**Physician Burnout: Stop Blaming the Individual**

<http://catalyst.nejm.org/videos/physician-burnout-stop-blaming-the-individual/?utm_campaign=editors-picks&utm_source=hs_email&utm_medium=email&utm_content=50027064&_hsenc=p2ANqtz-9znLPkR6AwRqKgOTlvWFXL1oLpuaf7lFiLWK2BMogDsDw6YKqvl3royhfQwfHthLQIX_E_aWg8M1Lh78SJLdTRM5pAng&_hsmi=50027064>

In 2011, 45% of U.S. physicians had at least one symptom of professional burnout, according to a study from the Department of Medicine Program on Physician Well-Being at Mayo Clinic. That number rose to 54% in 2014. And projections from the Department of Health and Human Services suggest that by 2020, the U.S. will face a shortage of 50,000 physicians. “The [rising tide of burnout](http://catalyst.nejm.org/videos/the-dangers-of-physician-burnout/), coupled with its effects on quality of care and access, make burnout a major threat to the health care delivery system,” says Program Director [Tait Shanafelt](http://catalyst.nejm.org/about/thought-leaders/tait-shanafelt/).

Burnout affects physicians across all specialties, but it is particularly acute in primary care. Yet only bandages have been applied to address the problem thus far, in the form of stress management, resiliency workshops, and teaching mindfulness to individual physicians.

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“We tell physicians to get more sleep, eat more granola, do yoga, and take better care of yourself. These efforts are well intentioned,” says Shanafelt. “The message to physicians, however, is that you are the problem, and you need to toughen up.”

“We need to stop blaming individuals and treat physician burnout as a system issue,” argues Shanafelt. “If it affects half our physicians, it is indirectly affecting half our patients.”

To move to a better framework, Shanafelt says we must:

1. Start trusting physicians again. Eliminate intrusive regulations that do not add value to patients’ medical care, and devise more accurate approaches to assessing quality.
2. Let physicians focus on doing the work that only they can do. While physicians work at the top of their licensure, mini tasks should be delegated to support staff.
3. Set workload expectations based on what it takes to provide good patient care. “The current reality of physicians working 14-hour days at the clinic or hospital and then going home to spend 2 to 3 hours charting in the EHR is not sustainable,” says Shanafelt. “We have the metrics and tools to determine the time necessary to provide good care.”
4. Measure, track, and benchmark the well-being of physicians as a strategic imperative necessary to provide high-quality medical care.

Realizing these changes requires effective leaders to work in partnership with physicians. “Physicians and leaders working together constructively to identify, develop, and implement solutions for problems in the practice environment demonstrates to physicians that improvement is possible,” says Shanafelt. “The approach transforms physicians from victims in a broken system to partners working with leaders to create their own future.”

*From the NEJM Catalyst event*[*Leadership: Translating Challenge to Success*](http://catalyst.nejm.org/events/leadership-translating-challenge-to-success-2016/)*at Mayo Clinic, June 2, 2016. See “*[*The Dangers of Physician Burnout*](http://catalyst.nejm.org/videos/the-dangers-of-physician-burnout/)*” to engage in the burnout conversation with other members of the NEJM Catalyst community.*