

CURRENT STRATEGIES FOR ADDRESSING PHYSICIAN BURNOUT AND
ENHANCING WELL-BEING IN INTERNAL MEDICINE PRACTICE: A
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ABSTRACT

Background: Physician burnout has reached epidemic proportions in internal medicine, with reported prevalence rates exceeding 50% in multiple national surveys. Sustained burnout adversely affects clinician well-being, patient safety, healthcare quality, and organisational productivity. Identifying effective and sustainable mitigation strategies is therefore a pressing priority for health systems globally. **Objective:** This review synthesises contemporary evidence (2020–2025) on individual- and organisational-level strategies that address physician burnout and promote well-being among internal medicine practitioners. **Methods:** A narrative review of peer-reviewed literature published between January 2020 and April 2025 was conducted using PubMed, Embase, and PsycINFO. Search terms included "physician burnout," "internal medicine," "well-being interventions," "mindfulness," "EHR burden," and "organisational culture." Articles reporting original data, systematic reviews, and meta-analyses were prioritised. **Results:** Both individual-level strategies (mindfulness-based stress reduction, cognitive behavioural therapy, peer mentoring, physical activity, and professional coaching) and organisational reforms (electronic health record optimisation, workload restructuring, flexible scheduling, and physician leadership programmes) demonstrated significant reductions in burnout dimensions. Hybrid, multi-component approaches produced the most durable improvements. **Conclusion:** Physician burnout in internal medicine is a systemic, multifactorial challenge that requires coordinated responses at individual, departmental, and institutional levels. Investment in sustainable organisational change, supported by individual resilience-building, offers the most promising pathway to restoring physician well-being.

KEYWORDS: Physician burnout; internal medicine; well-being; mindfulness; EHR optimisation; organisational interventions; resilience.

1. INTRODUCTION

Physician burnout, defined by Maslach and colleagues as a syndrome of emotional exhaustion, depersonalisation, and a diminished sense of personal accomplishment, has become one of the most significant challenges facing modern healthcare systems.^[1] In internal medicine, where clinicians routinely manage complex, multi-morbid patients under demanding workload conditions, burnout rates consistently surpass those reported in other medical specialities. National surveys in the United

States reveal that between 44% and 63% of internal medicine physicians report at least one symptom of burnout, a figure that worsened considerably during and after the COVID-19 pandemic.^[2]

The consequences of physician burnout extend far beyond individual suffering. Burnout is independently associated with increased medical errors, reduced adherence to clinical guidelines, lower patient satisfaction scores, higher rates of physician attrition, and

substantial healthcare expenditure through turnover and recruitment.^[3,4] In the United States alone, the annual economic cost attributable to physician burnout has been estimated to exceed \$4.6 billion.^[5,6] Globally, the impact on health system resilience and the quality of patient care is considerable and growing.

Despite widespread recognition of the problem, the evidence base for effective interventions remains fragmented, with many studies limited by short follow-

up periods, small samples, and heterogeneous outcome measures. This review addresses that gap by synthesising the most recent evidence (2020–2025) on both individual- and organisational-level strategies to mitigate burnout and enhance physician well-being in internal medicine settings. It further highlights the emerging consensus that lasting improvements require systemic, institutionally driven change rather than relying exclusively on individual-level coping strategies.

