Frontline dispatches from the burnout battle

Karen Titus

June 2018—Bryan Bohman, MD, doesn't spend his days wandering the Bay Area handing out buttons that read "Lift people, not the bottom line." But don't rule this out as a possibility someday, either.

Dr. Bohman, chief medical officer, University Healthcare Alliance, and clinical professor of anesthesiology and perioperative and pain medicine, Stanford Health Care, is campaigning against physician burnout. Yes, it threatens the quality of medical care, he says, and yes, it's expensive. But he and others with an interest in the topic are learning, from experience as well as from emerging research, that the most important bottom line rests with physicians themselves. Like modern-day apostles, they are beginning to spread the word, even if not everyone wants to hear it: Physician well-being matters.

While the concepts of mental health days and self-care have wiggled their way into popular culture, campuses, and even some businesses, medicine is playing catch-up, says Luke Perkocha, MD, MBA, a pathologist with The Permanente Medical Group, Northern California. "People don't understand what burnout is," says Dr. Perkocha, who is also a member of the group's physician health and wellness committee. It's not caused by long hours or hard work. "It's a kind of cynicism and lethargy that occurs when people become disillusioned with what they're doing. They feel like they're not accomplishing anything, that they're ineffective as physicians, or that they work in an environment that is unsupportive or incongruent with their values."

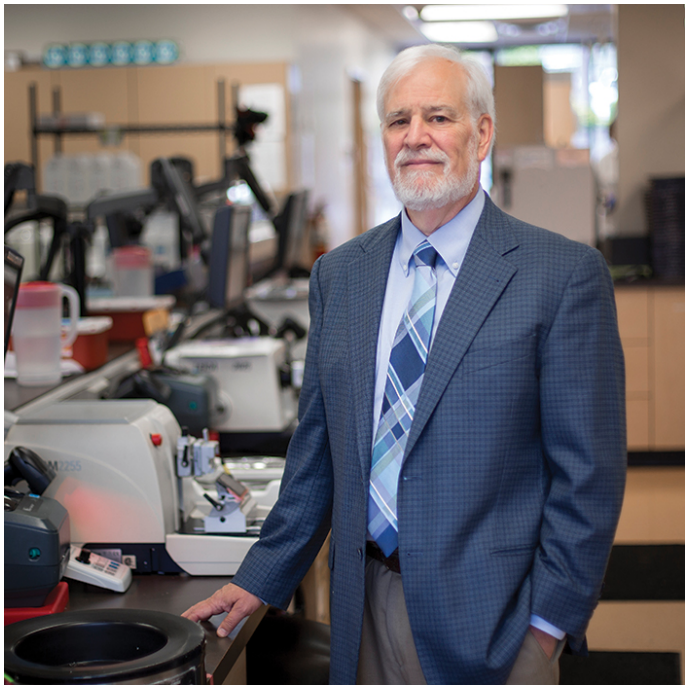
Even when they do know the definition, physicians often react by practicing the art of cognitive dissonance. That's certainly true for pathologists, says Jim Hernandez, MD, MS, associate professor of laboratory medicine and pathology, Mayo Clinic (in Arizona) School of Medicine and Science. A frequent speaker on this topic, he sees interest from quite a few colleagues as he travels throughout the country. But, he says, "I don't think a lot of pathologists are aware of how difficult this is for the profession, and the high prevalence."

As Dr. Perkocha puts it, "There's that wonderful, all-purpose defense mechanism of denial."

Numbers tell the tale

Medicine has never been for the faint of heart. Stress becomes normalized in medical school, when physicians become experts in—among other things—denial and delayed gratification. So when faced with symptoms of burnout in practice, the natural response might be to summon up one's inner Patton and say, *Toughen up! If I just hold on a little bit longer, there's light at the end of the tunnel.*

Perhaps that used to be the case. "Obviously we train for many years and are willing to work hard," says Dr. Bohman. "But what's been asked of us in the past decade is superhuman effort."



