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Update on Addressing Mental Health and Burnout in Physicians: What Is the Role for Psychiatry?

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Abstract

Purpose of Review—To highlight an emerging understanding of burnout and physician mental health. This review will provide a discussion of conceptual and diagnostic issues of the burnout syndrome with its relevance to psychiatry, and how psychiatry may interface with other medical disciplines to provide support in creating burnout prevention and treatment programs.

Recent Findings—Descriptive data of burnout correlations and risk factors are available while an understanding of burnout best practices is lacking but growing. Two recent meta-analyses provide efficacy data along with key subgroup analyses that point to greater efficacy among systemic/organizational over individual level interventions. Among individual interventions, groups work better than individual therapy and the incorporation of Mindfulness-Based Stress Reduction and/or Cognitive Behavioral Therapy modalities provide greater efficacy over other therapies. Ultimately, addressing burnout will be an iterative process specific to institutional cultures and therefore should be thought of as quality improvement initiatives involving leadership to adopt the quadruple aim of physician wellness and to seek institution-specific collaboration and feedback.

Summary—Psychiatry is uniquely positioned to help change institutional cultures regarding the burnout syndrome, which has been labeled a national crisis. Combinatorial strategies that combine efficacious individual-level interventions with systemic-level interventions that enhance workflow will likely provide the most sustainable model for preventing and treating burnout. Psychiatry should be involved, especially at the level of the liaison psychiatrist to assist with how these types of interventions may be best implemented in specific institutions.

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Keywords

Burnout; Depression; Psychiatry; Physician mental health; Physicians; Suicide; Empathy

Introduction

Burnout affects all medical disciplines and has insipient and dire consequences for physicians and patients. Rates of burn-out continue to rise even in the recent past for poorly understood reasons. While there are multitude risk factors leading to the burnout syndrome, direct causation of increased burnout is not entirely clear. Burnout is a fairly recently defined concept, but issues with mental health (e.g., depression, suicide, addiction) have long plagued the medical profession and have never been adequately studied and managed. Burnout describes a mismatch between the worker and the work environment that should enable the application of mental health interventions without stigma. Burnout has become a crisis and has drawn a significant amount of worldwide attention. Psychiatry has some unique workplace risk factors for burnout such as safety and violence. Psychiatrists tend to have high levels of emotional exhaustion, and it may not be clear that this is abnormal given role expectations [1]. At the same time, psychiatrists tend to be more self-aware than other physicians and can offer unique guidance to their colleagues on addressing burnout on both individual and organizational/systemic levels [2•]. While efficacious interventions exist, the dissemination and implementation of these interventions is less clear [3••, 4••]. Nonetheless, data suggest that systemic/organization and group interventions are better than individually based interventions and that mindfulness-based stress reduction (MBSR) and/or cognitive behavioral therapy (CBT) are better than other interventions. Root causes of burnout need to be explored and addressed to enhance workflow issues [5]. For example, the Electronic Health Record (EHR) usability should be a top priority for institutions [6•]. Consensus statements have indicated the importance of organization buy-in, leadership, and making clinician wellbeing a top priority by adapting the quadruple aim [7••].

Physician Mental Health

Physicians are physically healthier than the general population based on general metrics; however, physician mental health is worse than the general population in terms of addiction, depression, and suicide [9–11]. Physicians struggle with depression, addiction, and suicide at unacceptably high rates [12–15]. While physicians were able to stop smoking in the 1960s and curb obesity at rates higher than the general population [10, 16], issues with mental health and addiction are comparatively more complicated by underlying cultural and society factors. Medical culture prides itself on putting others first, working long hours, and doing whatever is necessary for the sake of the patient. The extra mile becomes the usual mile and neglecting aspects of necessary self-care became the norm. Doctors are exposed to multiple stressors including dealing with third party payers and regulatory agencies. Increasingly complicated medical science coupled with financial pressures to see an increasing number of patients have led to an abundance of stressors that individually and collectively require attention.

