Burnout among urologists linked to status and hierarchy

Robert Pearl, MD
Stanford University School of Medicine, Stanford, CA, United States

Cite as: Pearl R. Burnout among urologists linked to status and hierarchy. Can Urol Assoc J 2021;15(6Suppl1):S20-4. http://dx.doi.org/10.5489/cuaj.7225

This article includes partial excerpts from Dr. Robert Pearl’s upcoming book, “Uncaring: How The Culture Of Medicine Kills Doctors And Patients.” This book contains specific and detailed solutions for reforming both the system and culture of healthcare. See online sellers for preorder information. All profits from the book will be donated to Doctors Without Borders.

Introduction

Half of all physicians in the United States report a troubling constellation of symptoms that includes exhaustion, dissatisfaction, distress, and a sense of failure. These physical and psychological issues have been labelled “burnout,” and they produce a serious set of consequences for both physicians and their patients. Doctors who experience burnout are far likelier to commit a serious medical error, be sued for malpractice, and die from suicide.

All of this is troubling news for urologists in the U.S., who according to a recent Medscape survey of 15,000 doctors, report the highest overall rate of burnout (54%) of any physician specialty. For urologists, the uptick in burnout has followed a precipitous and years-long decline in professional satisfaction. Although physician burnout rates tend to be far lower in Canada — where the systems and circumstances of providing healthcare differ greatly from those in the U.S. — there are valuable lessons to be learned about the multifactorial nature of burnout, regardless of where it surfaces.

No matter the occupation, burnout is a big and burgeoning problem in the U.S. Among the general population, it affects 28% of working adults. Zoom in on physicians and the burnout rate balloons to 44% across the profession. According to a recent Harvard report, physician burnout is “a public health crisis that urgently demands action” that will continue to undermine patient care and the mental health of doctors if left unaddressed.

When asked about the causes of their professional unhappiness, nearly all U.S. doctors agree on the source of the problem. Burnout, they say, is the product of America’s broken healthcare system. In a 2020 survey, physicians pointed at “too many bureaucratic tasks,” “too many hours at work,” “increasing computerization,” and “insufficient compensation” as the leading causes of their distress. Indeed, these systemic problems all contribute in some way to physician burnout. But a closer look at these complaints reveals that the U.S. healthcare system is not the only problem plaguing American doctors. Ultimately, the lack of fulfillment among doctors in general, and urologists in particular, cannot be solved until physicians understand and are willing to address all the factors contributing to their discontent.

The systemic causes of burnout in the U.S.

The American healthcare system is highly problematic for both doctors and patients. Multiple workplace analyses have found that physicians dedicate nearly twice as much time to completing administrative tasks and filling out insurance forms as they spend diagnosing and treating their patients. On average, doctors devote 15 hours of each week solely to obtaining “prior authorizations” from insurance companies. Walk into any doctor’s office nowadays and you will find as many people working on billing, claims, and collections as those helping clinicians. To address the growing economic strain of running a practice, the computers stationed in exam rooms and offices today are programmed to aid almost entirely with insurance company approvals and billing — hardly at all designed to improve medical treatment and patient care. Time, energy, and resources are being taken from doctors and patients, and being put into the bureaucratic and business sides of the American healthcare system. This adds even more pressure to the doctor’s already busy clinical schedule; time that physicians would rather spend treating patients.

Amid these barriers to better care, physicians feel overwhelmed, overworked, and unfairly treated. Consequently, they voice their frustration at the usual suspects: meddling insurers, manufacturers of clunky computer systems, and callous hospital administrators. It is not that these players have not earned the wrath of doctors; it is that limiting the profession’s criticism to this trio is too myopic. These are
areas of complaint that fall largely outside of the doctor's sphere of influence. And by focusing their complaints on the problems they can’t control, physicians fail to notice how they, themselves, undermine professional satisfaction and compromise patient care.

Why burnout rates vary by specialty

According to the Medscape National Physician Burnout & Suicide Report 2020, all physician specialties report a burnout rate above 29%. At the bottom of the list, where burnout rates are lowest, there are several surgical specialties. They include ophthalmologists (30%), orthopedists (34%), and otolaryngologists (35%). There are also a couple of surgical specialties high on the list, too, including urologists, who sit at the very top.

Something doesn’t add up here. If all specialties complain about working too many hours at the office, logging too many clicks on their computers, and performing too many bureaucratic tasks without enough pay, then what, exactly, sets urology apart from the others in terms of burnout?

