Why Burn Out? A Personal and Professional Journey

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Clinicians are perceived to be at increased risk these days for professional burnout, a condition that is frequently attributed to low reimbursement relative to plumbers, lawyers, and CEOs; frustration with paperwork; medical liability; and a loss of personal autonomy brought about by managed care. Medical staff lounge conversations are regular distribution points for such wisdom, and not even patients in exam rooms find sanctuary from such complaints. What’s going on here? Are the doomsayers—“Will the last doctor turn out the lights when they leave . . .?”—right? Is the reputed burnout epidemic attributable to purely external factors, or might there be some ownership of the problem at a personal level as well? Although I have performed no formal research on the question, I have been interested in the issue for some time now.

I frequently have an opportunity to travel and serve as faculty for quality improvement collaborative initiatives involving chronic care. I have asked participants from coast to coast to answer the following question: “Do you love your work?” Generally, they respond overwhelmingly that they do love their jobs.

As I stared at the ceiling over a Thanksgiving weekend in the early 1980s, I was overwhelmed by a series of disturbing possibilities: blindness, heart attacks, amputations, kidney failure—the end of life as I knew it. I was 2 years out of my residency in family medicine, but nothing I had learned in my training prepared me for what I faced that night. I had type 1 diabetes. My blood glucose and triglycerides were > 1,000 mg/dl, and my ketones were 4+. I was close to passing out. I was terrified, and I felt helpless and alone in the world.

My wife and practice partner, also a family physician, went to the local bookstore and came home with a self-help book on diabetes called Diabetes: The GlucograF Method for Normalizing Blood Sugar by Richard K. Bernstein, MD,¹ the inventor of home glucose testing. She also came home with an early glucose meter (the size of a brick), some syringes, and vials of “N” and “R” insulin. During my residency, I had inserted needles into veins (large and small), arteries, and assorted solid organs, but it took 45 minutes for me to summon the courage to give myself that first shot of insulin.

Although much of what Bernstein wrote bordered on the obsessive (e.g., recommending hemoglobin A₁c [A1C] should optimally be in the 4% range and impossible-to-follow low-carbohydrate diets), the basic idea was that I could adjust my insulin dose by dose and thereby keep my blood glucose in a controlled range. I had been taught little about insulin and nutrition for patients with diabetes in my training. In fact, I had been taught that tight control was dangerous, that preventing hypoglycemia was the most important part, and that glucose levels > 200 mg/dl were OK “as long as the patient isn’t symptomatic.”

Remember, this was 8 years before the Diabetes Control and Complications Trial was published. Tight control was still only a promise lacking an evidence basis. But lying in bed that night, it was the only hope I had. I needed to believe that it was worthwhile to try to do a good job with my blood glucose control. Otherwise, why bother?

By Monday, I was under control and back at work. I was taking multiple shots a day, testing my glucose frequently, and making my own adjustments based on what I planned to eat, when I planned to exercise, and what my glucose was at the time of the shot. It may seem commonplace today, but back then it was highly irregular to allow patients to control their own medication and make their own dosing decisions. Only physicians were thought to have the skill and experience to prescribe and adjust medication. Being a physician, I could “self-treat” without having to bargain for control over dosing with another doctor. I was glad to have that luxury and spared the humiliation of being put in my place. Dr. Bernstein went to medical school after he developed his approach, and I’m sure a part of his decision was based on a similar desire to be in charge of his own care.

I live and practice in a small town, and the grapevine soon put out the word that I had developed diabetes. Patients with diabetes began appearing in my office; we learned from each other. I had special knowledge about the pathophysiology and treatment,
whereas they often had far more experience than I in actually living with the disease. Together, we developed novel approaches to various problems. I focused on the A1C as an actual measure of the damage process, which meant that if I could keep it in the normal range, I could prevent complications. I needed to believe that in order to simply go on. I spread that hope to my patients, frequently adopting an “us versus the world” attitude that turned us into a membership club of sorts. Testing blood glucose at home was new then, and my patients learned to adjust their doses based on a simple algorithm (add or subtract 1 unit of regular insulin for every ~30 mg/dl above or below 90–120 mg/dl pre-meals). Testing became a personal experiment, not a task assigned by the doctor. Almost all patients with diabetes could master it once they believed that they could prevent complications by controlling their blood glucose. The results were amazing to me and to them.

It was a message of personal power, the same message that had pulled me up from the depths that first November night. I didn’t have to end up a victim, and neither did my patients. Many of these patients remain in my practice to this day, and most are without complications. It was my peer role, rather than my physician role per se, that made me attractive to my patients and increased my effectiveness. This was gratifying stuff.

Although I had success with many patients, there were several that seemed immune to my cheerleading. One of them, a divorced retiree, never had an A1C < 10% and often was > 14%. He smoked cigarettes, despite lung and heart disease, and he liked to eat pancakes with syrup, washing it down with whole milk. I don’t think he ever took a shot of insulin that I didn’t witness. He would go on extended trips to visit his children in another state, almost never taking any of his medications with him, and return with his LDL cholesterol in the high 200 mg/dl range, his blood glucose in the 500 mg/dl range, and his blood pressure 180/110 mmHg. At such times, he would sheepishly appear in my office, ready for the lecture he knew was coming, which would include such gems as “Are you trying to commit suicide?” and “Which part do you think will fall off first?” He would thank me as he left, saying “I know you say those things to me for my own good,” and promise to do better. But nothing ever changed.

