The Role of Mindfulness in Mitigating Burnout

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Burnout affects more than half of all practicing physicians in the United States, with 54% meeting criteria for emotional exhaustion or depersonalization. The rate for general internists in this study exceeded the overall average. A study of academic internal medicine practices by Linzer and colleagues found that 38% of providers were experiencing high levels of burnout, and 67% high stress levels. We found very similar rates of burnout (40%) and high stress (66%) in a recent survey of all Department of Medicine faculty members at the University of Virginia using the same instrument (the MiniZ). According to the AMA, burnout rates among physicians increased from 46% to 54% between 2011 and 2014. Why is this so?

Several explanations for this have been postulated. For example, two principal work-related factors that contribute to burnout are high workload and low control over work. Both of these describe the current work environment for many physicians and health care providers. Productivity expectations continue to rise as do the pressures to lower costs and reimbursement. At the same time, physicians are dealing with the increasing complexity of electronic medical records. All of this is in the context of decreasing physician autonomy as more physicians choose employment models which limit their control over their work environments. This combination of high workload and low control is a recipe for burnout. Additional work factors contributing to burnout that Maslach and Leiter have described include not feeling rewarded, a lack of community, perceived lack of fairness, and institutional values inconsistent with personal values.

System issues and responses are important, but individual factors can also contribute to burnout. Often primary among these are compulsive or perfectionist personality traits. A compulsive triad has been described that is common among physicians—self-doubt (i.e., we are often our biggest critics and cannot live up to our own expectations), an exaggerated sense of self-importance that leads us to feel responsible for things that are actually out of our control (such as whether patients choose to follow our recommendations), and excessive feelings of guilt when things don’t go well.

Mindfulness has been shown to decrease burnout among physicians in a number of studies. Krasner and colleagues at the University of Rochester showed that burnout rates decreased significantly among primary care physicians who participated in an eight-week mindful communication course, and that these improvements persisted for 15 months. At the University of Virginia, we have studied the impact of a mindfulness course for health care providers from a variety of specialties modeled on Mindfulness-based Stress Reduction which resulted in significant improvements in all three measures of burnout as measured by the Maslach Burnout Inventory. In a recent meta-analysis, West and colleagues found that mindfulness interventions resulted in somewhat greater reductions in both emotional exhaustion and depersonalization than other interventions.

Mindfulness is defined as intentional present-moment awareness without judgment. As physicians, we often expend time caught up in thinking, planning, worrying, and judging ourselves and our experiences. Stressors, such as EMR burdens, time constraints and personal demands, detract from our ability to attend to our own experiences in the present moment as we engage with patients. In contrast, when we intentionally focus on our present-moment experience, we can begin to assess how we are feeling, both physically and emotionally. When we pause to observe how we are feeling, we can then choose our responses rather than be hijacked by them. For example, if we see the name of a patient on our schedule who we may have found difficult to deal with in the past, we may easily slip into telling ourselves a negative story about them. This might include thoughts about how they are non-adherent and demanding, and we may feel that we just don’t have time to deal with them. By the time we get into the room, we may already be activated and defensive, and may find it hard to be empathic. In addition, we may negatively judge ourselves for having these negative feelings.

On the other hand, if we take time to pause first to pay attention to our feelings and realize we’re tensing up, we can then choose to take a few breaths, and acknowledge the conflict between our negative emotions and our professional obligation to proceed. We can recognize that being activated before beginning the patient encounter is unlikely to achieve our goals of being efficient and empathic. It is helpful to understand that feelings, which arise from the limbic system, are not under conscious control. Therefore, guilt resulting from these negative emotions does not make physiologic sense.
What we do have control over is our response to the situation once we recognize the feelings. We can pause to decide how to respond most effectively. This enables us to also reduce any guilt we experience as a result of these feelings and, rather than judging ourselves, accept that the work we are doing is hard.

Finally, one of the factors that seems to contribute to burnout is repeated exposure to strong emotions which can result in empathic distress. Evidence suggests that empathy is largely mediated in such a way that when we are faced with suffering in another corresponding parts of our brains are stimulated so that we actually experience some of the same emotions as that other person. The closer we feel to the other person, the more the areas of activation overlap. This has been referred to as the “merging of self and other.” Faced with repeated experiences with patients who are suffering, we may begin to repress these feelings and block them out, resulting in depersonalization.

The concept of paying attention to our present-moment experience without judging it may be simple, but in practice is not easy. We can cultivate this ability through meditation, or formal mindfulness practice. This is called practice because it requires repetition to change neural pathways and gain the capacity apply this skill real-time, in the moment, during our everyday lives. Taking a mindfulness course, such as Mindfulness-Based Stress Reduction, is an ideal evidence-based way to learn this technique. Another option is to listen to guided meditations for 5 to 10 minutes several times a day, and gradually increase this over time. Many tools are readily available, including mindfulness apps for Smartphones, and instructional videos. One resource, the University of Virginia Mindfulness Center’s Web site (https://med.virginia.edu/mindfulness-center), contains free, downloadable guided meditations.

In addition to practicing formal meditation, pausing to practice mindfulness throughout the day is helpful. This simply entails remembering to stop to take a deep breath and notice the feelings, sensations and thoughts that are present. As soon as we pause like this, space opens for us to choose our responses with more awareness. STOP is an acronym that can aid in doing this: S stands for Stopping; T is for Taking a few breaths; O is for Observing present-moment experience with kindness; and, P stands for Proceeding with awareness. A time to consider doing this is when using hand sanitizer before entering a patient’s room. At UVA, we call this gelling in and breathing. It’s an easy place to start.

References
5 Krasner MS, Epstein RM, Beckman H. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. JAMA. 2009; 302:1284-93.