Physician Wellness and Burnout

Report and Recommendations of the Workgroup on Physician Wellness and Burnout

Adopted as policy by the Federation of State Medical Boards
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Executive Summary:

The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout was convened in April of 2016 by FSMB Chair Arthur S. Hengerer, M.D. to identify resources and strategies to address physician burnout.

While the Workgroup examined the issue of physician burnout from a broad perspective, reviewing as many facets of this complex issue as possible, including existing research, resources, and strategies for addressing it, the recommendations for state medical and osteopathic boards (hereinafter referred to collectively as "state medical boards") found in this report focus first and foremost on the licensing process. The Workgroup also saw fit to include commentary and recommendations on several other aspects of physician wellness and burnout, though some of these areas may not be under the direct purview of the FSMB or its member boards. The FSMB recognizes the importance of collaboration for effectively supporting physicians and protecting patients in the face of circumstances that lead to burnout, which is ultimately a patient safety issue. A shared accountability model that includes responsibilities to be carried out by providers from all the health professions, including physicians and physician assistants, and with organizations from across the health care community is therefore recommended as the most promising course of action to address this important issue.

Recommendations for state medical boards related to the licensing process include considering whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure or their renewal, and whether the information these questions are designed to elicit, ostensibly in the interests of patient safety, may be better obtained through means less likely to discourage treatment-seeking among physician applicants.

Where member boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, several recommendations are included in this report for the appropriate phrasing of such questions, including focusing only on current impairment, which may be more meaningful in the context of a physician's ability to provide safe care to patients in the immediate future.

State medical boards are also encouraged to approach physician wellness and burnout from a non-punitive perspective, avoiding public disclosure of any information about a physician's diagnosis during licensing processes and offering "safe haven" non-reporting

options (mentioned later in this report) to physicians who are under treatment and in good standing with a recognized physician health program (PHP) or other appropriate care provider.

It is also recommended that boards take advantage of all opportunities available to them to discuss physician wellness, communicate regularly with licensees about relevant board policies and available resources, and make meaningful contributions to the ongoing national dialogue about burnout in order to advance a positive cultural change that reduces the stigma among and about physicians seeking treatment for mental, behavioral, physical or other medical needs of their own.

The Workgroup's recommendations to external organizations and stakeholders focus on increasing the awareness and availability of information and resources for addressing physician burnout and improving wellness. The value of noting and listing the availability of accessible, private, confidential counselling resources is a particular point of emphasis in this report, as is dedicating efforts to ensuring that any new regulation, technology, or initiative is implemented with due consideration to any potential for negative impact on physician wellness.

This report, which follows two years of careful study, evaluation and discussion by Workgroup members, FSMB staff, and various stakeholders, is intended to support initial steps by the medical regulatory community to begin to address the issues associated with promotion of physician wellness and mitigation of burnout, to the extent that is possible. The information and recommendations contained herein are based on principles of fairness and transparency, and grounded in the primacy of patient safety. They emphasize a responsibility among state medical boards to work to ensure physician wellness as a component of their statutory right and duty to protect patients.

Background and Charge:

In 2014, the Ethics and Professionalism Committee of the Federation of State Medical Boards (FSMB) engaged in several discussions about the risks to patient safety that may result from disruptive physician behavior. As these discussions proceeded, it became apparent from a review of the literature and discussions with state medical boards that a link exists between many instances of disruptive behavior and symptoms of professional burnout experienced by so-called "disruptive physicians." The Committee, chaired by Dr. Janelle A. Rhyne, M.D., MACP, determined that further research into physician health, self-care, and burnout should be conducted to identify resources that may be of value for state medical boards and physicians alike, and to outline possible roles for the FSMB and its partners to better promote patient safety and quality health care.

Given the complexity of the issue and the many factors contributing to physician burnout, in 2016, Dr. Arthur S. Hengerer, MD, (while serving as Chair of the FSMB), established the FSMB Workgroup on Physician Wellness and Burnout to study the issue further. The Workgroup was specifically charged with identifying resources and strategies to address

physician burnout. To accomplish its charge, the Workgroup reported that it would engage in a multi-part work program that would likely involve: 1) educating state medical boards and physicians through the creation of a compendium of research and resources on identifying, managing and preventing physician burnout; 2) raising awareness about the prevalence of burnout among physicians and other health care professionals, helping reduce the stigma sometimes associated with physicians seeking help for burnout symptoms; 3) evaluating current research on the impact of physician burnout on patient care; and 4) convening stakeholder organizations and experts to discuss physician wellness and to recommend best practices for promoting physician wellness and helping physicians identify, manage and prevent burnout throughout their career continuum (i.e. from medical school through residency training and throughout their years of licensed, unsupervised practice.)

The purpose of this report is to summarize the steps taken by the Workgroup in fulfilment of their charge, to share information gathered as part of this process, and to provide a series of recommendations for state medical boards and others to consider for addressing burnout and its symptoms. It should be noted that the Workgroup's charge does not include tasks related to defining the phenomenon of burnout or performing further analysis into the concept itself, as it was felt there is a significant amount of valuable research that has already been done in these areas and is ongoing. Much of this research, including some that is inchoate, was reviewed by the Workgroup in fulfilment of the third component of its charge. This body of research is referenced herein and informs many of the recommendations contained in this report. While burnout is a phenomenon that may impact physicians at all stages of their career, it should be noted that the recommendations specific to state medical boards in this report focus primarily on the licensing process. The Workgroup feels it is also important, however, to share information in this report related to issues beyond the licensing process. Such additional information and guidance is provided for the benefit of relevant partner organizations and stakeholders responsible for undergraduate, graduate and continuing medical education; medical school, residency training and health facility accreditation; governance, information technology, health insurance, and other activities and functions that support the provision of health care to the nation's citizens.

