



## **Physician Morale and the Medical Workplace A Canadian Perspective**

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**Overview.**

Physician health and well-being has received a great deal of attention in recent years both nationally and internationally. Increasingly, physicians, organized medicine and others are realizing that issues surrounding the health of individual physicians, as well as the environment in which they work, need to be addressed in order to sustain Canada's physician workforce. Currently, five million Canadians (approximately 15%) do not have access to a family physician and of OECD countries Canada ranks 26 out of 30 with respect to physician to population ratio. The resultant burden on individual Canadian physicians is significant as evidenced by the following unsolicited comment made by a physician to a Canadian Medical Association (CMA) survey.

*"I strive to appear to be patient and enthusiastic to patients and colleagues and put their needs ahead of my own, meanwhile I am silently burning-out inside, and finding work less rewarding. I would quit practising medicine but I am trapped."*

While historically data on the health of Canada's doctors has been lacking and the impact of poor physician morale has been hard to fully quantify, this paper provides a Canadian perspective on the factors influencing the health of physicians and the impact this might have on physician resource planning and the sustainability of our workforce.

**Background: Physician health and morale in Canada.**

The field of physician health has evolved over the past twenty years. In the early 1960's, energy and activity was primarily devoted to identifying, treating and monitoring colleagues who were misusing drugs and alcohol. During this time there was a growing awareness that a proportion of this population was also dealing with other mental illness, especially depression and bipolar disorder. This prompted the emergence of a small number of physician health programs across Canada to provide assistance to these physicians. However, the stigma of mental illness coupled with a medical culture that promotes strength and shuns the demonstration of weakness meant that many physicians who might benefit from the services of a physician health program were continuing to suffer in quiet desperation.

Over the past decade the physician health community and organized medicine have worked hard to de-stigmatize physician ill health and to create awareness of the enhanced resources that are now available to support physicians. In 2001, the Canadian Physician Health Network was founded to provide a forum for the provincial physician health programs now available across Canada. In 2003, the Canadian Medical Association followed the direction set in an earlier policy and launched the CMA Centre for Physician Health and Well-being to serve as a national coordinating body to advance physician health across the country.

Despite these important initiatives, it appears the combined effects of physician shortages, growing wait times and complex chronic disease, to name but a few, are having a significant toll on the health and morale of physicians and other health providers in Canada. While surveyed Canadian physicians report a relatively high level of satisfaction with their "professional life" <sup>1</sup> more physicians than ever before are

declaring chronic work overload, and are seeking assistance for such things as stress, burn-out, anxiety and depression.

These trends have not gone unnoticed by Generation X and Y physicians who are choosing to establish much different practices and attempting to place boundaries on their personal time. We remain unsure of their success as it pertains to their personal health; however these new practice patterns must be better understood and acknowledged as we undertake future physician resource planning.

The health of physicians is inextricably linked to the future of our health care system and the health of our patients. The ill health of a single physician initiates a cascade of negative effects, both for their patients unable to access services and for their physician colleagues left to assist them. These remaining physicians are now at significant risk of burn-out themselves in a system working at capacity with no reserve.

Addressing the health of physicians must continue to be a key priority for medical organizations and must assume its place as a sustainability issue for governments. We want to work together to ensure that our helping profession continues to be healthy and able to help others because as one Canadian physician put it;

*“You shouldn’t have to choose between saving yourselves and serving your patients.”*

## **Discussion**

In this paper, we address several questions:

- What is morale?
- How is morale measured among groups of physicians and what is the level of physician morale in Canada?
- What factors influence the morale of physicians? What makes a doctor happy? What makes a doctor unhappy?
- What is the impact of low morale on the medical workforce?

Within this paper we refer to the theory of motivators and de-motivators as put forward by clinical psychologist and pioneer of ‘job enrichment’ Dr. Frederick Herzberg<sup>2</sup> in his 1959 book ‘The Motivation to Work’. Dr. Herzberg’s original survey work on engineers and accountants remains a fundamentally important reference in motivational study.

