# What's the Opposite of Burnout?

*Ronald M. Epstein, MD*

Center for Communication and Disparities Research, Departments of Family Medicine, Psychiatry, Medicine, and Wilmot Cancer Center, University of Rochester School of Medicine and Dentistry, Rochester, NY, USA.

*KEY WORDS:* mindfulness; physician; well-being; resilience; burnout.
J Gen Intern Med 32(7):723–4
DOI: 10.1007/s11606-017-4034-x


When considering the epidemic of burnout and physician discontent so well documented in most medical specialties, my colleagues frequently ask, "What is the opposite of burnout?" Even those who study burnout cannot agree whether outcome assessment should focus on wellbeing, resilience, work engagement, quality of care, attrition, or burnout itself. While it is tempting to think that all would be related, sometimes they are not. It is possible, for example, to be empathic *and* burned out when one takes on the suffering of others without sufficient self-other differentiation[1] and to be both resilient and burned out—the walking wounded. "Work engagement" seems too limited. Perhaps the goal should be *eudaimonia*, Aristotle's word for human flourishing.[2] Aristotle considered eudaimonia a moral virtue and a pinnacle of human achievement because it frees us to work more effectively and effortlessly for the good of others.

Eudaimonia, according to Aristotle, comes from within, not merely in response to external motivators; it is a practical wisdom that comes from a "good indwelling spirit," a "good genius." This makes sense to me as a clinician. Eudaimonia is a sense of deep engagement and coherence and a sense that that work reflects the practitioner's deepest values and that he or she has treated others with competence, compassion, and kindness. I would add, eudaimonia-enhancing actions are not merely directed toward others; they also include positive actions and attitudes toward oneself.

These values have particular relevance to the current state of discontent in the health care workforce. By now, it is apparent that this discontent is not merely the self-indulgent complaint of a societally privileged class—and not because clinicians lack virtue, strength, or resolve. Rather, clinician discontent is rooted in disengagement from work and demoralization—"an erosion of the soul."[3] Discontent, disengagement, and demoralization are due to extrinsic factors such as perverse financial incentives, meaningless work, and cumbersome electronic health records; intrinsic factors such as lack of self-awareness, stress-management skills, and resilience; and factors that fall somewhere in the middle, such as low perceived control and autonomy. The consequences are well documented: poor care, medical errors, professional lapses, and poor communication with patients and colleagues.[4] If there were just a few unhappy doctors the public would have few worries, but now the majority of physicians are burned out and the numbers are rising,[5] and the care that they provide is less than it should be. A CEO of a large health care system recently suggested that patients fire physicians who were non-empathic and burned out.[6] Given the statistics, though, where would patients go?

In this issue of JGIM, an article by Hyo Jung Tak and colleagues[7] fills an important gap in our understanding of physicians' relationship to their work. Using the lens of "organismic integration theory," related to Deci and Ryan's self-determination theory,[8] Tak et al. build on the psychological principle that intrinsic motivators—such as a sense of calling and meaningful long-term relationships with patients—are often more powerful than extrinsic factors—such as income, academic vs. community practice, and work with underserved populations. The article examines how intrinsic motivators might directly and indirectly (via external motivators) affect burnout (an intermediate outcome) and the scaffolding of eudaimonia—a healthy relationship between individuals and their work that incorporates satisfaction with career, satisfaction with life, finding meaning in work, and commitment to continuing to practice. Intrinsic motivators, especially a sense of calling, were powerful predictors of these outcomes, overshadowing most external factors. The authors also asked about "personally meaningful hours" of work per day and found an interesting pattern: career and life satisfaction increased as meaningful hours increased, but only up to a point. Satisfaction declined for those who reported 7.5 meaningful hours per day or more, likely a consequence of overwork or feeling overwhelmed by strong feelings that come up during clinical care.

Current iterations of self-determination theory distinguish among different types of extrinsic motivators, which vary along a spectrum. External motivators that help people to accomplish a goal that is concordant with their values (e.g., an exercise buddy) might promote a sense of autonomy and competence, whereas incentives to accomplish goals that are meaningless or contrary to one's values not only lead to lower motivation, but also may undermine important internal motivators. Incentives to increase productivity and throughput, thus, may impoverish attention to relationships with patients and addressing their needs, activities that clinicians also find personally rewarding and sustaining.

Meaning, positive emotion, resilience, and engagement with work can be improved through self-awareness and meaningful discussions with colleagues.[9] Experience with such

*Published online March 27, 2017*

varied innovations as Schwartz Rounds, in which health care teams discuss, in a public forum, their own feelings of connection and difficulties in caring for seriously ill patients,[10] and mindfulness training, in which participants learn to be aware of their own inner lives in the service of being available to patients,[11] provides some evidence that even experienced practitioners can reawaken their sense of calling to the profession. These approaches ask clinicians to consider, "What do you find most meaningful about your work?"—a frighteningly simple question that physicians don't ask themselves or their colleagues very often. These interventions refocus discussions with colleagues from "what is wrong" toward a clearer vision of what "better" might actually look like and how it would feel. In that way, intrinsic motivators, such as a sense of calling, can be grown and cultivated.