In developing the content and recommendations of this report, the Workgroup understands and endorses the importance of the "quadruple aim," which added a call for improvements in the quality of work lives of physicians and other health care providers[1] to the existing three aims of improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care.[2] As argued by proponents of the fourth aim, improved population health cannot be achieved without ensuring the health and well-being of health care providers.

[1] Bodenheimer T, Sinsky C (2014), From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Ann Fam Med*, 12 (6): 573-576.
[2] Berwick DM, Nolan TW, Whittington J. (2008). The Triple Aim: care, health, and cost. *Health Aff* (Millwood), 27(3):759–69.

Several definitions have been applied to the phenomenon of physician burnout and, for the purposes of this report, it is considered a psychological response that may be experienced by doctors exposed to chronic situational stressors in the health care practice environment. This is characterized by overwhelming exhaustion, feelings of cynicism and detachment from work, and a sense of ineffectiveness and lack of accomplishment.[3] While burnout's manifestations and consequences vary widely, they could result in significant harm to patients.

It has been widely reported for more than a decade that nearly 100,000 preventable medical errors occur in the United States each year.[4] More recent findings suggest that between 210,000 and 400,000 deaths each year are associated with preventable harm.[5] Many of these errors may be attributed to physician burnout and its drivers, such as excessive caseloads, negative workplace culture, poor work-life balance, or perceived lack of autonomy in one's work.[6] Burnout affects a significant proportion of the U.S. physician workforce. A 2012 study conducted by Shanafelt and colleagues showed that 45.5% of surveyed physicians demonstrated at least one symptom of burnout.[7] When this study was repeated three years later with a different sample, the authors demonstrated that burnout and work-life dissatisfaction had increased by 9% over the three year period.[8] In addition to obvious risks to patient safety, an alarming and extreme result of physician burnout has been the disproportionate (relative to the general population) levels of suicide in recent years by physicians, medical residents and even medical students.[9,10] One is hard-pressed to find a phenomenon that negatively affects a broader array of stakeholders in health care than burnout. It impacts providers from all health professions. State medical boards' duty to protect the public, in this regard, also includes a responsibility to ensure the wellness of its licensees.

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[3] Maslach, C., Jackson, S.E. (1981). The Measurement of Experienced Burnout. *Journal of Occupational Behavior*, 2(2):99-113. See also, Maslach C, Jackson SE, Leiter MP. *(*1996). *Maslach Burnout Inventory Manual. 3rd ed*. and Maslach C, et al. (2001). Job Burnout. *Annu Rev Psychol*, 52:397–422.

[4] Kohn LT, Corrigan J, Donaldson MS. (2000). To Err Is Human: Building a Safer Health System. Washington, DC: National Academies Press (US).

[5] James JT. (2013). A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. *Journal of Patient Safety***,** 9(3):122-128.

[6] Shanafelt TD, Noseworthy JH. (2016). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*, 92:129-146.

[7] Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, 172(18):1377-1385.

[8] Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc,* 90:1600-1613.

[9] Rubin R. (2014). Recent Suicides Highlight Need to Address Depression in Medical Students and Residents. *JAMA*, 312(17):1725-1727.

[10] Gold KJ, Sen A, Schwenk TL. (2013). Details on suicide among US physicians: data from the National Violent Death Reporting System. *Gen Hosp Psych,* 35:45-49.

Features and Consequences of Burnout:

Physicians experiencing burnout, according to the medical literature, exhibit a wide array of signs, symptoms and related conditions, including fatigue, loss of empathy, detachment, depression, and suicidal ideation. The three principal components of burnout are widely described in the medical literature as emotional exhaustion, depersonalization, and diminished feelings of personal accomplishment.[11] Many of these symptoms are also said to be linked to low levels of career satisfaction.

Career satisfaction may be diminished by even a single influencing factor. Unreasonable increases in workload, for example, may quickly lead to dissatisfaction with one's career. Loss of job satisfaction has been noted as both a primary contributor to burnout as well as a contributor to its further progression.[12] Burnout has specifically been found to be the single greatest predictor of surgeons' satisfaction with career and choice of specialty.[13] It may also be a significant contributor to increased rates of suicidal ideation among both physicians[14] and medical students.[15]

Physicians experiencing manifestations of burnout are also reported to be more prone to engage in unprofessional behavior,[16] commit surgical or diagnostic medical errors,[17,18,19] and lose the trust[20] of their patients, while also decreasing their satisfaction.[21] At a time when there is compelling evidence of a shortage of qualified practicing physicians in many parts of the United States, losing additional physicians to early or unnecessary retirement would have a detrimental impact on patient access to care across the country. As the American Medical Association's Policy on Physician Health and Wellness states,

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[11] Maslach C, Schaufeli WB, Leiter MP. (2001). Job burnout. *Annual Review of Psychology*, 52:397-422.
[12] Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Burnout among leaders of the Department of Veterans Affairs medical centers: contributing factors as determined by a longitudinal study. *J Health Hum Serv Adm*, 21:390-412, and Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Trends in burnout and related measures of organizational stress among leaders of Department of Veterans Affairs medical centers. *J Healthc Manag*, 44(5):353-365. (Via Chopra SS. (2004). JAMA, 291(5):633).

