Physician Burnout and Distress: Is the Health Care System Impaired?

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Impairment is defined as the inability to practice with reasonable skill and safety due to a health condition. Among health professionals, a variety of health conditions (and their treatments) can cause impairment. Illness is not impairment. Illness exists on a continuum of severity while impairment is a functional classification that implies the inability of an ill person to perform specific activities. Illness typically pre-dates impairment, often by many years, and most health professionals who become ill can function effectively in the initial stages of illness due to their extensive training and dedication. Early identification and treatment of illness can prevent progression to impairment and protects patient safety [1]. Historically, the concept of impairment has been applied to safety-sensitive health care workers. Perhaps the time has come to evaluate whether the health care system itself is impaired – and the impact that might have on patient safety.

There is an extensive and evolving literature demonstrating the relationship between physician distress and poorer health care outcomes for patients [2-4]. Not only do healthy physicians provide better care, but it has become stunningly clear that professional burnout and psychological distress negatively impact safe and effective care.

Despite increased awareness and numerous well-intentioned calls to action from all quarters of organized medicine, little progress has been made to combat the epidemic of physician burnout and distress that has infected the U.S. health care system. Experts have speculated that uncertainty among organizational decision-makers is at least partly to blame for this anemic response. One source of uncertainty stems from the invisibility of the economic costs of physician burnout. Given limited resources, what is the return on investment in physician well-being? Another source of uncertainty is rooted in pessimism about whether anything really can be done to alleviate a problem of this scope and complexity. In response, the national dialogue has increasingly focused on making the business case for physician well-being and identifying key steps organizations can take in to strategically impact the drivers of physician burnout and distress [5].

The changing discourse has resulted in two important conceptual shifts. The first is recognition that the key targets for reducing burnout live at the level of the organization not the individual. We have spent far too much time focused on the wrong target, blaming the victims of burnout and encouraging them to develop more resilience. This is not to say that health-promoting behaviors should be de-emphasized. On the contrary, personal wellness should be a core value within the culture of medicine, woven into our identity starting in medical school and supported by the organizations we serve across the career span. But burnout interventions aimed at improving personal wellness will never do more than provide better shelter from the storm. The second (and related) conceptual shift is that the organizational correlates to burnout have negative downstream effects on patient safety and care quality.

Our health care system is ailing. In an analysis by the Commonwealth Fund, the U.S. health system spends far more on health care yet ranks dead last in overall performance (including health outcomes for patients) compared to other high-income countries [6]. Costly, inefficient, and lagging, our health care system is now generating unprecedented rates of burnout among its workers. Burnout, the final common pathway of systemic dysfunction, creates a vicious, self-reinforcing cycle of performance decline. A recent meta-analysis by Panagioti and colleagues is sobering. Across 47 studies and 42,473 physicians, burnout was associated with 2-fold increased odds for unsafe care, unprofessional behaviors and low patient satisfaction. The depersonalization (callousness) dimension of burnout showed the strongest link with these outcomes, while the association between unprofessionalism and burnout was highest across studies of residents and early-career physicians [7].

Like alcohol on the breath of a physician at work, burnout and distress are ominous signs of an impaired health care system. We have progressed beyond the early stages of a systemic illness that is now placing patients (and health professionals) at risk. Recognizing and addressing impairment is most often impeded by denial. Denial is not deception, it is an unconscious defense that permits us to ignore truths that are too painful to acknowledge.
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With patient safety in the balance, we do not have the luxury of our uncertainty or collective denial. We have a moral imperative to take action.

In 1999, the Institute of Medicine (IOM) released To Err is Human: Building a Safer Health System [8]. In the 2 decades that followed, health care organizations invested enormous resources to build a massive safety and quality infrastructure. This robust response was not the result of some deep fiscal analysis, it was simply the right thing to do for our patients under the disinfected light of the IOM’s denial-busting report. Efforts aimed at addressing “physician wellness” perpetuate our denial and are a distraction from what is, ultimately, a patient safety and care quality issue. We can and should use our existing quality and safety infrastructures to intervene on our impaired system, address the drivers of professional burnout and dissatisfaction that reside within the environment of care and begin the recovery process. The only resource we really need is the will to act.


New Opioid Prescribing and Monitoring Rules are Effective January 1st.

The Medical Commission has been busy with the implementation and education requirements needed for the rules around opioid prescribing and monitoring as required by ESHB 1427.

We have accomplished the following in our efforts to educate providers and the public about the changes to opioid prescribing that are effective January 1, 2019:

- We have presented at over 20 organizations and events;
- We have issued over 200 CME credits that meet the requirement as outlined in the rules;
- We have created information materials and a dedicated webpage;
- We have held 3 Twitter town halls to answer general questions;

But we are not done yet! We are still scheduling informational sessions and webinars into the New Year. If you would like to discuss having a medical commission representative speak to your organization about the new opioid rules, please contact us.

Be on the lookout for:

- Self-paced webinars for CME credit;
- Opioid prescribing guide to be mailed;

We are here to help.

We are a resource.

Use us!