DISCUSSION

FRAMEWORK TO GAUGE PHYSICIAN BURNOUT

By Daniel K. Zismer, PhD

ABSTRACT: Physician burnout is receiving increasing attention within the profession. The incidence and prevalence appear to be increasing within and across clinical specialties and types of practices. An underlying framework remains largely unattended and unexplained, leaving physician leaders lacking a sound theoretical framework from which they may observe, examine, analyze and approach the problem.

PHYSICIAN BURNOUT IS NOT ONLY THE TOPIC of much discussion regarding symptomatology and etiology, but it generates multiple theories regarding syndrome management.[1] Many, if not most, therapeutic tips can be useful. However, even successful attempts at mitigating the effects of the symptoms can leave the underlying etiological framework unexplained.

This article intends to provide a well-researched and -documented social psychological framework for what is often labeled as "burnout" within the medical professions — a theoretical framework that can have practical relevance for the both the "patient" and attending professionals, including physician leaders charged with managing the effects of burnout within the physician workforce in an organization.

First, framing the problem: Dictionary definitions of "burnout" provide for applications to both the physical sciences and the psychology of the human condition. For the physical sciences, "burnout" can be defined as the reduction of a fuel or substance to nothing through use or combustion. For the psychology of the human condition, burnout can be defined as "a physical or mental collapse by overwork or stress." With both conditions, the endpoint is beset by finality. The point to be made is under both sets of conditions, the outcome can be relatively the same if left uninterrupted.

But a coherent and tested theoretical framework can be applied to give physician leaders a foundation from which the problem of burnout can be understood and addressed within organizations.

ROTTER'S SOCIAL LEARNING THEORY

Rotter's social learning theory, developed by American psychologist Julian B. Rotter (1916-2014), is predicated on the assumption that an individual's personality does not exist independent of that individual's environment. The principle on which his theory is constructed is the empirical law of effect, which holds that people are motivated to see positive stimulation. Behavior is a function of a person's expectation for a reward. A person's behavior and personality are shaped by that person's experiences and interactions with their social environment.

Rotter postulated that behavior (and potential behavior) is a function of an individual's expectation for a reward that is valued *(see Figure 1),* with interest, reward value and expectations, operating separately and together to affect behavior. With this model, "attitude" is considered to be a behavior. Rotter goes deeper to describe the "expectations variables" as being related to one's sense of personal control over life in general (an individual's general locus of control orientation) and/or one's specific locus of control orientation (an individual's situationally specific locus of control orientation; the practice of a profession, for example).

An individual's general and specific locus of control can operate independently and together as an individual interacts with the environment presented, including one's work environment. Those who are more internally oriented generally feel they can and need to exert more control over their environment. Those more externally oriented feel less personal control over their environment. Extremes on the "scale" can be problematic.

Reward structures and incentives are important within the model as well. Simply stated, as long as an individual's perceptions of rewards acquired for efforts expended are equal to or greater than a minimal expectation, individuals feel they are ahead. Falling below the expected minimum reward value creates dissonance and worse. A negative reward imbalance occurs when individuals believe external and intrinsic rewards gained are insufficient when stacked up against all efforts required to attain them.

FIGURE 1: ROTTER'S THEORY EXPLAINED

$$B = f(Ex + Rv + \psi)$$

ψ = Situational state, including intervening environmental factors—real or perceived.

Rv = Reward value. Behavior is affected by perceived value of the reward available. Value affects an individual's likelihood to engage in the behaviors required to attain the reward.

Ex = Expectancy for a reward (tangible or intangible). Expectancy can be affected by an individual's locus of control (specific or general); an individual's expectation for their ability to exert personal control over an outcome.

Description: Julian Rotter's social learning theory defines the causality of behavior (including related attitudes and emotions) as a function of individual expectancy for a valued reward, plus situational factors and circumstances operating within the related environment. Change to one or all factors can affect behavior or behavior potential of an individual.