At the same time, there is a long-standing entrenched stigma for physicians and other health professionals experiencing mental health issues. Perhaps the ideals of perfection, infallibility, and responsibility limit physicians' ability to acknowledge these true, valid, and humanistic limitations. Mental health stigma is greater for both medical trainees and practicing physicians than for non-physicians [17, 18]. While mental health stigma precludes appropriate health-seeking behaviors, those in the medical field are most affected, and consistently are the least likely to enter care with a mental health professional [19–21]. In fact, physicians are much less likely to seek help for depression or another mental health issue or to have been taking an antidepressant at the time of suicide than non-physician suicides [22]. Physicians are more likely to have been taking sedative-hypnotic medications at the time of suicide [22].

Depression tends to begin in medical school where up to 28% of medical students experience depression versus 8% of the general population [23]. Depression tends to persist into training and eventually clinical practice. Rates of suicide among physician populations supersede the general population by 1.4× for men and 2× for women resulting in approximately 300–400 physicians suicides in the US annually [12]. Rates of suicide are also elevated in Europe where a study of female Hungarian physicians found that 2% had attempted suicide [24]. This was similarly revealed in Finnish physicians where approximately 25% had also seriously considered suicide [25].

A psychological theory explains why physicians kill themselves [26, 27]. Joiner et al. describes the interpersonal-psychological theory of suicidal behavior in physicians as (1) perceived burdensomeness (feeling like a burden to others-not wanting to take time off), (2) thwarted belongingness (feeling outside the highly valued social group of physicians), and (3) learned fearlessness. This theory is helpful in its description of some of the unique aspects of the suicidal physician who feels outside of a highly valued social group and feels like a burden. Interventions should better understand and counteract these predicaments.

Historically, physicians' problems with depression, suicide, and other mental health issues have been largely ignored. The general approach to physician mental health was to avoid the problem. The prevailing sentiment was that one's place in medicine could have been given to someone more deserving so it is better not to say anything. In other words, it was a personal failure that was a harmful and hurtful approach that did not speak to the real issues that physician face or a way to improve those issues. At the same time, the golden age of medicine which flourished in the mid to late twentieth century was a time of tremendous scientific advances aligned with financial freedom and medical spending that was largely un-checked. A drastic change has occurred over the last 30 years in medicine with the implementation of tremendous oversight to reduced medical errors and streamline pathways etc. Today, medicine has relinquished control to many other entities to deal with skyrocketing insurance and other administrative complexities. It seems not to be a coincidence that burnout was described in the helping professions as this golden age of medicine was coming to an end. The topic of burnout has its roots in the helping professions of the 1970s. Currently, the phenomenon of burnout in medicine is known widely through popular press. Within academic circles, burnout is increasing drastically from 2011 to 2014 based on national registry data across every medical specialty [28].

Physician mental health has also gained attention in academic and the lay press. At the same time, the related issue of burnout has become increasingly important as physician work environments and physician autonomy have changed over time. In fact, ten CEOs of major health systems across the USA declared burnout a public health crisis in a *Health Affairs* article in 2016 [29]. While interventions to help physicians with common mental illness have increased, burnout represents an opportunity to both enhance physician mental health and the work environment, involving systemic change. In theory, burnout should take the onus off of the individual to some extent and therefore de-stigmatize the experience.

