

AI-04714 Fault Tree Analysis-Failed MD Practice Year 1

#fta

Perform an Fault Tree Analysis of a new Internal Medicine MD in Hernando, FL discouraged, thinking failure, relocating thoughts 1 year as a co-practicing physician in a small 35-year medical clinic.

Fault Tree Analysis (FTA)

New Internal Medicine MD → Discouraged, Thinking “I’m Failing,” Considering Relocation

First-Year Risk in a Small, 35-Year Medical Clinic — Hernando, Florida

Analysis perspective: This is a hypothetical organizational and professional-risk analysis—not a diagnosis of the physician or a prediction that relocation will occur. The purpose is to identify how a capable new physician might move from **normal first-year difficulty** to **discouragement, perceived failure, and thoughts of leaving**, and where the chain can be interrupted.

Important distinction: A physician feeling discouraged or considering relocation is not necessarily failing. It may be a rational response to a mismatch between expectations, workload, support, autonomy, compensation, or the practice environment.

Research consistently identifies workload, administrative burden, insufficient resources, low autonomy, conflict, and inadequate organizational support as contributors to physician burnout and turnover intentions. ([PubMed](#))

1. Define the Top Event

● TOP EVENT

New Internal Medicine MD becomes sufficiently discouraged during the first year that the physician begins to believe the practice is a professional failure and seriously considers relocating or leaving the clinic.

This top event has three distinct levels:

Level	Meaning	Observable indicators
Discouraged	Work is not meeting expectations emotionally or professionally	Frustration, disappointment, reduced enthusiasm
Thinking “I’m failing”	Difficulties become interpreted as personal inadequacy	Self-doubt, loss of confidence, comparing self unfavorably
Relocation thoughts	The physician begins considering departure as a solution	Searching for other jobs, discussing moving, evaluating other practices

FTA objective: Prevent ordinary professional friction from escalating into a sustained perception that **“I cannot succeed here.”**

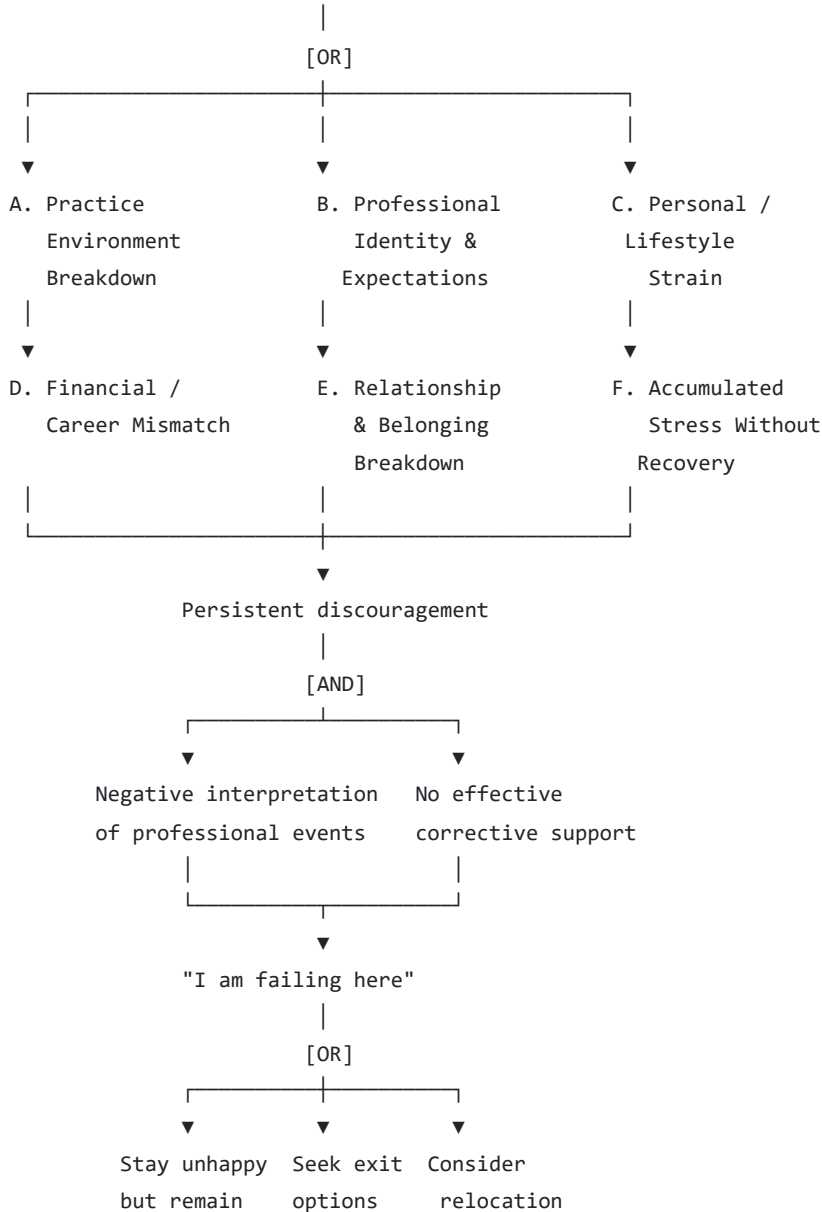
2. Fault Tree — High-Level Structure

Logic notation

- **OR:** Any one pathway can contribute to the top event.
- **AND:** Multiple conditions must occur together.
- **Transfer:** A contributing subsystem is expanded separately.

