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Provider Burnout: Stressors and Solutions

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Key Takeaways:

Burnout is defined by a triad of emotional exhaustion, depersonalization, and low sense of personal accomplishment related to one's work.

Provider burnout affects over half of physicians and physicians-in-training and one-third of nurses, leading to increased risk of medical errors, significant financial costs, and staggering rates of suicidal ideation.

The causes of burnout are related to a sense of misaligned values, motivations, and incentives between the healthcare provider and the broader health system.

It is important to distinguish between intrinsic and extrinsic motivators of work. Intrinsic motivators include autonomy, competency, and relatedness. Extrinsic motivators of work include financial compensation, non-monetary benefits, and promotional titles.

Strategies to mitigate burnout include (a) Reducing sources of burnout; (b) Ensuring a culture of workplace positivity; and (c) Building individual and organizational resilience

Introduction

Burnout is a chronic, work-related stress syndrome defined by a triad of emotional exhaustion, depersonalization, and reduced sense of personal accomplishment related to one's work. This phenomenon first became a focus of attention and research in the 1970s when American Psychologist Herbert Freudenberger coined the term to describe a set of symptoms that resulted from the "excessive demands on energy, strength, or resources" in the workplace and a subsequent loss of idealism, passion, and even physical wellbeing.[1] It later was described in detail by Maslach and Jackson, who in 1981 devised the Maslach Burnout Inventory (MBI), which remains the most commonly used tool to quantitatively assess the syndrome.

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Figure 1. Maslach Burnout Instrument Questions

	Item
1.	I feel emotionally drained from my work.
2.	I feel used up at the end of the workday.
3.	I feel fatigued when I get up in the morning and have to face another day on the job.
4.	I can easily understand how my recipients feel about things.
5.	I feel I treat some recipients as if they were impersonal objects.
6.	Working with people all day is really a strain for me.
7.	I deal very effectively with the problems of my recipients.
8.	I feel burned out from my work.
9.	I feel I'm positively influencing other people's lives through my work.
10.	I've become more callous toward people since I took this job.
11.	I worry that this job is hardening me emotionally.
12.	I feel very energetic.
13.	I feel frustrated by my job.
14.	I feel I'm working too hard on my job.
15.	I don't really care what happens to some recipients.
16.	Working with people directly puts too much stress on me.
17.	I can easily create a relaxed atmosphere with my recipients.
18.	I feel exhilarated after working closely with my recipients.
19.	I have accomplished many worthwhile things in this job.
20.	I feel like I'm at the end of my rope.
21.	In my work, I deal with emotional problems very calmly.
22.	I feel recipients blame me for some of their problems.

Burnout amongst healthcare providers has been a growing problem, reaching epidemic levels globally and exacerbated by the COVID-19 pandemic.[2] In recent years, over one-half of physicians and one-third of nurses have reported suffering from symptoms of burnout.[3–5] This epidemic has seeped into the education and training system as well, with pre-medical undergraduates, medical students, and residents reporting rates of burnout higher than peers in other occupational fields. The causes of burnout amongst health providers are multifactorial, and can stem from long working hours, misaligned personal and organizational incentives, and difficulty finding a sense of meaning within one's work. Burnout poses a significant threat to both providers and their patients, and is described as the harrowing tipping point at which job-related stress "begins to overwhelm [providers], eventually pushing them into depression and suicide."[3]

The Effects of Provider Burnout

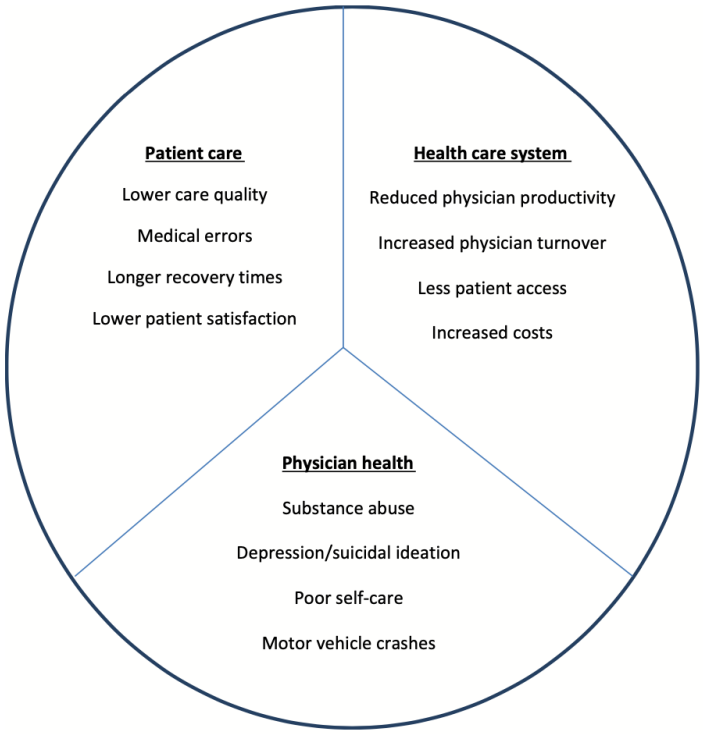
For healthcare providers, burnout's triad of emotional exhaustion, depersonalization, and low sense of personal accomplishment related to one's work manifest in unique ways:

