09 - 9 Physician Well-Being

9 Physician Well-Being

Lisa M. Bellini, Vivek H. Murthy

Physician Well-Being PART 1 The Profession of Medicine PHYSICIAN WELL-BEING: AN HISTORICAL PERSPECTIVE The practice of medicine is often viewed as a calling and as a way of life. The term resident originated from Dr. William Osler in 1890, when he established the first full-time, live-in medical residency training program at Johns Hopkins Hospital in Baltimore, Maryland. There, residents lived in the administration building. With the duration of their training undefined, many stayed for years. Personal sacrifices came at the cost of professional expectations and norms of the time. The twentieth century ushered an era of standards and policies for medical education, and for the profession more broadly. In 1904, the American Medical Association (AMA) formed the Council for Medical Education (CME) to strengthen medical education training programs and policies. In 1910, the AMA supported an evaluation of the quality of these programs in the United States and Canada, which resulted in the Flexner Report, which called for the creation of a new model for medical education by recommending that medical schools enact higher admission and graduation standards and adhere strictly to the proto cols of mainstream science in their teach ing and research. There was no reference to physician well-being. The AMA's CME supported the report, leading to the birth of the Federation of State Medical Boards in 1912, the American Board of Medical Specialties in 1933, the Licensing Com mission of Medical Education (LCME) in 1972, and the Accreditation Council of Graduate Medical Education (ACGME) in 1981. Again, physician well-being was not prioritized in causes for reform. Through this time, residents worked long hours, with little sleep or days off for ill ness and time with their families. Most were expected to work 36 hours every other night, often exceeding 100 hours per week. Factors associated with burnout among health workers Societal and Cultural Concerns mounted about the potential impact of fatigue on resident well-being and patient care; both were inevitably and inextricably linked. Yet, changes in policy were slow to follow. In 1975, New York City medical residents went on strike calling for fewer hours on duty. The tragic death of Libby Zion in 1984, following a misdiagnosis, was linked to medical resi dent fatigue and inadequate supervision. By 1989, New York became the first state to regulate resident duty hours. These regulations limited duty hours to an aver age of no more than 80 hours per week, with no more than 24 hours of continuous duty, and at least 24 hours free from clini cal duties weekly. Subsequently, medical residents across the country petitioned the Occupational Safety and Health Administration in 2001 to nationally limit duty hours. The ACGME responded to concerns by 2003 with national standards limiting resident duty hours for all of its programs. Organizational Workplace and Learning Environment FIGURE 9-1 Factors associated with burnout among health workers. (Adapted from Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce, p. 12. Available at https://

www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf.) In 2000, the Institute of Medicine (IOM) landmark report “To Err Is

Human: Building a Safer Health System” shifted the discourse away from individual-level factors toward system-level changes needed to address alarming patient safety concerns. Efforts soon after acceler ated to ensure patient safety and quality of care alongside physician well-being. Over the past 20 years, there has been an increasing focus on physi cian well-being with the introduction of wellness programs to promote self-care. Such programs have diffused into undergraduate medical education and biomedical training, but there are fewer standards governing physicians in independent practice. While individual-level stressors are important determinants of physician well-being, the most important drivers are the workplace systems in which students and residents learn and where physicians work. CHALLENGES IN THE CURRENT HEALTH CARE LANDSCAPE As health care systems have grown more complex and the demand for care has outpaced resources, chronic workplace stress and burnout have defined the contemporary experience of many physicians. Burn out is an occupational syndrome resulting from chronic workplace stress due to an imbalance between job demands and resources and other organizational, societal, and cultural factors in health care. The concept and contributing factors are included in the 11th Revision of the International Classification of Diseases (ICD-11) and the Surgeon General’s Advisory on Addressing Health Worker Well-Being (Fig. 9-1). • Politicization of science and public health • Structural racism and health inequities • Health misinformation • Mental health stigma • Unrealistic expectations of health workers • Limitations from national and state regulation • Misaligned reimbursement policies • Burdensome administrative paperwork • Poor care coordination • Lack of human-centered technology Health Care System • Lack of leadership support • Disconnect between values and key decisions • Excessive workload and work hours • Biased and discriminatory structures and practices • Barriers to mental health and substance use care • Limited flexibility, autonomy, and voice • Lack of culture of collaboration and vulnerability • Limited time with patients and colleagues • Absence of focus on health worker well-being • Harassment, violence, and discrimination “This is beyond my control...” Office of the U.S. Surgeon General

