

## Do Geriatricians Get Burned Out?

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**What factors are associated with physician burnout? Have any interventions been proven to be effective in preventing or reversing burnout?** Question submitted by Devon Neale, MD, and Carla Herman, MD, MPH, University of New Mexico School of Medicine with response posted to the Portal of Geriatric Online Education [<http://www.pogoe.org>] on November 21, 2010

The original question asked by Dr. Neale and Dr. Herman pertained to the risk of burnout among geriatricians and, specifically, geriatricians working in academic settings. No literature exists at this level of granularity. Many authors, however, have studied and written about physician burnout as a broader topic. In 1990, the National Library of Medicine even introduced "Burnout, Professional" as a Medical Subject Heading (MeSH) term and defined it as "an excessive stress reaction to one's occupational or professional environment. It is manifested by feelings of emotional and physical exhaustion coupled with a sense of frustration and failure."<sup>1</sup> This mirrors the traditional three part definition of burnout as comprising of emotional exhaustion (EE), or a loss of enthusiasm for work; depersonalization (DP), or a tendency to treat people as objects; and a feeling of low personal accomplishment (PA), or a sense that one's work lacks meaning.

The causes of burnout among physicians are many and differ from physician to physician according to a unique combination of factors such as age, gender, specialty, work environment, personality characteristics, family and community support, and litigious atmosphere. Recommended solutions are as diverse as the origins of the problem itself. They range from taking time for oneself and exercising, to mentoring programs, to restructuring of the entire practice environment. A few studies have reported on formal interventions. One took place at an institutional level and did indeed involve the restructuring of a multi-site primary care physician practice. A second involved intensively training a cohort of primary care physicians in the art of mindful communication. Both resulted in improvements in physician well being and, by extension in patient well-being. More details on these and other interventions are provided below.

1 National Library of Medicine. MeSH Database. <http://www.ncbi.nlm.nih.gov/mesh?term=burnout> Accessed May 5, 2011.

### Background

Although the term burnout is used frequently and casually in conversation, the syndrome of professional burnout has three defining criteria. These are 1) emotional exhaustion manifested as a loss of enthusiasm for work; 2) depersonalization, or a tendency to treat people as if they were objects; and 3) a feeling of low personal accomplishment and/or a sense that one's work is devoid of meaning.<sup>1-6</sup> Although often associated with depression,<sup>7</sup> it is distinguished from depression by the fact that it is specifically associated with one's working life.<sup>1,5</sup> Professional burnout is most prevalent among individuals who work closely with people and includes physicians, nurses, social workers and teachers.<sup>5</sup>

Among many physicians there is a sense that the overwhelming stresses of the profession are no longer counterbalanced by its many satisfactions. Abigail Zuger,<sup>8</sup> in a 2004 *New England Journal of Medicine* Special Report entitled "Dissatisfaction with Medical Practice" identifies a "widespread professional malaise."<sup>8(p.69)</sup> To outsiders medicine seems like "a profession in retreat, plagued by bureaucracy, loss of autonomy, diminished prestige, and deep personal dissatisfaction,"<sup>8(p.69)</sup> and insiders can find themselves going through Kubler-Ross's five stages of mourning as they witness these changes in their profession.<sup>8</sup>

Some authors emphasize the negative impact of phenomena unique in the American healthcare system, such as health maintenance organizations (HMOs), rising malpractice premiums, decreasing autonomy, and decreasing reimbursement, as primarily responsible for physician burnout.<sup>7</sup> Zuger, however, notes that physicians outside of the United States also seem to be experiencing an overall unhappiness, which suggests that there is some aspect of modern medicine that inherently contributes to burnout.<sup>8</sup> According to figures cited by Brown and Gunderman, 40% of younger physicians would not choose to go to medical school again and 20% of all physicians are dissatisfied with the practice of medicine.<sup>9</sup> Schindler et al. similarly cite a Kaiser Foundation national study which, in

2002, reported that of 2,608 physicians surveyed, 45% would not encourage students to pursue a medical career.<sup>7</sup>

### Spiral and Ripple Effects

Physician dissatisfaction does not affect just physicians alone. When physicians are unhappy, they are more prone to making mistakes,<sup>6,8,9</sup> which leads to even less enthusiasm for work, lower feelings of personal accomplishment, and a tendency to make more mistakes.<sup>6</sup> Conversely, when physicians are satisfied, their patients are also more likely to be satisfied with the care they get and are more likely to follow their physicians' recommendations.<sup>8,9</sup> On a larger scale, dissatisfied physicians contribute to higher rates of turnover in offices and hospitals-- which leads to increased fragmentation and lower quality of care.<sup>8,9</sup> Burnout, as noted by Golub et al. "may even be contagious, leading to spread between academic ranks of physicians, nurses and medical students."<sup>1</sup> (p. 1951) The effect on students may be especially pernicious as they, consciously or unconsciously, absorb their role models' feelings of despair or indifference<sup>1</sup> and learn, by example, to treat patients as if they were objects.