Dr. Herzberg showed that different factors were associated with high and low levels of fulfillment. That is, fulfillment and dissatisfaction are not at the opposite ends of the continuum. The motivators, usually intrinsic to the work, included factors such as the nature of the work, achievement, recognition, responsibility, and growth. The de-motivators tended to be factors extrinsic to the job, such as administrative policies, supervision, salary, interpersonal relationships, and working conditions. The motivators caused people to work harder, but did not cause dissatisfaction if they were lacking. By contrast, the de-motivators resulted in deep dissatisfaction, but enhancing them, for example by improving salary or workplace conditions, did little to boost performance or improve fulfillment. Although not specific to physicians, this concept furthers our understanding of physician motivation, fulfillment and satisfaction.

## **Defining morale**

The Merriam-Webster on-line dictionary defines 'morale' as the mental and emotional condition (as of enthusiasm, confidence, or loyalty) of an individual or group with regard to the function or tasks at hand, a sense of common purpose with respect to a group, and the level of individual psychological well-being based on such factors as a sense of purpose and confidence in the future.<sup>3</sup>

This describes, then, how doctors feel about their work in medicine, their level of satisfaction and fulfillment, their sense of purpose, and ongoing excitement and dedication. A variety of studies have revealed that it is the patient-physician relationship that has the potential to provide the greatest level of reward and create purpose for physicians.<sup>4</sup>

## **Measuring physician morale in Canada**

Since it is not easy to define morale concretely, it is not easy to measure it accurately. Many studies measure the health of the medical workplace, the presence of perceived stress and the prevalence of burnout, and extrapolate this to reflect the existing level of morale.

The Maslach Burnout Inventory, developed by Christina Maslach, is commonly used to assess the level of burnout in the workplace<sup>5</sup> and has been used by many authors<sup>6 7 8 9</sup> to assess the health of a group of physicians. Burnout is the result of chronic overstress. While it is not a psychiatric diagnosis, it is of concern as it can lead to many serious diagnoses. In burnout, the demands of the workplace exceed and exhaust the resources available. This is becoming a way of life in medicine in Canada.

The first stage of physician burnout is emotional exhaustion. The doctor manages to function and get through the day, but is emotionally drained at the end with little energy left. They become more irritable and negative, and start to pull away from people. In this second stage, depersonalization, the doctor is more isolated from family, friends, colleagues, patients, and increasingly cynical and negative. This can lead to the final stage in which the doctor feels he is no longer effective, and has lost the earlier sense of satisfaction from his work. It is at this point that many consider leaving medicine. Burnout can cause difficulties at work, errors and law suits; marital problems; physical problems including sleep disorders, hypertension, and cardiac disease; alcoholism and drug addictions; and psychiatric illnesses such as depression, anxiety, eating disorders, and suicide.

A 2003 study of physicians by Boudreau et al in Alberta, Canada,<sup>11</sup> used four measures of burnout, including the Modified Maslach Burnout Inventory, the Pines and Aronson Burnout Measure<sup>12</sup>, the Boudreau Burnout Questionnaire, and the Rafferty et al Overall Self Assessment of Burnout<sup>13</sup>. It showed that 48.6% of the respondents were in the advanced stage of burnout. Another recent Ontario study showed that almost half of practicing physicians find the practice of medicine stressful or very stressful<sup>14</sup>. In a 2006 survey of CMA members, 31% said they would not recommend medicine to their children citing high levels of stress, poor lifestyle and suboptimal work environment as the cause.<sup>15</sup>

There are some specific tools that measure job satisfaction. A modification of the Warr, Cook, and Wall Job Satisfaction Scale was used by O'Sullivan in her study of predictors of mental health and job satisfaction among Irish general practitioners<sup>16</sup>. Grembowski and colleagues used a scale adapted from Greenfield et al, to measure primary physician job satisfaction<sup>17</sup>. The 2007 National Physician Survey indicated that while overall satisfaction with professional life was relatively high at 75%, just over half (56%) were satisfied with their ability to maintain balance between their personal and professional commitments. Furthermore, for those where it was applicable, only 20% were satisfied with their ability to find a locum.<sup>18</sup> It is this lack of control or disempowerment that is a fundamental contributor to poor morale and burn-out.