Example: An individual might ascribe value to receiving a promotion on the job, but expectancy for it is low and the company might be at risk for sale. So, the individual's expectancy for that valued promotion is sufficiently low, predicting that efforts to go "above and beyond" to achieve the desired reward is unlikely.

The last variable of importance in the model is the unforeseen or uncontrollable external factors in the environmental mix — the uncontrollable disruptive events, often described in clinical psychology as "situational disorder." These are the external events that occur as a result of the nature of health care delivery in the United States interacting with the nature of the human condition — for example, the unforeseen changes in health policy and economics; the vicissitudes of political environments, mergers and acquisitions; and changes in the financial fortunes of organizations that employ physicians and other professionals.

In Rotter's social learning theory, behaviors (including attitude) are a function of an individual's expectation for a reward that is valued, plus any environmental dynamics that may interact with the individual in their environment. One or all relevant factors might influence behavior over time. Pernicious imbalances of the relevant factors are proposed here as a legitimate explanatory framework for what is described as "physician burnout."

APPLYING THE MODEL TO PHYSICIAN BURNOUT

Before discussing application of the model to physician burnout, consider this:

A five-physician internal medicine group is acquired by a community health system. Concern for the future of small, independent practices drove the decision. The going-in expectation was the trading of some autonomy (personal control) for future financial security. Some of the concerns related to "selling out to the hospital" were allayed by the promise from health system leadership that, "Nothing has to change. You keep practicing medicine as you have, and we will take care of everything else." Six months following the closing of the practice purchase, the guaranteed compensation payments convert to a risk-based, work-relative value production model. Three months after that, the groups are presented with the need to change referral patterns from specialists they have used and trusted for years to specialists employed by the health system.

Shortly thereafter, the conversion to the new electronic health record and office staff cuts are implemented to reduce practice operating expenses and a new patient experience evaluation system is implemented. The results of the first round of responses demonstrate some negative results for the practice. The physicians dispute the interpretation of the results. Physicians are becoming disquieted by their decision and know that noncompete agreements restrict their personal and professional freedoms of opportunities unless they want to disrupt their personal lives and those of their families to leave their communities. Attitudes of many of the physicians turn negative. A general malaise overtakes the group. Patients ask staff members, "Why doesn't my doctor like working here anymore?" There is little energy for sitting down to talk about the group and its future, and the principal focus of two of the "partners" has become generating as many wRVUs (financial reward value) as possible until they can leave without violating their noncompetes.

How would the application of Rotter's theory create a framework for a diagnosis of the social psychological state of the group?

The physicians here were expecting that by selling their practice they could escape an unfriendly environment (a changing health care marketplace); that the sale to the health system would insulate them from current and future financial risk. In return, all they needed to do was practice medicine as before and somehow the economics would work out for the acquirer, although the specific and necessary questions about this never were addressed directly by the acquired or the acquirer. Limitations on professional freedoms began to mount and the realities of the contractual obligations attendant to the sale of the practice became evident to the physicians. Personal control over trusted, reliable and comfortable professional referral relationships was disrupted. The realities of the evolving compensation design (the physicians' most tangible reward system) began to be perceived as lacking the security (the reward value) they believed they were promised.

Physicians suffer from progressive "burnout" from perceived loss of personal and professional freedoms interacting with a perceived insufficiency of tangible and intrinsic rewards coupled with expectations of future diminishing control over their professional practice, professional relationships and work environment.

WHAT PHYSICIAN LEADERS CAN DO

In the above vignette, let's presume we can restart the transaction, including the involvement of the physician leader within the health system that acquired the practice.

The goals of this process are defined within the framework of our Rotter's model:

- Establish the expectations for personal and system control within the relationship.
- Demonstrate how those who join matter (and "belong") in the context of the whole and its mission and plan.
- Explain how physicians will have a voice in the framework of the whole to exercise on behalf of colleagues and self.
- Define how changes in the system will involve affiliated physicians in organizational change.

Setting the expectations of "joining the system" from the beginning, what could have been done by a physician leader within the acquiring health system?

