

**Donald W. Light**

## **Alienation and Stress among Doctors: Dilemmas and Possible Solutions**

As someone who has been writing for a long time about the historical development of the medical profession in its societal contexts, I want to share some observations based on this special issue of Professions and Professionalism. Are doctors aware of how many researchers are studying their distress?

Is John McKinlay right, that the causes of alienation, stress, and burnout lie in the proletarianization of the profession by corporate and public managed care hierarchies devising clinical guidelines after 1980? (McKinlay & Arches, 1985; McKinlay & Marceau, 2011). This April, a US e-newspaper published an article on “How being a doctor became the most miserable profession. Nine of 10 doctors discourage others from joining the profession, and 300 physicians commit suicide every year” (Drake, 2014). In August, a prominent article by an MD explained “why doctors are sick of their profession” (Jauhar, 2014). Only six percent described their morale as positive. One wrote, “I wouldn’t do it again... I get too little respect from patients, physician colleagues and administrators, despite good clinical judgment, hard work, and compassion for my patients” (Jauhar, 2014, para. 7).

### **Unclear concepts and relationships**

One problem with the literature on dissatisfaction and its correlates is that concepts are defined and measured differently by different authors, and sometimes quite vaguely. Their relationships with each other vary and can be tricky. For example, Casalino and Crosson report in this special issue (2015) that “the high frequency of physician burn-out contrasts sharply with the high percentage of physicians in the U.S. who reported being ‘somewhat satisfied’ or ‘very satisfied’...”. How can these contradictory general findings be reconciled? Their figure on physician dissatisfaction defines it as an undifferentiated mélange of “burnout, depression, sense of stress, and poor self-care.” Treated as an independent variable, physician dissatisfaction is said to reduce “cognitive capacity, concentration, effort, empathy, and professionalism” (whatever that is), as they suffer from “stress, burnout, depression, poor self-care, and substance abuse” (Casalino and Crosson, 2015). What should one make of this stew?

The authors point out, as do others, how many studies of the relationships between one variable and another rest on small, one-time, local studies that measure them differently. While physician dissatisfaction appears to be a powerful, frightening syndrome that harms patients, staff, and self, its empirical composition and effects are unclear. Researchers use “may,” “suggests,” and “hypothesized” to han-

*Donald W. Light*  
Department of  
Psychiatry  
Rowan University

**Contact:**  
*Donald W. Light*  
Department of  
Psychiatry  
Rowan University  
One Medical  
Center Drive  
PO Box 1011  
Stratford, New  
Jersey 08084  
USA  
[dlight@  
princeton.edu](mailto:dlight@princeton.edu)

dle the problem. What the world needs are well-defined, longitudinal studies to observe how changes in a specific variable affect others. For example, the clear reform of reducing stress, fatigue, and burnout by eliminating extended work shifts and hours worked per week in intensive care, reduced serious medical errors from 13.6% to 10.0% (Landrigan et al., 2004). This means stressed, fatigued doctors treated very sick patients without error 86.4 percent of the time, and this specific reform increased it to 90.0 percent. Likewise, I suspect that changes to reduce other attributes of “burnout” or “alienation” would find only small changes in clinical outcomes.

## **A consumerist perspective**

By starting with physicians’ dissatisfactions rather than with clinical quality, the conference reflected a consumerist perspective of medicine that echoes the contemporary attention to patient satisfaction and a market orientation. Behind this is often the tacit assumption that during the Golden Age of Medicine when physician autonomy and eminence-based medicine prevailed, doctors were happy. More widely, a consumerist orientation contributes to physician disempowerment and loss of respect. But during that era, clinical quality varied greatly, and excessive treatments drove up costs relentlessly as they also put patients more often at risk. Governments and other “buyers” began to distrust doctors and develop ways to achieve reliable quality at reasonable cost based on accountability rather than autonomy (see Figures 1 & 2). Since then, more constrained and unhappy doctors have been achieving ever-better outcomes (Light, 2001, 2004).

Figure 1  
*The Buyer's Revolt against rising and various costs by autonomous providers*  
 (Light, 1988).