### **Understanding the factors that influence physician morale**

The identification of factors that make doctors happy are welcome and would be useful in better understanding and creating more positive medical workplaces. As noted, a number of studies have revealed that the patient-physician relationship has the potential to provide the greatest level of reward and create purpose for physicians. Canadian physicians are very satisfied with their relationships with patients (86%) and with colleagues (76%). However, they are most dissatisfied with their relationship with hospitals, availability of locum coverage and their inability to balance their personal and professional lives.<sup>19</sup>

A review of the physician satisfaction literature provides valuable insights into the basic factors influencing physician morale. The previously cited work of Comeau shows that amongst Canadian doctors, location of practice (rural vs. urban) and type of practice (group vs. solo) makes very little difference in the level of physician satisfaction with current professional life. Meanwhile, payment mechanism (fee for service vs. blended) does make a difference in how physicians rate their current professional life with those being paid in a non-fee-for-service method more likely to be satisfied.<sup>20</sup> The impact of age, gender and practice specialty on physician satisfaction are less clear as described below.

Regarding age, a national survey of US internists conducted by Lewis et al shows that the older colleagues were much more likely than their junior colleagues to report a definite decrease in their level of professional satisfaction since the start of their practice.<sup>21</sup> Another study described a U-shaped curve of practice satisfaction plotted against age, with the greatest satisfaction experienced by doctors under age 35 years and older than 75 years<sup>22</sup>. This is consistent with Canadian data.

Dr. Erica Frank and colleagues showed that the overall career satisfaction of US female physicians was similar to that found in mixed groups.<sup>23</sup> This corresponds to the minimal difference found in satisfaction amongst male and female doctors in Canada<sup>24</sup>. A US study of female doctors showed they were more likely than their male colleagues to state they were satisfied with their relationships with patients and colleagues, and were equally likely to state satisfaction with their overall careers. However, they were 60% more likely than the male doctors to report burnout.<sup>25</sup>

The impact of practice specialty has not been thoroughly studied and therefore a definitive statement of which medical specialists are happier is not possible. A small US

study compared internists, ophthalmologists, and cardiologists, and showed the internists feel their work to be significantly less rewarding.<sup>26</sup> However, another study of satisfaction among specialists showed a higher level of satisfaction among primary care specialists than surgical subspecialists.<sup>27</sup> It was postulated that this may reflect consequences of managed care and resultant decreases in income and job availabilities for the surgeons, and the increased malpractice rates and risks.

Zuger<sup>28</sup> summarized the current state of dissatisfaction with medical practice in the US. Several reasons for dissatisfaction were offered, including managed care, the malpractice crisis, disparate expectations between the doctor and patient, lack of time, and doctors multiple roles. In the qualitative work of Maranda et al at the University of Laval, Canadian physicians identified loss of autonomy, administrative burdens and bureaucracy, depleting physician resources, new and complex disease, information technology and excessive responsibility as key contributors to dissatisfaction<sup>29</sup>

Generally stress at work is caused by mismatches between the person doing the job and the job itself. These mismatches include: Work Overload, Lack of Control and Choice, Lack of Reward and Recognition, Lack of Community and Connection, Lack of Fairness and Respect, and Conflicting Values. The first four of these mismatches are expanded upon below.

- Work Overload as a stressor was reinforced by Barnett's study, which studied women doctors and showed that those who worked reduced hours had stronger relationships and better professional outcomes than their full-time colleagues.<sup>30</sup> Not surprisingly, amongst Canadian doctors the more hours worked the more likely the physician will be in an advanced stage of burn-out<sup>31</sup>
- Lack of Control and Choice is a key factor leading to workplace dissatisfaction. A study of factors that could predict professional satisfaction, organizational commitment, and burnout among physicians found the single most important predictor was a sense of control over the practice environment.<sup>32</sup> Keeton et al<sup>33</sup> studied factors associated with physician career satisfaction, and found that burnout is an important predictor of career satisfaction and control over schedule and work hours are the most important predictors of work-life balance and burnout.
- A lack of reward and recognition is commonplace within medicine. Anecdotal evidence abounds in which doctors feel they are taken for granted, expected to always be available, and only given feedback if there is a problem. It is difficult to work with such intensity, accept and manage a high degree of responsibility, while feeling unappreciated.
- A lack of community and connection with colleagues adds to the negativity of the medical workplace, and encourages ill health and job dissatisfaction. In this computer age, it is easier and quicker to communicate with a colleague via email, and the personal touch is slowly being lost. Lilius and her team at the Compassion Lab<sup>34</sup> showed the value of workplace compassion. They concluded that there is significant and lasting impact of small compassionate acts, such as allowing peers to take time off for appointments, asking how they are doing daily, and showing care in difficult personal times. There is also

serious damage done by the lack of compassion. Colleagues who receive such care and support readily return it to others when needed, and see the resultant improvement in patient care.