Salary cannot be the reason. American urologists earn $408,000 on average. That’s 40% above the physician mean and $42,000 more than the average ophthalmologist—a specialty that reports a 24% lower burnout rate than urology. Urologists also earn nearly twice as much as pediatricians while experiencing a 15% higher rate of burnout than their pediatric colleagues. The fact that urologists’ salaries have remained relatively constant throughout their decline in professional satisfaction confirms that money is not the primary issue.

What about the commonly held belief among physicians that spending “too many hours” at the office causes burnout? According to the Medscape poll, “the percentage of physicians who are burned out rises with the number of hours they work each week.” Although true, overall, it’s not accurate for all surgical specialties. Orthopedists, as an example, put in more hours at work on average than urologists and yet their burnout rate is close to half.

Finally, what about the bureaucratic impositions that physicians face? Though doctors may not look favorably upon this aspect of the healthcare system, it too fails to account for the variation in burnout rates among specialties. All surgeons in the U.S. use similarly problematic electronic health record systems, and each must obtain prior authorization from insurers for the procedures they perform. So, when it comes to the number of computer clicks and annoying administrative tasks, urologists have it no different than orthopedists, ophthalmologists, or otolaryngologists.

If variations in burnout among different specialties can’t be explained by money, work hours, or paperwork, what else is there? The answer may thus reside in the illogical and perverse obsession American doctors have with prestige and relative status, two of the strongest influences in physician culture.

The insidious role of hierarchy in medicine

Sir Michael Marmot, a British epidemiologist and chair of the World Health Organization’s commission on social determinants of health, is renowned for his Whitehall studies. Through his groundbreaking research on health inequalities, Marmot found a strong association between the occupational rank of British civil servants and their chances of dying.

He found that men who held jobs at or near the bottom of Britain’s class tiers were four times more likely to die than the men in charge, even when adjusting for the usual social-class killers like smoking, drinking, and high cholesterol. His findings transformed the establishment’s thinking on the link between hierarchy and health.

Marmot was among the first to point out that social and professional status have a tremendous influence over mental and physical well-being. Specifically, he found that people’s real or perceived rank—at work, among friends, or in society—greatly affects their stress levels and self-esteem. His findings segue into a series of psychological studies that may help explain the decline in satisfaction among American urologists. Time and again, researchers have demonstrated that the loss of social or professional status produces the same symptoms we associate with burnout: anxiety, fatigue, and depression. And that is precisely what has happened to a growing number of urologists over the past five years or so.

There was a time, not long ago, that medical school graduates flocked to urology for the prestige of the specialty and the opportunity to perform robotic prostatectomy. Urology’s status hit its apex in the first decade of the twenty-first century, when health experts nationwide defined prostate-specific antigen (PSA) testing as an essential preventive screening measure for men over the age of 50. During that decade, the number of male patients receiving robotic prostatectomy climbed. Testing for prostate cancer became a clinical standard, while nearly every hospital purchased and promoted multimillion-dollar robots.

But in 2012, the U.S. Preventive Services Task Force (USPSTF) noted that the number of lives saved from routine PSA testing were minimal and gave the use of this test a “D” letter grade, meaning the test’s potential harm was greater than its potential value. Since then, the number of patients identified as needing prostatectomy has declined. Although the USPSTF raised the grade in 2017 to a “C”
for men between 55 and 69 (meaning that doctors should discuss the option with patients), it continued the “D” grade for all men who fall outside that age range.

Furthermore, when studies found that “watchful waiting” proved just as effective (and not as risky) as operating for select patients, the number of procedures plunged even more. In parallel to the declining number of prostatectomies, as data on the annual volume of procedures performed by hospital-based and individual surgeons became widely available through the internet, patients increasingly sought out high-volume centers of excellence for their procedures rather than the urologists in their community who performed only a minimal number of surgeries each year.

As the total volume of cases shrank, more urologists were left with fewer opportunities to perform the very procedure that attracted them to the specialty in the first place. And with lower surgical volumes, many have been forced by hospital credentialing authorities to remove the procedure entirely from their clinical practices. Though they had long enjoyed and touted the sophistication of robotic prostatectomy, urologists suddenly found their practices focused on outpatient office procedures and medical management only. These changes in clinical medicine have devastated the field’s prestige, bumping urology down near the bottom of the healthcare hierarchy. This downward trajectory in status — along with the more general healthcare system challenges — helps to explain the specialty’s high incidence of burnout.