Burnout in Physicians

The concept of burnout was first introduced in the research literature in 1974 by Herbert Freudenberger [30, 31]. Informally, the term emerged colloquially in the 1960s as a way to describe the psychological burden experienced by clinical staff caring for vulnerable patients. He described burnout as a "state of mental and physical exhaustion caused by one's professional life" seen predominately in human service workers [32]. Maslach and Jackson later characterized burnout as (1) emotional exhaustion—feeling that one's emotional and physical reserves are depleted and overburdened, (2) depersonalization—subsequently defined as cynicism and negative attitudes toward people, and (3) a diminished sense of personal accomplishment [33, 34]. Perhaps most telling are the words used to describe the syndrome by Maslach "… an erosion of the soul caused by a deterioration of values, dignity, spirit, and will" [35]. Or, "… an experience of physical, emotional, and mental exhaustion caused by long-term involvement in situations that are emotional demanding" [36]. The concept of burnout is more involved than simply experiencing stress at work. Burnout involves the feeling of having no "out" and is a final step in a progression of unsuccessful attempts to cope with a variety of negative stress conditions [37]. Burnout involves a progression of symptomatology developing over time as a maladaptive coping mechanism. In fact, these negative attitude changes (reduced work goals, loss of idealism, heightened self-interest, increasing emotional detachment from work) have been characterized as self-protective mechanisms in a mismatch between work and worker. Specifically, the depersonalization is particularly an instructive approach to detachment as a means of protection against further emotional drain, or an attempt at homeostasis in an emotional exhausted worker [38].

Burnout is a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment (depersonalization) from work, and a sense of ineffectiveness and lack of accomplishment [33]. This is a three-dimensional model that places individual stress experience within a social context and involves the person's conception of both self and others. As such, risk factors for burnout can be divided into individual and organizational or systemic factors. Individual risk factors include compulsiveness, extraversion, neuroticism, and a willingness to loosen boundaries. That is, it disproportionately affects the most driven, compulsive physicians who are striving to do well in their job performance. In addition, the structural risk factors include increasing work load/administrative demands, lack of control of daily tasks, use of Electronic Health

Record (EHR), limited decision-making, unclear job expectations, changing (merging) health care systems, and care of terminally ill patients [39].

Burnout may represent a non-stigmatized and systemic way to treat a long-standing issue in medicine with mental health initiatives as either preventative or treatment oriented.

Issues with Burnout as a Concept

Burnout is a syndrome and not a psychiatric diagnosis. Although burnout is a known entity, the conceptual underpinning of burnout has been disputed. Understanding the underlying issues helps solidify an understanding of the complexities of the burnout syndrome. There are a number of specific debates, and the actual components of burnout are often scrutinized.

Is Burnout Just Depression?

There is a clear overlap between depressive symptoms and burnout. Some experts have argued that burnout is a manifestation of depression, which is in itself multifaceted in its presentation. Correlation between burnout and depression is high. In a large study of physicians, of the 10.3% who met criteria for a major depressive episode, 50.7% were also affected by burnout symptoms (OR 2.99). This study also showed that worsening depression leads to a higher likelihood of burnout symptoms as well [40•]. Given the multifaceted aspects of depression as an umbrella term, this argument certainly makes sense. The issue is that burnout only occurs in relation to the work environment and would be ameliorated by either changing removing the person from the work environment or fixing the mismatch between the person and the workplace. Depression would not be expected to improve once the person is removed from work. Even still, burnout may either represent purely depression or may be comingled with depression. Certainly, those healthcare workers who are depressed may be more likely to experience burnout and similarly burnout symptomatology may seep into other domains of patients' lives and become depression.

The Three Domains of Burnout Are Not Given Equal Weight

The three domains (emotional exhaustion, depersonalization (or cynicism), and decreased sense of personal accomplishment) do not seem to be equally representative of the burnout syndrome, and often, personal accomplishment is excluded in analyses. While exhaustion appears to be the most agreed upon dimension, depersonalization or cynicism and decreased sense of personal accomplishment are concepts whose importance is questioned. Alternative explanations include the idea that depersonalization is a coping strategy and not a core feature of burnout and that reduced personal accomplishment is a consequence rather than a feature of burnout [41]. Alternative dimensions have also been proposed. For example, burnout for some may be defined by two core dimensions—exhaustion (affective, physical, and cognitive exhaustion) and disengagement from work [42]. Other workers have taken to simply evaluating the antithesis of burnout which is engagement at work [43•].

What Is the Role of Empathy?