Maranda and researchers at the University of Laval interviewed a number of Quebec physicians who had been treated for stress related issues to better understand the contributing factors unique to medicine and the medical workplace.<sup>35</sup> Specifically, they set out to examine what causes a heavy workload to result in chronic overwork and hence burn-out. In their cohort they determined that the physicians worked excessively to cope with the realities of the profession, a response to what they called “work-induced suffering”. In a vicious cycle, they concluded that overwork blocks out the pain associated with a heavy workload (ie: loss of personal and family time, inability to meet patient demands). This response is fuelled by the physician personality which is performance driven, overly conscientious and often creates a merged identity between self and their professional role. Their inability to provide the care they feel patients need and deserve is interpreted as a personal failure. This creates a “perfect storm” in a health care system that lacks the human resources to meet patient needs and relies on the Herculean efforts of its providers to function.

A recent Canadian study identified positive and negative factors associated with physician well-being.<sup>36</sup> The findings show the importance of co-worker support, both in terms of being directly related to physician well being as well as buffering the negative effects of work demands. Patient interactions appeared to be both a key source of stress, and a major source of satisfaction for physicians.

### **Morale and the medical workplace**

With respect to physician supply, poor morale can lead to burn-out and ultimately mental and physical health issues that may remove the physician temporarily or permanently from their practice. The loss of even a single physician can upset an already tenuous physician supply balance in Canada and lead to poor morale and burn-out in other physicians in that community.

Barnett’s study<sup>37</sup> showed that both career satisfaction and intention to leave employment correlated with the quality of home life. Another study of job satisfaction and turnover in the primary care physician by Buchbinder et al showed that dissatisfied primary care givers were 2.38 times more likely to leave.<sup>38</sup> Interestingly, this study showed that specialty, gender, age, race, and practice setting were not associated with primary care physician turnover. Buchbinder also led another study in which data from a national review of physician compensation and productivity, and data from physician recruiters, were combined with primary care physician cohort data to estimate recruitment and replacement costs associated with turnover. Estimates of the recruitment and replacement costs for individual primary care physicians were \$236,383 for general/family practice, \$245,128 for general internal medicine, and \$264,645 for paediatrics, highlighting how physician turnover has major fiscal implications.<sup>39</sup>

One of the more insidious effects of poor morale and overwork in the Canadian context is the loss of collegiality within the profession. Although very difficult to accurately assess and determine causation there appears to be a growing tension in some medical

workplaces amongst physicians. Recent data from the 2007 National Physician Survey<sup>40</sup> reveals that only 31% of non-primary care specialists were very satisfied with their relationship with family physicians and only 24% of family physicians were very satisfied with their relationship with other specialists. When asked about barriers to care, respondents to this survey cite complexity of patients, chronic disease management, increasing patient expectations and an aging population as the most challenging.<sup>41</sup> Faced with prolonged wait times for diagnostic services and specialist consultations all physicians are frustrated with their inability to meet the needs of their patients. One can speculate that this loss of control in the face of chronic overwork sets up tension within the profession who seek the services of their colleagues. Family physicians in particular are left to manage a growing cohort of medically complex patients from their offices while the specialist to whom they would refer feel equally disempowered to find the clinic or operating room time to meet demands.

Fuelling this dynamic is the more recent trend of professional isolation and loss of the opportunity for social networking amongst physicians. The work of Lemaire and Wallace presented earlier<sup>42</sup> demonstrated that the presence of support from colleagues is a key factor in enhancing relationships and fostering resiliency in ones professional career.