It is characterized by a high degree of emotional exhaustion, deperson alization (e.g., job cynicism), and a low sense of personal achievement at work. In 2014, the Institute for Healthcare Improvement advanced the Quadruple Aim, adding a fourth goal to improve health workforce well-being, directly acknowledging that the existing goals in health care—to enhance the patience experience, improve population health, and reduce costs—cannot be met without the health and well-being of our nation’s healers. Subsequently, in 2017, the National Academy of Medicine (NAM) formed a Clinician Well-Being Action Collaborative, gathering leaders to highlight and act on the alarming burnout crisis across all health care specialties and settings. NAM declared “crisis levels” of burnout in 2019, even before the pandemic, with 35–54% of nurses and physicians and 45–60% of medical students and residents experiencing varying degrees of burnout. The COVID-19 pandemic acutely brought the nation’s attention to the unprecedented demands placed on physicians and other health workers. It also highlighted the moral distress, moral injury, and com passion fatigue experienced by many physicians and other health care providers who were forced to choose between caring for patients and keeping their families safe; who witnessed countless patients suffer and die, without family or friends at their bedside; and who had to help lessly ration inadequate supplies, beds, or treatment to their patients. One survey published in Mayo Clinic Proceedings found that an alarm ing 63% of physicians reported burnout during the pandemic in

2021, compared with 38% in 2020 and 44% in 2017. Decades of research and evidence have found, as referenced by the Surgeon General's Advisory on Addressing Health Worker Burnout in 2022, that chronic work stress and burnout have harmful effects on physician health and well-being. Chronic work stress is associated with poor health outcomes such as impaired cognitive function, increased risk of cardiovascular disease, type 2 diabetes, fertility issues, sleep disruptions, isolation, relationship conflict, and risk for substance use and misuse. Burnout is also associated with mental health challenges including anxiety, depression, and suicidal ideation. Surveys by health care professional associations have also found widening gender and racial gaps, especially among female physicians and groups underrep resented in medicine. Physicians and other health workers who report burnout are more likely to reduce working hours, report intent to leave jobs or medical school, or leave medicine altogether. One in every five physicians has reported intent to leave medical practice due to burnout, contributing to a projected shortfall of up to 86,000 physicians in the United States by 2036. These shortages will only compound the vicious cycle of increasing physician work demands that often lead to burnout. CORE ELEMENTS FOR BUILDING A THRIVING PHYSICIAN WORKFORCE A thriving physician workforce requires a dynamic, multipronged, and collective approach to solve the complex array of institutional, structural, cultural, and societal factors that impact physician health and well-being (Figs. 9-1 and 9-2). Fundamental change in the orga nizational environment, including the systems and cultures where all physicians learn, train, and work, is the necessary first step. ■ ■PROTECTION FROM HARM Strengthen physician protections from physical and psychological harms in the clinical learning and work environment. This includes ensuring adequate personal protective equipment during and outside of public health emergencies, sufficient staffing, shift coverage and rest, and clearly communicated policies that protect physicians from all threats and acts of harassment, intimidation, and violence at work and in their communities. The Joint Commission released workplace violence prevention standards in 2021 to guide leaders with implemen tation. Health care organizations must also explicitly support inclusion and equitable access to policies and programs (e.g., paid leave, career advancement) that can comprehensively address diversity and acces sibility. Doing so can address the microaggressions, implicit bias, dis crimination, and racism that many physicians face.

