

American Psychiatric Association

Psychiatrist Well-being and Burnout

A Report by the

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Board of Trustees Ad Hoc Work Group on
Psychiatrist Well-being and Burnout

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Introduction and Context

With the transformation of the American health care system focused on the Triple Aim of improving the experience of care, improving the health of populations and reducing the per capita cost of care, there has been a marked increase in physician dissatisfaction and increased awareness of physician burnout, depression, suicide and other problems. This has led to widespread interest in defining these phenomena, measuring their prevalence and studying interventions designed to increase physician well-being and decrease burnout and psychiatric illness. The notion of the Quadruple Aim, which includes physician work experience as a fourth imperative, has been proposed to drive a systemic response to the problem of burnout (Bodenheimer & Sinsky, 2014).

Physician well-being is defined by “quality of life, which includes the absence of ill-being and the presence of positive physical, mental, social, and integrated well-being experienced in connection with activities and environments that allow physicians to develop their full potentials across personal and work-life domains.” (Brady, Trockel, et al, 2018) Physician burnout is less clearly defined. It is regarded as a condition associated with the workplace and has most frequently been characterized by “overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment” (Maslach, 2016). Its relationship to depression, suicidality and other psychiatric conditions is under study. Isolation and loss of connectivity among physicians is increasingly discussed as a risk factor for burnout.

Interventions designed to increase well-being and decrease burnout, depression and other psychiatric illness include individual level approaches directed toward enhancing individual well-being as well as systemic interventions aimed at changing workplace factors such as culture, leadership, autonomy, and workflow.

This resource document will summarize the (i) data on physician well-being and burnout, (ii) evidence base supporting interventions to improve well-being, burnout and depression, (iii) data collected on burnout and depression on close to 2000 psychiatrists by the work group, and (iv) tools created by the workgroup to address these problems.

Physician Burnout, Depression, Suicidality and other Psychiatric Conditions

The workgroup conducted literature reviews that revealed that physician rates of burnout range across age groups, gender, specialty and perhaps race and ethnicity. There is significant convergence among the major scales used to assess burnout, including the Maslach Burnout Scale (1981) and the Oldenburg Burnout Scale (Demerouti & Bakker, 2008), although many of the major studies of burnout use abbreviated versions of these scales. Rates of burnout among physicians are much higher than other occupations, even when controlling for major demographic variables, and 54% of American physicians endorsed at least one of the three major symptoms of burnout: emotional exhaustion, depersonalization or decreased

personal efficacy (Shanafelt, Hasan, Dyrbye, et al, 2014). Some studies suggest the rate of burnout is highest among medical students, lower among housestaff and less frequent among early career physicians (Dyrbye, 2014). Rates of burnout among specialties range from 38% to 73%, with psychiatrists showing a 48% rate of burnout (Shanafelt, et al, 2015).

Rates of depression among physicians mirror the trend for burnout, with the highest prevalence among medical students, then residents and then lowest among early career attending physicians (Dyrbye, 2014). Over 15% of psychiatrists reported self-prescribing for depression (Balon, 2007). 40% of German psychiatrists reported having had a history of depression compared to 17% lifetime prevalence in the German lay population (Braun, 2010). Physicians may be vulnerable to other psychiatric illnesses, and 31% of Canadian psychiatrists endorsed having had an experience with mental illness (Hassan, et al, 2015).

Rates of suicide among physicians are higher than among dentists and the general population (Petersen & Burnett, 2008), and the suicide rate was 1.41 times higher for male physicians and 2.27 times higher for female physician compared to the general population (Schernhammer & Colditz, 2004). In addition, the likelihood of a job-related problem was a greater risk factor for physicians than controls (Gold, Sen, Schwenk, 2013). Finally, most studies of suicide rate by specialty reveal that psychiatrists have higher rates of suicide completion than the average physician (Rich & Pitts, 1980; Torre, Wang, Meoni, et al, 2005).

We do not fully understand the relationship between burnout, depression, psychiatric illness and suicide at this point. Burnout is generally conceptualized as a condition that reflects workplace concerns, while depression and other illnesses are seen as individual-level problems. Suicide is poorly understood but correlated with psychiatric illness, genetic vulnerability, burnout, and psychosocial stressors. Two models for the complex relationship between these problems include a) burnout as a risk factor for physician psychiatric illness and suicide, and b) psychiatric illness presenting as burnout among physicians because it is a less stigmatizing framework for distress.

Interventions for Physician Burnout

The work group conducted a literature search in PubMed, Scopus, CINAHL, PsychINFO and OvidSP using the terms “burnout”, “physician(s)” and “intervention(s).” Our search identified two randomized controlled trials not previously included in West et al., (2016) and Panagioti et al.’s (2017) prior meta-analyses. Thus, combining our search with these works, we found a total of 26 published randomized controlled trials that have examined the efficacy of interventions for the reduction of burnout in physicians.