Dr. David Hoak of Incyte Diagnostics is leading the effort in his practice to address burnout, and says he's grateful to his group for participating. "Just the fact that we're thinking about it and talking about it provides some help," he says. [Photo: Hannah Max]

Ten years ago, as chief of the medical staff at Stanford Hospital, he witnessed a rise in physician distress, due in part to the piling on of quality and productivity metrics, patient satisfaction surveys, and regulatory requirements. Stanford was also setting up its electronic health record, he recalls. Taken together, he says, "You realize, that's a lot of additional 'asks' of folks—without additional support."

In other fields, human resources might be expected to step in with help. Not so in medicine, he says, "partly because physicians never acted like they wanted that sort of thing." And while employee satisfaction surveys were done annually, there was no equivalent survey of physicians.

Though Stanford boasts a strong program for helping physicians with substance abuse and behavior problems, Dr. Bohman characterizes it as too little, too late. "It occurred to me that we should be paying more attention to the physicians who are struggling under some of these burdens, to keep them from going down the road of burning out or potentially exhibiting negative behaviors."

Stanford took the usual next steps—forming a task force, creating a wellness committee—but unlike a legislative committee, where bills are sent to die (as the old joke goes), Dr. Bohman says he and like-minded colleagues wanted answers that would lead to action. "We started finding out what was going on in our organization."

A lot, as it turned out. It wasn't a pretty picture. And Stanford wasn't alone.

In 2013 the committee conducted its first physician wellness survey, breaking away from traditional questionnaires that focused on the health system and patient referrals. The data turned out to be eye-opening. The burnout rate among physicians was 24 percent. Around the same time, a leading figure in physician burnout research, Tait Shanafelt, MD, then with Mayo Clinic's Division of Hematology, found in a national survey that 54.4 percent of physicians reported at least one symptom of burnout, and that rates were rising. A similar survey done three years earlier showed 45.5 percent of physicians reported at least one symptom of burnout. And satisfaction with work-life balance had dropped, from 48.5 percent to 40.9 percent.

Nor were Stanford physicians getting better. A follow-up survey in 2016 showed the burnout rate rose to 39 percent, while the personal fulfillment rate dropped from 24 percent to 14 percent.

Pathologists have their own numbers to cogitate. A Medscape survey from 2015 puts the specialty on fairly happy ground compared with other specialties. In the category of physicians who are burned out, depressed, or both, pathologists (along with rheumatologists) weighed in at 42 percent.

Is that good? Out of 29 specialties, neurology "led" the pack at 55 percent, followed by critical care at 54 percent. Burnout rates were lowest in plastic surgery, at 32 percent, just ahead of dermatology (34 percent) and orthopedics (36 percent).

When it came to being happiest at work, pathologists ranked third (34 percent) among specialties (behind ophthalmology, 37 percent, and plastic surgery, 35 percent). The unhappiest groups were cardiology and internal medicine, both of which brought up the rear at 21 percent.

Outside of work, pathologists were also fairly happy—48 percent reported out-of-office satisfaction, along with radiologists and critical care physicians. (Allergists and immunologists were the happiest when they left the office, at 61 percent, while cardiologists were the least happy, at 40 percent.)

Does this mean pathologists are fine?

"So we're better compared to other specialties," concedes Dr. Hernandez. "But that's still a lot of pathologists." Just as troubling is the gender gap—45 percent of women pathologists are affected by burnout/depression, versus about 33 percent of men, he notes.

Dr. Hernandez thinks about it this way: As he walks through his lab and talks with his colleagues, he's mindful that even if he can't see it directly, about a third of them are burned out. "And this is a pretty good place to work!" he says.

Worries of their own

In some respects pathologists may seem to have it easier than some of their clinical colleagues (as the Medscape survey might indicate). Pathologists have a built-in stress reliever in how they practice their profession, Dr. Hernandez says. Colleagues show cases to one another, and immediate decision-making is confined primarily to frozen sections and blood banking.