### What factors are associated with burnout?

#### Specialty Choice

There is conflicting data about which specialties, if any, are more associated with physician satisfaction or dissatisfaction. Zuger cites one study that showed internists to be less satisfied than cardiologists and ophthalmologists, and another, larger study showing greater satisfaction in primary care specialties such as geriatrics and infectious diseases when compared with gynecology, otolaryngology and plastic surgery.<sup>8</sup>

Brown and Gunderman comment that physicians in procedurally based specialties are less satisfied than those in cognitively oriented ones,<sup>9</sup> but in the same breath note that dissatisfaction is greater among psychiatrists and emergency physicians—which doesn't quite fit

that pattern—especially for psychiatrists. Overall, however, Brown and Gunderman report no significant differences between primary care physicians and specialists in community settings.<sup>9</sup> However, in academic medicine, they note more dissatisfaction among primary care faculty-- who feel both less institutional support and less support from colleagues.<sup>9</sup>

### Town vs. Gown

Specialty considerations aside, is it possible to generalize about whether community physicians experience more or less burnout than academic physicians? Here again, reports are conflicting. Tait Shanafelt, who has written extensively about physician burnout, cited figures in a 2003 *American Journal of Medicine* article entitled “The Well-Being of Physicians,” (which he wrote with coauthors Jeff Sloan and Thomas Habermann) that indicated a greater prevalence of burnout among community physicians --55-67% compared with 37-47% among academic faculty.<sup>5</sup> Nonetheless, perhaps because academic physicians are more likely to conduct studies and publish them, much has been written about medical faculty discontent. Specifically, many authors comment on the fact that physicians are drawn to academic settings because they enjoy not only taking care of patients, but the opportunities for research, teaching and continuous learning through both formal continuing education opportunities and the many informal venues for interacting with colleagues.<sup>1,7,10,11</sup> Along with this synergistic mix of opportunities offering increased professional fulfillment, however, come an equal number of sources of disappointment. As institutions find themselves increasingly short of funds, pressure on faculty to see more and more patients increases. This may be compounded by recent legislation limiting the number of hours residents can work, shifting many patient-care responsibilities back to attending physicians.<sup>1,4</sup>

The increase in clinical responsibilities, sometimes at the expense of teaching, research or administrative time, can be especially problematic for faculty who derive the most satisfaction from these activities. Indeed, Shanafelt et al. found this phenomenon of career fit mismatch to be one of the strongest predictors of academic faculty burnout.<sup>11</sup> They conducted a survey of 556 internal medicine physicians, with 465 responding, at the Mayo Clinic in Rochester, Minnesota. Participants answered a battery of questions related to practice characteristics, activities that were most meaningful, and coping strategies. Time spent on the most meaningful activity was used as the indicator of career fit. Respondents also answered the 22-item Maslach Burnout Inventory, a standardized instrument that is widely judged to be the gold standard for determining burnout. It specifically measures the three components which comprise the definition of burnout: emotional exhaustion (EE) depersonalization (DP), and a sense of low personal accomplishment (PA). Participants were also questioned about the likelihood they would be leaving academic medicine in the coming 2-3 years, or leaving or reducing their time in their present position within that time frame.

The researchers' results showed that 156-- or 34.0% of physicians were burned out. Those who spent less than 20% of their time on the activity they found the most meaningful were more likely to be burned out than those spending more than this percentage on their most rewarding activity. Not surprisingly, a higher percentage of physicians who were experiencing burnout reported that they were planning to leave their current position within the next 36 months.