<b>Dimensions</b>	<b>From provider-driven</b>	<b>To buyer-driven</b>
<b>Ideological</b>	Sacred trust in doctors	Distrust of doctor's values, decisions, even competence
<b>Clinical</b>	Exclusive control of clinical decision-making	Close monitoring of clinical decisions, their cost and their efficacy
	Emphasis in state-of-the-art specialized interventions	Minimize high-tech and specialized interventions
	Lack of interest in prevention, primary care, and chronic care	Emphasis on prevention, primary care, and functioning
<b>Economic</b>	Carte blanche to do what seems best: power to set fees; incentives to specialize	Fixed prepayment or contract with accountability for decisions and their efficacy
	Informal array of cross subsidizations for teaching research, charity care, community services	Elimination of "cost shifting" pay only for services contracted
<b>Political</b>	Extensive legal and administrative power to define and carry out professional work without competition, and to shape the organization and economics of medicine	Minimal legal and administrative power to do professional work or shape the organization and economics of service
<b>Technical</b>	Political and economic incentives to develop any new technology in protected markets	Political and economic restraints on developing new technologies
<b>Organizational</b>	Cottage industry	Corporate industry
<b>Potential excesses and dislocations</b>	<ul style="list-style-type: none"> <li>- Overtreatment</li> <li>- Iatrogenesis</li> <li>- High cost</li> <li>- Unnecessary treatment</li> <li>- Fragmentation</li> <li>- Depersonalization</li> </ul>	<ul style="list-style-type: none"> <li>- Undertreatment</li> <li>- Cuts in services</li> <li>- Obstructed access</li> <li>- Reduced quality</li> <li>- Swamped in paperwork</li> </ul>

Figure 2  
*The new professionalism*

Traditional professionalism based on <i>Autonomy</i>	The new professionalism based on <i>Accountability</i>
Quality focused on treating individual patients well. Results in large variations in process and outcomes.	Quality focused on populations-based outcomes. Aims to reduce variations through guidelines and protocols.
Oriented towards episodic treatment of acute problems.	Oriented towards prevention and risk management in populations.
Physician-based practice and authority. Delegated work to nurses, others.	Team-based practice and collaboration.

### Inherent problems using market competition

While responsible forms of managed care to move doctors towards accountable rather than autonomous professionalism has improved quality, using classic price competition in medicine is dangerous. There is little evidence that commercial markets in medicine increase efficiency and quality. Medical services fail to meet the requirements for competition that benefit society by rewarding increased quality and value, as outlined in Figure 3. Because needed services depend expertise applied to varying, contingent, and uncertain problems, patients as “buyers” cannot know what they are “buying.” Figure 3 specifies other forms of what economists call “market failure.” I call what happens *pernicious competition* because not meeting the requirements for beneficial competition allow sellers or providers to exploit consumers or patients. When done within a firm budget, providers profit by ignoring, dropping, or underserving less profitable patients (Hsiao, 1994; Jasso-Aguilar, Waitzkin, & Landwehr, 2004; Stocker, Waitzkin, & Iriat, 1999). Pernicious market pressures make doctors alienated, stressed, and discouraged, or cynical and greedy.

Figure 3  
*Structural and organizational conditions for beneficial and pernicious competition*

Beneficial competition	“Market failure” as pernicious competition
<ul style="list-style-type: none"> <li>▪ Buyers: sovereign, maximize clear preferences using gd info, shop frequently</li> <li>▪ Product or service sought is clear</li> <li>▪ Prices clear, known in advance</li> <li>▪ Free, accessible information on features, limitations or dangers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Buyers: embedded in relations, mixed preferences, partial info, shop infrequently</li> <li>▪ Product or service sought is unclear</li> <li>▪ Prices unclear, indirect, or known later</li> <li>▪ Partial, incomplete, garbled, or unreliable information</li> </ul>

<ul style="list-style-type: none"> <li>▪ Information is free, easy to get</li> <li>▪ Many buyers and sellers</li> <li>▪ No relation to each other</li> <li>▪ Can purchase from full array of providers</li> <li>▪ No barriers to entry or exit</li> <li>▪ Market signals quick; markets clear quickly</li> <li>▪ No externalities. No harms (or benefits) to other parts of society not captured in market transactions</li> </ul>	<ul style="list-style-type: none"> <li>▪ Information is costly, difficult to obtain</li> <li>▪ Few buyers and/or sellers</li> <li>▪ Historical, cultural relations, overt or covert</li> <li>▪ Purchase from limited array</li> <li>▪ Barriers to entry and exit</li> <li>▪ Market signals &amp; change are slow, muddled</li> <li>▪ Externalities, often by design, in the market, services or products</li> </ul>
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Reforms can create organizational chaos, gaps in services, and provider misery. For example, when it comes to cancer care, the overlaps and gaps between various commissioning groups in the English NHS represent yet another, alienating re-organization of services (Buckman, 2013; Oxman, Sackett, Chalmers, & Prescott, 2005; Thomas & Miller, 2013). Different parts of the reforms have different incentives. Incurable conditions are regarded as “cost centres” that put doctors on “an accountant’s treadmill” and conflict with doctors’ duty to help patients. Categorical guidelines also leave out patients who do not fit them (McDonald, 2015). They become an “unreasonable” imposition on doctors who can win no points or pay for trying to help them. Patient improvement is assumed rather than measured.