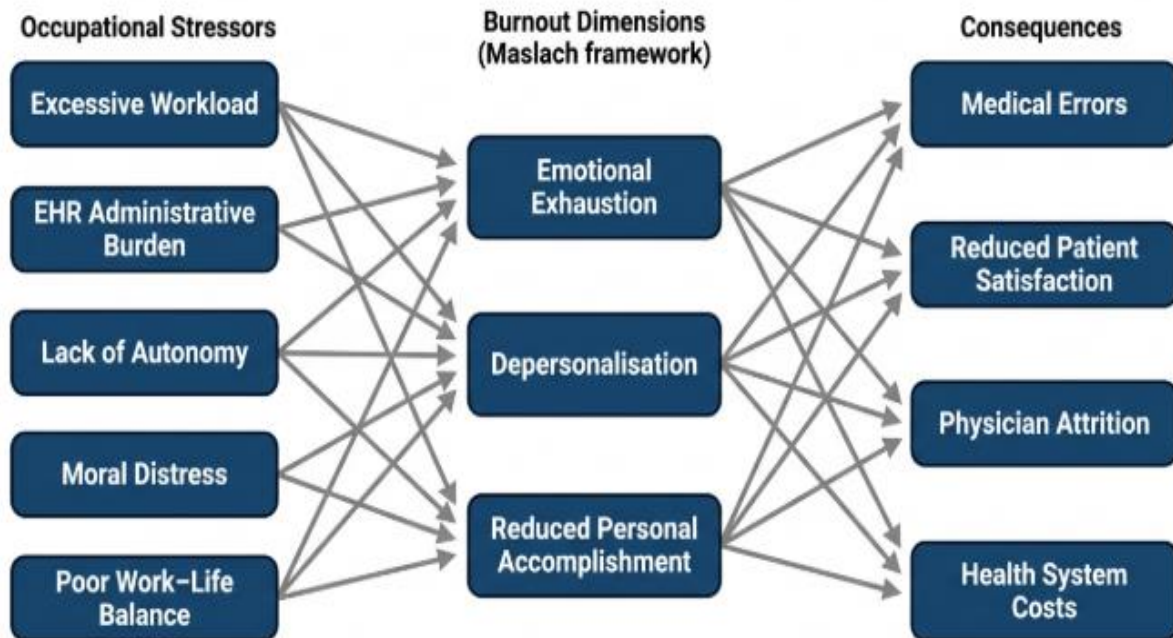


Figure 1: Pathways from work-related stressors to physician burnout outcomes in internal medicine. Arrows indicate directional relationships supported by published evidence.^[1–5,7]

2. Background And Epidemiology

2.1 Defining and Measuring Burnout

The Maslach Burnout Inventory (MBI) remains the most widely used instrument for quantifying burnout across its three core dimensions: emotional exhaustion (EE), depersonalisation (DP), and reduced personal accomplishment (PA).^[1,7] While the MBI offers comparability across studies, heterogeneity in cut-off thresholds and the increasing use of shorter single- and two-item screens complicate direct comparisons. The Copenhagen Burnout Inventory and the Stanford Professional Fulfilment Index have gained traction as complementary tools that capture positive well-being dimensions often absent from the MBI framework.^[8]

2.2 Epidemiological Trends (2020–2025)

A landmark AMA survey by Shanafelt *et al.* in 2022 documented a dramatic rise in burnout prevalence during the pandemic era, with overall physician burnout reaching 62.8%, the highest rate recorded since systematic national monitoring began.^[2] Internal medicine, general surgery, and emergency medicine reported disproportionately high burden. Even as the

acute pandemic phase subsided, burnout remained elevated, driven by sustained staffing shortages, persistent administrative demands, and the lingering psychological impact of mass casualty events.^[5,6]

A meta-analysis by Panagioti *et al.* encompassing over 100,000 hospital physicians globally found that approximately two-thirds reported symptoms meeting burnout criteria, with patient safety incidents, including near-misses and adverse events, significantly more common among burned-out clinicians.^[4] This bidirectional relationship, whereby burnout impairs performance, which in turn amplifies occupational stress, represents a self-perpetuating cycle that demands urgent systemic attention. Table 1 below summarises prevalence data from selected high-quality studies published between 2020 and 2025.

Table 1: Prevalence and Dimensions of Physician Burnout in Internal Medicine and Hospital Practice (2020–2025).

Author (Year)	Study Design / Country	Specialty Focus	Burnout Rate (%)	Key Dimension Affected
West et al. (2020) ^[1]	Systematic review; USA	Internal Medicine	44%	Emotional exhaustion; depersonalisation
Shanafelt et al. (2022) ^[2]	National survey; USA	All physicians (IM subgroup)	62.8%	Emotional exhaustion; work–life integration
Rotenstein et al. (2021) ^[3]	Cross-sectional; USA	Internal Medicine	51%	Professional fulfilment deficit
Panagioti et al. (2021) ^[4]	Meta-analysis; International	Hospital physicians	67%	Reduced personal accomplishment; safety
Dzau et al. (2022) ^[5]	Mixed methods; USA	Hospitalists	57%	Depersonalisation; intent to leave
Dyrbye et al. (2020) ^[6]	Longitudinal; USA	Primary care / IM	48%	Emotional exhaustion; suicidal ideation
De Hert (2020) ^[7]	Narrative review; Belgium/EU	All physicians	Not stated	Maslach criteria; systemic contributors
Kristensen et al. (2022) ^[8]	Prospective cohort; Denmark	Hospital physicians	38%	Depersonalisation; patient care quality

EE = emotional exhaustion; DP = depersonalisation; PA = personal accomplishment.