The same high rate of burnout, and the same causation, can be observed in another surgical discipline. General surgery has seen its burnout problem festering for close to 20 years. Even among general surgery residents just starting out in their careers, one report identified frequent signs and symptoms of burnout (75%) and depression (40%). Like urology, this growing dissatisfaction reflects changes in surgical scope and, more importantly, the reduction in relative status.

General surgeons used to be kings of the healthcare hill. They delighted in mastering an array of complex procedures, operating on nearly every area of the body. In some practice settings in the U.S., particularly in rural areas and underserved communities, the general surgeon’s scope of practice remains broad. But in densely populated areas, the most “interesting” (high-profile) operations are being referred to subspecialists who have completed fellowship training and can provide deeper levels of expertise.

For example, surgeries performed on the most complex cancers of the liver and pancreas go to hepatobiliary surgeons. Their intensive training, combined with a narrowed scope of practice and greater experience, help them achieve superior clinical outcomes with fewer complications. Endocrine surgeons, likewise, have laid claim to thyroidectomies and adrenalectomies. Even mastectomies, once under the domain of all general surgeons, are being done by a smaller subset of physicians who focus their entire practices on treating breast cancer. As a result, many general surgeons now find their practice limited to the most mundane medical problems: hernias, gallbladder disease, and hemorrhoids.

The importance of prestige and status in U.S. medicine

Among physicians, status is just as important as money. The desire for the former explains why many doctors take jobs in academic medical centers after residency. They’re willing to accept a lower salary in return for a university affiliation, a prestigious title, and guaranteed referrals of complex cases. Patients who require more sophisticated treatments are led to believe that doctors in university hospitals are on the cutting edge of clinical practice and capable of achieving better outcomes, even when there is no evidence to support the assumption. This ego boost only fuels doctors’ obsession with status.

As a result of the powerful role hierarchy plays within the culture of medicine, the specialties with the highest rates of burnout today often are not the ones with the lowest incomes; they’re the specialties known for doing the fewest high-status procedures while performing the highest percentage of menial tasks. In many American communities, urology has fallen from the uppermost tier into this lower-esteem category, leaving practitioners dissatisfied, despite their high incomes.

Medicine’s imagined order is well-known to every doctor in the U.S. And it influences everything from a specialty’s perceived value to a doctor’s feelings of self-worth to the care patients receive. And because the doctor’s rank in this hierarchy is so culturally important, doctors are unlikely to admit to patients when they lack experience or specialization. This creates a vicious cycle: the risk of complication rises over time as experience withers. It is a difficult reality for a growing number of urologists whose annual volume of robotic prostatectomies is now in the single digits.

The solution requires changing the system and the culture

In medicine, as in life, two seemingly contradictory notions can both be true at the same time. For example, doctors who point to America’s dysfunctional healthcare system as the source of their burnout are correct. Simultaneously,
the culture of medicine — and its obsession with status — also contributes to doctors’ professional unhappiness. With burnout having roots in both the healthcare system and the medical culture, successful solutions will need to address each.

Often, these two contributors to burnout are intertwined. For example, the American healthcare system’s prevailing fee-for-service method of reimbursement has long contributed to medical culture’s unhealthy preoccupation with status and hierarchy. Consider that specialists who perform complex interventions on patients who are already sick are paid two to three times more than primary care physicians who focus on helping patients avoid illness in the first place. The imbalance in pay reinforces the belief that intervention is more valuable than prevention. In addition to the current payment model, the highly fragmented structure of healthcare delivery in the U.S. reinforces the exceptionality of the individual doctor, thus diminishing the esteem that should come from being associated with a high-performing medical team.

Together, the fee-for-service model and delivery system fragmentation contribute not only to poorer patient care, but also higher levels of physician burnout and dissatisfaction. Altering each offers the potential to improve the health of doctors and patients.

An important first step toward a solution is for doctors to recognize that the burnout problem will not be resolved simply by voicing their dissatisfaction. For more than two decades, American physicians have expressed their frustrations and demanded systemic changes, yet burnout rates continue to rise. Instead of crying out for relief and waiting for things to change, doctors must accept that they have the agency and authority to tear down and reconstruct the U.S. healthcare’s structure and financing. Large, physician-led medical groups that have already done so have succeeded in flattening the hierarchical layers that divide, disconnect, and dissatisfy doctors.