TOP EVENT

New Internal Medicine MD becomes discouraged,
believes they are failing, and considers relocating

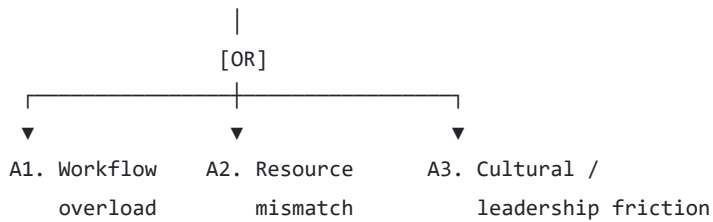


Interpretation: The physician does not need to experience every failure mode. One severe pathway—or several moderate pathways occurring together—may be enough.

3. Expanded Fault Tree A — Practice Environment Breakdown

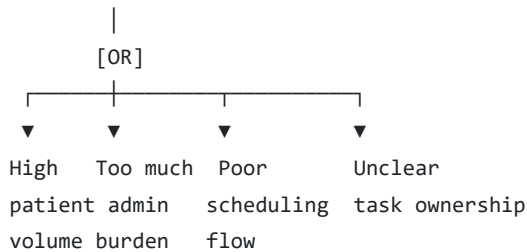
A. New Physician Experiences the Clinic as Difficult to Operate Within

A. PRACTICE ENVIRONMENT BREAKDOWN



A1. Workflow Overload

A1. WORKFLOW OVERLOAD

**Possible first-year manifestations:**

- Patient volume grows faster than the physician's familiarity with the clinic.
- Appointments are scheduled too tightly.
- Follow-ups, medication refills, results, messages, and documentation accumulate.
- The physician takes unfinished work home.
- The clinic's established workflow was designed around the founding physicians' habits rather than the new MD's needs.
- Staff may be accustomed to doing things "the way they have always been done."
- The physician feels constantly behind despite working hard.

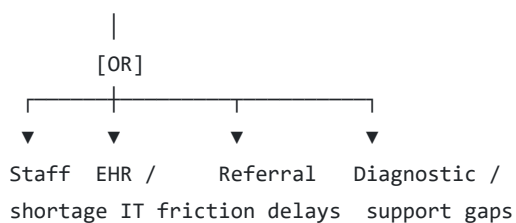
Failure mechanism:

Work accumulates → visible backlog increases → physician feels behind → confidence declines → work becomes emotionally threatening.

Time pressure, chaotic environments, low control over work pace, and unfavorable organizational culture are associated with physician stress, dissatisfaction, burnout, and intent to leave. ([AHRQ](#))

A2. Resource Mismatch

A2. RESOURCE MISMATCH

**Potential conditions:**

- Insufficient medical assistant or nursing support.

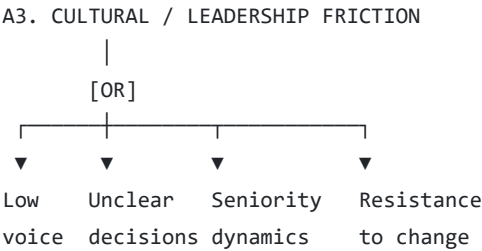
- Staff are competent but stretched across multiple physicians.
- EHR templates are inefficient or unfamiliar.
- Prior authorizations and referral coordination consume physician time.
- Lab and imaging results require excessive manual follow-up.
- The new physician lacks a reliable escalation pathway for complex cases.
- The physician is expected to solve operational problems personally.

Psychological conversion:

“The system is inefficient” can gradually become **“I am inefficient.”**

This is a classic attribution risk: organizational friction becomes internalized as personal incompetence.

A3. Cultural / Leadership Friction



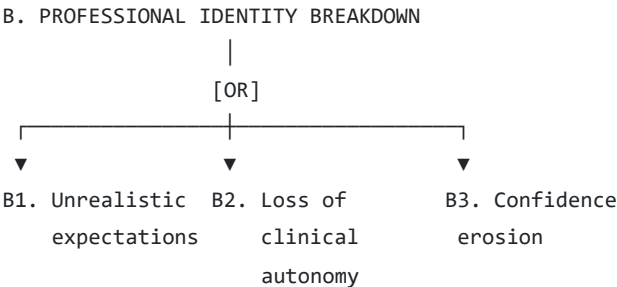
Examples in a long-established clinic:

- The founding physicians' preferences dominate every decision.
- The new MD has responsibility without meaningful authority.
- Feedback is delivered only when something goes wrong.
- The physician's ideas are dismissed as “not how we do things.”
- The new MD feels like an employee rather than a true co-practitioner.
- Expectations are communicated informally or inconsistently.
- There is no structured monthly review of how the partnership is working.