Increase access to quality mental health care for all physicians, including residents and students. These services can be offered on-site or via telehealth options including peer support groups, confidential physician health programs, or employee assistance program (EAP) ser vices (e.g., counseling, referrals, caregiver support). It is most impor tant to ensure that access to any service is convenient, meeting unique needs and work schedules.

CHAPTER 9 In the 2023 Physicians Foundation Survey of America's Current and Future Physicians, more than half of physicians (up since 2021) reported knowing of a physician who has ever considered, attempted, or died by suicide. A proactive, evidence-based approach to suicide prevention must be incorporated to embed voluntary, anonymous screening and tailored referrals and follow-up care. Physician Well-Being Furthermore, we must end barriers to mental health care, specifi cally stigma and policies that deter physicians and other health workers from mental health support services. Many physicians may be reluctant to seek formal short-term and recovery care for mental health chal lenges and conditions, given concerns regarding potential repercus sions on their license, hospital credentials, careers, and credibility. Health care organizations, academic institutions, and policymakers at all levels can review and remove intrusive, stigmatizing questions

on all applications and forms, ensuring alignment with national recom mendations set by The Joint Commission in 2020. ■ ■REDUCE ADMINISTRATIVE BURDENS Administrative burdens must be reduced to give physicians more time for what matters—their patients. A rapidly changing health care eco system, with new payment options, market consolidation, insurance and regulatory requirements, and advances in health information tech nology, has contributed to the loss of physician autonomy and a signifi cant reduction in time for patient care. For example, with the growing consolidation of the health care market and the corporate privatization of practices, many physicians feel their voices, decision-making, and sense of value have diminished over time. Systems-level changes are needed to ensure that the physician–patient relationship is at the very center of the health care system. Further, there are additional organiza tion-level practice changes that can also address inefficiencies and give physicians time back. Improve and streamline workflow processes (e.g., documentation requirements, inbox notifications, prior authorizations). As an exam ple, changes to documentation guidelines for outpatient evaluation and management (E/M) visit codes were updated in 2021 to better align with current medical practice and patient care. Health professional associations offer practical tools, including the AMA Saving Time Playbook and Electronic Health Records (EHR) Playbook. Researchers have found notable progress across health systems when leaders visibly apply the “Getting Rid of Stupid Stuff,” or GROSS, model, seeing mea surable reductions in the volume of unnecessary daily documentation tasks for physicians and the care team. Eliminate unnecessary and inefficient prior authorizations. In 2022, a majority of physicians surveyed (94%) reported that prior authoriza tions from insurers delayed access to necessary care. Many physicians also reported treatment abandonment by their patients because of prior authorization delays. Many policymakers and health profes sional association programs exempt clinicians from prior authorization requirements if they meet specific performance measures. Although evidence is mixed on the benefits of these efforts, it seems likely that any measurable reduction in administrative burden will improve costs and, if thoughtfully implemented, improve quality of care. With workforce shortages, organizations can harness, adopt, and implement technology in a physician- and patient-centered way. While the role of the physician will always be indispensable, particularly for direct patient interactions and complex clinical decision-making, there are growing opportunities to leverage trustworthy artificial intelligence (AI), machine learning, and other digital automation tools to support various stages of patient care, such as previsit planning, encounter documentation, prior authorizations, and follow-up communication. Importantly, AI companies have the responsibility to also ensure that such platforms safeguard patient safety and privacy, mitigate risk of

Thriving together: Solutions to health worker burnout We must shift burnout from a “me” problem to a “we” problem. PART 1 The Profession of Medicine Leadership commitment and organizational values Diverse and empowered health workforce Accessible mental health and substance use care Culture of healing, community and connection Human-centered technology Health Insurers and Payers Health Care Organizations Federal, State, Local, Tribal Governments Researchers Family Members, Friends, and Communities FIGURE 9-2 Thriving together: solutions to health worker burnout. (Adapted from Addressing Health Worker Burnout: The U.S. Surgeon General’s Advisory on Building a Thriving Health Workforce, p. 20. Available at https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf.) clinical harm, and measurably improve the quality of care. Further, EHR companies must strengthen platforms to focus on key features needed for patient care and design the systems to meet the needs of clinicians in ways that optimize usability as a clinical decision support tool. Finally, health care