[13] Shanafelt TD, et al. (2009). Burnout and Career Satisfaction among American Surgeons. *Annals of Surgery*, 250(3):463-471.
[14] Shanafelt TD, Balch CM, Dyrbye LN, et al. (2011). Suicidal ideation among American surgeons. *Arch Surg*, 146:54-62.
[15] Schwenk TL, Davis L, Wimsatt LA. (2010). Depression, stigma, and suicidal ideation in medical students. *JAMA*, 304(11): 1181-1190.
[16] Dyrbye LN, Massie FS, Jr., Eacker A, et al. (2010). Relationship between burnout and professional conduct and attitudes among US medical students. *JAMA*, 304: 1173-1180.
[17] Privitera MR, et al. (2015). Physician Burnout and Occupational Stress: An inconvenient truth with unintended consequences. *Journal of Hospital Administration*, 4(1).
[18] Shanafelt TD, Balch CM, Bechamps G, et al. (2010). Burnout and medical errors among American surgeons. *Ann Surg*, 251:995-1000.
[19] West CP, Huschka MM, Novotny PJ, et al. (2006). Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA*, 296(9):1071-1078.
[20] Haas JS, Cook EF, Puopolo AL, Burstin HR, Cleary PD, Brennan TA. (2000). Is the professional satisfaction of general internists associated with patient satisfaction? *J Gen Intern Med*, 15(2):122-128.
[21] Anagnostopolous F, Liolios E, Persefonis G, Slater J, Kefetsios K, Niakas D. (2012). Physician burnout and patient satisfaction with consultation in primary health care settings: evidence of relationships from a one-with-many design. *J Clin Psychol Med Settings*. 19(4):401-410.

"When health or wellness is compromised, so may be the safety and effectiveness of the medical care provided."[22]

Factors Contributing to Burnout:

While a large proportion of physicians are said to experience burnout and its correlates, they do not always experience it in the same way or for the same reasons. Physicians may be predisposed to burnout because of personality traits that led them to pursue a medical career in the first place, such as perfectionism, self-denial, and compulsiveness. These are traits that are said to be common among practicing physicians. Predisposition to burnout may be stronger in instances where personal factors such as denial of personal vulnerability, tendencies to delay gratification, or excess feelings of guilt are layered onto these aforementioned personality traits. While burnout is a distinct phenomenon from mental illness and substance use disorders, the latter two issues can play a compounding role in a physician's struggle with burnout, making the identification and effective treatment of its symptoms or causes even more difficult.[23]

It is a common misconception that physicians are more susceptible to suffering from burnout at later stages in their career, presumably from fatigue and aging. In fact, research has demonstrated that physicians in the middle of their careers are at the highest risk for burnout.[24] Education and training also appear to be critical peak times for physicians, physicians-in-training or medical students to suffer from burnout.[25,26]

The environment in which physicians work, including their choice of specialty, also plays a significant role in contributing to burnout. Shanafelt and colleagues have shown substantial differences in burnout rates by specialty, although changes in the highest and lowest rates were noted between 2011[27] and 2014.[28] The control, or lack thereof, that physicians have over their work environment plays a significant role in predisposition to burnout. This may explain why emergency medicine is frequently found at or near the top of the list of medical and surgical specialties with the highest proportion of physicians experiencing burnout. Emergency physicians often work in environments that are high-demand and low-control.[29] While finding meaning in one's work has long been claimed

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[22] *Code of Medical Ethics*, (2016). American Medical Association, Opinion 9.3.1.
[23] Oreskovich M, Kaups K, Balch C, et al. (2011). The prevalence of alcohol use disorders among American surgeons. *Arch Surg*, 147:168-174.
[24] Dyrbye LN, et al. (2013). Physician satisfaction and burnout at different career stages. *Mayo Clinic Proceedings*, 88(12):1358-1367.
[25] Dyrbye LN, Shanafelt TD. (2016). A narrative review on burnout experienced by medical students and residents. Med Educ, 50:132-149.
[26] Dyrbye LN, et al. (2014). Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Academic Medicine*, 89(3):443-451.
[27] Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, 172(18):1377-1385.
[28] Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc*, 90:1600-1613.
[29] https://www.medpagetoday.com/emergencymedicine/emergencymedicine/54916

to be the antidote to burnout,[30] it may be difficult to find such meaning absent an adequate degree of control over one's work environment.

The movement towards maximal standardization of processes, often labeled a phenomenon of "deprofessionalization," is also claimed to be a contributor to burnout among physicians. There is worry among some professionals, in medicine and other health care fields, that an expectation for rigid adherence to guidelines will replace what were formerly considered the more elegant, artistic and satisfying aspects of medical practice.[31] These movements need not be perceived as threats to physician autonomy or to the exercise of professional judgment. Rather, embracing evidence-based medicine, focusing on the value of care that is provided, and celebrating increasingly positive outcomes can contribute to great improvements in patient and population health. Professional judgment will continue to play an important role in realizing these improvements.