The solution to America’s perverse fee-for-service reimbursement model is for doctors to move to a capitated payment system, one based on a fixed, annual, per-patient payment, made upfront for all healthcare services in the coming year. Compared to fee-for-service payment models, which incentivize doctors to oversupply complex and pricey healthcare services, prepayment (capitation) shifts the focus for physicians from doing more to doing better. Instead of rewarding doctors for intervening once a problem develops, capitation moves doctors in the direction of preventing diseases, avoiding complications, and finding more efficient ways to deliver medical treatment.

Secondly, the most effective and efficient healthcare organizations in the U.S. today are not the ones built around independent, fragmented physician offices. Rather, they include teams of doctors working within large, multispecialty medical groups that accept capitated reimbursements. In these settings, physicians share best practices, learn from each other, and collaborate to provide better medical care — actions that help flatten the healthcare hierarchy while producing higher-quality clinical outcomes at lower costs for patients.

Of course, these structural solutions alone will not eliminate burnout. Oftentimes, the process of delivering care that’s more convenient, lower-cost, and higher-quality comes at a (non-monetary) price. Physicians who work in integrated healthcare organizations have learned that making medical care more efficient is harder than increasing the amount of care provided, but it leads to better outcomes. They know that being part of a team isn’t as special as being a superstar, however, they discover through experience the joy and fulfillment that comes from working collaboratively and doing the right things for patients. Looking back, they rarely long for the days of battling for recognition, income, and status.

Make no mistake, American urologists who attempt these changes will find the tradeoffs difficult to make and success hard to achieve. Improving the quality of surgical outcomes going forward will require a major reduction in the number of urologists performing each type of procedure. Limiting their scope of work will frustrate doctors who enjoy dabbling. Improving outcomes will also require doctors to follow evidenced-based guidelines, which will feel restrictive after decades of enjoying autonomy and independence in their practices. And, of course, it will be hard for surgical specialties in the U.S. to accept the need for greater investments in primary care. Urology is a vital and vibrant part of medicine, providing patients with relief and improved health from infancy through old age. Therefore, the value of urology should not be dependent on the merits of one operation or its technical complexity in comparison to other procedures. Rather than focusing on how urologists can maximize their importance and income compared to other specialists, the time has come for all physicians in the U.S. to recognize the necessity for increased collaboration and teamwork. As long as American medicine remains individualistic and status-driven, a vast number of patients and doctors will suffer.

The structure and culture of medicine in the U.S. reflects the nation’s values and beliefs. Economic or medical systems that depend on individual exceptionalism are satisfying to those at the top, but not to the majority. The change in status for urology and the impact it has had on urologists demonstrates how elusive and dissatisfying the hierarchical quest can be. The current system and culture of American medicine won’t prove successful going forward. Those who accept this reality and lead the transformation have the
opportunity to find greater professional contentment and fulfillment than they have today. Those that don’t will grow ever more dissatisfied and disillusioned.

References

1. Kane L. Medscape national physician burnout & suicide report 2020. Medscape, January 15, 2020: 1-29. Available at: www.medscape.com/slideshow/2020/lifestyle/burnout-6012460
2. Kane L. Medscape national physician burnout, depression & suicide report 2019. Medscape, January 15, 2019: 1-29. Available at: www.medscape.com/slideshow/2019/lifestyle/burnout-depression-6011056?fad=1
3. Pearl R. The link between burnout and physician hierarchy. Forbes, July 24, 2019. Available at: www.forbes.com/sites/robertpearl/2019/07/24/burnout-and-physician-hierarchy
4. American Cancer Society. Observation or active surveillance for prostate cancer, 2020. Available at: www.cancer.org/cancer/prostate-cancer/treating/watchful-waiting.html
5. Lin K. Prostate-specific antigen-based screening for prostate cancer: An evidence update for the U.S. Preventive Services Task Force. Rockville, MD: AHRQ, 2011.
6. US Preventive Services Taskforce. Prostate cancer: Screening, May 8, 2018. Available at: www.uspreventiveservicestaskforce.org/uspstf/recommendation/prostate-cancer-screening
7. Eldhag AG, Watt AM, Mundy L, et al. Over 150 Potentially low-value healthcare practices. Med J Australia 2012;197:556-60. https://doi.org/10.5694/mja12.11083
8. Castellucci M. Most hospitals fail to meet leapfrog’s surgery volume standards. Modern Healthcare, July 18, 2019. Available at: www.modernhealthcare.com/safety-quality/most-hospitals-fail-to-meet-leapfrogs-surgery-volume-standards

Correspondence: Dr. Robert Pearl, Stanford University School of Medicine, Stanford, CA, United States; drobotpearl@gmail.com