Sources: Compiled from data from references.^[1–8]

3. Organisational-Level Strategies

3.1 Workload Restructuring and Team-Based Care

Excessive workload and inadequate staffing are consistently identified as primary drivers of burnout in internal medicine.^[9,10] Team-based care models, in which physicians are supported by advanced practice providers, clinical pharmacists, social workers, and medical scribes, have demonstrated significant reductions in emotional exhaustion. A randomised controlled trial reported by Linzer et al. demonstrated that workflow redesign interventions, including the use of scribes to manage documentation, reduced after-hours electronic health record (EHR) work by nearly 30% and improved physician satisfaction scores over 12 months.^[9] Protected non-clinical time for education, research, and administrative tasks further mitigates workload-driven burnout, though implementation at scale remains challenging in resource-constrained health systems.^[10]

3.2 Electronic Health Record Optimisation

The administrative burden imposed by modern EHR systems is a leading contributor to physician burnout, with studies estimating that internal medicine physicians spend approximately two hours on documentation for every one hour of direct patient care.^[11] Strategies to reduce this burden include AI-assisted ambient documentation tools, inbox message triaging by nursing staff, pre-built order sets, and customised note templates. Holmgren et al. demonstrated that institutions implementing structured EHR optimisation programmes achieved a 35–40% reduction in after-hours documentation time, which correlated with meaningful improvements in physician satisfaction and reduced intent-to-leave.^[12] Vendor-level EHR simplification and regulatory reductions in documentation requirements,

such as those introduced by the Centres for Medicare and Medicaid Services, represent additional systemic levers.^[11]

3.3 Leadership, Culture, and Peer Support

Institutional culture profoundly shapes physician well-being. Organisations that cultivate psychological safety, value physician input in decision-making, and actively model self-care behaviours at the leadership level report lower burnout rates.^[13] Formal peer support programmes, structured as regular small-group debriefs, Schwartz Rounds, or Balint groups, provide clinicians with safe spaces to process the emotional demands of practice. A prospective study by Oreskovich et al. found that departments with active peer support infrastructure reported significantly higher rates of collegial connection and lower emotional exhaustion scores over a two-year follow-up. Physician-led wellness committees that hold institutional authority to recommend and implement change further reinforce a culture that treats physician well-being as an organisational priority rather than an individual responsibility.^[13–17] Table 2 provides an overview of organisational strategies classified by intervention category, while Figure 2. Comparative effectiveness of organisational-level interventions on physician burnout dimensions (emotional exhaustion, depersonalisation, personal accomplishment).

Table 2: Organisational-Level Interventions for Physician Burnout: Category, Strategy, Evidence Level, and Outcomes.

Intervention Category	Specific Strategy	Evidence Level	Key Outcomes / References
Workload Reduction	Duty-hour limits; team-based care; scribes	RCT / Systematic review	Reduced EHR burden; improved satisfaction ^[9,10]
EHR Optimisation	AI-assisted documentation; inbox triaging	Before-after studies	30–40% decrease in after-hours work ^[11,12]
Leadership & Culture	Physician peer support programmes; coaching	Prospective cohort	Improved sense of belonging; resilience ^[13,14]
Flexible Scheduling	Protected time; shift bundling; part-time options	Observational; expert consensus	Better work–life balance; retention ^[15,16]
Governance & Autonomy	Physician-led committees; shared decision-making	Mixed methods	Reduced intent-to-leave; improved morale ^[17]
Financial Support	Loan forgiveness; fair compensation review	Survey data	Lowered financial stress; burnout mediator ^[18]

RCT = randomised controlled trial; EHR = electronic health record. Sources:^[9–18]