### Other basic contributors

Certain basic trends contribute to medical work becoming more stressful and less satisfying. Diagnostic and testing tools have become more complex and fine-grained so that the more one looks, the more one finds; but often no effective treatment exists. Nursing and other health professions have become better trained and more specialized so that the doctor’s command of care is less clear and more challenged. The trend towards interprofessional teams makes sense, but relationships within teams often have unresolved tensions. Patients have become older and their problems more complex. Co-morbidities multiply those complexities. Each of these trends makes medicine inherently less satisfying and more stressful.

Contributing to co-morbidities is a contributor that reflects poorly on doctors and our trust in them: the epidemic of harmful side effects from the drugs they prescribe. They are the 4<sup>th</sup> leading cause of death, falls, road accidents, and a major cause of hospitalizations (2.7 million/yr. in the USA) (Light, 2010; Light, Lexchin, & Darrow, 2013). An estimated 81 million adverse reactions occur in the US each year, more in Europe. Yet nine out of every ten new medicines approved is found by independent medical teams to have few or no benefits for patients, and criteria for approval do not include evidence of clinical superiority. By contrast, the risk of serious adverse reactions is two in ten (Lexchin, 2012).

Pharmaceutical companies spend \$57 billion to persuade doctors to prescribe differently from how they would without it. Detailed studies show how this has corrupted the profession, medical science, medical knowledge, clinical practice, and patient trust. Patients in the US are so upset that Congress has passed the Sunshine Act that requires companies to report any payments over \$10 in a year to

physicians. Gottlieb (2014) writes that the medical profession rests on trust and principles of impartial service. Now, “there’s a clear view that doctors can’t be trusted to have any financial interactions with drug and device makers, no matter how small or simple these transactions. A free mug is as likely to influence a physician’s judgment as a \$50,000 consulting fee” (Gottlieb, 2014, para. 9). Even medical societies fully endorsed this Act, “the clearest admission of failing of these groups to provide any measures of self-regulation” (Gottlieb, 2014, para. 8). In the medical literature on which clinical guidelines are built, drug companies are five times less likely to have negative trials results published, while positive results are often published more than once. Sales reps capitalize on doctors feeling stressed and alienated: “Try this. Your patients will thank you for it.”

## Addressing alienation through collaboration

Many reforms generate alienation because they were not developed *collaboratively* for a larger, shared good. A contemporary example of how to simultaneously turn around low morale, burnout, alienation, and physician dissatisfaction, while improving quality, is a collaborative project in British Columbia that brings doctors and government administrators together to revive primary care, improve population health, control per capita costs, and make medical practice rewarding (Baldrey, 2014; Mazowita & Cavers, 2011). Physician-led care teams are paid for developing and implementing care plans for patients with a number of serious, chronic conditions and with complex medical needs. Within about eight years, alienated, burned out doctors have found their practices fulfilling, and the costs of well-managed patients with chronic conditions has dropped substantially. What matters is the process of full engagement, empowerment, and a sense of a shared, larger purpose. A second, deeper, and more famous example of managers and clinicians developing together a positive culture and ways to improve patient outcomes is Intermountain Healthcare in Utah and Idaho (James & Savitz, 2011). They built trust and a shared agenda to improve patient care within budgetary constraints. Doctors feel motivated and involved in improving clinical outcomes. These examples suggest that one start with the open, collaborative pursuit of better patient care, and the process will ameliorate much perceived alienation, dissatisfaction, stress, or burnout.

This idea and successful examples come just in time; for a new study from the Commonwealth Fund reports that Norwegian quality of care ranked last among eleven advanced systems (Davis, Strenikis, Squires, & Schoen, 2014). Norway scored especially low on engaging patients, attending to their preferences, and waiting times. I recommend that Norway (and other countries) draw on the British Columbia model and Intermountain’s impressive achievements under the leadership of Brent James to develop collaborative ways to improve the quality of patient care. One should be to screen out me-too drugs and prohibit drug marketing. And new study finds that superior new drugs sell themselves (King & Bearman, 2013). Jointly developed reforms with shared governance will also contribute to what physicians reported in the AMA-RAND survey were the attributes of high satisfaction: a shared goal of improving patient care, trust and faith in leaders who share their values, collegiality, a fair income, and a sustainable future.

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