technology companies must work with physi cians and other health workers to ensure accessible, meaningful, and unbiased processes and data. This includes assurance that interven tions do not add more burden onto the health care team. ■ ■BUILD CONNECTION AND COMMUNITY Opportunities for strengthening social connection and community in medical education, clinical training programs, and all health care work environments should be integrated into our systems. Physicians, including students and residents, should be included in these social networks, as appropriate. They may have fewer routine opportunities to connect meaningfully with colleagues and identify new colleagues

Reduced administrative burdens Safe and inclusive environments Community partnership Trust Academic Institutions Licensing and Accreditation Bodies Office of the U.S. Surgeon General and mentors, particularly when new to the community. The value of workplace connection and social support for physicians cannot be overstated, especially in an era of widespread societal loneliness and social isolation. Acknowledging that the common experience of loneli ness and isolation can be felt at all stages of medical education and throughout a career in medicine is a necessary and important first step. Peers, faculty, and health care organization and academic institution leaders are each well-positioned to model and foster opportunities for social connection and community. This can be through applying team work and team-based care models, establishing peer support groups and informal learning networks, reviving the modern-day doctors' lounge, and investing in mentoring and coaching programs. These efforts to cultivate social connection must be operationalized with protected time and infrastructure built into core working hours and the physical environment. This can help all physicians feel seen and heard, with time to pause and reflect on challenging circumstances

and morally distressing dilemmas together with peers and mentors. These efforts also help physicians build trusting relationships with one another and promote a culture that values connection within the workplace. Finally, such efforts also offer necessary time and space to reinforce connection through shared purpose, professional fulfilment, and a celebration of collective achievements in health care, research, and medicine. ■ ■BOLSTER THE HEALTH WORKFORCE Investments that bolster the health workforce need to be expanded. Health workforce shortages across all specialties and settings can negatively impact timely access, quality, and patient safety. As noted earlier, the American Academy of Medical Colleges has estimated a major shortage of physicians in the United States, and the challenge is much greater in most parts of the world. Health care needs will only increase as we address the ongoing mental health crises and a growing and aging population and strengthen our responses to climate change and its impact on health. Despite these gaps, there are hopeful signs and solutions. According to data compiled by the Federation for State Medical Boards, the U.S. physician workforce is 20% larger than it was over a decade ago. New medical schools and postgraduate training programs are being devel oped at an unprecedented rate in most industrialized countries and in many less developed parts of the world. There are renewed efforts to increase and diversify the workforce, especially to ensure more cul turally appropriate care. Many of these efforts encourage practice in specialties with shortages and in rural and underserved communities. We can also ensure support for equitable pathways via scholarships and tuition support. Additional career advancement, faculty salary support, and apprenticeship training programs can further retain and sustain instructors, preceptors, and mentors in the nursing, direct patient care, and behavioral health workforce. We must also sustain and increase investments for addressing unmet underlying social needs, such as housing, food,

and transportation. Doing so can not only reduce demands upstream for health care but can also address the moral distress physicians may experience when they encounter root causes of their patients' suffering and the obstacles to quality care that they cannot address. An annual survey by the Phy sicians Foundation in 2022 found that many (61%) felt they had little to no time to effectively address their patients' social determinants of health. Social determinants of health are estimated to account for upward of 80–90% of modifiable factors to health outcomes (Chap. 11). Health systems, together with community leaders in public health, are well-poised to focus on prevention and whole-person care, investing in evidence-informed models that keep individuals and communities healthy for the long term. ■ ■FOSTER A CULTURE OF PHYSICIAN WELL-BEING The culture of medicine must be transformed to center on physician health and well-being. For medical education and training programs, institutions can begin by addressing the hidden curriculum—the unwritten and unofficial values, and unintended lessons, that students learn by observing a teacher's actions, which may be at odds with the formalized curriculum. The American College of Physicians (ACP) reported that more than half of medical students experienced discon nect between what they were explicitly taught and what they perceived from faculty behaviors in practice. The ACP 2018 position paper is a helpful resource for physician leaders and faculty with recommenda tions and strategies for fostering values of respect, honesty, empathy, inquiry, and ethics, while promoting clinician wellness. Across any organization, leadership is critical in fostering a culture that values physician health and well-being. Concrete steps include operationalizing well-being as an organizational value; integrating it into strategic plans, performance indicators, and training; and establishing a chief well-being officer role. This position must have dedicated resources and decision-making authority. The role should collaborate with leadership in health care administration, human resources and talent management, finances, health information technology (IT), and equity, while proactively engaging physician