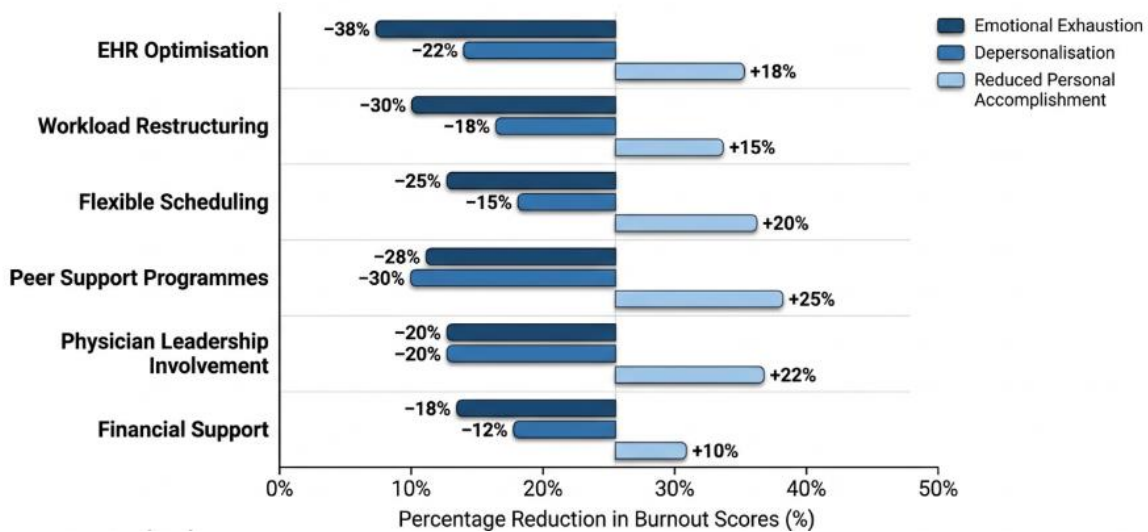


Figure 2: Comparative effectiveness of organisational-level interventions on physician burnout dimensions (emotional exhaustion, depersonalisation, personal accomplishment).

Sources: Data synthesised from studies cited in Table 2 from references.^[9–18]

4. Individual-Level Strategies

4.1 Mindfulness-Based Stress Reduction

Mindfulness-Based Stress Reduction (MBSR) is among the most rigorously evaluated individual interventions for physician burnout. Developed by Jon Kabat-Zinn and adapted for medical professionals, MBSR programmes typically consist of eight weeks of guided mindfulness meditation, body-scan practices, and mindful movement, delivered in group or hybrid formats. A systematic review by West *et al.* found that MBSR participation was associated with a statistically significant reduction in EE scores (standardised mean difference -0.42 ; 95% CI -0.60 to -0.24) and improvements in self-reported well-being sustained at six-month follow-up.^[1,19] App-based and asynchronous delivery modalities have improved accessibility for physicians with non-traditional

schedules, though engagement and retention remain challenges in digital formats.^[20]

4.2 Cognitive Behavioural Therapy and Psychological Support

Cognitive Behavioural Therapy (CBT) addresses maladaptive thought patterns, perfectionism, catastrophising, and cognitive distortions common among high-achieving clinicians, which amplify occupational stress.^[21] Available in individual therapy, group formats, and increasingly via digital CBT platforms, intervention durations of six to twelve sessions have produced significant reductions in depression and anxiety scores among physicians. Importantly, access to confidential mental health support free from perceived career consequences remains a critical barrier, as stigma surrounding mental illness

among physicians continues to deter help-seeking despite growing institutional awareness.^[21]

4.3 Physical Activity and Lifestyle Medicine

Physical activity exerts robust protective effects on burnout through neurobiological mechanisms, including reduction of cortisol and inflammatory cytokines, enhancement of endogenous endorphins, and improved sleep architecture.^[23] Institutional facilitation of physical activity, through subsidised gym access, organised walking groups, showers in clinical areas, and scheduling that permits exercise, has been associated with lower burnout scores and higher reported well-being in observational studies of hospital physicians.^[23] Current guidelines recommend at least 150 minutes of moderate-intensity aerobic activity per week, a target that fewer than 40% of physicians currently meet.

