



PHYSICIAN BURNOUT: Missing the Connection?

An Interview with Dr. Abraham Verghese

Abraham Verghese, M.D., MACP, is professor and Linda R. Meier and Joan F. Lane Provostial Professor, and vice chair for the theory and practice of medicine at the School of Medicine at Stanford University. He is also a critically acclaimed, bestselling author and a physician with an international reputation for his focus on healing in an era where technology often overwhelms the human side of medicine. In February 2014, he received a Heinz Award from Teresa Heinz and the Heinz Family Foundation. In September 2016, he received a National Humanities Medal from President Barack Obama. *Group Practice Journal* interviewed Dr. Verghese in anticipation of his presentation about physician burnout at a general session at the AMGA 2018 Annual Conference in Phoenix, Arizona.

GPJ: Why has burnout become such a huge problem among healthcare professionals?

Verghese: The incidence of depression in primary care doctors we are told is as much as 50%. That tells you this is not an individual problem but a systemic issue. I also think that physicians are speaking out in record numbers about their burnout and their disillusionment with the profession. It would be very hard for an administrator or an employer to ignore that kind of statistic while trying to improve patient satisfaction and other standard metrics. I would venture that physician and nursing satisfaction directly correlates with patient satisfaction.

GPJ: What are the chief causes of physician burnout?

Verghese: The proximate cause is the electronic medical record. The EMR has resulted in our spending twice as much time cumulatively with the machine than with patients, not to mention another hour or two at home dealing with the inbox. That, along with a sense of being pressured by increased volume and complexity and less time, have resulted in an attrition in the meaning of work. Mind you, medicine has always had stresses, but people can

do a lot when they think their work matters, when they feel they are connecting with people they serve. We are doing a great job of connecting with computers. Most of the additional tasks we face come with added keystrokes: the more regulatory things added, gradually, incrementally are not noticed at first until they become overwhelming. For young physicians, particularly for women, there is the additional pressure of trying to be a good mother, to not lose momentum because of having children.

In his writing and his work, Abraham Verghese, M.D., MACP, emphasizes the importance of bedside medicine and physical examination in an era of advanced medical technology.



GPJ: *In your book, **The Tennis Partner: A Doctor's Story of Friendship and Loss**, you examine addiction and the suicide of your friend, David Smith, as well as your own emotional struggles. Why do you think depression, isolation, and addiction are so prevalent in health care?*

Verghese: The kinds of people who go into medicine can be quite driven, competitive, not used to failure. We also can very easily feel complacent with our knowledge about drugs and have the sense that we can control them even if others cannot, that knowledge protects us.

I also think that physicians do a poor job, at least historically, in being in touch with their feelings,

much less talking about them. Part of that may come from the trick we do of disconnecting the emotional content of what we're seeing from its medical content. In a trauma situation it is most important to be thinking about

airway, breathing, circulation, and not about the patient's social connections or family situation. This trick of ours can make us very poor at recognizing when we ourselves are ill: instead, we often focus on symptoms and begin to treat or self-medicate. We would in a patient be more inclined to pursue the root cause, to inquire about other stressors. In short, physicians tend to deny their patienthood.

It's interesting that when I reviewed many narratives of physician addiction, very often they took a drug in the setting of pain only to find that the drug did much more than alleviate pain, it also took away the dysphoria of their existence. Physicians rarely take drugs

to produce euphoria, but more often it is to relieve the dysphoria that they may not even know they were carrying.

GPJ: *How can we help physicians address these challenges and achieve a balance in their lives?*

Verghese: I think administrators need to wake up and recognize the damage being caused by the current, most prevalent electronic medical record systems, which are designed for billing and that pay no attention to the physician or nurse user. The present dominant EMR is truly a mistake of epic proportions. I don't quite understand why in this day and age of seamless banking, personal cell phone devices that can do almost anything, that the physician remains the highest paid clerical worker in the hospital.

GPJ: *What are the key elements to prevent burnout among physicians?*

Verghese: We've alluded to some of them above. An administration that is very focused on physician welfare and willing to inquire and administer burnout questionnaires is key. We should also be committed to solutions even if they require painful fixes. For example, hiring scribes or using Google Glass may not be the most efficient way to relieve the burden, but in the short run, it might salvage the careers of physicians who might otherwise leave. All the various programs and tricks we use to help physicians cope better are important but they can only follow system changes that address the fundamental issues.

GPJ: *How do you think healthcare organizations should address this problem? Are there examples you see that should be emulated?*

Verghese: Stanford has taken this issue very seriously with a major

commitment from the Dean of the School of Medicine and the hospital to hire a full-time expert physician to direct a physician wellness program. The program has a research wing as well as an educational wing. Being proactive in addressing physician burnout is the key because very often the first indicator of burnout is when it's already too late. There are innovative programs at several other institutions that focus on resilience, increasing the sense of community and collegiality with our fellow workers by the hospital paying for periodic dinners with four or five colleagues.

GPJ: *You'll be a keynote speaker at AMGA's Annual Conference in March. What strategies and insights do you hope healthcare leaders in the room will take away from your presentation?*

Verghese: I hope I can leave the healthcare leaders in the room with a renewed appreciation for the magnitude of a problem that they know about. In summarizing the literature and also sharing some of my personal experiences as recounted in *The Tennis Partner*, I hope they will be inspired to seek innovative solutions of their own as well as incorporate existing models. [GPJ](#)

To hear more from Dr. Verghese, make plans to attend the AMGA 2018 Annual Conference, March 7-10 in Phoenix, Arizona. The event will feature galvanizing general sessions as well as real-world case studies and insights in nearly 40 peer-to-peer breakout sessions, led by AMGA member groups. In addition, the program features 15 hours of free-flowing and structured networking and immersion workshops with leading experts. Register today at amga.org/ac18.

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