From the JAMA Network

Deconstructing Burnout to Define a Positive Path Forward

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Burnout meets criteria for being an epidemic in health care. It affects a growing proportion of clinicians and other personnel, and there is an element of contagion—ie, clinicians who are burned out increase the risk that others around them feel the same.[1] Two recent studies[2,3] published in *JAMA* demonstrate the extent of this epidemic and provide insight into its risk factors and complexity. Collectively, these data make the case that health care systems will not find a single magic bullet that cures burnout; instead, as with most epidemics, progress will occur through a multifaceted approach.

For the first article, Dyrbye et al[2] surveyed 4732 US resident physicians twice—once during their last year of medical school and again during their second year of residency. They found symptoms of burnout in 45% of residents and regret about career choice in 14%. There was considerable variation in burnout prevalence among specialties and between sexes, and higher rates were found in those who had been more anxious or less empathic during medical school.[2] The second study by Rotenstein et al[3] described variation in the prevalence of burnout in a systematic review of 182 studies—the logical consequence of variation in how burnout and its subcomponents were defined. These authors call for standardizing the definition of burnout and measurement tools.[3]

We agree, and argue that, as with any epidemic, the next steps after standardizing criteria for making the diagnosis are understanding the pathophysiology, identifying risk factors, segmenting the vulnerable population, and delivering multifaceted responses. We have described a framework for deconstructing burnout[4] that reflects its pathophysiology and can be used to identify risk factors consistent with the findings of Dyrbye et al.[2] This framework (**Figure**) assumes that the balance between reward and stress determines clinicians' experience. It distinguishes rewards and stresses inherent to the role of caring for patients from those that are added. Variations in the stresses and rewards leads to variation in rates of burnout. "Resilience" can be thought of as a moderating influence that nudges the fulcrum of that balance to a point where more stress is bearable.

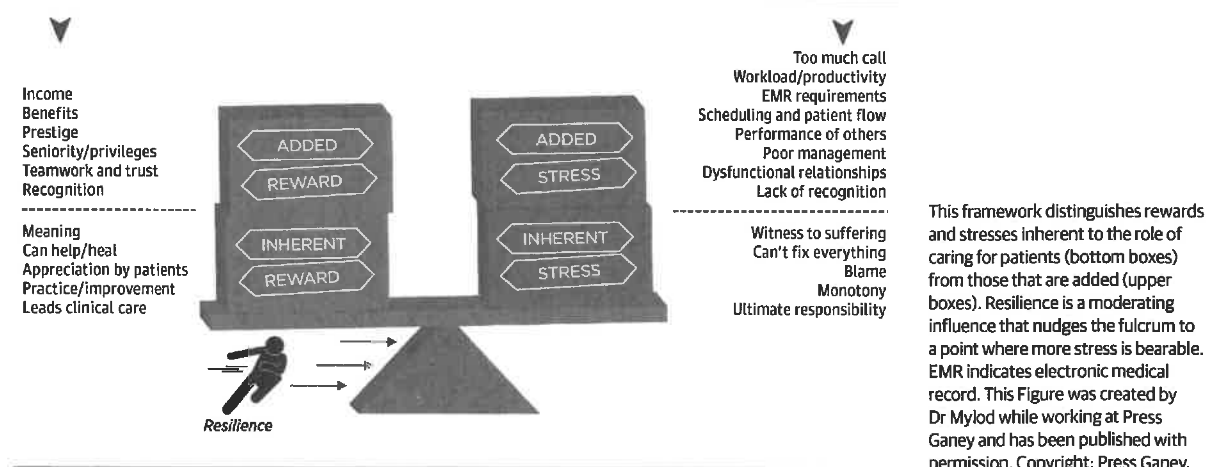
Using this framework, it strikes us that the rewards and stresses inherent to patient care are intertwined. For example, clinicians who try to curb empathy with dying patients will diminish their ability to feel meaning in their work. These stressors are often described by clinicians as things they "signed up for"—complexity, challenge, life or death issues—not things they are looking to shy away from. In fact, the ability to decompress and disconnect from the stresses of work appears to be less associated with engagement than the ability to find meaning and accomplishment in work.[5]

Therefore, balance cannot be improved by decreasing inherent stresses. Instead, the first major area of opportunity is increasing the impact of inherent rewards. An example of an intervention is giving physicians a chance to talk about their work with each other, heightening awareness of their impact and reinforcing pride in their work. One randomized trial showed that physicians who participated in regular small group meetings had a 15.5% decrease in depersonalization symptoms.[6] Based on such data, many organizations now support dinners and other gatherings that foster socialization among clinicians.