Frustrations have also been voiced in relation to the move in health care delivery away from paper-based records to electronic health records (EHRs). Many physicians have expressed dissatisfaction with the intrusiveness and complexity of EHR use and the limits this sometimes places on the ways in which they are able and capable of effectively documenting treatment decisions and provision of care.[32] These frustrations exist in addition to those related to the often complex, redundant, or non-intuitive methods of data entry and other elements of medical record keeping associated with EHRs,[33,34,35] as well as the fact that most systems are not yet fully interoperable. However, complaints made about particular aspects of an evolving or disruptive technology should not be interpreted as calls to abandon the important gains in patient safety, professional communication, and even efficiency that have been brought about by the introduction and implementation of EHR systems. Rather, they should be interpreted as important user feedback that may contribute to ongoing improvement of such technology.

The constantly changing and evolving nature of medicine, as well as the challenges faced by the American health care system itself, also appear to be affecting the way many physicians feel within their professional roles. A recent study reported that 65% of physicians who were surveyed predicted an ongoing deterioration in the quality of health care that they deliver, which in turn has been attributed, in part, to the erosion of

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[30] Sotile W. (2002). *The Resilient Physician*.
[31] Aasland OG. (2015). Healthy Doctors – Sick Medicine. *Professions and Professionalism*, 5(1).
[32] Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, https://www.rand.org/pubs/research_reports/RR439.html.
[33] Arndt BG, et al. (2017). Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations. *Ann Fam Med*, 15(5):419-426.
[34] Levinson J, Price BH, Saini V. (2017). Death By A Thousand Clicks: Leading Boston Doctors Decry Electronic Medical Records. Common Health, http://www.wbur.org/commonhealth/2017/05/12/boston-electronic-medical-records.
[35] Sinsky C, et al. (2016) Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Ann Intern Med*. 165:753-760.

physician autonomy.[36] When evolving requirements are layered onto new expectations with regard to technology, quality reporting, increased clinical volume, and numerous other initiatives required by payers, employers, and even state medical boards, it may not be surprising that physicians are experiencing burnout at alarming rates. While many of the initiatives that place additional burdens on physicians are grounded in strong rationales related to patient safety and quality care, the burnout resulting from their combined effect may actually inhibit the success of the initiatives themselves.[37] This should certainly bring pause to those charged with implementing initiatives and requirements to carefully evaluate their effectiveness, unintended consequences, and potential burden, but also to communicate their goals and perceived value. The reaction of the profession to the ongoing changes that are occurring may also indicate particular attitudes within the culture of medicine that would benefit from further discussion, as would support to integrate positive change into practice.

Burnout is not always related to stressors arising in a physician's work environment or to a physician's character traits. Family issues, personal and professional relationships, financial pressures, insufficient work-life balance, or other external stressors may also contribute to burnout. Efforts aimed at the identification, treatment, or prevention of burnout must, therefore, approach the issue from a broad enough perspective to take all of these factors into account.

Challenges and Barriers to Addressing Burnout:

While there has been a promising rise in the number of peer-reviewed research publications addressing the topic of physician burnout, in the academic medical literature, popular media and so-called gray literature (e.g., white papers, position statements, organizational reports), there seems to be a perceived lack of resources available to identify and address the issue. This perception may be misguided, however, since several academic institutions, health systems, medical specialty societies, independent physicians, physician health programs, and state medical boards make many useful, high-quality resources available (See Appendix A.). While more resources would be beneficial to physicians, and ultimately their patients, their development should be complemented with efforts aimed at highlighting best practices. Research is also needed to identify how sources of burnout might differ for male and female physicians in order that resources may be appropriately tailored. A more coordinated effort to raise awareness not only about the issue of physician burnout but also about resources for ameliorating related circumstances may also serve to reduce stigma and facilitate identification and treatment. It may also help improve systems issues that impact burnout by improving communication, team building, and collaboration within and among health care

[36] Emanuel EJ, Pearson SD. (2012). Physician autonomy and health care reform. *Journal of the American Medical Association, 307*(4), 367-368.
[37] Dyrbye LN, Shanafelt TD. (2011). Physician Burnout: A Potential Threat to Successful Health Care Reform. *JAMA 305(19):2009-2010*.

professions. Broader awareness may also better equip physicians in their capacity as leaders to improve circumstances for those with whom they work.[38]

Many physicians are reluctant to seek help for burnout or any of its many underlying causes for fear that they will be perceived as weak or unfit to practice medicine by their colleagues or employers, or because they assume that seeking such care may have a detrimental effect on their ability to renew or retain their state medical license, arguably the most important credential a physician receives during their professional career.[39,40,41,42,43] This stigma may be felt as early as medical school,[44] a particularly dangerous cultural feature in a population where symptoms of anxiety and depression have been found to be more prevalent than in the general population.[45] In a study by Dyrbye and colleagues, it was found that only a third of the medical students experiencing features of burnout sought help and that stigma was seen as a barrier for those who chose not to seek help.[46] The same reluctance is seen with respect to help-seeking for other types of stigmatized suffering such as depression, substance use disorders, or suicidal ideation.[47] Without adequate modeling of appropriate self-care behaviors among faculty mentors, progress at stigma reduction will likely be slow. Further, while there are laudable examples of programs at academic medical centers across the country which responsibly offer accessible, complementary, private, and confidential counselling to medical students,[48] these programs are by no means widely available.