Contrary to what many believe, being empathic should not lead to burnout. Confusion exists between the concepts of empathy, sympathy, and compassion. Therefore, these concepts which point to a reaction to another person's experience are thought to induce emotional exhaustion and burnout. Important distinctions, however, between these concepts elucidate the relationship between applying these principles to do clinical work and becoming burned out. In essence, empathy highlights the self-other distinction and leads to emotional regulation in the clinician [44]. Emotional regulation should prevent burnout. In fact, there is an inverse relationship between empathy and burnout, which is also why a potential burnout treatment strategy is to increase empathy [45, 46]. Empathy has clearly shown enhanced patient outcomes as well that go along with an engaged clinician who is not suffering from burnout [47]. At its core, empathy is about finding a shared perspective that is cognitive in nature [48•]. Affective, moral, and behavioral components of empathy also exist. Sympathy, in contradistinction, is self-oriented and as such, the clinician draws from his/her own experience which may or may not accurately portray what the patient understands and feels. Essentially, this is why people feel like they do not want sympathy but value the experience of being understood. Sympathy asks "how would I feel if this happened to me?" and is self-oriented, whereas empathy focuses on understanding the others' perspective. Similarly, compassion does not necessarily require a shared perspective or understanding. One can have compassion and a very limited understanding. In fact, the experience of understanding others' perspectives and sharing this connection is deeply rewarding (i.e., engaging) and can easily be thought of preventing burnout by increasing engagement and making work rewarding.

In other words, emotional exhaustion comes from grappling with one's own emotions that are called up vicariously in dealing with patients' hardships. While there is overlap in the clinical experience, the term "clinical empathy" has been used to describe the requisite emotional labor needed to care for patients [49]. Clinical empathy accurately portrays the work involved with treating patients as a physically and emotionally draining. However, engaging with this type of intense clinical work is not necessarily burnout-inducing if it is rewarding, meaningful, purposeful, and enhances patients' experience.

Burnout in Psychiatry?

A recent meta-analysis of 62 studies of burnout in mental health professionals found that the pool prevalence for emotional exhaustion was 40% (CI 31%–48%), while the rates of depersonalization (cynicism) were 22% (CI 15–29%) and 19% (CI 13–25%) for low levels of personal accomplishment [50]. The investigators found that age was associated with greater depersonalization (cynicism) but also increased personal satisfaction. Workload and relationships at work were key determinants for burnout, but several protective factors were also identified (role clarity, sense of professional autonomy, being fairly treated, and access to regular clinical supervision). Psychiatry appears to be among the middle of medical subspecialties in terms of burnout prevalence [51••]. However, there may be higher rates of emotional exhaustion among psychiatrists given the nature of their work, the vicarious trauma involved in continuous exposure to psychological laden content, and the belief that

becoming emotionally exhausted is just part of the job [52•, 53]. While becoming emotionally exhausted may negatively impact patient care and the individuals' health, it may also serve a protective role in that it allows for a way out of what appears to be an impossible or emotionally draining situation. Freudenberg originally described depersonalization as a homeostatic mechanism or means of protection against depletion of additional emotional resources [54]. These changes in attitude, such as reduced work goals, heightened self-interest, emotional detachment, with more pragmatism and less idealism can be seen as a form of coping as well [55]. These changes may also collide with some of the personality factors among psychiatrists. As a group, psychiatrists score higher on items of neuroticism but also openness and agreeableness. Higher levels of neuroticism may explain reportedly higher levels of emotional exhaustion, depression, addiction, and even suicide among psychiatrists [56–59].

In addition, there are specific and unique risk factors for burnout among psychiatrists that are different from other specialties. For example, the threat of violence is unique to working with disorganized and disenfranchised individuals and has been identified as a risk for psychiatry related burnout [60]. Psychiatrists are also particularly prone to working in areas of limited resources, crowded inpatient wards with poorly defined roles as consultants but having responsibility without authority, all of which sets up psychiatrists for burnout [1, 61]. Also, a culture of blame is noted to creep into mental health services as another predominate source of stress of psychiatrists working collaboratively [62]. Of course, high work demands, conflict between responsibility toward employers versus patients, and isolation of consultants working in community mental health teams and lack of feedback all affect engagement of the psychiatrist and lead to physical/mental exhaustion and burnout [55, 63].