Key risk: A **35-year history** can be a major asset—patient trust, reputation, referral relationships, and operational knowledge—but it can also create inertia if the new physician is expected to assimilate without being meaningfully integrated.

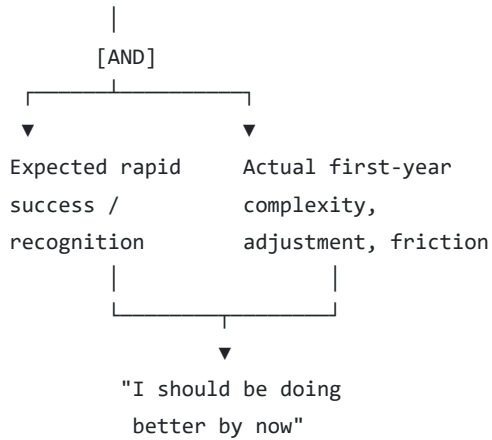
4. Expanded Fault Tree B — Professional Identity & Expectation Breakdown

B. The Physician Interprets Normal Difficulty as Personal Failure



B1. Unrealistic Expectations

B1. EXPECTATION MISMATCH



Potential expectation mismatches:

- Expecting immediate patient-panel growth.
- Assuming an established clinic automatically means effortless integration.
- Expecting the patient population to accept the new physician immediately.
- Expecting compensation to reflect future productivity before the panel matures.
- Expecting the practice to operate like a residency or hospital system with abundant support.
- Expecting clinical competence to translate automatically into business, workflow, and relationship competence.

Failure interpretation:

Adjustment period → "I am underperforming."

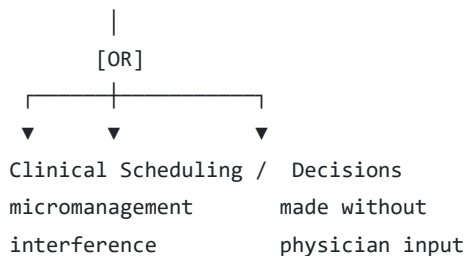
Learning curve → "I am not good enough."

Slow panel growth → "Patients do not want me."

Operational friction → "This practice is rejecting me."

B2. Loss of Clinical Autonomy

B2. LOSS OF AUTONOMY



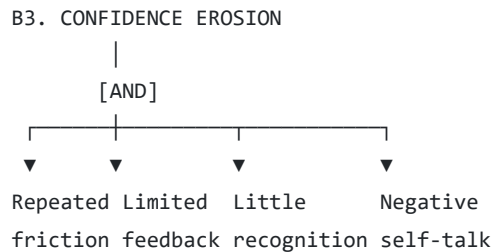
A new physician may become discouraged when expected to carry the responsibility of medical decisions but lacks control over:

- Appointment duration.
- Patient scheduling.
- Staffing support.
- Clinical protocols.
- Referral processes.

- Time allocation.
- Workload boundaries.
- Practice improvement priorities.

Autonomy and flexibility are repeatedly identified as protective factors, while constrained organizational structures and lack of control are associated with burnout risk. ([PubMed](#))

B3. Confidence Erosion



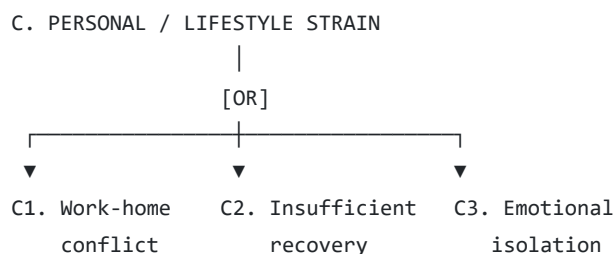
Possible progression:

1. A difficult patient encounter occurs.
2. A referral, documentation, or workflow issue goes poorly.
3. The physician receives little positive feedback.
4. Similar events accumulate.
5. The physician begins selectively noticing evidence of failure.
6. Normal uncertainty becomes evidence of inadequacy.
7. Confidence decreases.
8. Avoidance, indecision, irritability, or withdrawal may increase.

Important: A physician can be clinically capable while temporarily experiencing low professional self-efficacy.

5. Expanded Fault Tree C — Personal, Family & Lifestyle Strain

C. Work Stress Exceeds Recovery Capacity



C1. Work–Home Conflict

- Long workdays.
- Documentation after clinic hours.
- Unpredictable patient or administrative demands.
- Difficulty protecting evenings or weekends.
- Family expectations not aligned with the new work reality.