Low physician morale in a community can also have a significant impact on the ability to attract and retain new physicians. Shortt et al reviewed retention and recruitment issues in Ontario and determined that poor morale was readily identified and a significant deterrent for those seeking a new practice location.<sup>43</sup>

In an academic centre, students and medical residents are particularly influenced by the poor morale of their teachers and preceptors. These interactions can have a significant influence on the choice of speciality for students. When students are looking at many different factors to decide their future career path, poor morale and burn-out can be a significant deterrent. At a time when fewer students are selecting specialties like family medicine many schools are looking at the impact of the so called "hidden curriculum" on students. The University of Western Ontario in London, Canada has undertaken a specific initiative to ensure that family medicine faculty present a positive mentorship experience for students to encourage family medicine as a career choice while allowing for an honest and informed decision.

Unfortunately, patients are also impacted by poor physician morale. Apart from the implications of burn-out and ill health on the availability of services as previously discussed, the quality of care can also be negatively impacted in a medial workplace with low morale.

In Australia, a government-funded study reported that low morale among GP's is a "major barrier to the practice of high quality general practice".<sup>44</sup> The MEMO study (Minimizing Errors, Maximizing Outcome) introduces a model to explain how physician work attitudes and level of satisfaction impacts patient safety. The authors found that stressed, burned out, and dissatisfied physicians do report a greater likelihood of making errors and more frequent instance of suboptimal patient care.<sup>45</sup> It is postulated that doctors who are stressed, depressed or anxious are not able to fully engage with their patients and so do not provide optimal care.<sup>46 47</sup> A prospective study of depressed and burnt out residents showed that depressed residents made significantly more medical errors, 6.2 times as many as their non-depressed peers.<sup>48</sup>

Patient reported satisfaction is also impacted negatively when medical care is delivered by doctors with low morale and job satisfaction. Haas et al<sup>49</sup> studied the relationship between the satisfaction of general internists and their patients. They found that the patients of physicians who have a higher sense of professional satisfaction may themselves be more satisfied with their health care and recent physician visit. As well, focusing on improving physician wellbeing may diminish the threat of malpractice suits and litigation.<sup>50</sup>

### Strategies to improve physician morale

A key aspect to preventing physician burnout and improving morale is to support and promote personal and professional wellbeing. The Canadian Medical Association created and adopted a policy on Physician Health and Wellbeing, outlining goals, strategies, and recommendations covering a wide range of issues for physicians.<sup>51</sup>

The first Canadian academic faculty wellness program for physicians was launched at the University of Ottawa in 2000. This program was committed to the enhancement of the well being of the faculty, with comprehensive initiatives in the five areas of Education, Prevention, Research, Resources, and Intervention, and has proved to be very successful.<sup>52</sup> One venture of this was the creation of a municipal Physician Appreciation Day, to encourage public appreciation for all that doctors do and assisting in the improvement of physician morale.

The Canadian Medical Association Centre for Physician Health and Well-being is solely focussed on enhancing physician well-being and morale through national awareness, education, advocacy and promotion. The Centre has a variety of programs in place ([www.cma.ca/physicianhealth](http://www.cma.ca/physicianhealth)) including two professional development programs for physician leaders to assist them in creating healthier workplaces, supporting their colleagues and dealing with difficult issues like addictions and disruptive behaviour. In addition to making available the Physician Health Programs, our provincial and territorial medical associations, as the negotiating bodies for doctors, have worked hard to establish benefits such as maternity leave, on call stipends and retention incentives that support the needs of physicians, recognize their contributions, and help to create more balance.

Student and resident organizations in Canada have equally provided significant leadership by working with medical schools to define more manageable on call responsibilities, establish well-being days and set policy on intimidation and harassment in the training environment.

Spickard et al summarize issues that are factors leading to physician burnout, and offer some strategies to help prevent burnout in physicians.<sup>53</sup> They address the role of the health care organization in promoting physician wellbeing, including measuring intrinsic values such as the experience of a sense of meaning in one's work; and extrinsic values such as productivity, establishing physicians' health committees; creating mentorship programs; provision of confidential support groups, physician retreats, membership in fitness centers, requiring all physicians to have their own primary care physician, educational programs, flexible scheduling, involvement of physicians in management of

their work environments. They also review ways in which the individual physician can promote their own well-being, and maintain personal growth and renewal.

In 2006 Brown and Gunderman drew on Frederick Herzberg's landmark theory of motivators (described previously in this paper) in their review of the sources of professional fulfillment among physicians, and included physician autonomy, relationships with colleagues, relationships with patients, compensation and income, work hours, and demographic information.<sup>54</sup> The authors outlined ways to enhance professional fulfillment within physician organizations and recommended a strategy of focusing on intrinsic factors, to ensure long term improvements.