Privacy and confidentiality of a physician's health and treatment history is important to allow those in need of help to come forward without fear of punishment, disciplinary

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[38] Shanafelt TD, et al. (2015). Impact of Organizational Leadership on Physician Burnout and Satisfaction, *Mayo Clinic Proceedings*, 90(4):432-440.
[39] Chew-Graham CA, et al. (2003). 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education*, 37(10):873–880.
[40] Federation of State Medical Boards. (2011). Policy on Physician Impairment.
[41] Guille C, et al. (2010). Utilization and Barriers to Mental Health Services Among Depressed Medical Interns: A Prospective Multisite Study, *Journal of Graduate Medical Education*, 2(2):210-214.
[42] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry*, 43:51–57.
[43] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[44] Schwenk TL, et al. (2010). Depression, Stigma, and Suicidal Ideation in Medical Students. *JAMA*, 304(11):1181-1190.
[45] Rotenstein LS, Ramos MA, Torre M, et al. (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students, a systematic review and meta-analysis. *JAMA*, 316(21):2214-2236.
[46] Dyrbye LN, et al. (2015). The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students with Burnout. *Academic Medicine*, 90(7):961-969.
[47] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[48] Examples include the HEAR Program at UC San Diego (available to everyone at the UCSD Health System, not only medical students), the Henderson Student Counseling Center at Nova Southeastern University, the Wellness Resources offered at Oregon Health and Science University, and the Medical Student Counseling and Wellness Center at the Herbert Wertheim College of Medicine, Florida International University.

action, embarrassment or professional isolation. The use of confidential services whenever possible in lieu of regulatory awareness is preferred in order to mitigate fear of negative impacts on licensure, employment, or collegial relationships. When confidential services are not utilized, it is less likely licensees will receive early intervention and appropriate treatment, thereby foregoing opportunities for early detection of potentially impairing illness or recovery.

Funding for important programs and initiatives such as those identified above is often difficult to obtain. However, there is a growing body of research that identifies the cost savings for hospitals and employers associated with providing them, particularly when costs associated with medical errors and lower quality of care attributed to burnout are mitigated, as are high turnover rates, absenteeism, and loss of productivity.[49]

Another challenge to identifying and addressing burnout is the fact that the associated stigma may reduce the degree to which the phenomenon itself is discussed. This impacts not only a physician's own willingness to discuss or seek help for burnout, but also the willingness of fellow physicians to address or report instances of impairment among their colleagues, especially that which unduly risks the safety of patients. While the duty to report impairment or incompetence and the duty to encourage help-seeking may seem to conflict, in that a fear of being reported could cause a physician to conceal problems and avoid help, the duty to report is actually based on principles of patient safety and ethics. The duty to report also aims to assist physicians in seeking the help they need in order to continue practicing safely.

In addition to the cultural stigma associated with admitting experiences of burnout, recent research has shed light on the potential impact of licensure and license renewal processes of state medical boards that may discourage treatment-seeking among physicians.[50,51] State medical boards may inadvertently discriminate unfairly against physicians suffering from mental illness or substance use disorders, or against those who choose to take a leave of absence from practice to prevent or recover from burnout. The very presence of application questions for medical licensure or licensure renewal may stigmatize those suffering from mental and behavioral illnesses for which physicians might otherwise seek care. In fact, questions about substance abuse and mental illness on state medical licensure renewal applications have nearly doubled between 1996 and 2006.[52] While information about a physician's health status (both mental and physical) may be essential to a state medical board's solemn duty to protect the public, the FSMB has previously noted that a history of mental illness or substance use does not reliably predict future risk

[49] Shanafelt T, Goh G, Sinsky C. (2017). The Business Case for Investing in Physician Well-Being. *JAMA Intern Med*. 177(12):1826-1832.
[50] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry*, 43:51–57.
[51] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[52] Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3): 372.

to the public.[53] It is also very important to recognize that court interpretations of the Americans with Disabilities Act (ADA) have suggested that state medical boards should focus on current functional impairment rather than a history of diagnoses or treatment of such illness.[54]

In carrying out their duty to protect the public and ensure that only individuals who are fully qualified to practice medicine are granted licenses, state medical boards usually, and for good reasons, insist that they must have sufficient information with which to make medical licensure decisions. During the licensure granting process, state boards also work diligently to ensure that candidates for licensure (or renewal) provide a thorough assessment of their fitness to practice, balanced by protecting their rights as contained in ADA legislation. Fear among prospective and current licensees about potential limitations placed on their ability to practice medicine independently, however, or of their previous diagnoses or treatments somehow being made public despite HIPAA and other federal privacy and confidentiality laws, may cause some physicians to misrepresent personal information that is requested or not respond accurately at all to licensing application questions.[55] In such instances, paradoxically, the efforts of state medical boards to get comprehensive information may not yield the accurate information they seek about a physician's practice risks to patients. They may also discourage treatment-seeking among physicians, thereby increasing the degree of risk to patients presented by physicians experiencing conditions that remain undiagnosed or untreated.