- Emotional exhaustion occurs when one feels over-extended and "used up" by excessive work responsibilities or long work hours, leading to a depletion of emotional energy.

- Depersonalization is a cynicism marked by a lack of humanized relationships with others, including feelings that patients are objects of disease or units along an assembly line.
- A low sense of personal accomplishment involves a perception of ineffectiveness in being able to help patients. This often leads to an inability to perform tasks, an increased risk for medical errors, and an increased risk of leaving one's medical practice.

The staggering effect of burnout on care providers is essential to consider because of the downstream consequences on care providers themselves, their patients, and the healthcare system. Studies have shown that a physician's degree of burnout increases the risk of suboptimal patient care practice, medical error, and medical malpractice lawsuits.[6–8] Among nurses, higher degrees of burnout are associated with patient mortality and dissemination of hospital-transmitted infection.[9,10] These studies have suggested that burnout can operate within a vicious cycle, where increased odds of medical errors in turn are associated with worsening burnout, depressive symptoms, and quality of life. Burnout also affects the physician workforce by decreasing productivity, increasing job dissatisfaction, and increasing the desire to leave a current practice.[7,11] The financial implications of these effects are significant. The cost of medical errors, malpractice claims, absenteeism, and lower productivity are conservatively estimated to $5,000 to $10,000 per physician per year.[12] Put another way, the estimated loss of productivity due to physician burnout is the equivalent of eliminating seven medical school graduating classes.[13] Moreover, the cost of replacing a provider due to job turnover can be upwards of $500,000.[14] The consequences of burnout on individual physicians are also alarming. Physician burnout is associated with a 25% increased odds of alcohol use / dependence, a doubled risk of suicidal ideation, and an increased risk of completed suicide.[15,16]

Figure 2. Consequences of Physician Burnout



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The Pathway to Burnout

Burnout is driven by a sense of futility within one's work and the overextension of oneself. To understand how an individual begins to experience this, it is important to understand what contributes to meaningful work and self-determination.

Gagné and Deci's work in 2005 built upon a body of literature on motivation to distinguish between intrinsic and extrinsic motivators of work.[17] Intrinsic motivation is supported by three pillars: autonomy (the agency one has in their work), competency (the ability to share expertise and make an impact), and relatedness (the connection one has with those involved in their work). On the other hand, extrinsic motivators of work include financial compensation, non-monetary benefits, and promotional titles.

Swensen and Shanafelt's work expands upon this idea of intrinsic motivation by defining three refined key elements of self-determination. These include agency (the ability to control one's practice and work-life balance), comradery (the sense of teamwork and group accomplishment), and coherence (the alignment between one's day-to-day tasks and their sense of purpose and meaning).

For many who enter the medical field, the sense of intrinsic motivation is strong: Medicine has long attracted hard-working individuals who are drawn to the challenges and lifelong learning required to expertly and compassionately care for patients.[3] There is often a deep connection one has to their work, both intellectually (with their medical field) and relationally (with their patients and team members).

Implicit with this understanding of intrinsic motivation and self-determination is the role of extrinsic motivators (e.g., expectations, incentives, policies) in destabilizing the individual. As our health system has advanced, many efforts have been made to increase the efficiency, quality, and safety of healthcare. These efforts have resulted in significant improvements of care from a quality and safety perspective and have also fundamentally changed how we care for patients. Electronic health records have allowed physicians to easily access past records and see patients remotely, but they have also provided a platform for increased documentation and legal / clerical requirements in patient charting. The institution of payment innovation and quality metrics have steered physicians toward best practices, reducing the variability of care quality and ensuring a more consistent standard of care at a population level. However, they have also increased the administrative complexity of providing care by requiring monitoring and documentation at multiple levels to ensure quality targets are met. Furthermore, they structurally define patients as objects of certain thresholds or targets and bisect the patient into both human and statistic for the provider.