In addition to lack of career fit, age less than 55 years, number of hours worked, and being a generalist as opposed to a subspecialist, were all independently associated with burnout. Lack of career fit, however, was the strongest predictor. The authors point out those faculty members who value teaching or research above patient care may naturally have the most trouble securing time for those activities since the system is weighted heavily in favor of clinical responsibilities.<sup>11</sup>

An earlier study by Lowenstein, Fernandez and Crane<sup>12</sup> also reported a high rate of intent to leave academic medicine. In their study, 42% of 532 respondents to a survey at the University of Colorado School of Medicine were planning to leave within five years. The authors sought to “provide a snapshot of faculty discontent at one medical school,”<sup>12(p.4)</sup> and constructed a “top ten” list of reasons for this discontent. These included the following:

- absence of meaningful feedback from department heads;
- inadequate faculty development programs;
- lack of recognition of quality of, or time spent, taking care of patients-- including not counting clinical service when faculty members were being considered for promotion;
- lack of recognition for excellence in teaching;
- family/career imbalance;
- lack of collegiality-- (“Less than half of faculty reported having even one ‘weekly substantive teaching or research conversation’ with any colleague—in their own department, in the medical school or anywhere in the University system.”<sup>12(p.5)</sup>); and
- absence of meaningful communication channels with institutional leaders such as the Dean and Chancellor.

### Age

Given the fact that dissatisfaction among physicians seems to be a growing phenomenon, and that the profession now appears, to many, to be only a pale reflection its past glory, one might expect that older physicians, who have had the chance to live in both worlds, would be among the least satisfied. Schindler and her colleagues<sup>7</sup> postulated exactly this in their 2006 *Academic Medicine* article; “The Impact of the Changing Health Care Environment on the Health and Well-Being of Faculty at Four Medical Schools.” They hypothesized that “older faculty who had experienced the most changes in their academic careers would be more negatively affected by the changing environment, resulting in poorer mental and physical health and decreased job and life satisfaction.”<sup>7(p.28)</sup> What they found, however, was the opposite; namely, that “older faculty were the least affected by various stressors.”<sup>7(p.31)</sup>

Greater satisfaction among older physicians is one of the few consistencies in the literature on medical burnout.<sup>1,6,7,9,13,14</sup> As discussed by Peisah et al.,<sup>14</sup> this may represent a ‘survival bias’— meaning that physicians who have experienced burnout have already elected to change careers or to retire by the time they would otherwise be asked to complete satisfaction surveys. They acknowledge the limitation of their own study, which, as a cross-sectional study did not permit them to see if physicians underwent a maturational process that allowed them to develop successful mechanisms for coping with the stress of their careers, or if they were truly a “survivor cohort.” It certainly seems reasonable to assume that older physicians, particularly in academic settings, have already achieved some level of professional recognition and stature, eliminating at least the failure of recognition—which played such a large role in the Colorado study-- as one of the sources of stress. Older physicians are also

more likely to be financially secure, eliminating another source of anxiety. Finally, older physicians, if nothing else, have the security of knowing they can, if they choose, retire at any point—without losing face or facing the challenges of starting a brand-new career.

## Gender

Various studies have reported that female physicians either experience more career satisfaction,<sup>13</sup> the same level of career satisfaction,<sup>12</sup> or less career satisfaction<sup>1,3,6,9,11,15</sup> when compared with their male counterparts. To add to this confusion, Zuger reports

In one study, female doctors were more likely than male doctors to say they were satisfied with their relationships with patients and colleagues and were equally likely to say they were satisfied with their overall careers, but they were 60% more likely than the men to report burnout. A survey of 4500 female physicians found that overall levels of career satisfaction were similar to those found in mixed groups.<sup>8(p. 70)</sup>

Shollen et al.,<sup>15</sup> in a 2009 article in *Academic Medicine*, sought to tease out some of the factors that might help explain some of these conflicting findings, particularly as applied to women in academic medicine. Their study was conducted at the University of Minnesota Medical School—whose data about women faculty is reflective of national data on women faculty in medical schools (and women faculty in American universities as a whole). Overall, they report, women faculty leave academia at higher rates than men, and also do not achieve the rank of full professor in the same percentages as men. At the University of Minnesota Medical School, a previous study of faculty between 1969 and 2004 revealed that although the same percentages of men and women were promoted from assistant to associate professor, far fewer women went on to become full professors. Women did not take longer to become full professors; they were just more likely to leave before achieving full professorship. In their 2009 study, Shollen et al. sought to analyze why women tend to leave academic medicine.<sup>15</sup>

In their 72 item questionnaire, the authors explored “faculty perceptions about professional/collegial relationships, mentoring, obstacles to satisfaction, institutional policies, circumstances that contribute to departure, gender equality, family issues, work life, and demographics.”<sup>15(p. 88)</sup> Of 615 surveyed individuals, 354 returned the questionnaire. Although there was no overall difference in satisfaction between women and men, deeper analysis did, in fact, reveal interesting differences at both at the individual physician level, and at the institutional level, which help explain why women tend to leave academic medicine.