Recommendations:

The majority of the recommendations that follow are designed for state medical boards to consider and pertain mainly to the inclusion and phrasing of questions on state medical licensing applications. Appropriately addressing the issue of physician burnout provides a unique opportunity for state medical boards to declare, directly or indirectly, that it is not only normal but anticipated and acceptable for a physician to feel overwhelmed from time to time and to seek help when appropriate. This is also an important opportunity for state medical boards to highlight and promote the benefits of physician health, both mental and physical, to help reduce stigma, to clarify related regulatory and reporting issues, promote patient safety and assure the delivery of quality health care. Physicians should feel safe about reporting burnout and be able to take appropriate measures to address it without fear of having their licensure status placed in jeopardy.

Safeguarding physician wellness and mitigating damage caused by burnout cannot be accomplished through isolated actions and initiatives by individual organizations alone. Coordinated efforts and ongoing collaboration will be essential not only for addressing

[53] Federation of State Medical Boards. (2006). Federation of State Medical Boards: Americans With Disabilities Act of 1990. License Application Questions: A Handbook for Medical Boards.
[54] Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3):373.
[55] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry*, 43:51–57.

the many systemic issues that contribute to burnout but also for ensuring that appropriate tools, resources, and programs are continuously in place and readily available to help physicians avoid and address burnout. As such, the FSMB also offers suggestions and recommendations to its partner organizations, many of which have been instrumental in furthering the FSMB's current understanding of burnout, its related features, and the role of the regulatory community in addressing and safeguarding physician health.

Ultimately, the Workgroup and the FSMB believe that a shared accountability model that includes several related responsibilities among regulatory, educational, systemic, organizational, and administrative stakeholders provides a promising way forward. The specific recommendations outlined below begin to address what such responsibilities should entail.

The FSMB recognizes its responsibility to help address physician burnout, not only through following its own recommendations and promoting the resources provided in this report, but also by continuing its collaborative efforts with partner organizations from across the wider health care community.

For State Medical Boards:

1. The FSMB recommends that state medical boards review their medical licensure (and renewal) applications and **evaluate whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use**, and whether the information these questions are designed to elicit in the interests of patient safety may be obtained through means that are less likely to discourage treatment-seeking among physician applicants. For example, some boards subscribe to notification services such as the National Practitioner Data Bank's "Continuous Query" service or other data services that provide information about arrests or convictions, including for driving under the influence, within their states which can serve as a proxy finding for physician impairment. The FSMB also recommends in its *Essentials of a State Medical and Osteopathic Practice Act* that boards require applicants to satisfactorily pass a criminal background check as a condition of licensure.[56]

2. Where state medical boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, they should **carefully review their applications to ensure that appropriate differentiation is made between the illness with which a physician has been diagnosed and the impairments that may result**. Application questions must focus only on current impairment and not on illness, diagnosis, or previous treatment in order to be compliant with the Americans with Disabilities Act (ADA).

[56] Federation of State Medical Boards. (2015). *Essentials of a State Medical and Osteopathic Practice Act.*

3. The ADA requires licensure application questions to focus on the presence or absence of current impairments that are meaningful in the context of the physician's practice, competence, and ability to provide safe medical treatment to patients. **Applications must not seek information about impairment that may have occurred in the distant past and state medical boards should limit the time window for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred.**

   Questions that address the mental health of the applicant should be posed in the same manner as questions about physical health, as there is no distinction between impairment that might result from physical and mental illness that would be meaningful in the context of the provision of safe treatment to patients.

   Where boards wish to retain questions about the health of applicants on licensing applications, **the FSMB recommends that they use the language:** ***Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?*** **(Yes/No)**[57,58]

4. **The FSMB recommends that state medical boards consider offering the option of "safe haven non-reporting" to applicants for licensure who are receiving appropriate treatment for mental health or addiction**. While it is up to boards to determine what constitutes appropriate treatment, the FSMB recommends that physicians who are monitored by, and in good standing with, the recommendations of a state or territorial Physician Health Program (PHP) be permitted to apply for medical licensure or license renewal without having to disclose their diagnosis or treatment to the board. The option of safe haven non-reporting should only be offered when treatment received is commensurate with the illness being treated and has a reasonable chance of avoiding any resultant impairment.

5. **State medical boards should work with their state legislatures to ensure that the personal health information of licensees related to an illness or diagnosis is not publicly disclosed as part of a board's processes**. Information disclosed must relate only to impairment of professional abilities, medical malpractice, and professional misconduct.[59]

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[57] American Psychiatric Association. (2015). Position statement on inquiries about diagnosis and treatment of mental disorders in connection with professional credentialing and licensing.
[58] The American Psychiatric Association (APA) passed an Action Paper in November 2017, resolving to query state medical boards and notify them about their compliance with APA policy and the ADA.
[59] Center C, Davis M, Detre T, et al. (2003). Confronting depression and suicide in physicians: a consensus statement. *JAMA*, 289(23):3161–3166.

6. **State medical boards should emphasize the importance of physician health, self-care, and treatment-seeking for all health conditions by including a statement to this effect on medical licensing applications, state board websites, and other official board communications**. Where appropriate, options for treatment and other resources should be made available, such as information about a state Physician Health Program (PHP), services offered through a county, state, or national medical society, and any other relevant programs. These means of communicating the importance of physician health and self-care are aimed at helping physicians with relevant information and resources but could also help raise awareness among patients of the importance of physician wellness and the threat of burnout to their doctors and their own care.