- Relocation-related household or financial adjustments.

C2. Insufficient Recovery

- Sleep disruption.
- Reduced exercise.
- No protected personal time.
- Persistent cognitive load after leaving the clinic.
- Inability to mentally “switch off.”
- Using days off to catch up rather than recover.

C3. Emotional Isolation

- The physician feels unable to admit difficulty.
- Fear that asking for help signals incompetence.
- Limited peer network in the new community.
- No trusted person at the clinic for confidential discussion.
- Comparison with established physicians who appear effortlessly successful.

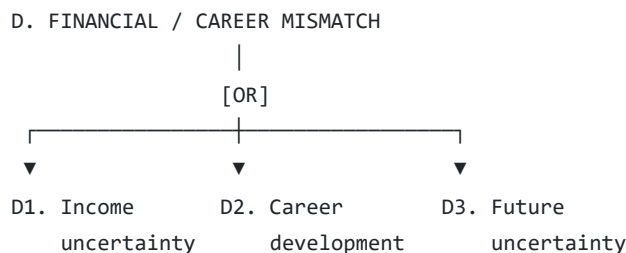
Fault mechanism:

High demand + low recovery + low support → reduced resilience → ordinary problems feel overwhelming.

Work-home conflict, long hours, loss of support, and deteriorating control are established contributors to physician burnout. (DOI)

6. Expanded Fault Tree D — Financial & Career Mismatch

D. The Practice Does Not Deliver the Expected Career Outcome



D1. Income Uncertainty

Potential causes:

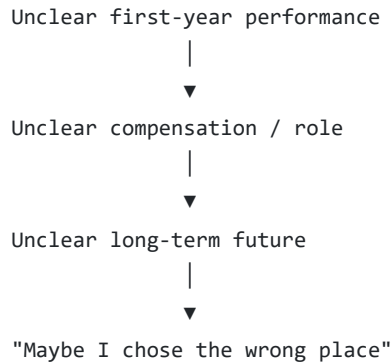
- Patient panel grows more slowly than anticipated.
- Compensation formula is unclear.
- Collections lag behind visits.
- Overhead allocation is not transparent.
- Productivity expectations are not aligned with ramp-up time.
- The physician feels financially under-rewarded for effort.

D2. Career Development Uncertainty

- No defined pathway toward partnership or ownership.

- Unclear decision rights.
- No professional development budget.
- No protected time for specialization or clinical interests.
- No plan for expanding the physician's patient base.
- The physician cannot see how year two will improve.

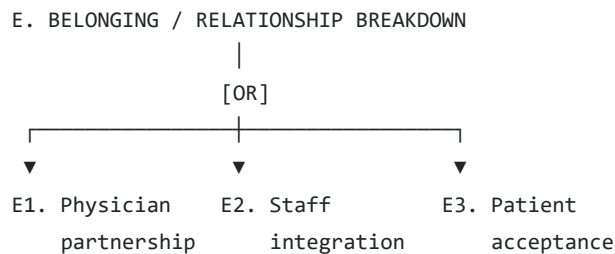
D3. Future Uncertainty



Critical insight: The physician may not be trying to escape medicine. They may be trying to escape an unclear career trajectory.

7. Expanded Fault Tree E — Relationship & Belonging Breakdown

E. The New MD Never Fully Becomes a Co-Practitioner



E1. Physician Partnership Problems

- Existing physicians retain informal control.
- Clinical disagreements are not resolved constructively.
- The new MD's schedule or preferences are treated as secondary.
- Workload distribution is perceived as unfair.
- The new physician is not included in strategic decisions.
- Feedback is either absent or overly corrective.

E2. Staff Integration Problems

- Staff do not know the new physician's preferences.
- Staff loyalty is primarily to established physicians.
- Communication styles differ.
- Instructions are inconsistently followed.
- The physician feels they must repeatedly prove legitimacy.

E3. Patient Acceptance Problems

- Long-term patients prefer the founding physicians.
- Patients ask to be transferred back.
- The new physician is compared to the predecessor.
- The physician interprets patient preference as rejection.
- The community's established relationships take time to develop.

Potential internal narrative:

"I am not really part of this clinic."

"I am only covering a need."

"The patients belong to the other doctors."

