INTRODUCTION AND BACKGROUND

There are many points in career pipelines that effect the adequacy and distribution of Mississippi’s physician supply, a problem with which the state has grappled for years (Cossman, 2003). Doctors make series of individual decisions that have implications for the composition of the state’s physician workforce: choosing a medical school, choosing a residency program, choosing where to set up initial practice. While all of these processes have been studied thoroughly, researchers have paid less attention to circumstances such as professional “burnout,” which may happen later in professional careers, influencing the decisions physicians make about geographic or practice moves in mid-career, or choices to stop practicing medicine before traditional retirement age.

For these reasons, better understanding of the factors that contribute to physician burnout will improve knowledge about career patterns in the Mississippi physician workforce and provide evidence critical for policymakers. Understanding physician burnout is important, not just because physicians experiencing burnout are more likely to leave the workforce or to reduce their hours (Rohland, Kruse and Rohrer, 2004; Williams et al., 2001; Maslach, Jackson, and Leiter, 1996) but also because burnout is associated with reduced continuity and quality of patient care (Rohland, Kruse and Rohrer, 2004). Ultimately, physician burnout may influence patient satisfaction and compliance (Williams et al., 2001; Maslach, Jackson and Leiter, 1996). Burnout is highly correlated with physician professional satisfaction, and previous research has shown that burnout can result in poor clinical management, noncompliant and dissatisfied patients, and high turnover (Zuger, 2004; Pathman et al., 2002; Haas et al., 2000; DiMatteo, 1993).

DATA AND METHODS

A validated single measure of burnout (Rohland, Kruse and Rohrer, 2004) on the 2007/8 MSMD survey asked the physician respondents to:

“Please choose the single item that most closely represents how you feel: (1) I enjoy my work. I do not feel burned out. (2) Occasionally I am under stress, and I don’t always have as much energy as I once did. But, I don’t feel burned out. (3) I am definitely burning out and have one or more symptoms of burnout, such as physical or emotional exhaustion. (4) The symptoms of burnout that I’m experiencing won’t go away. I think about frustrations at work a lot. Or (5) I feel completely burned out and often wonder if I can go on. I am at the point where I may need to make some changes or may need to seek some sort of help.”

The two highest burnout scores (symptoms won’t go away and feeling completely burned out) were combined into a single measure of persistent burnout. Respondents were then categorized by reported levels of burnout in their professional lives, ranging from (1) no burnout to (2) stressed [no burnout], (3) occasional burnout, or (4) persistent burnout.
We analyzed the association between burnout responses from actively practicing physicians (N=633) in conjunction with four practice-related items (one related to patient load, three related to practice autonomy) on pressures that potentially have negative effects on medical practices:

- I feel pressure to see more patients each day.
- I feel pressure to limit the number of tests I order.
- I feel pressure to limit the number of referrals to specialists.
- I feel pressure to limit what I tell patients about treatment options.

For each of these four statements, physicians could respond that they felt no pressure, felt pressure but it did not affect the patient care they provided, or that they felt so much pressure that it did affect patient care. Results of the association between burnout and each of the four practice-related items are displayed in Figures 1-4.

**FINDINGS**

**Pressure to see more patients.** Two thirds of Mississippi doctors reported feeling at least some pressure to see more patients each day. But how is feeling pressure to take on more patients associated with burnout? Among physicians who felt no pressure to see more patients, one third reported feeling *no burnout* symptoms, while about half reported feeling *stressed*, but no burnout; only 10 percent reported feeling *occasional burnout*, and fewer than five percent reported *persistent burnout* (column 1, Figure 1). Among doctors who felt so much pressure to see more patients that it affected patient care, only six percent reported *no burnout* at all and nearly half reported *occasional or persistent burnout* (column 3, Figure 1).

**Pressure to limit tests.** Two in five MS physicians reported feeling at least some pressure to limit tests. Among physicians who felt no pressure to limit tests, less than one fifth reported feeling *occasional or persistent burnout* (column 1, Figure 2). In contrast, fully one third of doctors who felt pressured to limit tests (whether they perceived limiting tests as having an effect on patient care or not, columns 2 and 3, Figure 2), reported feeling either *occasional or persistent symptoms of burnout*.