Over half (57.7% (15/26)) of the randomized controlled trials evaluating the efficacy of interventions for the reduction of burnout in physicians were conducted in the United States, and the majority of these studies have taken place in a university setting (65.3% (17/26)). To

date, there do not appear to be any randomized controlled trials evaluating the efficacy of interventions for the reduction of burnout in psychiatrists.

The majority of studies (73.1% (19/26)) evaluated interventions targeting the individual physician and 42.1% (8/19) of these studies demonstrated a significant reduction in symptoms of burnout. Intervention types are typically physician-directed and include elements of mindfulness, stress management and education. Intensity and duration of interventions are quite variable. Only 26.9% (7/26) of studies evaluated organizational interventions for the reduction of burnout, with 71.4% (5/7) of these interventions demonstrating a significant reduction in symptoms of burnout among participants. Organizational interventions include efforts to reduce workload and increase autonomy of schedule, as well as improve communication and team communication.

APA Data on Psychiatrist Burnout and Depression

The workgroup, with strong support from the APA Department of Education, created an online assessment tool coupled with online resources designed to help members self-assess their burnout and depression and learn more about these problems (psychiatry.org/wellbeing). We chose the Oldenburg Burnout Scale (Demerouti & Bakker, 2008) because it included positive and negative toned questions and was more cost effective than the alternatives. The PHQ-9 was used because it is widely validated and efficient.

As of 7/6/18, 1968 psychiatrists have taken the assessments and visited the resource page. 73% of respondents scored above 35 on the Oldenburg Burnout Scale, indicating they are at risk for burnout (Demerouti & Bakker, 2008). 15% of respondents had a PHQ-9 score of greater than 10, which indicates the presence of moderate to severe depression. In our sample, the burnout scores are correlated with gender (with female gender leading to higher scores), recent medical school graduation and perceived inability to control one's schedule, controlling for depression score and other demographic variables. Among non-depressed respondents, burnout scores were slightly lower in academic and academic-affiliated practice settings.

Limitations of the APA psychiatrist well-being, burnout and depression data include convenience sampling, the limitations of the instruments chosen, a scarcity of longitudinal data, and insufficient power to study important questions like the relationship between burnout and diversity.

Conclusions

The APA data are consistent with the literature on physicians in general and are compelling evidence that the psychiatrists are neither unique in their vulnerability to burnout

nor their protection from it. Our field is deeply affected. The workgroup has formed the following conclusions:

1. Burnout, depression, and suicide are significant problems among psychiatrists, especially women, younger psychiatrists and perhaps those outside academic settings.
2. Burnout is best addressed as a systemic problem with systemic interventions directed at changes in the workplace. These interventions include those targeting workflow, autonomy, isolation, communication and teamwork.
3. Although psychiatrists may not be unique in their vulnerability to burnout, we may have a special ability to contribute to understanding burnout and its relationship to depression, psychiatric illness and suicide, and a particular capacity to promote systemic responses as well as individual level responses to illness.
4. Gathering data on burnout, depression and suicidality will help to increase awareness of these problems, promote attention to them within health care organizations, and provide an effective means of assessing interventions.
5. Specific tools can be developed to help promote awareness about burnout and depression within our field, as well as among our colleagues in other specialties, and psychiatrists can and should provide leadership to develop interventions to lessen these problems in order to enhance physician well-being.

Workgroup Products

[Psychiatry.org/wellbeing](https://www.psychiatry.org/wellbeing) *Online Resource Page*

The online assessment tools, including the Oldenburg Burnout Scale and PHQ-9, are easily available for member use, in association with a variety of demographic questions. Users receive an individualized printable page with their results in comparison to other respondents and are directed to a resource page with a wide variety of links and materials on burnout, depression, substance use and suicide. This page can be expanded easily. The site is enriched with brief engaging videos about burnout, depression, and self-assessment created by psychiatrists.

Wellbeing Ambassador Slide Deck and Manual

We developed a comprehensive [PowerPoint presentation](#) and [manual](#) to support APA members to serve as ambassadors in their home institutions with the goal of improving wellbeing and reducing rates of burnout, depression, and suicide among the physician workforce, including psychiatrists and physicians of all specialties.

The slide deck is a comprehensive review of the topic and can be modified by users for focused presentations. The slides describe background information on the definition and epidemiology of burnout, depression and physician suicide, and review potential protective factors. They also review intervention literature with examples of programs already

implemented and inventory interventions related to leadership, workload and schedules, and work environment. The deck ends with suggested steps to implement interventions at an organization level.

The manual serves as a short practical guide and a “how to” tool. There are sections on how to spread awareness at the user’s home institution by using the presentation materials as well as speaker suggestions. The manual also describes how a psychiatrist can support a health care organization in conducting a needs assessment and advocating for and prioritizing specific interventions to promote wellbeing. We include a recommended reading list and an inventory for screening tools.

[Best Practices for Employed Psychiatrists to Promote Wellbeing](#)

Because burnout is a workplace issue, physician job description and parameters are central to promoting wellbeing. This media-ready graphic characterizes those features of an employed psychiatrist’s job that promote wellbeing and help to prevent burnout. This material is designed to be utilized by employers and employees.

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