They also don't regularly interact with patients, often a source of stress for many specialties. On the other hand, says Dr. Perkocha, their interpersonal conflicts and satisfaction are determined by fellow physicians. "So the medical group becomes more important, and there are a lot of dysfunctional medical groups out there," he says. "That can be a tremendous amount of frustration and burnout."

The subtle interplay between practice and personality also weighs on pathology. Compared with other specialties, says David Hoak, MD, pathologist and former president, Incyte Diagnostics, Bellevue, Wash., the stress that pathologists experience relates to fear of making a misdiagnosis. "That's always kind of lingering," he says. "I think it affects some pathologists more than others."

"The expectation is we'll always have the right answer," he adds, which can bring more stress. "It may also prevent us from being more open about emotional things. It is hard for us to get up in front of a tumor board and say, 'I don't know what this case is.' That's not a very comfortable place to be."

When clinicians make mistakes, says Dr. Perkocha, they often do so within a gray zone: *Was that heart murmur really there?* But the findings of a slide don't change. "If you miss them today, and someone else finds them tomorrow, or next year, they were always there," says Dr. Perkocha. One could argue that only in retrospect are mistakes made obvious (Pickett's Charge notwithstanding), but while pathologists are sued at lower rates than

many of their clinical colleagues, “mistakes are often more apparent in pathology,” he says.

Dr. Perkocha

Pathologists by definition tend to be inquisitive and conscientious, Mayo’s Dr. Hernandez says. Left unchecked, these attributes hurtle toward perfectionism. Acknowledging and learning from a mistake translates into excellence. The flip side is dysfunction. When fear of making a mistake causes paralyzing indecisiveness, then it’s time to seek help, says Dr. Hernandez, who calls himself a recovering perfectionist. Pathologists might take a hint from baseball’s star closers. “You have to move on,” he says, “and not perseverate about past errors.” There’s also little point, he says, in obsessing about extremely rare disorders in the differential diagnosis.

Dr. Hoak cites another type of anxiety, one he links to pathologists’ place in the health care hierarchy. “We’re always servants to the hospital, and servants to the clinicians, and servants to the patients.” That leads to a quandary when trying to tackle each day’s workload. *Do I start on this new breast biopsy, or do I start on the case that I was working on yesterday?* “I know somebody is going to call me about some case, but I don’t know which one,” he says. If emergency physicians are trying to triage patients, then pathologists are trying to triage cases.

Looking for solutions

Compared with Dr. Shanafelt’s national figures, the Stanford physicians looked relatively cheerful, an organization full of sunny Mary Richardses in a world of Lou Grants. Dr. Bohman feared Stanford leadership would respond in that vein: *Hey, you’re better than average—what are you crying about?* His worries were unfounded. “That wasn’t their response,” he recalls. Instead, they said, ‘That’s not acceptable. We need to do something about it.’”

The task force recommended setting up a Well MD center, which was a five-year commitment from the school of medicine and Stanford’s two hospitals. Dr. Shanafelt was hired to oversee the center, replacing Dr. Bohman, who was serving as interim director. “He’s been here less than a year, but he’s already doing great work,” Dr. Bohman says.

Dr. Bohman

Dr. Bohman cites Stanford’s peer support program as an especially welcome step. If a physician has an unexpected bad outcome—with a patient, for example, or a misdiagnosis—they get a call from a peer who is trained to offer support, not delve into details of the case.

He draws on his own experience to explain how valuable this is, noting that some years ago he was involved in an unexpected patient death in the OR. Compounding matters, the patient happened to have been a local celebrity. “It was in all the news outlets, and it was quite devastating. Your lawyers tell you not to talk to anybody. I could really understand firsthand how important it was to have support, because when it happened to me I felt there was

a real lack."

Withholding support is akin to leaving a wounded soldier on the battlefield, he says. It's damaging not only in the immediate aftermath but also long term. "It's been shown that unexpected bad outcomes affect people profoundly," Dr. Bohman says. "They're likely to have other negative outcomes after that because they're not recovering well."

