
More exhausted doctors – what to do?

A DOCTOR'S LIFE

FREDRIK BÅÅTHE

LEFO – Institute for Studies of the Medical Profession

Are there lessons to be learned from the ‘burnout epidemic’ reported by doctors in the United States?



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Over a number of years it has been reported that American doctors are increasingly affected by the phenomenon referred to as ‘burnout’ [\(1\)](#). Studies show that a little more than 50 % of all American doctors indicate that they are affected in at least one of the three dimensions of burnout: exhaustion, cynicism and reduced work effectiveness [\(2, 3\)](#). This is reported to be significantly higher than in other groups of American professionals, and a documented increase occurred in the group of doctors from 2011 to 2014 [\(3\)](#).

The Mayo Clinic, a private healthcare organisation that each year receives 1.3 million patients and employs a staff of 63 078, whereof 4 590 are doctors and researchers, has for years sought to understand the reasons for doctor burnout and also attempted to find solutions to handle this increasing problem [\(4\)](#). In a general article from 2017, Tait Shanafelt MD, Director of the Program on Physician Well-being, and the CEO, John Noseworthy MD, present their experience from the attempts to understand and reduce the occurrence of burnout in the Mayo Clinic [\(5\)](#).

In their opinion, doctor burnout cannot be regarded as an individual problem, but should rather be seen as a complex interplay between the individual and the organisation. The researchers refer to a number of studies and describe how burnout in doctors affects care quality, undermines patient satisfaction and reduces the number of patients that a doctor can handle. They underscore that burnout is primarily a matter of the organisational preconditions that apply wherever doctors work, and they also highlight the importance of well-functioning leadership by the doctor's immediate superior.

Accordingly, they seek to debunk two recurring myths concerning organisational solutions. The first is the belief that a doctor's well-being or job satisfaction will be incommensurate with the goals of a healthcare organisation. The second concerns the assumption that effective interventions to combat doctor burnout will be costly. They argue that a committed and satisfied group of doctors is the foundation for achieving the various goals of care, small investments may have large effects, and many effective interventions are cost-neutral. They go on to give a relatively detailed presentation, with references to academic publications, of nine organisational strategies to reduce burnout and increase job satisfaction among doctors. Shanafelt and Noseworthy emphasise that these strategies are not an exhaustive list, but rather pragmatic ways to take action on the basis of evidence or practical experience.

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1. Take the question of doctor satisfaction/burnout seriously and monitor trends over time
 2. Do not underestimate the effect of the doctor's immediate superior
 3. Develop and implement interventions that target specific local needs
 4. Establish structures that facilitate collegial collaboration and social exchange
 5. Use individual result-based pay sparingly in the team-based structures of health care
 6. Ensure that the strategies and values of the organisation can be converted into clinical practice
 7. Support planned flexibility for individual doctors and promote work-life balance
 8. Provide resources to strengthen individual resilience and facilitate self-care
 9. Facilitate and fund organisational research to provide more evidence-based knowledge
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Despite the geographic and cultural distance to the United States it is interesting to note that the majority of their nine strategies concern aspects that are also highlighted in Norway, in Report No. 13 to the Storting, *Quality and patient safety* (6).

The interpretation of data on burnout, even those collected with the same instrument, varies from one country to another. The American and Norwegian figures are thus not immediately comparable. However, in light of an ongoing

study at LEFO, which investigates ‘the interaction between organisational factors, doctors’ job satisfaction and the importance of these factors for quality in patient treatment’, we can find a lot of frustration among Norwegian doctors with regard to current organisational structures (yet unpublished material). Right now, we may thereby be presented with a golden opportunity to embrace experience and evidence from the United States. This appears to be a good occasion to act proactively and start working in accordance with these nine strategies.

LITERATURE

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