**Pressure to limit specialist referrals.** About 20 percent of physicians reported there was at least some pressure to limit specialist referrals. Only about one in five physicians who felt no pressure to see more patients reported feeling *occasional or persistent burnout* (column 1, Figure 3). Much higher levels of *occasional or persistent burnout* were reported by physicians who felt pressure to limit specialist referrals (regardless of the impact of limits on patient care) (columns 2 and 3, Figure 3). Similar to burnout patterns in the figures on pressures to...
see more patients (Figure 1) or to limit tests (Figure 2) physicians who felt any pressure to limit specialist referrals had significantly lower no burnout responses.

**Pressure to limit what physicians tell patient about treatment options.** Seventeen percent of MS physicians felt at least some pressure to limit what they told their patient about treatment options. Among doctors who felt no pressures to limit what they told patients about treatments, only 4 percent said they felt persistent burnout (column 1, Figure 4). In contrast, for doctors who did feel pressure to limit what they told patients but felt it had no effect on patient care, 7 percent felt persistent burnout (column 2, Figure 4). Among physicians who felt they had to limit treatment option communication in ways that impacted patient care, 14 percent reported they experienced persistent burnout (column 3, Figure 4).

**IMPLICATIONS**

In general, pressures to take on more patients or to limit practice autonomy (tests, referrals and discussion of treatment options) are systematically associated with patterns of physician burnout. The magnitude and perceived effects on outcomes associated with the escalation of practice-related pressures is mirrored by escalating perceptions of burnout, ranging from no burnout or some stress on the low end (when little practice related pressure is experienced) to more serious occasional or persistent burnout at the other. Given the systematic patterns of relationships between practice pressures and physician burnout, it is important to understand the processes that contribute to burnout both to preserve physician and patient satisfaction and to ensure the resulting quality of care. Among the potential practice-related stressors we considered in this brief, feeling pressured to see more patients affected the largest proportion of physicians. However, feeling pressured to limit practice autonomy caused higher levels of occasional and persistent physician burnout. Since burnout is one push factor related to reducing work hours and leaving the workforce, continuity and quality of care may be compromised when practice related burnout is a widespread or long-standing problem. Physician burnout poses a serious risk, especially in places like Mississippi where the physician workforce is often regarded as too small, since burnout can push physicians out of career paths.

Precisely what or who causes the pressures that Mississippi physicians experience were not asked explicitly in the 2007/08 MSMD survey, although some plausible causes can be identified. Several recent trends in Mississippi likely have influenced the levels of stress and burnout that doctors experience. Pressure to take more patients likely occurs due to physicians’ need to maintain adequate revenue to run a practice in the face of inadequate reimbursement levels in state (Medicaid) and federal (Medicare) programs coupled with high costs of medical liability insurance. This need for practice revenue, combined with the twin problems of undersupply of physicians in Mississippi and an overabundance of high need patients, likely contributes to pressures to see more patients. Managed care, a culprit contributing to physician autonomy limits elsewhere, contributes little to burnout stressors like limiting tests or referrals in Mississippi, simply because managed care never really penetrated the state healthcare system. However, spatial maldistribution of specialists and high technology medical centers, low levels of reimbursement for tests and procedures under some insurance arrangements, high levels of uncompensated patient care, and regulations that limit allowable tests and procedures all contribute to pressures physicians experience as limiting what they can do in their practices. So, too, do constraints that exert pressures arising from liability concerns, employment sector (private practices versus public employment), compliance with regulations, and the need to seek permission for certain kinds of testing and procedures to meet insurance demands.

It is not surprising that physicians who feel pressured to take on more patients or to limit practice components are at risk for significantly higher levels of occasional or persistent burnout than their counterparts who report less pressure. A priority is to understand who or what is applying the pressure physicians feel, and what might be done to ameliorate it, since burnout puts segments of the physician workforce at risk of reducing workloads or retiring early. This brief provides systematic evidence of the relationships between pressures in physician practices that contribute to burnout. Understanding these processes will be critical if policymakers are to devise effective ways to reduce pressures that
unduly influence doctors to take on ever-increasing patient loads or to limit medical practice, increasing the risk of burnout. If burnout can be avoided, so too can the indirect effects of burnout on physician supply be minimized, ultimately safeguarding the continuity and quality of patient care.

REFERENCES


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