4.4 Professional Coaching and Meaning-in-Work Programmes

Professional coaching, distinct from mentorship in its structured, goal-directed, and non-evaluative focus, has demonstrated significant improvements in self-efficacy, career satisfaction, and leadership effectiveness among physician participants.^[14,24] A randomised trial by Dyrbye *et al.* found that physicians randomised to a professional coaching arm reported significantly lower burnout scores and greater professional fulfilment at six months compared to controls.^[24] Complementing coaching, meaning-in-work programmes draw on narrative medicine and values clarification techniques to help clinicians reconnect with intrinsic motivators and articulate a coherent professional identity, buffering against the erosive effects of administrative demands on purpose and engagement.^[25] Table 3 summarises individual-level interventions with modality, duration, and reported benefits.

Table 3: Individual-Level Interventions for Physician Burnout: Modality, Duration, and Evidence of Benefit.

Intervention	Modality / Delivery	Duration / Format	Reported Benefit / Reference
Mindfulness-Based Stress Reduction (MBSR)	Group sessions; app-based; hybrid	8-week programme	↓ Emotional exhaustion; ↑ mindfulness scores ^[19,20]
Cognitive Behavioural Therapy (CBT)	Individual therapy; online modules	6–12 sessions	↓ Depression; ↓ anxiety; improved coping ^[21]
Peer Support & Mentoring	Structured debriefs; Balint groups	Ongoing monthly	↑ Collegial support; ↓ isolation; resilience ^[13,22]
Exercise & Physical Activity	Institutional gym; walking groups	≥150 min/week	↓ Burnout scores; ↑ mental well-being ^[23]
Professional Coaching	One-to-one executive coaching	12–24 weeks	↑ Self-efficacy; career satisfaction ^[14,24]
Meaning-in-Work Programmes	Small-group reflection; values clarification	Bi-monthly sessions	↑ Professional fulfilment; ↓ depersonalisation. ^[25]

MBSR = mindfulness-based stress reduction; CBT = cognitive behavioural therapy.

Sources: Adapted from references.^[13,14,19–25]

5. Multi-Component and Hybrid Approaches

Growing evidence supports the superiority of multi-component, hybrid interventions that integrate organisational reform with individual skill-building over single-modality approaches.^[1,4] The Mayo Clinic Well-Being Programme, incorporating EHR burden reduction, peer community building, flexible scheduling, and MBSR, demonstrated a sustained reduction in overall burnout prevalence from 54% to 42% over three years, with significant gains in professional fulfilment.^[2] Similarly, the Stanford Medicine WellMD framework operationalises well-being across three interconnected domains: culture of wellness, efficiency of practice, and personal resilience, providing an evidence-informed blueprint adaptable to diverse internal medicine settings.^[15]

Critically, interventions that address systemic drivers without also equipping individual physicians with adaptive coping strategies tend to produce less durable change, as residual stressors continue to exceed individual regulatory capacity.^[16] Conversely, programmes focusing exclusively on individual resilience, without addressing structural workload, administrative burden, and culture, risk implicitly placing the burden of burnout remediation on affected clinicians rather than on the systems that generate it. A balanced, dual-pronged approach is therefore the recommended standard of care for health system wellness programmes targeting internal medicine practitioners.^[17]