In terms of individual/family circumstances, the authors found that women reported approximately 31 hours a week devoted to family and household responsibilities while men reported 19 hours. Nineteen percent of women and 5% of men stated that they did not have a partner. Seventy percent of women had a partner who was working full time and 12% had partners who were not working or working part-time, compared with 36% of men who had partners who were working full time and 59% who were not working or working part-time. The authors postulate that since a greater percentage of men had partners, and a greater percentage of their partners were not working, or working part time, the fact that women faculty overall carry a heavier burden of household responsibilities makes sense. They also found these statistics consistent with the higher interest of women faculty (33% compared with 14%) in pursuing a part-

time tenure track. Similarly, a higher percentage of women than men reported a lack of institutional flexibility in terms of things such as part-time promotion tracks, on-site day care (for both older adults and children), and insufficient parental leave, as being barriers to career success.

At the institutional level, more women than men perceived subtle gender bias as reflected in attitude and behavior of individuals in the departments in which they worked. At the interface between individual and institutional levels, significantly fewer women had clearly articulated plans for achieving career goals (51% compared with 73% of men). Shollen and her co-authors conclude that women faculty face challenges in both their family and work domains which contribute to their higher likelihood of leaving academic medicine and academia in general.

They offer specific suggestions for redressing the gender imbalance at the higher ranks of academic medicine. These include policy changes that increase support for physicians’ family responsibilities including

creation of a part-time tenure track, availability of on-site emergency child care and on-site adult care, improved parental leave policies and restructured meeting times that do not require evening or weekend hours. Many of these changes would benefit not only women, but all faculty.<sup>15(p. 93)</sup>

Shollen et al. also recommend careful investigation of both obvious and subtle manifestations of gender bias. Finally, the authors strongly recommend mentoring programs that will help women, and all faculty, to better formulate and realize their career goals.

## The Work Part of Work-Life Balance

Although reasons for burnout are multi-factorial, it is often expressed in the literature that the work part of work-life balance contributes more to burnout than the life part. In some instances, as noted in the discussion above, it is institutional lack of support for the life part that plays a major role. Related to this is the almost universal finding that it is the sense of control over one’s practice environment that plays the largest role in physician satisfaction; and conversely that a feeling of loss of autonomy is one of the major contributors to burnout.<sup>1-6,9,11,13,14,16,17</sup>

One organization, the multi-site Legacy Clinic in Portland Oregon, actively solicited input from its 22-32 physicians about factors that were perceived as most important to their work satisfaction and then, during the study period between 2000 and 2005, systematically instituted changes that were inspired and guided by that feedback.<sup>17</sup> To address issues of *control*, regular group meetings were established to solicit physicians’ concerns. Work was then restructured to meet those concerns. This included instituting flexible schedules, customized scheduling templates, and accommodating the special interests of the physicians to better match career fit—e.g. allowing those more interested in teaching or research to devote more time to those pursuits. To address issues of *order*, reflected in efficient office design and high quality staff, the clinic incorporated a medical assistant program; adopted the Institute for Health Improvement (IHI)’s ‘Idealized Design of Clinical Office Practice;’ added case management; a hospitalist program; and electronic medical records. To address issues of *meaning*, meetings were redesigned to focus on clinical cases and not administrative problems, and time was taken during meetings to mourn patients who had died.<sup>17</sup>

By all measures used (ACP/ASIM survey on physician satisfaction, the Maslach Burnout Inventory (MBI), and the Quality Work Competence (QWC) survey), physician satisfaction improved. Significantly less emotional and work-related exhaustion was reported at the end of the study. Organizational health as measured by the QWC also improved and stabilized.

As the authors themselves point out, this is one of the few published articles describing an institution-wide intervention (although, in the literature on burnout, there exists no shortage of suggestions for such interventions). Despite the fact that the physician organization was small and not an academic medical center with a long-established institutional culture to address and change, this study by Dunn et al. certainly offers reasons for optimism and proof that positive organizational change is possible.