- The mission, vision, value and strategy of the health system are made clear.
- The collective "belief system" of the health system's plan to succeed is made clear. Clarity of belief systems is rare in health systems, yet they are essential to their success. The collective beliefs of leaders direct and guide those behaviors that are the health system in action.[2]
- The purpose, role and goals of the physician group within the health system are made clear. That is, its reason to exist within the context of the whole of the integrated health system.
- The longer-term strategic plan for the physician network is made clear, including each subsequent group addition to the network. Each physician and group know how they "matter" to the team and the game plan.
- Descriptions of expectations of behavior as a member of the team are made clear. That includes how being a member of the team differs from being in "private practice."
- The benefits of being a member of the team are made clear from the perspective of the physician leader (the reward system available to participating physicians).
- Expectations of professional freedoms and exercisable personal controls over patient care and physicians' control over their professional practice are made clear.
- Physicians' abilities and obligations to participate in decision-making at the practice and network level are made clear.
- How the network "keeps score" is presented, as are the practice performance "scorecards" used.
- How the opportunity presented differs from private practice because to join means change is required, and change does present challenges; more for some, less for others.
- The expected attributes of the operating culture of the network.[3]

The process required to do a sufficient job with the bullet-points above is essential, but it's not time-consuming. It should be done physician to physician with a nonphysician leader present, so all are aware of what is being said and what it means.

APPLICATION OF ROTTER'S THEORY

The approach above prevents problems experienced by practices joining the health system by way of acquisition. There's more — physician burnout within established physician communities.

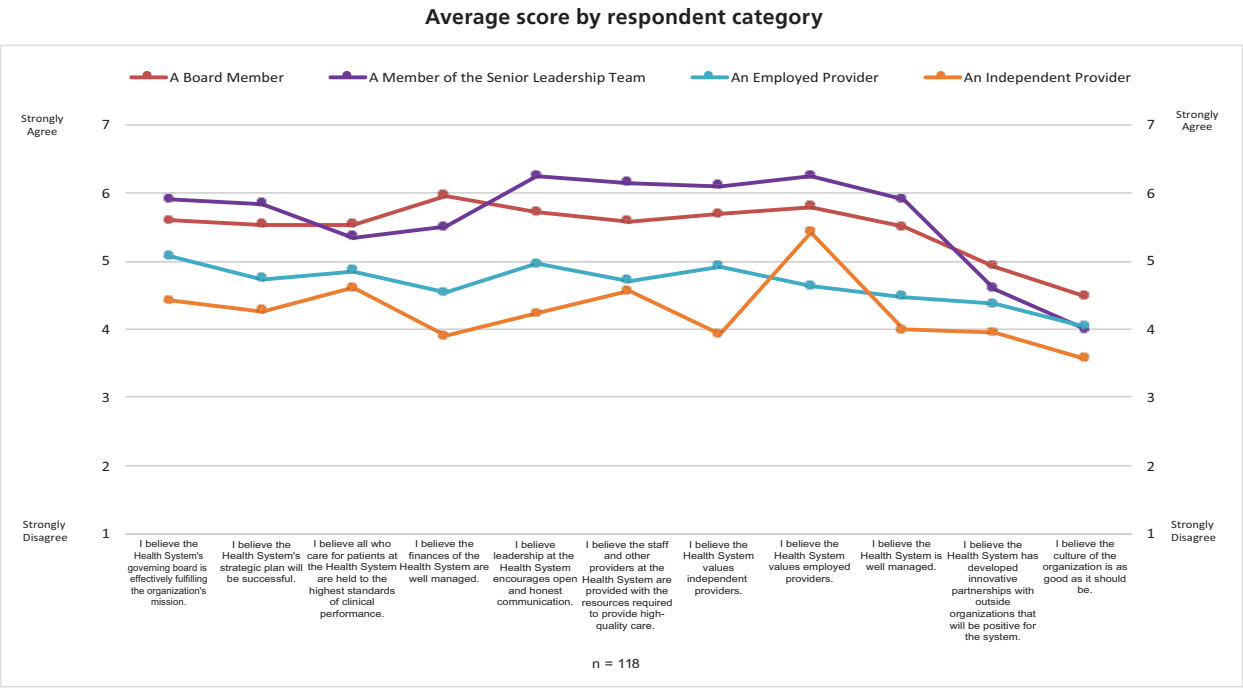
Given the growth curve of the physician organizations within health systems, physician leaders will not be available to attend to individual physicians at-risk for burnout. As such, they may wish to consider a "public health" approach to addressing the problem.

