Physician Wellness Is an Ethical and Public Health Issue

Rosandra Walker, MD¹ and Harold Pine, MD¹

Abstract
Attention to physician well-being has traditionally focused on substance abuse, usually with disciplinary implications. But, in recent years, greater notice has been granted toward physician burnout and overall wellness. Burnout and its sequelae not only affect physicians and physicians-in-training as individuals, but the impact then multiplies as it affects these physicians’ patients, colleagues, and hospital systems. In addition, the American Medical Association Code of Medical Ethics charges physicians with a responsibility to maintain their own health and wellness as well as promote that of their colleagues. Therefore, the question of physician wellness has both public health and ethical implications. The causes of burnout are multifactorial, and the solutions to sustainable change are multitiered.

Keywords
physician wellness, burnout, ethics, public health

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The American Medical Association Code of Medical Ethics Opinion 9.3.1 states, “physicians have a responsibility to maintain their health and wellness . . . . Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.”¹ This responsibility includes preventing or treating acute or chronic diseases, including disabilities, mental illness, and occupational stress. This charge stems from the principal onus of preserving the quality of physicians’ performance to provide safe and effective care for patients. Traditionally, the focus has been on impairment due to substance abuse, leading to performance deterioration. But now, an old entity with newly fanned flames, “burnout,” is gaining traction as a source of physician impairment.

Characterized by emotional exhaustion, cynicism, depersonalization, reduced perception of personal efficacy, and reduced effectiveness, burnout is a psychological response to work-related stress.²,³ It can affect physicians at any point throughout training and practice, even as early as medical school, and is estimated to affect at least 50% of US physicians.²,⁴ Burnout can affect a physician’s ability to deliver quality health care. In fact, an association has been found between the depersonalization dimension of burnout and patient outcomes of patient satisfaction and recovery time (after controlling for patients’ severity of illness and other demographics).³ With ~980,000 active physicians, fellows, and residents responsible for the health care of 323 million people in the United States,⁵ the potential impact on patient care (eg, direct negative effect on day-to-day health care delivery, worsened patient outcomes, physicians leaving the direct-patient-care workforce) becomes exponential, with a substantial proportion of the population incurring the harms. These combined factors support the notion that the issue of physician wellness not only is a personal one for physicians and their families or friends but also poses an ethical miscarriage and public health danger.

The Present
The Council on Ethical and Judicial Affairs for the American Medical Association encourages physicians to engage in honest self-assessment regarding the ability to practice when there is a compromise to personal health or wellness. Sometimes, lack of insight can impede this responsibility, wherein physicians may be reluctant or unable to see themselves (or their colleagues) as needing help with any health-related affairs.⁶ The current culture of medicine also contributes to factors intrinsic to the physician by encouraging individual physicians to value self-neglect in the name of pathologic levels of sacrifice or a supernatural “toughness” philosophy.

For the physician who does perform the appropriate reflection and identifies a health issue requiring intervention (eg, time off for a clinic appointment, starting a medication, undergoing therapy, taking a mental health day), the fear of incurring shame, stigmatization, and even licensure consequences can pose a significant deterrence to seeking care.⁶

¹Department of Otolaryngology–Head and Neck Surgery, University of Texas Medical Branch, Galveston, TX, USA

Corresponding Author:
Rosandra Walker, MD, Department of Otolaryngology–Head and Neck Surgery, University of Texas Medical Branch, 301 University Blvd, Galveston, TX 77555, USA.
Email: Rolwalke@utmb.edu
In addition, practice demands and time constraints (eg, unable to take time off because of lack of clinic coverage) may obstruct the physician from practically seeking care. This is an example of how factors extrinsic to the physician, specifically the cultural climate and organizational system, can influence an individual’s own decision and ability to pursue improved wellness.

The Future

Dr Vivek Murthy, the 19th US Surgeon General, stated, “Culture change is what allows policy initiatives and policy intentions to be sustained.” The increasing national awareness of physician burnout has been accompanied by several noteworthy endeavors. Within the past 2 years alone, we witnessed the founding of the inaugural American Conference on Physician Health, the first ever appointment of a Chief Wellness Officer at an academic medical center, and the establishment of the American Academy of Otolaryngology—Head and Neck Foundation Physician Wellness Taskforce. These momentous measures acknowledge the complexity of the issue and offer multitiered solution-based approaches. Two of the pioneering institutions in this revolution have been the Mayo Clinic and Stanford University School of Medicine. Through structured, deliberate efforts, Mayo Clinic saw the burnout rate of its physicians decrease by 7%, even though there was an 11% rise nationally. Similarly, Stanford University School of Medicine established the Stanford WellMD Center, where the aforementioned first Chief Wellness Officer at an academic medical center was appointed. Another team, with the support of the American Medical Association, has described 3 reciprocal domains of physician well-being: personal resilience, culture of wellness, and practice efficiency. The significant scholarly contributions of these groups and others can be used to model interventions in other institutions and practices.

While it may take time to enact changes at the systemic level, there is no excuse for not taking action right now. Medical staffs and centers across the country should follow the lead of these pioneer programs by establishing, for example, their own wellness committees and appointing a Chief Wellness Officer. “Wellness” is not a magic pill to be taken at the sign of burnout. Instead, it is a lifestyle to be cultivated on a daily basis through personal effort, sustained by environmental resources and reinforced by the organizational culture. More research needs to be driven in this area to compile evidence-based approaches that will yield the most benefit. Intervention and quality improvement should be taken at the sign of burnout. Instead, it is a lifestyle to be cultivated on a daily basis through personal effort, sustained by environmental resources and reinforced by the organizational culture. More research needs to be driven in this area to compile evidence-based approaches that will yield the most benefit.

Conclusion

Encouraging physicians to “take better care of themselves” is only one piece of the puzzle, which must be accompanied by tangible organizational avenues to do so and creating a culture that truly celebrates self-care. We must continue to engage in honest dialogue to create awareness, while enacting policy, restructuring culture, and redesigning practice efficiency to drive an already shifting paradigm. The issue of burnout and physician wellness is much more than one individual’s personal problem—the consequences are reverberating throughout the nation. The steps we take today will shape the future of medicine for years to come.

Author Contributions

Rosandra Walker, substantial contributions to conception and design, revising critically for important intellectual content, final approval of the version to be published; Harold Pine, substantial contributions to conception and design, revising critically for important intellectual content, final approval of the version to be published.

Disclosures

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