MCHW
Mississippi Center for Health Workforce

Health Workforce Brief

Autonomy, Satisfaction and Physician Burnout

Debra Street & Jeralynn Cossman

This is the final brief in a series of four Mississippi Center for Health Workforce Research Briefs on physician burnout. Data are from the Mississippi Workforce Study (2007/08 MSMD); over 1400 doctors licensed to practice in Mississippi (2006-07) responded to the 2007/08 MSMD survey. Data from physicians in active practice involving direct patient care who answered the questions on burnout (N=636) are analyzed in this brief.

Introduction and Background

Burnout is higher among physicians than among other professionals, plaguing some physicians from the residency phase of their careers (Shanafelt et al. 2002; Eckleberry-Hunt et al. 2009). Physician burnout is an occupational hazard, a syndrome that includes depersonalization (diminished capacity to relate to patients, family, and friends), emotional exhaustion, and a reduced sense of accomplishment (Shanafelt, et al. 2002; Spickard et al., 2002). Stress and burnout are a challenge for maintaining an optimally healthy and effective physician workforce, particularly if the combination of patient needs and insufficient physician supply push some practitioners past reasonable practice limits.

Research on the profession links satisfaction and physician autonomy (Schneider 1998; Konrad et al, 1999; Landon, Reschovsky and Blumenthal, 2003). Career *satisfaction* reflects both the enjoyment and sense of accomplishment physicians experience in their daily practice of medicine and a holistic perspective on an entire career in a medical specialty. Professional *autonomy* reflects the capacity for physicians to practice medicine as they prefer (Warren, Weitz and Kulis 1998; Mello et al. 2004), consistent with medical training and professional ethics, free from third party interference. While individual characteristics certainly matter, contextual circumstances also influence physicians' sense of satisfaction and autonomy, and ultimately, levels of stress they may experience in their medical practices. When stress leads to burnout, it creates problems for individual physicians and for the physician workforce more generally. Burnout may contribute to lower quality patient care (Freeborn 2001) and, more broadly, the size of the physician workforce, since stress may push physicians to leave the profession (Steiger 2006).

The evolving delivery of modern health care has challenged physician autonomy as third party actors (such as insurance companies and government agencies) have increased power to intervene in medical decision-making (Light and Levine 1988; Williams et al. 2002). Without a doubt, such changes in power sharing are a stressor for at least some physicians. Medical practice management and workload particulars also shape physician morale and satisfaction (Huby et al. 2002; Jensen et al. 2008) and the sense of fulfillment physicians derive from their work. Physicians who resent third party incursion into their medical practice are at high risk of burnout. Similarly, physicians experiencing greater satisfaction from their medical careers likely have lower levels of stress compared to dissatisfied physicians, who may be at risk for higher levels of stress and burnout. Therefore, a clearer understanding of the relationships among autonomy, satisfaction and burnout is important.

Data and Methods

A validated single measure of burnout (Rohland, Kruse and Rohrer, 2004) on the 2007/08 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*. Nearly 25 percent of Mississippi physicians who responded to the 2007/08 MSMD survey reported occasional or persistent burnout, with an additional 55 percent saying that they experienced stress and lack of energy.

We analyzed the association between burnout responses from the actively practicing physicians (N=633) who responded to that section of the 2007/08 MSMD survey alongside items measuring different aspects of physicians' career satisfaction and professional autonomy. The first set of items measured agreement with statements used to assess physicians' perceptions of professional autonomy:

- Outside reviewers rarely question my professional judgment.
- Formularies or prescription limits restrict the quality of care I can provide.
- I can keep patients in the hospital as long as is medically necessary.
- In my practice, it often feels like bureaucrats are second-guessing me.
- Clinical guidelines restrict my freedom to practice.