The seemingly simple step of providing support is also part of a radical shift in attitudes and practice, one that would have physicians do nothing less than "accept their humanity," he says. "You're not trying less. You're accepting that no matter how hard you try, bad things can still happen, and it can be your fault."

"The culture of medicine is so harsh on ourselves," Dr. Bohman explains. "You don't get better if you just beat yourself up after an error." He prefers to frame the issue as one of compassionate self-improvement. Aware that this can sound more Esalen Institute than Stanford—he concedes that some of his colleagues call this approach namby-pamby—he notes that lack of self-compassion is highly predictive of burnout.

On a more low-key level, the center has organized mindfulness courses and medicine-in-literature groups, where members meet over a meal to talk about something they've read that might help them reflect on their profession. They also took a page from Dr. Shanafelt's work at Mayo, subsidizing groups of providers to go out to dinner together, where they select a question from a provided list to launch the conversation. "We call it the Camaraderie Project," Dr. Bohman says.

Getting personal

Sometimes a darker, more personal event prompts physicians to look more closely at burnout.

Some two years ago, a colleague of Dr. Hoak's took his own life. Dr. Hoak, who had worked with the pathologist two weeks earlier, called the event shocking. "I didn't see it coming."

In a subsequent conversation with a pathologist friend outside the group, Dr. Hoak began to understand that this terrible incident wasn't an isolated case, that physician stress, burnout, and suicide appeared to be a growing problem. Dr. Hoak's next step was to read articles on the topic and share them with other members of his pathology group.

And then he started running into roadblocks. Some colleagues, he says, embraced the concepts about stress and resiliency. Others were skeptical. "There was this feeling that talking about burnout was a means for those who were lazy to shirk work."

Dr. Hoak has used surveys to gather and disseminate information on the topic. In a first step, early on, he conducted a mini-survey of his group's leaders. "They expressed a lot of symptoms of burnout," he recalls. "Even so, there was a lot of denial."

That was the response Dr. Bohman expected at Stanford when he first began delving into burnout. At the time, the solution to burnout often took the form of an admonishment: *Just buck up.* "We see a lot less of that now," Dr. Bohman says. There is "a recognition that this is a serious problem, and that it's not just a bunch of privileged individuals crying about their own problems."

As further evidence that the ironman approach to practicing medicine might be slowly melting, he notes that major medical organizations, including the AMA and the National Academy of Medicine, are addressing it. In fact, the scientific plenary at CAP18 in October in Chicago is on burnout, with Drs. Hernandez and Bohman among the speakers.

"The College can't solve everything locally," Dr. Hernandez says. "But simply the fact of College leadership saying, 'Yes, this is a problem, and we want to help pathologists deal with it,' will go a long, long way. It's going to open a

Pandora's box," he predicts.

These outward signs of progress make Dr. Bohman optimistic, "though I'm not sure we've bent the curve yet." Denial, like a special counsel investigation, doesn't flow in just one direction. Physicians can overlook burnout in themselves as well as in their colleagues.

Dr. Hoak takes heart from colleagues he meets, including one pathologist who, after hearing Dr. Hoak speak at a meeting, approached him and said, "I never realized these feelings I was having were related to burnout. As you were giving your talk, I felt my larynx choke up."

But even something that visceral—a physical reaction to words—isn't enough to convince everyone. Attitudes, like any habit, are hard to break, especially when they're reinforced by education, training, and colleagues. It's not uncommon, observers say, to hear physicians suggest that burned-out colleagues are dodging work, not unlike shell-shocked soldiers in World War I who were accused of malingering.

Dr. Hoak says until he started learning about the subject, he didn't recognize the symptoms in his own life. "I started thinking back over my career, and I've probably had multiple episodes of burnout," incidents that he self-treated by cutting back on his workload, changing positions in the company, dropping off committees, and delegating duties, among other things. When asked how burnout manifested itself, he laughs and says, "My wife used to buy me a lot of self-help books, the kind aimed at workaholics. I think I was getting lots of clues from her."