7. **State medical boards should clarify through communications, in print and online, that an investigation is not the same as a disciplinary undertaking**. Achieving an understanding of this distinction among licensees may help begin to dispel the stigma associated with reporting burnout and remove a barrier to physicians seeking help in times of need.

8. **State medical boards are encouraged to maintain or establish relationships with a PHP in their state and to support the use of data from these programs in a board's decision-making**.

9. **State medical boards should examine the policies and procedures currently in place for working with physicians who have been identified as impaired in a context that is meaningful for the provision of safe care to patients to ensure that these are fair, reasonable, and fit for the purpose of protecting patients. All such processes should be clearly explained and publicly available.**

10. **State medical boards should be aware of potential burdens placed on licensees by new or redundant regulatory requirements**. They should seek ways of facilitating compliance with existing requirements to support licensees and ensure that they are able to spend time with patients and in those areas of medicine which they find most meaningful. "Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance physicians' ability to focus on patient care."[60]

Upon implementing some or all of the above changes to state medical board policy or processes that are meant to reduce the stigma associated with mental health issues and encourage treatment-seeking, the board should communicate these, and their rationale, to current and prospective licensees, as well as patients and the public. State medical boards should also raise the issue of physician burnout more often, emphasizing the importance

[60] Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, https://www.rand.org/pubs/research_reports/RR439.html.

of physician wellness, help-seeking, and the availability of accessible, confidential, and private counselling programs for physicians and all health professionals.

For External Stakeholders and Partner Organizations:

Professional Medical Organizations and Societies:

11. Professional medical societies at local, state, and national levels have a key role to play in encouraging physicians to seek treatment, both preventive and curative, for the physical and mental health issues they face, as well as for features of burnout. The FSMB recognizes the many exemplary programs and initiatives of professional medical societies and encourages their continued advocacy for physician wellness and the availability of support and treatment services.

12. The FSMB recommends a sustained focus in the medical profession on the importance of self-care with an aim to reduce the stigma attached with seeking treatment for health issues, particularly ones related to mental health.

13. The FSMB recommends that attempts be made to expand the availability of accessible, private, and confidential counseling for physicians through medical societies, such as those provided by organizations like the Lane County Medical Society (Oregon), which has a program with several features identified as best practices for physician wellness by the Workgroup. Counseling via telehealth could also enhance access and provide greater assurance of privacy to those seeking care.

14. Given the prevalence of burnout, all physicians need to be educated about the resources currently available regarding burnout, including those referenced in Appendix A, for self-awareness, and for identification and referral of peer professionals who may have burnout. Medical societies are encouraged to partner with other organizations identified in this report to improve awareness of resources and their dissemination.

15. The FSMB recommends that professional medical societies and organizations representing physicians, such as the American Medical Association, the American Osteopathic Association, and the Council of Medical Specialty Societies work with state medical boards to raise awareness among the public of the importance of physician wellness not only because of its inherent value to physicians themselves but also as a significant contributor to patient safety.

Centers for Medicaid and Medicare Services:

16. The FSMB recommends careful analysis of any new requirements placed on physicians to determine their potential impact on physician wellness. Any new

requirements that could serve as a driver of burnout in physicians must be supported by evidence and accompanied by a strong rationale that is based in improving patient care to justify any new burdens imposed on physicians.

State Government, Health Departments, and Legislatures:

17. As state government, health departments, and legislatures make decisions that can impact physicians, the FSMB recommends that they weigh the potential value of proposed new regulations against potential risks to the health of physicians and other clinicians.

Vendors of Electronic Health Records (EHR) systems and standard setting organizations:

18. As a promising advancement in the provision and documentation of care, but also a key driver of frustration with medical practice, EHRs need to be improved in a way that takes the user experience into greater consideration than it does currently. This experience may be improved through facilitating greater ease of data entry into the system, as well as ease of access to data from the system. Vendors are encouraged to include end-user physicians on their builder teams to optimize input about operability and interoperability.

19. Efforts to reduce redundant or duplicative entry should be required by standard setting organizations, such as the Office of the National Coordinator for Health IT (ONC), and reflected in the EHR systems ultimately designed by vendors.

20. EHR vendors are encouraged to focus future improvements on facilitating and improving the provision of patient care. The primary purposes of an EHR relate to documentation of care received by a patient, retrieval of patient care related information and data, and patient communication.

Medical Schools and Residency Programs:

21. The FSMB encourages the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, the American Medical Association, the American Osteopathic Association and the institutions they represent, to continue their laudable efforts at improving the culture of medicine and facilitating open conversations about illness and wellness in order to promote positive change.

22. The FSMB recommends continued efforts to encourage medical students and residents to value self-care and understand the positive impacts that physician wellness can have on patient care.

23. The FSMB recommends that medical schools, residency programs, and their accrediting bodies consider ways of amplifying the medical student and resident voice on systemically induced pressures and support trainees by providing means for raising issues related to medical student and resident health and well-being anonymously.

Hospitals/Employers:

24. The FSMB recommends that hospitals revise, where necessary and appropriate, their questions asked as part of their credentialing process according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

25. The FSMB recommends that hospitals and health systems assess physician health at regular intervals using a validated instrument and act upon the results. Employers should keep results of these assessments internal to the organization or health system in order to promote workplace change, while avoiding threatening or punitive cultures.