The second set of statements measured agreement with items designed to ascertain the level of career satisfaction Mississippi physicians experienced:

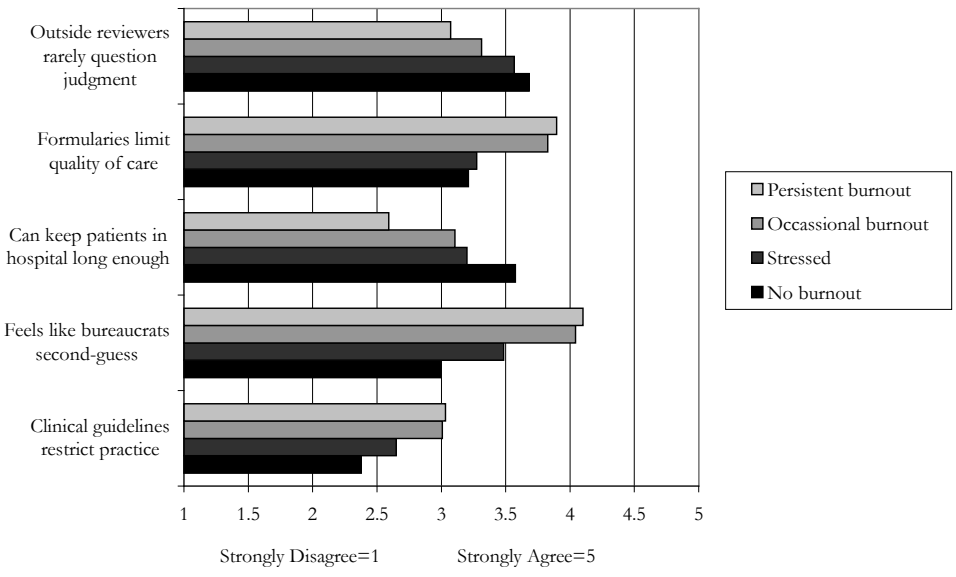
- In general, practice in my specialty has met my expectations.
- I find my present clinical work personally rewarding.
- If I were to choose again, I would not become a physician.
- I would recommend medicine to others as a career.
- All things considered, I am satisfied with my career as a physician.

The association between burnout level, professional autonomy and career satisfaction are depicted in Figure 1 and Figure 2, respectively. Higher average scores on the autonomy and satisfaction items indicate higher levels of agreement with statements (5=strongly agree to 1=strongly disagree).[1]

FINDINGS

Professional autonomy. Third party actors who participate in medical decision-making represent the main challenge to physicians' professional autonomy and physicians' perceptions of them contribute to the levels of stress and burnout Mississippi physicians' experiences. As Figure 1 shows, physicians who reported that outside reviewers rarely questioned their professional judgment and were able to hospitalize patients for as long as medically necessary were less

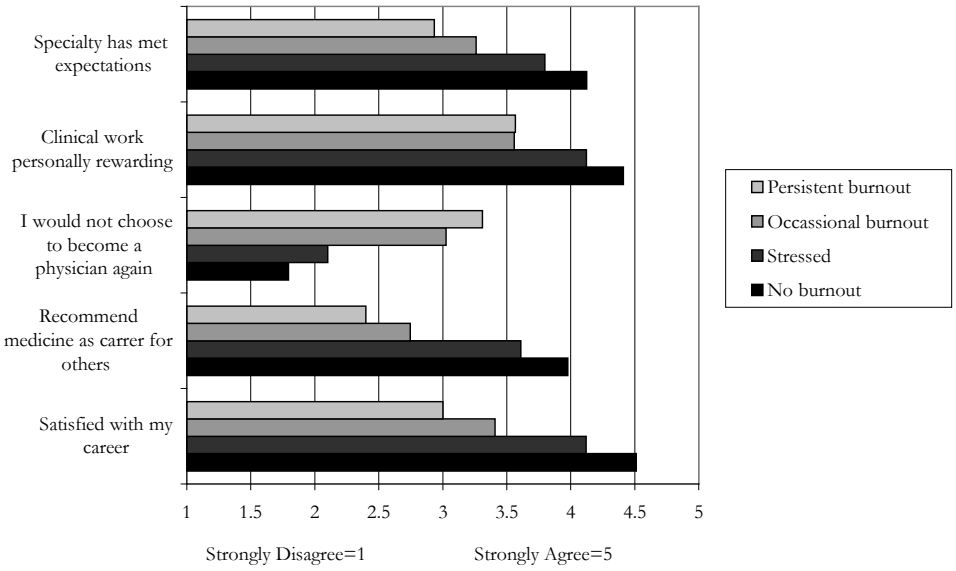
Figure 1. Burnout and Professional Autonomy.