Inside the lab, there are other clues. Dr. Hernandez, who has also lost colleagues to suicide, cites the trio of extreme exhaustion, cynicism, and reduced effectiveness, which often manifest as cynical comments: *What's the use? It's never going to get better.* They may also notice decreased productivity and quality of care, or increased errors, in themselves or colleagues.

Bringing the issue to mind is only a first step, says Permanente's Dr. Perkocha. But the next step—talking about it—can be scary. "That's always been hard in medicine," he says (and in life, he adds). "Because it involves admitting you're not coping well." Noticing signs of distress in a colleague doesn't necessarily smooth the path, either, since there's a natural reluctance to broach difficult subjects with others.

Is it easier, or more difficult, to hear concerns raised by one's colleagues?

Dr. Hoak ponders the question for a bit before admitting he has no definitive answer. "My feeling is that colleagues are kind of closed off from each other," he says.

At Incyte, the problem is compounded by the fact that pathologists are spread across 16 hospitals, four independent labs, and two clinics in three states, he says. "Some people never see each other."

Even when physicians are at the same site, crossing paths isn't a given. "The socialization that used to occur in the doctors' lounge doesn't occur much anymore," says Dr. Perkocha. Many hospitals don't even have lounges.

And when there is regular contact, it can still be hard to raise the issue, Dr. Hernandez acknowledges. How—and even whether—to approach a colleague has as much etiquette as a royal wedding. A person in authority may not be as well suited to approach a pathologist as a colleague who's also a friend. It may be difficult (to say the least) for a technologist to approach a pathologist who seems to be suffering burnout.

A good place to start is with a simple inquiry: *Everything OK? Anything I can do to help? It seems like it might be a challenging time for you right now.*

But there's no need to wait for things to unravel. Dr. Hernandez says he makes it a point to set an optimistic tone as a matter of course. "Not in an intrusive way, but to show I care. We can let people know, in no uncertain terms, that we're supporting them."

Dr. Hernandez

At Mayo's lab, this includes an approach called a just culture. When a mistake occurs, "We ask if two people could make the same error," and if the answer is yes, then it's a system error that requires a different solution. "Most of the time it's a slip or a lapse. It's not an egregious error, so it's up to everyone to anonymize whoever made the error, and then see what we can do to improve it."

In addition to letting his colleagues know he's got their backs, Dr. Hernandez says he regularly lets them know he cares about them personally. "I want them to enjoy coming to work. It's hard enough as it is, and I don't want to add to their stress." There's nothing complicated about this. During Laboratory Week, for example, he made a point of thanking each person in the lab for their work and acknowledging their critical role in patient care. While despair can be infectious, he says, so can optimism.

He cautions that it's not OK to pry, however. "We can't ask if they've gotten help. We can offer support and point to resources. But we can't ask if they've gotten help, or even push them to get help."

Despite the skeptics, Dr. Hoak is persisting. Last fall, during a group retreat, he presented more information about burnout. He also launched two more surveys, both of which showed that his group matched information he had gleaned from articles: About 50 to 60 percent of pathologists and lay executives were affected by symptoms of burnout.

This gave Dr. Hoak the traction he needed to take his next steps, which included setting up a wellness committee, which he chairs—"At least for the next two months," he says, noting that he planned to retire this summer—and attempting to dig deeper with more surveys to figure out how to help group members and leaders. They have also signed on for Mayo's well-being index, which will provide resources as well as enable the committee to regularly survey pathologists to see if changes are leading to improvement.

And in one small gesture, he asked those on the retreat to send him a photo of something that gave them joy or made them feel awe. "For that brief moment, it was kind of like a collective social media thing," he says, recalling the photos of family and nature that flowed in.

"It was a good connection."

Though his group is only in the early stages, Dr. Hoak sees glimmers of hope. "Just the fact that we're thinking about it and talking about it provides some help," he says.

Beyond the personal

Dr. Hoak found very few takers when Incyte's wellness committee offered to hire experts to train pathologists in relaxation and mindfulness techniques. Ditto for planning social events or offering the services of an independent financial advisor. People might feel isolated or stressed about finances, but those weren't the problems they wanted to tackle.