The working environment of psychiatry has undergone significant changes as well that may lead to increased work stress. For example, societal expectations of what should be done tend to outpace what can be done within psychiatry [64]. People seek out psychiatry not only for relief from a disorder but for a multitude of problems in everyday life that psychiatrists may not necessarily feel equipped or be comfortable taking on such roles [65]. There may be an increasing expectation to be able to predict aggressive or violent behavior [65].

In particular, burnout in psychiatrists appears to be more intimately related to factors in the work environment than other disciplines [66]. Psychiatry likely differs from other disciplines in and outside of medicine in that burnout and stress are not inversely related to job satisfaction [67]. That is, psychiatrists can have high levels of burnout and still report relatively high levels of job satisfaction [68]. A burnout model that relies on job satisfaction would be of poor predictive value for psychiatrists. The interpersonal work environment also makes a difference as the emotional connectedness is highly valued in psychiatry but can also have untoward chronic affects, especially when a patient attempts or completes suicide [69].

Psychiatry is in a unique position to inform solutions for burnout. There are many constitutional, work environment issues that may set psychiatrists up for burnout.

Psychiatrists, however, also possess many tools that can be used to better understand how to address burnout.

How Can Psychiatry Help Other Medical Disciplines with Burnout?

The interventions needed to address burnout are both individual and systemic/organizational. Data on interventions to address burnout are in evolution. Interventions for burnout should address the root causes for burnout in the first place [5]. Factors that create and enable burnout should be discovered and ameliorated. This concept highlights the contribution of both the worker and workplace. Efficacy data are available for both individual and systemic interventions. A meta-analysis looking at interventions to decrease overall burnout found a reduction of burnout from 54 to 44% ($p < .001$) with moderate heterogeneity $I^2 = 15\%$ among five randomized controlled trials and nine cohort studies using the MBI [3]. Differences were even greater for physicians who started out with high emotional exhaustion or depersonalization. This meta-analysis found that structural/organizational interventions were more efficacious ($p = .03$), but this was based on a limited number of studies and had higher heterogeneity ($I^2 = 79\%$). Among individual interventions, MBSR or stress management interventions were the most effective types of interventions for both emotional exhaustion ($p < .001$, $I^2 = 47\%$) and depersonalization ($p < .001$, $I^2 = 0\%$). In addition, another systematic review/meta-analysis looking at interventions to reduce symptoms of common mental disorders and suicidal ideation in physicians included eight studies (seven RCT, one cohort) and found a moderate-large effect size standardized mean difference (SMD) 0.62 [4••]. Planned a priori subgroup analyses found no difference between high versus low bias studies or physician versus trainee. At the same time, group interventions (SMD 0.78) were more efficacious than individual interventions (SMD 0.39) and MSBR or CBT (SMD 0.79) was more efficacious than other types of therapy interventions (SMD 0.46). Only one study actually reported on suicide using the Patient Health Questionnaire-9 but found that an on-line individual CBT intervention had been efficacious with RR of 0.4 (60% less likely to have suicidal ideation). Both of these meta-analyses included mixed groups of physicians were symptomatic and asymptomatic. Overall, there were few organizational/systemic interventions aside from reorganization of work hours (e.g., moving from 4- to 2-week inpatient on call or reducing duty hours among residents) but not addressing workflow exactly. These data have significant limitations that reduce its overall applicability given the variability in outcome measures, context, type of intervention, and treatment setting.