[1] All mean differences presented in Figures 1 & 2 are statistically significant (alpha < .05).

likely to be burned out (*no burnout)* compared to physicians who reported more interference in their medical judgment (*stressed, occasional burnout* or *persistent burnout*). In a similar vein, physicians who found formularies and clinical guidelines as unduly restrictive had higher levels of stress and burnout. Compared to physicians who were neutral or unbothered by formularies and clinical guidelines, but especially among physicians who felt second-guessed by bureaucrats, levels of burnout were particularly high (*occasional burnout* and *persistent burnout*).

Figure 2. Burnout and Professional Satisfaction.



Career satisfaction. Not surprisingly, when presented with hypothetical statements about career satisfaction, physicians with the highest levels of burnout (*occasional* or *persistent burnout*) were the least likely to say they would choose medicine as a career if they had it to do over again, or to recommend a career in medicine to others. While physicians with lower levels of burnout (*stressed* or *no burnout*) found their clinical practices more personally rewarding, even physicians who were quite burned out (*occasional burnout* or *persistent burnout*) perceived that the clinical aspect of their careers was fulfilling to them. We also assessed the relationship between burnout and two holistic indicators of satisfaction (specialty lived up to expectations, satisfied with career). Compared to physicians who were burned out (*occasional burnout* or *persistent burnout*), physicians who were not (*no burnout* or *stressed)* were more likely to report that their specialty had lived up to their expectations, and were even more likely to say their careers were satisfying.

IMPLICATIONS

With burnout starting as early as the start of a physicians' career, it is important to understand its correlates. Clearly, higher levels of both professional autonomy and career satisfaction are associated with less burnout among Mississippi's physicians. Consequently, dampening risks for burnout among Mississippi physicians may depend, in part, on devising strategies to enhance career satisfaction and perceptions of professional autonomy. It is no surprise that physicians trained to make health-enhancing medical decisions sometimes feel that their power to do so is compromised via formularies, insurance regulations, and programmatic cost-cutting measures. Third party relationships and bureaucratic red tape that are unduly onerous undermine professional autonomy, which in turn is associated with higher burnout levels. Expecting that the medical profession will ever return to levels of professional dominance they enjoyed for much of the 20th century is not reasonable. However, there is undoubtedly more room for more collaborative third-party/physician consultation and negotiation over medical care decision-making, and untapped capacities to reduce the burden of paperwork and bureaucracy in modern medical practices. Small improvements in those areas could amplify physicians' perceptions of autonomy and career satisfaction, and by extension, burnout experiences. Of course, best practices and formularies may come to be regarded as valued components of medical practice, rather than third party intrusion into professional autonomy. That depends on physicians seeing them as more than just another round of cost-cutting measures or bureaucratic mandates imposed by policy makers and insurance carriers. Evidence-based clinical guidelines, when there is enough flexibility for departure from them when physicians regard it as medically necessary, honors physician training and their individual capacity to appropriately enact their professional roles.

While career satisfaction correlates with burnout, only additional research can determine the direction of that relationship. More satisfied physicians report lower level of burnout; those who report higher levels of burnout are

less satisfied. What we cannot determine from the 2007/08 MSMD data is whether low satisfaction causes burnout, or burnout causes low career satisfaction. In fact, the combined effects of professional autonomy, career satisfaction, and presence or absence of burnout expresses the complexities of physicians' experiences in modern medical practice. In all likelihood, the effects of each on the others are circular and reinforcing. Understanding the specific experiences (processes, relationships, and outcomes) within medical practice that influence both professional autonomy and career satisfaction are important next steps in understanding risks for burnout and potential interventions more completely. Additional research on the factors that contribute to resiliency to burnout could also contribute evidence for practice innovations, adding to the repertoire of tools physicians have to build satisfying careers.