As research has begun to show, personal factors, while important, aren't the major cause of burnout—two-thirds of the drivers are institutional, fueling what some call a burnout environment. You can teach people to prepare healthful meals, but it counts for naught if they can't easily buy fresh food or lack time to cook. Likewise, physicians can learn resiliency through techniques such as mindfulness meditation—a move many encourage—but the looming question remains: resilient to what? As Dr. Bohman puts it, "We can't expect physicians to heal themselves."

Permanente has begun to recognize this, says Dr. Perkocha, and it has developed an "address the pebbles in the shoe" approach to burnout. "That's what gets to you," Dr. Perkocha says. "It's not the walk. It's the pebble in the

shoe. People want to feel like they're making progress in their day and that they're doing something of value, not wasting their time while the important stuff is piling up unaddressed."

He points to a step Permanente has taken: Many regulatory compliance matters are covered in a succinct presentation by the compliance director, a physician, in an interactive, grand-rounds-like format. Staff nurses administer PPD tests and flu shots to the physicians who attend. "This reduces the burden of online training, the gnawing e-mail reminders, and so on. We get it done more efficiently, and a little thing like that goes a long way to removing that pebble in the shoe," he says, before reconsidering: "Actually, that's more of a boulder."

A physician who works in a toxic or frustrating environment, Dr. Perkocha says, may work a long or a short day, but goes home exhausted, unable to sleep, and returns to work the next day feeling compromised, prone to making errors and ruminating about work-related problems and conflict.

In a healthy environment—the pathologist likes their job, feels supported by colleagues and the institution, and works with efficiency and effectiveness—getting slammed by a 12-hour workday can still lead to exhaustion. But it stops there. "They go home, go to sleep, and wake up ready for a new day. That's how I conceptualize the difference between a burned-out physician and one who's just tired because they're working hard."

Dr. Hoak and fellow wellness committee members asked their colleagues at Incyte what 10 problems they'd most like to see addressed. The second biggest concern was inconsistency in when work arrives at pathologists' desks (sandwiched between flexibility in scheduling PTO, at No. 1, and fixing inefficiencies at each location, No. 3).

Ranked fourth was workload itself, followed by availability and timeliness of IT support. Often these two items are linked—it's easy for work to pile up when dealing with issues related to the LIS, HIS, and EHR. Dr. Hoak recalls a recent voice recognition virus that incapacitated transcription services at one hospital for a week. "Pathologists were typing up their own reports and dictating into their phones. It was a mess."

Workloads are also frustratingly unpredictable, Dr. Hoak says, based on OR volumes from the previous day. He wonders, in fact, if workload issues were a factor in his colleague's suicide. Shortly before, Dr. Hoak says he made a mistake in his own work, on a case he had shared with his colleague. "We were both busy," he recalled. "We were just really, really busy. And I think in years past we would have sat down and double-headed on the microscope and probably talked about the case. Instead, it was, *Yeah, I agree,* and then I sent it out. And it was wrong." When he later followed up with the patient, says Dr. Hoak, "I kept wondering about what would have happened if my colleague was more like he used to be."

Dr. Hoak says he's hoping small changes will be enough to help with some institutional problems. At one location, improving work conditions could mean making ergonomic adjustments to a chair or microscope; at another, it might mean asking histology to ensure the work arrives as punctually as the pathologist.

Dr. Bohman and his colleagues—he is chief medical officer for Stanford's community medical group of about 350 providers across the Bay Area—have also tackled inefficiencies at each site. "In the operating room, you can look at how you schedule your patients," he says. "In our organization, we still have elective cases at 7 PM—why is that? Can we do something about that? Because at the end of the day, what makes a physician personally fulfilled and prevents burnout is if he or she can provide excellent patient care without superhuman effort."