In contrast to the inextricable nature of inherent rewards and stresses, there is little to no connection between added rewards and stresses. For example, additional income cannot mitigate the frustration that results from clunky electronic medical records. Therefore, the second major area of opportunity is shown on the upper right portion of the Figure—organizations must show that they are serious about reducing work demands that have nothing to do with improving clinicians' care of patients, and in fact may be counterproductive.

An example of an organizational initiative to take on this dysfunction is Hawaii Pacific Health's Get Rid of Stupid Stuff (GROSS) program, through which the organization invites personnel to identify required work that does not add value, such as documentation

Figure. Framework for Deconstructing Burnout



This framework distinguishes rewards and stresses inherent to the role of caring for patients (bottom boxes) from those that are added (upper boxes). Resilience is a moderating influence that nudges the fulcrum to a point where more stress is bearable. EMR indicates electronic medical record. This Figure was created by Dr Mylod while working at Press Ganey and has been published with permission. Copyright: Press Ganey.

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that was either never really intended to be performed routinely (eg, with every encounter) or could be accomplished more efficiently in some other way. Clinicians and other personnel have been vigorously appreciative of this program.[7]

It is important to recognize that the fulcrum on which the scale of rewards and stressors sits is not fixed. As mentioned earlier, better personal resilience can move the fulcrum to the right so that stressors become more tolerable, and interventions to improve resilience and mindfulness have been shown to be associated with small reductions in burnout.[8] In addition, an individual's interpretation of his or her role and connection to the organization may serve to shift the balance. If clinicians identify strongly with their organizations, and the relationship brings them pride and respect, that supports resilience and moves the fulcrum to the right. If clinicians believe that the leaders and middle managers of the organization share the right values (eg, commitment to zero harm and reducing patients' suffering), that helps keep the fulcrum in a place where stress feels more manageable. But if clinicians feel like they are "relative value unit machines" for a soulless corporation focused on margin growth, the fulcrum moves to the left, and they become less resilient in the face of even minor increases in stress.

The path forward that emerges from this framework is a multidimensional effort. There is no single magic bullet. Instead, organizations should reinforce individual clinicians' ability to find meaning in their work, reduce clinicians' work that is external to patient care, and define an organizational culture with values that make clinicians proud. Greater clarity and consensus is needed to define what it means to be burned out, its antecedents, and its consequences. But we need not wait for that clarity to address known issues that reduce clinician well-being today. Organizations can act now to counter the forces that worsen burnout and work to enhance the reasons for clinicians to find pride in their work.

ARTICLE INFORMATION

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REFERENCES

1. Bakker AB, Schaufeli WB, Sixma HJ, Bosveld W. Burnout contagion among general practitioners. *J Soc Clin Psychol*. 2001;20(1):82-98. doi:10.1521/jscp.20.1.82.22251

2. Dyrbye LN, Burke SE, Hardeman RR, et al. Association of clinical specialty with symptoms of burnout and career choice regret among US resident physicians. *JAMA*. 2018;320(11):1114-1130. doi:10.1001/jama.2018.12615

3. Rotenstein LS, Torre M, Ramos MA, et al. Prevalence of burnout among physicians: a systematic review. *JAMA*. 2018;320(11):1131-1150. doi:10.1001/jama.2018.12777

4. Mylod DE. One way to prevent clinician burnout. *Harvard Business Review*. October 12, 2017. https://hbr.org/2017/10/one-way-to-prevent-clinician-burnout. Accessed December 28, 2018.

5. Mylod DE, Lee TH. Helping health care workers avoid burnout. *Harvard Business Review*. October 12, 2018. https://hbr.org/2018/10/helping-health-care-workers-avoid-burnout. Accessed December 28, 2018

6. West CP, Dyrbye LN, Rabatin JT, et al. Intervention to promote physician well-being, job satisfaction, and professionalism: a randomized clinical trial. *JAMA Intern Med*. 2014;174(4):527-533. doi:10.1001/jamainternmed.2013.14387

7. Ashton M. Getting rid of stupid stuff. *N Engl J Med*. 2018;379(19):1789-1791. doi:10.1056/NEJMp1809698

8. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet*. 2016;388(10057):2272-2281. doi:10.1016/S0140-6736(16)31279-X

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