### **Time and Money**

If sense of control over one's practice environment is the largest predictor of physician satisfaction, time, specifically the number of hours worked is probably the most significant dimension of that sense of control. Keeton et al.,<sup>13</sup> in their 2007 study, "Predictors of Physician Career Satisfaction, Work-Life Balance, and Burnout," found that "the strongest single predictor of emotional resilience and personal accomplishment was control over schedule and hours worked..."<sup>13(p.954)</sup> Ironically, working long, long hours is often romanticized within the culture of medicine. Shananfelt et al., for example, quote "One marital expert [that] noted that resident 'role models range from academic superstars with impressive research credentials and international acclaim to committed clinician-teachers who are at the hospital seven days a week... their heroes lead lives that are desperately out of balance.'"<sup>5(p.514)</sup> Very interestingly, however, Brown and Gunderman note that although the number of hours worked is proportionate to the degree of dissatisfaction that physicians feel, the converse is not true. Reducing the number of hours worked does not increase satisfaction to the same degree.<sup>9</sup>

The inability to increase satisfaction by decreasing the variable whose presence is directly correlated with dissatisfaction apparently applies not only to time, but also to money. Although physicians in higher income brackets (\$250,000-\$299,999/yr) are reportedly happier than those whose with lower incomes (below \$100,000)<sup>8,9</sup>, Brown and Gundermann note that, here again, "Dissatisfaction rises more sharply with decreasing income than satisfaction rises with increasing income."<sup>9(p. 579)</sup>

As an aside, it is interesting to note how infrequently income level in general is discussed in the literature as a major contributor to physician satisfaction or dissatisfaction.

### **Malpractice**

Although income per se may not contribute significantly to physician satisfaction, the finances relating to malpractice insurance do.<sup>7,8</sup>

Zuger writes:

The problems that some physicians are having in finding malpractice insurance, in paying steeply rising premiums, or both, are at or near crisis proportions in 44 of the 50 states according to the American Medical Association.<sup>8 (pp.71-72)</sup>

Even more distressing to most physicians is the fear of being sued - surpassed only by the actual experience of being a defendant in a malpractice suit.<sup>4-8, 11,13,17</sup> Once again according to Zuger, "No matter what the background or outcome of the suit, physician-defendants routinely describe feelings of shame, self-doubt, and disillusion with medical practice that may persist for years."<sup>8 (p.72)</sup> This description bears an uncannily close resemblance to the very definition of professional burnout.

### **The Life Part of Work-Life Balance**

Are there personal characteristics which incline physicians to being more or less satisfied with their career? According to Spickard, Gabbe and Christensen,<sup>6</sup> one of the very traits which helps so many of us through medical school may also be a key to our unhappiness: compulsiveness.

The compulsive triad of doubt, guilt feelings, and an exaggerated sense of responsibility has been well described. Physicians with compulsiveness have chronic feelings of not doing enough, difficulty setting limits, hypertrophied guilt feelings that interfere with the healthy pursuit of pleasure and the confusion of selfishness with healthy self-interest.<sup>6(p. 1448)</sup>

This can further lead to "a psychology of postponement"<sup>6(p.1448)</sup> characterized by putting personal relationships, and meaningful mind and heart-expanding life experiences on a back burner until the next plateau is reached-- which, of course, is inevitably followed by another hill to climb instead. Physicians can thereby set themselves up for isolation, absence of intimacy, and alienation from loved ones—the very social characteristics that put them at further risk for burnout. Repeated throughout the literature is the importance of a supportive partner in assuring physicians' satisfaction with their careers.<sup>5-7,15</sup>

The presence of a spiritual or religious dimension in physicians' lives is also frequently mentioned as an important protective factor against burnout.<sup>5,6</sup> Not analyzed, however, is the question of whether it is a very internalized sense of spirituality which is key, or the community connection afforded by religious affiliation.

### **The Balance part of Work- Life Balance**

Although character traits and personal circumstances certainly affect physicians' work, it clearly remains the work itself which leads to satisfaction. If, as we have seen, a major component of the definition of burnout is a feeling of low personal accomplishment and/or a sense that one's work is devoid of meaning, then the corollary is also true: a feeling that one's work matters, and that as a physician, one makes a difference, greatly contributes to a sense of professional satisfaction. Keeton et al. state the following:

problems with work-life balance are much less predictive of career satisfaction than sense of personal accomplishment and level of resilience and ... physicians can struggle with work-life balance yet remain highly satisfied with their career.<sup>13(p. 953)</sup>