Combinatorial strategies probably offer the most promise but have been rarely tested. At the same time, consensus statements have been provided by multiple medical societies and physician-administration collaborations that make common sense and may have a priori applicability [7••]. It is crucial to think about workflow and target redundant and often meaningless tasks in EHRs that slow down productivity and take time away from patients. These extra administrative tasks may be reduced using third apps called API since EHRs can be slow to change [6]. Atul Gawande has cautioned us that "… a system that promised to increase physicians' mastery over their work has, instead, increased their work's mastery over them" [43•]. Collaboration between these institutional entities needs leadership initiatives.

Burnout reduction is institution-specific and needs to be an iterative process with multiple levels of feedback and collaboration between physicians, administrators, staff, and leadership. Institutions must adapt the quadruple aim (i.e., physician wellbeing) to make burnout reduction a priority and adopt institution-specific culture change around burnout and mental health of clinicians. Healthcare workers need to feel and believe that the institution has their individual best interest in mind. To this end, addressing burnout needs to incorporate a comprehensive approach as a group and for individuals. Policies should be set in place to reduce stigma that individuals may feel to seek mental health care. In other words, an occasional collective retreat on wellness without proper longitudinal options for non-stigmatized mental health care sends a disingenuous message. Psychiatrists can help administrators understand underlying psychological themes that are created by policies and help create a healthy, stigma-free environment where clinicians are not afraid to seek emotional help when needed. Other industries, the airline industry in particular, have done this well by making the emphasis job performance rather than a personal failing.

Quality initiative (QI) measures that represent an iterative process are emerging as ideas between clinicians and administrative leadership to address this overwhelming problem. Creative QI projects can be contextualized, measured, and reported. Leadership plays a large role in addressing burnout at an institution level. In addition, data showing efficacy exist on both individual and system study levels. Given that burn-out is a systemic problem, systemic level solutions are needed. The responsibility is on both system and the individual. Individuals have felt accused previously of becoming burnt out (guilty). Although there are effective individual level interventions, sustainable and more effective changes come in the form or organizational/systemic interventions.

How Might the Consult-Liaison Psychiatrist Help His/Her Colleagues with Burnout?

The CL psychiatrist can be involved on both individual and organizational levels. The CL psychiatrist might function as a conduit for other clinicians who could benefit from a psychiatric evaluation or who may need help in the community. As confidentiality and respecting boundary issues are key to providing dignified care, this would ideally happen as part of employee assistance. The fields of Occupational and Preventative Medicine are growing and would benefit from psychiatric perspectives in understanding and addressing burnout. Many interventions for burnout have been developed without a well-informed and documented psychiatric perspective. A Cochrane review of communication skills training studies found little improvement in established burnout, but many of these trainings do not benefit from a psychiatric input either [70].

At the same time, the CL psychiatrist is poised to offer their skills and expertise in developing burnout interventions on both individual and structural/organizational levels. For example, CL psychiatrists can conduct “Balint Group” meetings where physician groups strive to gain alternative and salutary perspectives on their interactions with patients [71, 72]. These interactions help clinicians understand their own feelings while experiencing a sense of community among colleagues. In addition, specific burnout interventions such as

cognitive behavioral therapies and MBSR can be utilized and taught by the CL psychiatrist [73]. On an organizational level, CL psychiatrists can provide guidance in working through system-wide projects to prevent or treat burnout or physician mental health. These types of structural changes can have lasting salutary effects that would clearly benefit from the understanding of organizational psychology.

Conclusion

Psychiatry is in a strong position to contribute to the growth of knowledge regarding burnout. Burnout prevention and treatment needs to involve psychological perspectives on both individual and systemic/organizational levels. Organizations need to understand the psychological implications of policies while striving to create a stigma-free environment. While there appears to be considerable new collaborations between clinicians and administration, these collaborations should involve mental health clinicians as well who can weigh in on applicability. At times, individual burnout may require an actual psychiatric evaluation in order to rule out psychiatric disorders, such as depression, or evaluate for disability. Residency training programs should start to include burnout in their curricula. For consultation liaison psychiatrists, growing attention to burnout represents a unique opportunity for extending the liaison role to enhance colleagues' mental health.

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