## **Summary**

Canada's physicians are committed to ensuring the best possible care for their patients, yet it appears that given the constraints of our current healthcare system, limited physician resources and a number of other external pressures, this level of care is only possible through extraordinary effort and considerable personal sacrifice. Clearly this is not a sustainable model, both patients and providers deserve better.

Despite this, physicians report a surprisingly high level of satisfaction with their professional life when asked in isolation; yet burn-out rates are high and physician health programs have witnessed a significant increase in the number of physicians seeking treatment for stress and anxiety related disorders. The evidence suggests that it is not hard work or long hours but rather chronic overwork and lack of control over their lives that is responsible for this trend. The intriguing work of Maranda et al has revealed that the personality traits desired of physicians are in fact those that put us at most personal risk and which are exploited by a health care system reliant on this over-commitment to function. Rather than being rewarded for this effort, physicians are often seen by governments and others as a cost centre rather than a value centre; a negative viewpoint that further impacts physician morale.

While this overwork response to increasing demands and lack of control may not always be in the consciousness of physicians, other external factors are more obvious and have been identified as key contributors to stress.

They include:

- Complexity of disease/chronic disease management
- Excessive wait times and poor access to services
- Inability to manage personal commitments
- Massive expansion of new knowledge
- Need to adopt new technology
- Increased patient demands and expectations
- Threats to self regulation and autonomy
- Infringements on scope of practice

One only needs to look at the trends in medicine and practice patterns over the past decade to determine how physicians have adapted to cope in this new reality. There has been a strong movement away from solo practice into groups to provide greater

flexibility and enhanced efficiencies. As of 2007, only 27% indicated working in a solo practice environment. As well in 2007, 27% indicated they had reduced their work week in the last two years and 35% planned to do so within the next two years.<sup>55</sup> In 2004, six percent indicated they planned to retire and while this intention did not actually occur (as best it can be measured) it may be an indication of dissatisfaction.<sup>56</sup> As previously stated, the new generation of physicians, while equally committed to their patients and careers, are attempting to put boundaries on their professional lives in order to maintain balance. There is a significant trend away from generalist specialities such as family medicine and general surgery that require the acquisition of a vast body of knowledge, often involve greater ambiguity and uncertainty and in many circumstances have a more significant impact on personal time.

While these coping strategies have created some intra-professional and intergenerational tensions within medicine and have influenced physician resources planning across Canada, it appears they are necessary to ensure the overall sustainability of our physician workforce.

We must work hard to further assess the factors that lead to physician satisfaction and create resiliency in the profession. The evidence clearly demonstrates a link between physician satisfaction and morale and critical issues such as recruitment and retention, quality and safety, patient satisfaction, collegiality and inter/intra-professionalism.

However there is much that is unanswered and many key questions remain such as:

- How does the profession reconcile the need for patient primacy and the maintenance of professionalism while still establishing personal/professional boundaries and protecting ones well-being?
- How do we bridge the generation gap in medicine and create working arrangements that respect differing needs?
- How do we renew the collegiality that is a cornerstone for personal resiliency and enhance the opportunity for social networking that has been a casualty of overwork?
- How do we get governments to see physicians as a value centre rather than a cost centre?
- How do we assess applicants to medical schools and prepare medical students and residents for a more resilient and satisfying career?

## **The Future**

The building blocks are now in place to develop a long-term strategy to promote and enhance physician morale in Canada. As we continue to better understand the factors that affect the well-being of Canadian physicians an infrastructure is being created to provide leadership, break down stigma, educate physicians and others and advocate for changes to the system that will support the efforts of all providers. In making “healthy physicians” one of five key priority areas, the CMA is committed to further identifying and understanding the linkages between physician well-being, quality patient care and a sustainable health care system. Clearly, asking physicians and other providers to work harder and longer is not a solution for meeting the health care needs of Canadians. We must make changes to the medical workplace that empower physicians, re-establishing a sense of control over their professional lives and reinvigorating their practices.

For in the words of the Honourable Roy Romanow, Q.C., Commissioner, Commission on the Future of Health Care in Canada

*“If physicians don’t look after themselves, who will look after the rest of us”*

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