REFERENCES

Eckleberry-Hunt J, Lick D, Boura J, Hunt R, Balasubramaniam M, Mulhem E, et al. 2009. An Exploratory Study of Resident Burnout and Wellness. *Academic Medicine, 84*(2), 269-277.

Freeborn D. Satisfaction, commitment, and psychological well-being among HMO physicians. *West J Med.* 2001 January; 174(1):13–18.

Huby G, Gerry M, McKinstry B, Porter M, Shaw J, Wrate R. Morale among general practitioners: qualitative study exploring relations between partnership arrangements, personal style, and workload. *BMJ* 2002; 325(7356):140.

Jensen PM, Trollope-Kumar K, Waters H, Everson J. Building physician resilience. *Can Fam Physician* 2008; 54:722-729.

Konrad TR, Williams ES, Linzer M, et al. Measuring physician job satisfaction in a changing workplace and a challenging environment. *Med Care* 1999; 27:1174-82.

Landon BE, Reschovsky J, Blumenthal D. Changes in career satisfaction among primary care and specialist physicians, 1997-2001. *JAMA* 2003; 2389:442-9.

Light D, Levine S. The changing character of the medical profession: a theoretical overview. *Milbank Q* 1988; 66(Suppl 2):10-32.

Mello MM., Studdert DM, DesRoches CM, et al. Caring for patients in a malpractice crisis: physician satisfaction and quality of care. *Health Affairs* 2004; 23(4):42-53.

Rohland, BM, Kruse GR, Rohrer, JE. Validation of a single-item measure of burnout against the Maslach Burnout Inventory among physicians. *Stress and Health* 2004; 20(2):75-79.

Schneider CE. *The Practice of Autonomy: Patients, Doctors, and Medical Decisions.* New York NY: Oxford University Press 1998.

Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med.* 2002; 136:358-367.

Spickard A, Gabbe SG, Christensen JF. Mid-career burnout in generalist and specialist physicians. *JAMA* 2002; 288:1447-1450.

Steiger B. Doctors Say Morale is Hurting. *The Physician Executive 2006;* 32(6).

Warren MG, Weitz R, Kulis S. Physician satisfaction in a changing health care environment: the impact of challenges to professional autonomy, authority, and dominance. *J Health Soc Behav* 1998; 39(4):356-367.

Williams ES, Konrad TR, Linzer M, McMurray J, Pathman DE, Gerrity M, et al. Physician, practice, and patient characteristics related to primary care physician physical and mental health: results from the Physician Worklife Study. *Health Serv Res* 2002; 37(1):121-43.

ABOUT THE AUTHORS

***Debra Street**, an Associate Professor of Sociology at the State University of New York at Buffalo, is an alumna of the Robert Wood Johnson Scholars in Health Policy Research Program and a member of the National Academy of Social Insurance.*

***Jeralynn S. Cossman**, Clinton Wallace Dean's Eminent Scholar and Associate Professor of Sociology at Mississippi State University, is the Director of the Mississippi Center for Health Workforce.*

The North East Mississippi Area Health Education Center (NE MS AHEC, www.nemsahec.msstate.edu) is hosted by the Social Science Research Center at Mississippi State University and is an affiliate of the Mississippi Area Health Education Center Program (MS AHEC) at the University of Mississippi Medical Center. The MS AHEC Program is partially funded by a grant from the Health Resources and Services Administration (HRSA). The Mississippi State Medical Association, the Mississippi Academy of Family Physicians, the American Academy of Family Physicians, and the Social Science Research Center at Mississippi State University provided resources for the Mississippi Workforce Study (2007/08 MSMD). The material in this brief reflects the authors' perspective, but not necessarily those of affiliated organizations and funding organizations.