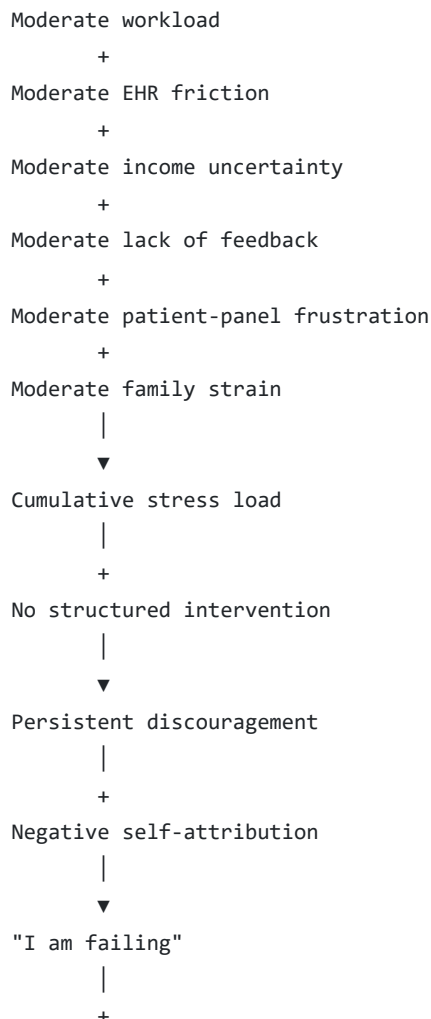
"I will never have a successful practice here."

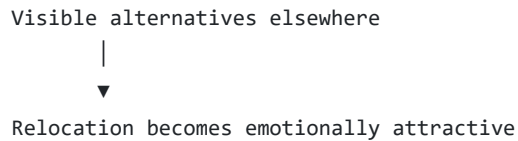
Collegiality, meaningful work, supportive leadership, and feeling valued are protective organizational factors for physician well-being. ([BMJ Open](#))

8. Expanded Fault Tree F — Accumulation & Escalation

F. Multiple Moderate Problems Become One Large Psychological Event

This is often the most realistic pathway.





The “Last Straw” Principle

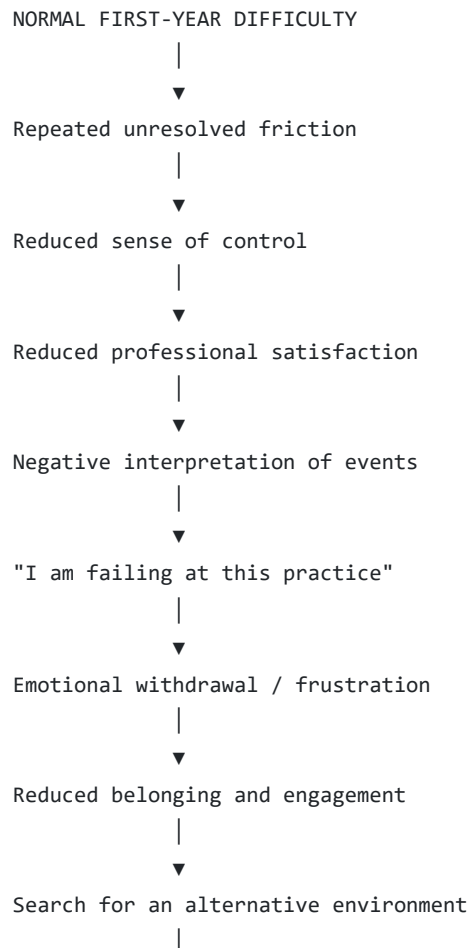
The final trigger may be relatively small:

- A difficult meeting.
- A compensation disagreement.
- A patient complaint.
- A scheduling conflict.
- A rejected workflow proposal.
- A particularly exhausting week.
- A comparison with another physician's success.
- A family member asking, “Are you happy there?”

The last straw is rarely the whole cause. It activates accumulated unresolved problems.

9. Detailed Fault Tree: From Discouragement to Relocation

The Escalation Chain



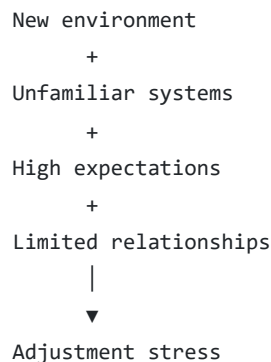
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Relocation thoughts

Escalation Gates

Gate	Question	If "No," risk increases
Gate 1: Reality	Is the problem objectively identified?	Everything feels like generalized failure
Gate 2: Support	Can the physician discuss it safely?	Problems remain hidden
Gate 3: Control	Can something about the situation be changed?	Helplessness develops
Gate 4: Feedback	Does the physician receive balanced, specific feedback?	Self-doubt fills the information gap
Gate 5: Belonging	Does the physician feel like a genuine member of the practice?	Exit becomes more attractive
Gate 6: Future	Is there a credible path to a better second year?	Relocation appears rational

10. Fault Tree by First-Year Timeline

Months 0–3: Orientation Shock



Typical vulnerabilities

- Learning the clinic's workflow.
- Learning staff communication patterns.
- Understanding patient expectations.
- Establishing referral relationships.
- Learning local practice norms.
- Comparing current performance with an imagined ideal.

