² In general, all programs that prevent or mitigate physician burnout also ultimately benefit patients.

One recent physician survey found a correlation between physician burnout and identifying medicine as a calling.¹⁴ Physicians who regarded medicine as a lifelong calling that was personally rewarding and served a greater good (as

opposed to regarding medicine as a job to earn a paycheck) found more meaning in their work and expressed a greater resilience and tolerance for the frustrations of daily practice. This attitude appeared to prevent the development of burnout. Maintaining the patient-centered ethos of medicine in the face of external pressures presents a continuing challenge but benefits both physicians and their patients.

Author contributions

J. L. Bernat: Drafting/revising the manuscript. N. A. Busis: Drafting/revising the manuscript.

Study funding

No targeted funding reported.

Disclosure

J. Bernat receives publishing royalties from *Ethical Issues in Neurology*, 3rd ed. (Lippincott Williams & Wilkins, 2008) and *Ethical and Legal Issues in Neurology: Handbook of Clinical Neurology*, 3rd series, volume 118 (Elsevier, 2013); serves/has served on the editorial boards of *Neurocritical Care*, *Neurology Today*, *The Physician's Index for Ethics and Medicine*, *Multiple Sclerosis and Related Diseases*, and *Neurology: Clinical Practice*; and has received research support from NIH. N. Busis receives honoraria for speaking at American Academy of Neurology courses and for serving as Alternate CPT Advisor for American Academy of Neurology; and is a former member of the American Academy of Neurology Board of Directors. Full disclosure form information provided by the authors is available with the full text of this article at Neurology.org/cp.

References

1. Sigsbee B, Bernat JL. Physician burnout: a neurologic crisis. *Neurology* 2014;83:2302–2306.
2. Busis NA, Shanafelt TD, Keran CM, et al. Burnout, career satisfaction, and well-being among US neurologists in 2016. *Neurology* 2017;88:797–808.
3. Levin KH, Shanafelt TD, Keran CM, et al. Burnout, career satisfaction, and well-being among US neurology residents and fellows in 2016. *Neurology* 2017;89:492–501.
4. Miyasaki JH, Rheume C, Gulya L, et al. Qualitative study of burnout, career satisfaction, and well-being among US neurologists in 2016. *Neurology* 2017;89:1730–1738.
5. Bernat JL. How can neurologists avoid burnout? *Neurology* 2017;88:726–727.
6. Busis NA. To revitalize neurology we need to address physician burnout. *Neurology* 2014;83:2202–2203.
7. Melnick ER, Powsner SM. Empathy in the time of burnout. *Mayo Clin Proc* 2016;91:1678–1679.
8. Sergay SM. The burnout patient. *Neurol Clin Pract* 2018;8:346–348.
9. Percy W. *Love in the Ruins*. New York: Farrar, Strauss, and Giroux; 1971.
10. Bernat JL. Ethical and quality pitfalls in electronic health records. *Neurology* 2013;80:1057–1061.
11. Shanafelt TD, Dyrbye LN, Sinsky C, et al. Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clin Proc* 2016;91:836–848.
12. Bernat JL. Challenges to ethics and professionalism facing the contemporary neurologist. *Neurology* 2014;83:1285–1293.
13. Shanafelt TD. Addressing physician burnout: the way forward. *JAMA* 2017;317:901–902.
14. Jager AJ, Tutty MA, Kao AC. Association between physician burnout and identification with medicine as a calling. *Mayo Clin Proc* 2017;92:415–422.