Since Tak's data were collected in 2009 and 2011, the intrusiveness of electronic health records and administrative mandates has grown, and the corresponding increases in burnout probably reflect these changes.[5] Thus, while it is important for individual clinicians and clinical teams to be more aware of stressors and distractions and learn ways of addressing them, individual clinicians can do just so much; health care organizations need to recognize and address the problem on a systems level. For example, the toxic effects of electronic health records—stealing clinicians' attention away from face-to-face relationships with patients and creating a torrent of meaningless and demeaning clerical work—can erode clinicians' intrinsic sense of meaning and purpose. Ditto for "meaningful use" documentation, prior authorizations for necessary care, and clumsy maintenance of certification programs.

We have likely reached a tipping point. Health care organizations must recognize that health care is a fundamentally human enterprise and that clinicians' cognitive resources are limited and are increasingly overloaded with bloodless administrative tasks and demoralizing incentive programs. They should work to direct clinicians' attention to what really matters—data gathering, decision-making, and therapeutic relationships, face to face with patients. An intelligent look at electronic media is one possible way in which organizational, team, and individual efforts can be synergistic and move toward a goal of supporting (rather than eroding) patient-clinician relationships and clinicians' sense of autonomy, control, purpose, and meaning in their work. Clinicians who are aware of and can regulate their own attentional focus can make choices about their relationship to the EHR—when to look at, share, or turn off the computer monitor in the service of relationships with patients, and in that way build the communication, trust, and presence within which both clinicians and patients find meaning, coherence, wise decisions, healing, and wellbeing. I discovered this personally when I decided that the first few minutes of each office visit would be a "computer-free zone" during which I talk, face-to-face, with the patient, only later interacting with the electronic health record when necessary. Patients noticed. So did I. We both had a better sense of connection, and with that, a greater sense that the time spent was of higher quality. But, here, the electronic health record still is an interference to be managed. Instead, the design of EHRs should utilize cognitive ergonomics, informed by the limits of cognitive processing, memory, and attention, and should be designed around clinical need rather than administrative convenience. They should reflect the goals of medicine as a relational, humane enterprise, not merely a transaction between providers and consumers.

Rather than providing answers, Tak et al. suggest a new perspective on clinician wellbeing as an interaction among intrinsic motivators and external factors. Change to address these motivators has been slow, though. While many physicians and health care organizations have moved from the precontemplative to the contemplative phase of change, fewer are taking action. Now that the connections between physician burnout and quality of care have been established and effective programs to address burnout have been developed,[9] we cannot afford to wait; we need an organized effort to promote a healthier relationship between physicians and their work.

***Corresponding Author:*** *Ronald M. Epstein, MD; Center for Communication and Disparities Research, Departments of Family Medicine, Psychiatry, Medicine, and Wilmot Cancer CenterUniversity of Rochester School of Medicine and Dentistry, 1381 South Ave., Rochester, NY 14620, USA (e-mail: Ronald_Epstein@urmc.rochester.edu).*

## REFERENCES

1. **Halifax J.** A heuristic model of enactive compassion. Curr Opin Support Palliat Care. 2012;6(2):228–235.
2. **Epstein R.** Healing the healer. Attending: Medicine, Mindfulness, and Humanity. New York: Scribner; 2017:157–175.
3. **Maslach C, Schaufeli WB, Leiter MP.** Job burnout. Annu Rev Psychol. 2001;52:397–422.
4. **Friedberg MW, Chen PG, VanBusum KR, Aunon FM, Pham C, Caloyeras JP, Mattke S, Pitchforth E, Quigley DD, Brook RH.** Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy. 2013. http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR439/RAND_RR439.pdf.
5. **Shanafelt TD, Hasan O, Dyrbye LN, et al.** Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc. 2015;90(12):1600–1613.
6. Chicago Tonight. Head of Mayo Clinic on 'Epidemic of Burnout' Among Doctors. Septeimber 2016. http://www.pbs.org/video/2365841837/ . Accessed February 19, 2017. Interview with Dr. John Noseworthy.
7. **Tak HJ, Curlin FA, Yoon JD.** Association of intrinsic motivating factors and markers of physician well-being: a national physician survey. J Gen Intern Med. 2017. doi:10.1007/s11606-017-3997-y.
8. **Deci EL, Ryan RM.** Intrinsic motivation and self-determination in human behavior. New York: Plenum Press; 1985.
9. **West CP, Dyrbye LN, Erwin PJ, Shanafelt TD.** Interventions to prevent and reduce physician burnout: systematic review and meta-analysis. Lancet. 2016.
10. **Lown BA, Manning CF.** The Schwartz center rounds: evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. Acad Med. 2010;85(6):1073–1081.
11. **Krasner MS, Epstein RM, Beckman H, et al.** Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. JAMA. 2009;302(12):1284–1293.