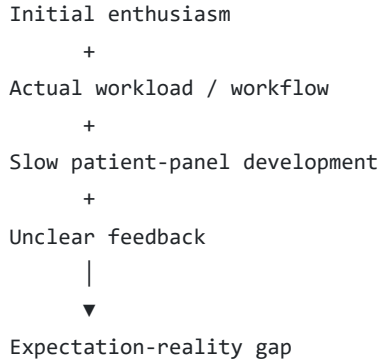
Early warning signs

- "I didn't expect it to be this difficult."
- "I am still trying to figure out how things work."
- Frequent questions about workflow.

- Staying late to complete routine work.
- Hesitation to ask for help.

Interpretation: Usually an **integration problem**, not evidence of failure.

Months 3–6: Reality Gap



Typical vulnerabilities

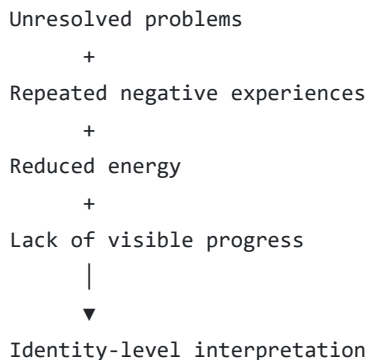
- The novelty wears off.
- Operational inefficiencies become more visible.
- Compensation and productivity expectations become tangible.
- Patient acceptance may be slower than expected.
- The physician begins evaluating whether the arrangement is sustainable.

Early warning signs

- "I work hard, but I don't feel like I'm progressing."
- "I don't know what success looks like here."
- "I am not sure what they expect from me."
- "I feel like I am carrying responsibility without authority."

Interpretation: This is a critical **feedback and redesign window**.

Months 6–9: Identity Risk



Typical vulnerabilities

- "Maybe I am not suited for this."

- “Maybe I made the wrong career decision.”
- “Maybe I should practice somewhere else.”
- Increased comparison with established physicians.
- Emotional detachment from the clinic.

Early warning signs

- Avoiding practice discussions.
- Less willingness to propose improvements.
- Reduced enthusiasm for patient care.
- Irritability or cynicism.
- Quietly exploring other opportunities.

Interpretation: The problem may have moved beyond workflow into **professional identity and belonging**.

Months 9–12: Decision Point



Possible outcomes

Outcome	Description
Thriving	Physician feels competent, supported, valued, and optimistic
Surviving	Physician remains but feels emotionally or professionally strained
Renegotiating	Physician seeks changes in workload, compensation, autonomy, or role
Relocating	Physician concludes another environment may fit better
Leaving medicine/practice	Distress becomes broad enough to affect professional direction

Relocation is not automatically a failure event. If the practice is genuinely incompatible with the physician's needs, leaving may be an appropriate professional decision. The risk is when relocation is driven by an inaccurate conclusion that **“I am personally a failure,”** rather than a clear assessment of fit.

11. Primary Root Causes vs. Secondary Effects

A useful FTA distinguishes the **root causes** from the **visible symptoms**.

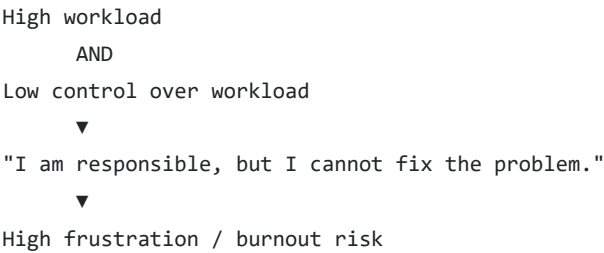
Root cause	Intermediate event	Visible effect
Unclear expectations	Physician cannot assess progress	“I don't know if I'm doing well”

Inadequate staffing	Work accumulates	Exhaustion, frustration
Poor feedback	No objective calibration	Self-doubt
Low autonomy	Responsibility exceeds control	Helplessness
Weak integration	Physician feels peripheral	Withdrawal
Unclear compensation	Effort-to-reward mismatch	Resentment
Poor workflow	Excessive after-hours work	Work-home conflict
No future plan	No reason to expect improvement	Relocation thoughts
Lack of psychological safety	Problems remain unspoken	Sudden exit consideration

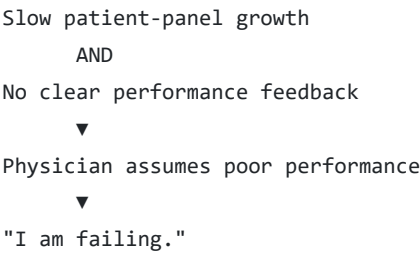
12. Critical Fault Combinations

The following combinations are particularly dangerous because they amplify one another.