26. Hospitals, as well as the American Hospital Association and related organizations, are encouraged to officially adopt the "Quadruple Aim" to demonstrate the importance they place in the health and wellness of the physicians and all other health professionals they employ and recognize the impact of provider health on safe patient care.

27. Hospitals should ensure that their policies and procedures are adopted with consideration given to the impact they have on the health of the hospital workforce. Decisions impacting hospital the health of hospital and health system employees should be made with adequate input from individuals representing the impacted sectors of that workforce.

28. While acknowledging the need for hospitals to acknowledge all staff in their programmatic development, employers are encouraged to make resources and programs available to physicians, including time and physical space for making connections with colleagues and pursuing personal goals that add meaning to physicians' work lives. Resources and programs should not always be developed and implemented in a "one size fits all" manner, but should incorporate consideration of the different stressors placed on male and female physicians, within and outside of the workplace, and be tailored appropriately. Resources related to EHR implementation and use should also be made available by employers, including training to optimize use and support for order-entry such as scribes or other technological solutions aimed at restoring time available to physicians.

29. Hospitals should ensure that mandatory reports related to physician competence and discipline are made available to state medical boards and other relevant authorities.

Insurers:

30. The FSMB recommends that insurance carriers revise, where necessary and appropriate, their questions on applications for professional liability insurance according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

31. In evaluating the quality of care provided by physicians, insurers should look beyond cost-saving measures and use metrics related to physician health and incentivize practice patterns that contribute to physician wellness.

Accrediting Organizations:

32. In its ongoing development of standards for the accreditation of undergraduate medical education programs, graduate medical education training programs, hospitals and healthcare facilities, the FSMB encourages those organizations charged with the accreditation of institutions and educational programs to include standards related to required resources and policies aimed at protecting medical student, medical resident and attending physician health.

Physicians:

33. Physician wellness is a complex issue, made up of system-wide and individual components. However, physicians have a responsibility to attend to their own health, well-being, and abilities in order to provide care of the highest standard.[61] This involves a responsibility to continually self-assess for indicators of burnout, discuss and support the identification of health issues with peers, and seek help or treatment when necessary. Physicians are encouraged to make use of services of state Physician Health Programs, which, where available, can be accessed confidentially in instances where patient harm has not occurred.

34. Physicians are encouraged to inform themselves about their ethical duty, oftentimes codified in state statutes, to report issues related to incompetence and unsafe care delivered by their peers. They are also encouraged to engage in open

[61] General Assembly of World Medical Association at Geneva Switzerland. (1948). *Declaration of Geneva*, as amended by the WMA General Assembly, October 2017.

dialogue with peers about the importance of self-care, treatment-seeking, and the threats to themselves and their patients presented by burnout.

35. Physicians are also encouraged to seek an appropriate balance between time spent on practice and related work and activities external to work, particularly ones with restorative potential.

Conclusion

The duty of state medical boards to protect the public includes a responsibility to ensure physician wellness and to work to minimize the impact of policies and procedures that impact negatively on the wellness of licensees, both prospective and current. The rationale for this duty is based on the link between physician burnout and its intendant risks to patient safety, the fact that some regulatory processes employed by state medical boards can have negative impacts on the health and wellness of physicians themselves, and the potential for regulatory change to support physician wellness and help prevent further instances of burnout.

The information and recommendations in this Report of the FSMB's Workgroup on Physician Wellness and Burnout are meant to support initial steps in the medical regulatory community and to contribute to ongoing conversation about patient safety and physician health.

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APPENDIX A: SAMPLE RESOURCE LIST

The following list is offered as a sample of resources available to support and facilitate the understanding, diagnosis, treatment, and prevention of symptoms of burnout or to maintain and improve physician wellness. The FSMB has not conducted an in-depth evaluation of individual resources, and inclusion herein does not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality. Further, while some resources listed below are available free of charge, others are only accessible through purchase.

Federation of State Medical Boards, Policy on Physician Impairment, 2011.

Federation of State Medical Boards: Americans With Disabilities Act of 1990. License Application Questions: A Handbook for Medical Boards. Dallas, TX: Federation of State Medical Boards of the United States, Inc., 2006.

The standard tool used to evaluate rates of burnout is the Maslach Burnout Inventory, developed in the 1980s by Christina Maslach, PhD, a psychologist at the University of California Berkeley.

The HappyMD.com – in particular, the burnout prevention matrix, 117 ways to prevent burnout

Accreditation Council for Graduate Medical Education – Physician Wellbeing Resources

American Academy of Family Physicians - Physician Burnout Resources Page:

American College of Emergency Physicians (ACEP) – ACEP Wellness Resource page

American College of Physicians – Resources on Physician Well-Being and Professional Satisfaction

American Medical Association Steps Forward website:

American Osteopathic Association – AOA Physician Wellness Strategy

Association of American Medical Colleges – Wellbeing in Academic Medicine

Federation of State Physician Health Programs

Mayo Physician Well-being Program:

National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience

Remembering the Heart of Medicine

Stress Management and Resiliency Training (SMART) program

SuperSmartHealth

The Studer Group

The Well-Being Index (Mayo Clinic)