Rotter's social learning theory provides the "blueprint" for this approach. Rotter's social learning theory would direct physician leaders to:

- "Vaccinate" as many people as possible with education — especially, other existing and emerging physician leaders. This validates reality within the organization, removes any stigma attached and ensures the pathway to care for those afflicted and those responsible for the environment and culture of the organization.
- Assess and evaluate the physician environment and climate. Physicians will tell leaders how they feel about the organization, their place in it and stressors they face *(see Figure 2)*. Physician leaders should be attentive to physicians employed by the organization as well as independents. An initial focus of this work is physicians' perspectives on the culture of the organization.
- Communicate frequently and liberally regarding where the physician organization "is" within the whole of the health system (its goals, objectives, forward progress, achievements and plans). Leaders can import and enhance the sense of "control" with clarity regarding where the organization is on its mission path and where physicians and their contributions fit.
- Include physicians in the discussion about how the organization is performing, including its contributions to the totality of the vision and mission of the organization, as well as quality of care, the patient

FIGURE 2: STAKEHOLDER ALIGNMENT SURVEY

This is a composite profile of "beliefs alignment" of key stakeholders of two community health systems. "Stakeholders" are defined as members of the governing board, the senior leadership team, select formal and informal leaders of the employed physician group and select formal and informal leaders of independent members of the hospital medical staff. It tests stakeholder alignment on a grouping of 10 beliefs relating to the performance of the organization. This grouping of 10 is a strong predictor of respondents' perspectives on whether the culture of the organization is as good as it should be.



Source: Castling Partners

experience and growth and development of the organization, financial performance and future investments. With this approach, there is a higher likelihood of physicians appreciating the intrinsic rewards derived from being part of the team.

Physician leaders need to remain ahead of the dynamics and potential "situational disorders" that can shock the culture of organizations. No reasonable individual physician can expect an environment free of organizational stressors. They can expect that leaders effectively represent their interests when they occur, and bring them into the conversation when it is time for problem-solving.

Figure 2 is a composite profile of "beliefs alignment" of key stakeholders of two community health systems. Stakeholders are defined as members of the governing board, the senior leadership team, select formal and informal leaders of the employed physician group and select formal and informal leaders of independent members of the hospital medical staff. A "stakeholder alignment survey" is constructed to test stakeholder alignment on a grouping of 10 beliefs related to the performance of the organization. This grouping is a strong predictor of respondents' perspectives on the 11th response item: "The culture of the organization is as good as it should be."

When the statistical power of the model, as a predictor of the state of the culture of the organization, is isolated to physician respondents only, it increases (adjusted R-squared equals 0.84 for physician respondents only; an adjusted R-squared equals 0.76 for all respondents). The construct of the alignment survey, as presented in the figure, is based largely on Rotter's social learning theory as the basis for the design of the items applied.

CONCLUSION

While Rotter didn't develop his social learning theory to address physician burnout specifically, his framework does provide physician leaders a basis for an explanation of etiology, as well as a blueprint for addressing the problem on an organizational scale. Physician leaders hold accountability to address the risk in their organizations at the levels of prevention, evaluation and pathways to intervention.

Daniel K. Zismer, PhD, is managing director and co-founder of Minnesota-based Castling Partners, which works with health care leaders on strategy. He holds the same roles with Minnesota's Keystone Culture Group, which helps organizations develop high-performance cultures.
daniel.zismer@castlingpartners.com

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