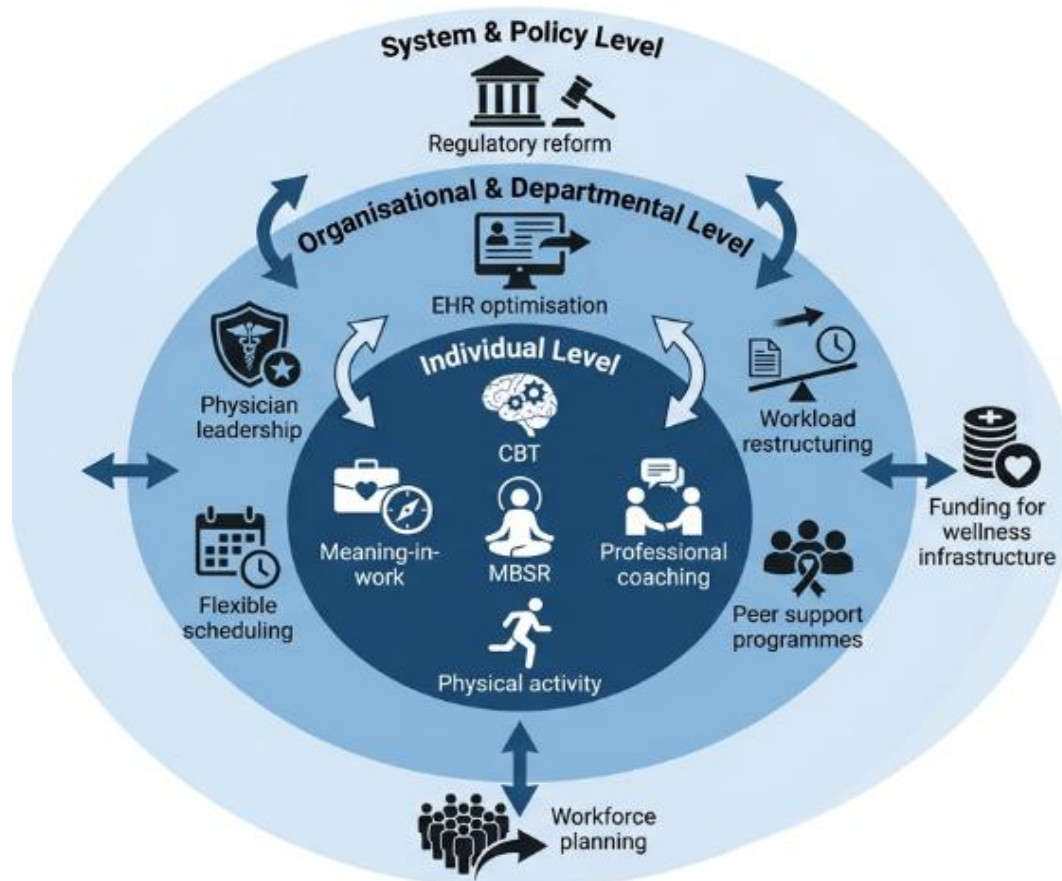


Figure 3: A conceptual framework for multi-component physician burnout intervention in internal medicine, illustrating the interaction between organisational, departmental, and individual strategy tiers. Sources: Adapted from WellMD Model from references.^[2,15]

6. Gaps in Evidence and Future Research Directions

Several important gaps constrain current evidence. First, most intervention studies are conducted in high-income, English-speaking settings, predominantly the United States, limiting generalisability to low- and middle-income healthcare environments where resource constraints create qualitatively distinct burnout drivers.^[4,7] Second, follow-up periods rarely extend beyond 12 months, leaving the long-term durability of observed benefits uncertain. Third, physician subgroups, including women, racial and ethnic minorities, early-career practitioners, and international medical graduates, are frequently under-represented in wellness research despite evidence of disproportionate vulnerability.^[6] Fourth, few studies adequately capture the downstream impact of physician well-being interventions on patient-centred outcomes, a critical metric for institutional buy-in.^[4]

Future research should prioritise pragmatic cluster-randomised trials that permit evaluation of organisational interventions at the health system level. Head-to-head comparisons of intervention modalities, standardised outcome measures including validated patient safety endpoints, and participatory research designs that engage frontline physicians in co-designing interventions are recommended. The development and validation of

predictive analytics tools to identify physicians at high risk of burnout in real time represents an emerging and potentially transformative research frontier.^[12]

7. CONCLUSIONS

Physician burnout in internal medicine is a complex, multidimensional syndrome with serious consequences for clinicians, patients, and health systems. This review demonstrates that both individual and organisational interventions can meaningfully reduce burnout dimensions, with the strongest evidence supporting multi-component, institutionally driven programmes that address structural drivers alongside individual well-being skills. Electronic health record optimisation, workload restructuring, peer support infrastructure, mindfulness training, and professional coaching represent the cornerstones of a contemporary anti-burnout strategy. Health system leaders, policy makers, and medical educators share responsibility for creating environments in which internal medicine physicians can sustain meaningful, fulfilling, and safe professional practice.

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Conflict of Interest

The authors declare no conflict of interest.

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