The Reasons Behind Physician Stress

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Changing responsibilities and differing ways of relating to patients can make burnout worse for older physicians.

Source: Physicians Practice

Physicians Practice spoke with San Francisco-based internal medicine physician Alan Rosenstein about the impact of stress and burnout on physician behaviors and strategies that smaller practices can deploy to support their team members. (Click here for part one of the interview.) The following is part two of this interview:

Physicians Practice: If a physician belongs to a smaller practice without the resources that a large health system can bring, what other approaches are there to find support or to find a mentor?

Alan Rosenstein: ... The first thing with the private practitioner is someone to talk to them and say, "We really appreciate what you do, you are a precious resource." So what you are doing is showing empathy and showing them respect. When people keep on blocking you and telling you what to do, it pushes down your ego. And that is not necessarily a good thing, because healthcare is about relationships.

... Then the second thing ... you could do this with a friend, a peer. It doesn't necessarily have to be a trained coach. [A friend, a department member, a family member, a chairman of the department.] There are resources out there. One of the best online resources comes from the AMA. There are specific resources on stress and burnout, and physician resiliency. (You don't need to be a member.) It is an online program that can help them achieve what they want to achieve.

PP: Do you see generational or gender differences in the way that physicians respond to greater stress?

AR: Gender issues are changing. It used to be that men are very direct and task oriented. Leave me alone and let me do my thing, if you bother me I'm just going to dig in. [Where] women are more gregarious. The workforce is changing, so I don't think that gender is much of an issue. Although, it is interesting, I do a lot of expert witness work on disruptive behaviors, and I'd say 20 to 30 percent of physicians are female, but 50 to 60 percent of the cases that I've been involved with are female. It's a small number, so I don't think it is a trend.

... The two big ones are generation and culture and ethnicity. The ones who are having more stress and more frustration with burnout are the physicians who are more in the baby boomer generation—they've been in practice for 20 years. They used to be in what we called "the golden age of medicine," fee for service, people thanked you for what you did, you were not overworked, and you were appreciated. That's the way you practice medicine, and then to throw on all the issues of economic reform, with administrative reform, utilization controls, with belonging to different groups and people telling you what you can and cannot do. That's the group that has the biggest frustration and what we are noting in a lot of the research we did was premature retirement.

And the premature retirement is occurring in doctors who are probably in their 60s, who would have gone for several more years, but said "I've had enough of it." I think the generation gap is of particular concern, because of the expectations of the baby boomer physicians and living that life for so long, and having it changed.

PP: Physicians in that age group had a different relationship with patients; the model
was more authoritarian. Does that make a difference?

AR: Yes, but not just patients, even the insurance companies didn't question, the organization that you belonged to [didn't question]. I was thinking more of utilization control, but absolutely with the wealth of information that's out there, right or wrong, people are beginning to question their physicians. Physicians don't like to be told what to do and they don't like people to question them. That's the other thing, if you give them 15 minutes with a patient, you have to turn them off and not even listen to them, because you have to get on to the next patient.

PP: Do physicians find it difficult being judged on patient satisfaction, when their time is so limited?

AR: Remember, I'm an internist. I don't want to give you antibiotics if you have the flu. I spend a half an hour explaining to them why antibiotics are not important. It's the right thing to do. So they leave there, they've consumed a lot of time, and they leave there and give me a poor patient satisfaction rating. Where another physician would say, "Sure, take the antibiotics, I don't care." The older physicians are a little bit more resistant to just giving them what they want, and so on and so forth.

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PP: Are there other factors that have increased physician stress and burnout?

AR: I think the other major change is culture and ethnicity. Out here in California, 50 percent of the staff, the doctors and the nurses, are not American born or American trained. And the same thing now with the population: [many are] not American born or American trained. There are certain cultural values, and there's a big push now for cultural competency. It's the right thing to do. But a lot of the doctors are not used to tapering their conversation, its emotional intelligence, to give a better understanding of what's going on in your world. What do you value? How do I present this so that you understand it, accept it, and be compliant. One, they don't have the wherewithal to know about it, and two, is they don't have the time to do it. And it puts both them and the patients in a frustrating situation.

It's the different values, the different views on authority, and gender with the different ethnic groups. Physicians need to be sensitive to those types of things. I think the older physicians have done all this stuff, it's very difficult to introduce new ideas, particularly when people have been doing it, have been so successful, and sort of rigid with a superego. I think that is another contributing factor.

PP: What can practices do to help physicians who are experiencing greater levels of burnout?

AR: My major concern is, "Yes it's out there, don't just leave it up to the physician to get help on their own, because they are not going to do it." We need to help them, and I'm not sure who "we" is. But we need to help them in a proactive manner, before they truly burn out or some bad event happens. For the individual practice, maybe it's MGMA, AMGA, maybe they are the ones that really need to work with physicians, like the AMA is doing. To work to get them motivated to engage.

The other thing is to show them how important this really is. That's where well-being comes in. So they need to take care of themselves, and then take care of the patients as well.

In private practice, I know it is not doable all the time, but maybe it's the nurse. The nurse could actually say, "Could we just sit down over a cup of coffee for a couple of minutes, and just talk about things?" It can be somebody in that office who feels comfortable enough about actually approaching them. Remember, the goal is not "Why are you doing this?" The goal is [to say] "I've noticed you look like you are not getting enough sleep." Just sort of give them an opportunity to open up. If you can get them to open up, that is the first step to get them motivated to something about it. They may say, "I don't need a coach. I don't have the time." But if someone in that office setting, where there is mutual respect, can take them aside and say, "How are things going?" And help pinpoint them in a direction that would be beneficial to them.