Physicians in all specialties like to think of themselves as masters of their craft, says Dr. Perkocha. Tasks that don't allow them to practice efficiently or effectively undermine them, as recent research has borne out, and can be a component in burnout. Think hours of email correspondence, clunky EHRs, the regulatory burden of box-checking—all of the nondescript character actors in medicine that make physicians feel nonproductive, he says.

He cites his own work in the CME arena. "It was getting to the point where I was spending more time doing the regulatory stuff for ACCME than I was preparing for the conferences I was giving." Dr. Perkocha eventually quit, and returned only when someone else was hired to do the regulatory tasks, allowing him to concentrate on the CME work itself.

It’s the low-value work that sends physicians to the burnout barn, agrees Dr. Bohman. The EHR “in some ways turns us into a stenographer or a typist,” he says. While there’s nothing wrong with these tasks per se, “It just doesn’t feel good to be asked to do work that’s different from what you spend so much time training to do. It’s wasteful to the system. You’re wasting a valuable asset” when you ask physicians to hunt and peck their way through an information system. And while pathologists might go to the mat with EHRs less frequently than other physicians, LISs and IT issues create their own brand of misery.

When money does talk

Efficiency cuts both ways. In the hands of a poor leader (another key factor in burnout), helping physicians work more efficiently could be used merely to crank more work through the system, leading to yet more burnout.

But recognizing the financial costs of burnout might be a way to persuade some holdouts to act.

It’s a good business model (and one whose value has long been recognized in the business world), says Dr. Perkocha. “Happy physicians make happy patients.”

At Stanford, Dr. Bohman says, faculty are twice as likely to leave if they’re burned out. “And that’s very expensive.” Interestingly, Stanford’s wellness program is starting to be used as a recruiting tool. “People are asking about these issues when they come to look at a residency program or to set up their practice after training,” he says.

Larger institutions are doing a better job than previously of tackling the problem. “Where pathologists suffer,” Dr. Perkocha says, “is in the smaller medical groups.” Some groups don’t have the resources to address the issue, he says. Others don’t have the interest. “I know of pathologists who’ve tried to make this more of a priority in their group, and met with resistance.” With small groups, he says, the fight may also be against a certain culture and personality. “It’s a bigger change for them” than it might be at places like Mayo or Kaiser or Stanford.

“Sometimes you just have to bludgeon people with what I call the costs that don’t show up as a line item in the budget,” he continues. “Recruiting and onboarding a new person when someone leaves prematurely is expensive, and there’s lower productivity during that time.” Other costs include higher risks of pathologists making mistakes, as well as disability, illness, and time off. Then there’s the risk of litigation (which, not surprisingly, has been identified as a factor in burnout as well).

Dr. Hoak is concerned when he sees younger pathologists leaving practices at high rates. (The Medscape survey found 38 percent of pathologists age 35 and younger were burned out.) Perhaps, he theorizes, it reflects, at least in some cases, their feelings of being burned out. The costs to individuals who might be burned out are substantial, but so is the impact on the bottom line, a factor not everyone realizes, he says. Though he talks to colleagues about the costs of recruiting, training, and retaining new pathologists when there’s turnover, “That doesn’t seem to resonate with everyone,” he says. “I thought people would be shocked by that.” Instead, it’s often met with a shrug.

What might work in these cases? Dr. Perkocha offers a couple of scenarios. Those who lean toward being late adopters might be convinced by the we-don’t-want-to-be-the-last-ones argument. Or there may be a shock, such as the suicide of a partner, that might bring it to bear.
And, he says, “Sometimes it’s an unsolvable problem. Once you have a critical mass of people who think one way, if it’s a matter of a vote it may be impossible.”

Despite the very real obstacles, however, those who are taking on physician burnout seem an optimistic bunch, drawn to hope like Brie to a baguette. And it’s not just the meditation talking. “I do think we’re about to begin to solve this problem,” says Dr. Bohman. With several large organizations leading the way, they say, it may be possible to chip away at unawareness and the defense mechanisms that keep many physicians from seeking help.
[hr]

Karen Titus is CAP TODAY contributing editor and co-managing editor.