In May 2005, I was hosting a large conference on diabetes self-management in my community. We had invited William Polonsky, PhD, CDE, author of Diabetes Burnout,2 to address a basic question posed by Martha M. Funnell, MS, RN, CDE, and Robert M. Anderson, EdD,3 in an article that had appeared 1 year earlier: “Why wouldn’t a person do everything in their power to live long and feel well?”

As it happened, my “noncompliant” patient had been admitted to the intensive care unit that week suffering multi–organ system failure. I spent most of the night before the conference with him in the intensive care unit deciding whether to intubate as he entered respiratory failure. He eventually chose no intubation, effectively sealing his fate. He died 2 hours before the meeting began, and his final words to me were to thank me for all I had done and to tell me all was OK. He faced death with great courage and was more concerned about how I was holding up than about how he was doing. I doubt that I could have been so brave in his position.

I felt tired and burned out as I headed to the conference room that morning. I felt that I had failed my patient in some profound way. It would have been easy to say that he had made his choice and that all I could have done was make sure his was an informed decision. But it wasn’t true. I had contributed to his demise in my own special way by showing my frustration and trying to scare him.

As I stood in front of the audience, I thought, “What right do I have to take the lead in a conference on self-management?” I set the stage for the audience regarding the reasons for the conference and then found myself relating my recent experiences with this patient. I barely held it together during my talk, then turned the program over to Dr. Polonsky, who talked of patients’ needing to believe it was worthwhile and achievable before they could succeed at self-management. He suggested that we ask our patients how they felt about their disease. He told us to listen and “never take sides in the patient’s ambivalence.” He had us practice motivational interviewing with each other. I had heard Dr. Polonsky speak once before, but that day, what had been theoretical became real for me.

I began to see what might have gone differently with my patient had I altered my approach and listened instead of delivering stern lectures. I have little idea what he really thought about his disease, largely because I had never asked. My educated guess is that he avoided shots and thinking about his disease in order to be “less of a diabetic” so that he could maintain his hopeful worldview through denial. He obviously never believed that he could have successfully prevented complications. He was relentlessly positive in his thoughts, even when they seemed unrealistic to me. Implicit in his “rose-colored view” was a belief system based on denial. Rather than explore it, I had repeatedly attacked his defenses with my threats of doom and gloom. Whatever it was he was truly thinking and feeling, what I had tried hadn’t worked.

The final story concerns a young internist who practices locally. She is a caring, dedicated, and talented physician who came to me in my role as independent physician association chief medical officer to discuss becoming a hospitalist. Our community has an electronic chronic care registry that she had tried (and failed) to implement in her large practice. Our association had invited her practice into a statewide diabetes collaborative, and she had come to discuss the invitation and tell me that she was through with ambulatory medicine, that it was burning her out just 5 years after her residency. As we talked, I sensed that her decision wasn’t coming from a lack of interest nor from financial concerns, but rather from a daily sense of futility in her work. I was able to keep her in the collaborative with the promise that primary care could be fixed. She trusted me enough not to laugh out loud, and her strong sense of duty kept her in the collaborative.
Simultaneously, her practice partner had learned at a statewide information technology conference about the clinical microsystems work being done at Dartmouth by John Wasson and his team. Soon, the practice suite started having biweekly team meetings. The agenda for the meetings was simple: Old Business, New Business, Pet Peeves, and Opportunities for Excellence. The meetings included all staff in the suite, including receptionists, medical assistants, medical records staff, physicians, and practice leadership. Chairing responsibility for the meetings was rotated, and minutes were taken. Each meeting resulted in something new to try, which was then reported on at the next meeting. Within a few months, the whole team had become energized; suddenly the registry worked fine, and performance on diabetes measures improved rapidly. For the internist, practice had become meaningful again. Soon, staff members from the other suites were demanding similar meetings.

What do these stories have in common? Each is an example of the need for self-efficacy. I was able to go forward as a person with diabetes only when I believed that I could influence my future and knew what to do. The lack of such a belief system contributed to the premature death of my patient; my threats did little to increase his sense of empowerment and certainly broke my heart as a clinician. Finally, doing a good job and being part of a functioning team saved a talented and empathic physician from abandoning her chosen path.

To quote Donald Berwick,“To shoulder the responsibility to change health care . . . requires one final element of trust—trust in the workforce. . . . Our premise is this: to achieve the health care we want, we will have to re-envision, and largely retrain, the health care workforce, so that they can become citizens in the improvement of their own work,” This applies to our patients (substitute the word “health” for “work”) and to ourselves as clinicians. This is why so many clinicians in quality improvement projects love their jobs, whereas others despair. We need to spread this concept across the entire health care system. We know it works for patients. Why not try it on ourselves?

References


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