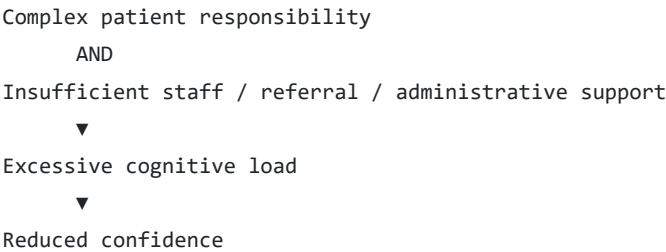
Combination 1 — Workload + Low Autonomy



Combination 2 — Slow Growth + Poor Feedback



Combination 3 — Clinical Responsibility + Weak Support



Combination 4 — Cultural Inertia + New Physician Expectations

Established 35-year clinic culture

AND

New MD expects meaningful participation

▼

Role ambiguity / belonging friction

▼

"I am not truly a co-practitioner."

Combination 5 — Work Stress + No Recovery

Persistent work stress

AND

Insufficient recovery

▼

Emotional depletion

▼

Normal problems feel intolerable

Combination 6 — Discouragement + Attractive Alternative

Persistent discouragement

AND

Awareness of another practice / city / opportunity

▼

Relocation becomes the default solution

13. Preventive Barriers — How to Break the Fault Tree

The strongest prevention strategy is not simply telling the physician to “be resilient.” Evidence emphasizes organizational interventions such as leadership support, practice efficiency, reduced administrative burden, autonomy, collegiality, and meaningful work. ([PubMed Central \(PMC\)](#))

Barrier 1 — Define Success Before Problems Become Personal

Create a written **first-year success agreement**.

Area	Define explicitly
Clinical	Patient-care quality, scope, referral support
Operational	Expected patient volume, schedule, documentation standards
Financial	Compensation formula, ramp-up period, collections timing
Relational	Decision rights, staff support, physician participation
Development	Mentoring, CME, specialty interests, professional goals
Review	30-, 60-, 90-day and quarterly reviews

Purpose: Replace vague self-judgment with observable criteria.

Barrier 2 — Build a 90-Day Integration System

NEW MD

- |
- |— Assigned physician mentor
- |— Named operational contact
- |— Staff workflow orientation
- |— EHR optimization session
- |— Referral / hospital process map
- |— Weekly check-in initially
- |— 30 / 60 / 90-day review

Key principle: Do not assume a highly trained physician automatically understands the operating system of a 35-year-old clinic.

Barrier 3 — Separate Clinical Feedback from Personal Worth

Poor feedback

"You need to do better."

Useful feedback

"Your clinical work is progressing well. The main issue is that results management is consuming too much after-hours time. Let's redesign that workflow."

The second statement identifies a **system problem** rather than converting it into an identity judgment.

Barrier 4 — Establish a Monthly Physician Operating Review

Suggested agenda

1. **Clinical workload**
2. **Patient-panel growth**
3. **Schedule pressure**
4. **Documentation burden**
5. **Staffing and workflow issues**
6. **Referral and hospital coordination**
7. **Compensation / collections clarity**
8. **Professional satisfaction**
9. **What should change next month?**

Three essential questions

- **What is working?**
 - **What is creating unnecessary friction?**
 - **What one change would make next month better?**
-

Barrier 5 — Give the New MD Real Agency

The physician should have defined input into:

- Scheduling design.
- Patient-panel management.
- Clinical protocols.
- Staffing requests.
- Workflow changes.
- Professional development.
- Quality-improvement initiatives.
- Practice growth strategy.

Responsibility without agency is a high-risk design.

Barrier 6 — Create a “No Silent Struggle” Rule

A new physician should know:

“If you are struggling, you are expected to raise the issue early. Asking for help is part of safe practice, not evidence of incompetence.”

This should be supported by actual behavior from senior physicians—not merely stated as a policy.

Barrier 7 — Establish a 12-Month Stay / Change / Exit Review

At approximately month 9–12, conduct a structured assessment:

Question	Purpose
Am I clinically satisfied?	Professional meaning
Is the workload sustainable?	Operational health
Do I have adequate autonomy?	Agency
Am I fairly compensated?	Financial alignment
Do I feel respected and included?	Belonging
Is the patient panel developing?	Career trajectory
Are problems improving after intervention?	Organizational responsiveness
Can I realistically see myself here in year three?	Future fit

Decision options should include:

- Continue as structured.
 - Adjust workload.
 - Improve staffing.
 - Renegotiate compensation.
 - Clarify partnership.
 - Change role.
 - Relocate if the fit remains unsuitable.
-

14. Early Warning Indicator Dashboard

A fault tree becomes useful when warning signs are measurable.

Domain	Green	Yellow	Red
Workload	Manageable during scheduled hours	Frequent after-hours work	Persistent unsustainable workload
Clinical confidence	Appropriate uncertainty and learning	Increasing self-doubt	"I am incompetent" despite evidence
Feedback	Regular, specific, balanced	Occasional or vague	Only criticism or no feedback
Autonomy	Can influence work conditions	Some constraints	Responsibility without control
Staff support	Reliable workflows	Repeated friction	Chronic operational obstruction
Belonging	Feels like co-practitioner	Feels peripheral	Feels unwanted or excluded
Compensation	Clear and predictable	Questions unresolved	Perceived unfairness / mistrust
Recovery	Protected personal time	Increasing depletion	No meaningful recovery
Future outlook	Sees a path forward	Uncertain	Actively planning exit

15. FTA Risk Ranking

This is a **qualitative prioritization**, not a calculated probability assessment. Actual risk requires interviews, workload data, compensation details, and the physician's own experience.