Similarly, Brown and Gunderman note that

Because the specific sources of physician fulfillment vary widely among different groups of physicians and practice settings, a universally applicable master list of interventions is impossible to compile. The first priority in every case, however, is to accentuate the intrinsically rewarding aspects

of the work. Above all, we need to feel that we have made a real difference in the lives of others.<sup>9</sup> (p. 581)

To focus on the central dimension of meaning, Krasner et al.<sup>2</sup> carried out a study in which they tested the effectiveness of a three part educational program that focused on mindfulness, communication and self-awareness on measures of burnout among a group of primary care physicians in the greater Rochester, New York area

Seventy physicians (out of an invited group of 871) participated in a continuing medical education course which consisted of an 8-week intensive portion involving 2½ hour sessions per week as well as one 7 hour retreat; and a maintenance portion involving one 2½ hour session per month for 10 months. The program was divided into three components: a didactic section, formal mindfulness meditation, and narrative and appreciative inquiry exercises. Every session had a theme and was initiated with short didactic presentation of topics ranging from unconscious biases to conflict resolution to boundary setting. Each presentation was followed by exercises designed to promote mindfulness, “the quality of awareness that includes the ability to pay attention in a particular way: on purpose, in the present moment, and nonjudgmentally.”<sup>2</sup>(p. 1285) Mindfulness was taught and practiced through four modalities: the body scan, sitting meditation, walking meditation and mindful movement. The third component of the program involved narrative and appreciative inquiry. Participants wrote and shared brief stories related to that week’s theme. Listening was fostered as much as the encouragement to use narration to analyze experience.

Participants completed a total of 5 surveys --at time of registration, at onset of study, after the intensive 8- week portion, at the conclusion of the program and 3 months after completion. Each survey included a 2-Factor Mindfulness scale, the Maslach Burnout Inventory, the Jefferson Scale of Physician Empathy, the Physician Belief Scale, a modified Big Five Factor Structure personality scale and the Profile of Mood States. Overall improvements were noted in mindfulness; the three components of burnout-- emotional exhaustion (EE) depersonalization (DP), and low personal accomplishment (PA); empathy; and personality as reflected in conscientiousness and emotional stability. The authors extrapolated that not only were measures of physician well-being improved, but, by extension patient well-being as well. The authors state that the physicians in their study

experienced positive changes in empathy and psychosocial beliefs, both indicators of a patient-centered orientation to medical care that has been associated with patient-centered behaviors such as attending to the patient’s experience of illness and its psychosocial context and promoting patient participation in care. Furthermore, these patient-centered behaviors have been associated with improved patient trust, appropriate prescribing, reduction in health care disparities, and lower health care costs.<sup>2</sup> (p. 1288)

Both the authors and Tait Shanafelt, who based his editorial in the same issue of *JAMA* on Krasner et al.’s article,<sup>4</sup> note that there were some limitations in the study. Among these were the following: 1) only 70 self-selected physicians participated. Whether non-participants would have achieved the same benefits remains unknown; 2) the study had a before and after design which is not as rigorous as a randomized controlled study; and 3) although the physicians demonstrated improved “patient-centeredness,” the actual affect on clinical outcomes was not measured.

Despite these limitations, the study demonstrated clear and lasting effects on physician well-being and on measures of burnout. As Shanafelt so eloquently expresses it, rather than responding to present and future challenges to medical practice by

retreating from work (eg, more time off, reduced scope of practice, retirement), the study by Krasner and colleagues demonstrates that training physicians the art of mindful practice has the potential to promote physician health *through* work. Physicians continue to control the most sacred and meaningful aspect of medical practice--the encounter with the patient and the reward that comes from restoring health and relieving suffering.<sup>4</sup> (p. 1340)

Mindfulness training thus has the potential to essentially remind physicians of why they chose medicine as their life’s work.

## Conclusion

The causes of burnout among physicians are many and differ from physician to physician according to a unique combination of factors such as age, gender, specialty, work environment, personality characteristics, family and community support, and litigious atmosphere. Recommended solutions are as diverse as the origins of the problem itself. They range from taking time for oneself and exercising, to mentoring programs, to restructuring of the entire practice environment. Although solutions may vary, that we are in need of solutions is clear. As stated by Brown and Gunderman, “We ignore the subject of physician fulfillment at our peril.”<sup>9</sup> (p.581) Professional burnout is a syndrome which warrants close attention by all practicing physicians and by the institutions with which they are associated—for the sake of the physicians, the hospitals and universities that employ them, and, perhaps most importantly, for the sake of their patients and the students who will be caring for those patients in the future.

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