and other health worker representatives. They must regularly assess the work environment for factors contributing to chronic work stress and burnout while also evaluating changes in policies and programs that impact the role, function, and well-being of physicians. NAM's Action Collaborative offers a compendium of resources, with vali dated tools for engaging staff, measuring physician well-being, and benchmarking success.

CHAPTER 9 All health care leaders must model and create environments where conversations about physical and mental health are normalized. Phy sicians should be able to talk openly about work stressors and their mental health without stigma or fear of repercussions on their licens ing, credentialing, or careers. This includes encouraging open and honest conversations about the mental health challenges they face in their day-to-day work and offering support and validation along their journey. This must begin early in medical training. Periodic physician well-being support and awareness campaigns can help physicians feel heard, supported, and valued and serve as useful tools for communicat ing information and updates about well-being services. The National Institute for Occupational Safety and Health, the NAM Action Collab orative, and numerous professional associations offer practical tools to support leaders with this type of communication and programming to support physician well-being. Physician Well-Being THE FUTURE OF PHYSICIAN WELL-BEING Medicine remains a calling, yet one that should be built on, not at the expense of, the well-being of our nation's healers. Failing to value and center their health and well-being at the core of our health care system puts us all at risk. When physicians look ahead, they should see a future where their dedication is not taken for granted, but one where their health, safety, and well-being are as much a priority as the well-being of the people and communities in their care. ■

■FURTHER READING The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. https://www.aamc.org/media/75236/download?attachment. Accessed April 29, 2024. Kohn L et al (eds): To Err Is Human: Building a Safer Health System. Institute of Medicine (U.S.) Committee on Quality of Health Care in America, Washington, DC, National Academies Press, 2000. https:// pubmed.ncbi.nlm.nih.gov/25077248/. Lehmann LS et al: Hidden curricula, ethics, and professionalism: Optimizing clinical learning environments in becoming and being a physician. A position paper of the American College of Physicians, 2018. Ann Intern Med 168:506, 2018. Linzer M et al: Trends in clinician burnout with associated mitigat ing and aggravating factors during the COVID-19 pandemic. JAMA Health Forum 3:11, 2022. Lyubarova R et al: Gender differences in physician burnout: Driving factors and potential solutions. Perm J 27:2, 2023. National Academy of Medicine: National Plan for Health Workforce Well-Being. Washington, DC: The National Academies Press. https:// doi.org/10.17226/26744. Accessed July 28, 2023. Philibert I, Taradejna C: Duty hour standards. Chapter 2: A brief history of duty hours and resident education, in Enhancing Quality of Care, Supervision, and Resident Professional Development. ACGME, 2011. https://www.acgme.org/globalassets/pdfs/jgme-11-00-5-111.pdf. Shanafelt T et al: Physician well-being 2.0: Where are we and where are we going? Mayo Clin Proc 96:10, 2021. US Department of Health and Human Services: Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce. https://www.hhs.gov/sites/ default/files/health-worker-wellbeing-advisory.pdf. Accessed July 28, 2023. ■ ■WEBSITES American Medical Association: www.ama-assn.org/ Physicians Foundation: www.physiciansfoundation.org/

Revision #1
Created 2026-01-06 16:30:58 UTC by Omar Ayman
Updated 2026-01-06 16:30:58 UTC by Omar Ayman