Failure mode	Likely impact	Early detectability	Priority
Unclear expectations	High	High	● Critical
Excessive administrative burden	High	High	● Critical
Responsibility without autonomy	High	Medium	● Critical
Weak physician integration	High	Medium	● Critical
Lack of feedback	High	High	● Critical
Compensation uncertainty	High	High	● Critical
Patient-panel growth mismatch	Medium–High	High	● High
Staff workflow friction	Medium–High	High	● High
Work-home conflict	High	Medium	● High
Insufficient recovery	High	Medium	● High
Normal first-year learning curve	Medium	High	● Moderate
Patient preference for established physicians	Medium	High	● Moderate

Relocation opportunity elsewhere	Amplifier	High	Moderate
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16. The Most Important Insight

The physician's internal failure statement may be a misleading output signal.

Observed:

"I am failing."

Possible underlying causes:

- └ I lack adequate support.
- └ My workload is poorly designed.
- └ My expectations were never defined.
- └ I have responsibility without autonomy.
- └ I am not receiving useful feedback.
- └ My role in the partnership is unclear.
- └ My compensation model is misaligned.
- └ I have not yet built patient relationships.
- └ I am exhausted and not recovering.
- └ The practice may genuinely be a poor fit.

The same emotional output—"I am failing"—can be generated by very different underlying causes.

Therefore, the correct intervention is not automatically:

"Work harder."

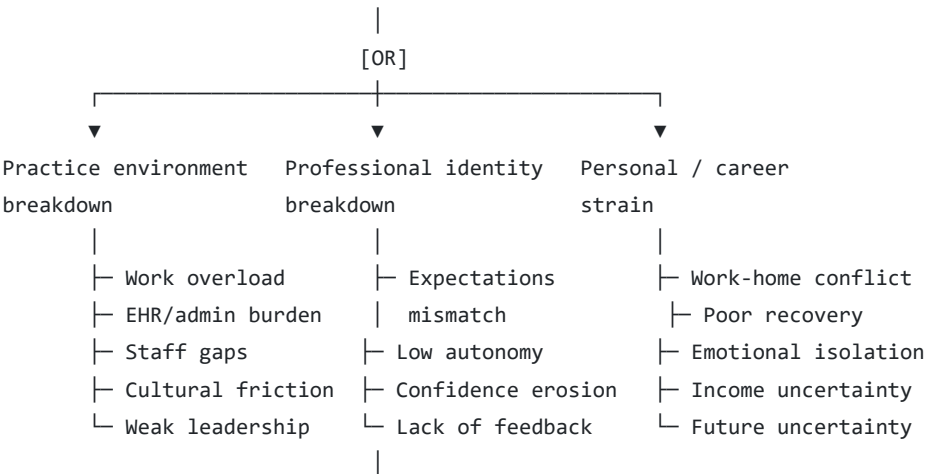
It may be:

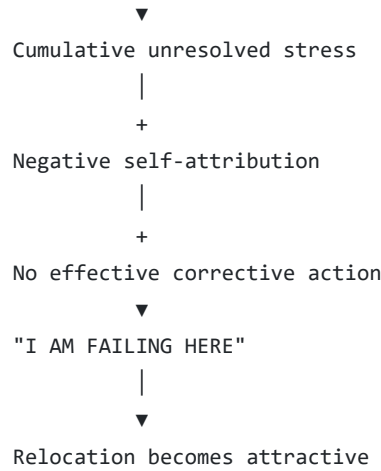
"Identify which part of the system is producing the failure signal, then determine whether it can be corrected."

17. Final Fault Tree Summary

TOP EVENT:

New Internal Medicine MD becomes discouraged,
believes they are failing, and considers relocation





Bottom Line

The highest-risk scenario is not simply a busy first year.

It is:

A demanding first year + unclear expectations + insufficient support + low autonomy + weak feedback + no visible path to improvement.

That combination can cause a capable physician to interpret **a fixable practice problem as a personal professional failure.**

A well-designed 35-year clinic can prevent this by making the new MD's first year a structured process of **integration, feedback, operational support, autonomy, and measurable progress**—rather than expecting the physician to succeed through individual effort alone.

Evidence Note

The organizational mechanisms in this analysis are consistent with physician-well-being research identifying workload, administrative burden, autonomy, leadership, collegiality, and work-life integration as important contributors to burnout and retention. These studies support the **risk pathways**, but they do not establish that this hypothetical physician will experience them or that relocation will occur. ([BMJ Open](#))