Provider burnout is ultimately a consequence of stressors that arise from misaligned incentives and values between the care provider and the broader health system. The values of the broader health system often emphasize productivity, efficiency, quality, and safety. Importantly, this is not to say that the values of the broader health system are poor values or that they should not be sought after. Rather, *it is the ways in which these values are communicated* (through organizational policy, accepted individual behavior, and cultural practices) that can often sit at odds with the intrinsic motivations of the care provider. As written by Epstein & Privitera, "physicians, disillusioned by the productivity orientation of administrators and absence of affirmation for the values and relationships that sustain their sense of purpose, need

enlightened leaders who recognize that medicine is a human endeavor and not an assembly line."[18]

Contributors of Physician Burnout
With this framework of understanding burnout, we can assess contributors of physician burnout.

- **Inefficient work processes and environments**: physician-entered documentation for notes and orders into electronic health records, other tasks that do not maximize the time providers spend working at the top of their licenses
    - The increasing use of EHRs was initially seen as a mechanism for reducing clerical burden and streamlining workflows. However, this has often not been the case. One study demonstrated that PCPs spend nearly six hours out of an 11-hour work day completing computerized tasks, including after going home.[19]
    - As Atrius Health President and CEO Steve Strongwater has said: "The electronic medical record has clearly added work to a physician's day, and people who are so dedicated and committed are working late into the evenings in what we would call 'pajama time.' In general, what seems to happen is that our docs will work during the day — they'll work a full day, sometimes eight or 10 hours or longer — they'll go home for a brief period of time, and then they'll get back on their record in order to finish the work of the day that evening."[20]
    - The average physician spends 2.6 hours per week (135 hours per year) complying with external quality measures.[21] Outpatient physicians also spend two hours of administrative and clerical work for each hour spent with physicians.[22]

- **Excessive workloads**: Long work hours, frequent overnight call duties, high work intensity
    - The average physician works 55 hours per week, with a quarter of physicians working over 61 hours per week.[23]
    - As of 2018, only 34% of residents reported work schedules that left time for personal lives. A majority of residents work 60+ hours per week, and 20% work 80+ hours per week, despite an 80-hour per week duty restriction.[24]
    - There is a 3% increase in odds of burnout for each additional hour of work per week[4]
    - 3-9% increased odds for burnout for each additional night or weekend on call[4]

- **Work-home conflicts**: inability to have fully protected time at home away from work responsibilities
    - 2% increased odds for each additional hour per week of work-related tasks done at home[4]

- **Loss of control and autonomy**: inability to practice medicine as desired due to administrative and regulatory burden

Solutions to Burnout
There is no silver bullet solution to addressing provider burnout and the sources of burnout – though similar in theme – are often rooted in the organizational context of a health system.

Broadly speaking, a framework for approaching burnout, as described by Swensen and Shanafelt include:[25]

1) Organizational: Mitigating the drivers of burnout (thus decreasing negativity) and cultivating a culture of wellness and leader behaviors that nurture professional wellbeing (increasing positivity)
2) Individual: Bolstering individual resilience (increasing tolerance of negativity)

Organizational changes can vary widely but encompass changes in both policy and in leadership. Structural policy changes can include implementing work schedules that reduce physician hours and workload, promote efficiency, and reduce clerical and administrative burdens.[4]

Individual-focused interventions include focusing on achieving self-care, self-awareness, and resiliency. Providers practice "mindfulness, stress management training, communication skills training, exercise programs, and participation in small-group programs promoting community, connectedness, and meaning".[26–28]

However, it is also essential to advance leaders within an organization who care about promoting a culture of wellness and who prioritize nurturing professional wellbeing.[25] At the Mayo Clinic, intentional development and selection of physician leadership has centered around surveys to all staff that are used to compute a score from 12 leadership dimensions.[29] This in turn empowers those who are committed to a continued development of a positive workplace culture.

Figure 3. Items evaluating physician opinion of the leadership qualities of their immediate physician supervisor

TABLE 1. Items Evaluating Physician Opinion of the Leadership Qualities of Their Immediate Physician Supervisor
To what extent do you agree or disagree with each of the following statements about (name of immediate supervisor)*?*
Holds career development conversations with me[a]
Inspires me to do my best[a]
Empowers me to do my job[a]
Is interested in my opinion[a]
Encourages employees to suggest ideas for improvement[a]
Treats me with respect and dignity[a]
Provides helpful feedback and coaching on my performance[a]
Recognizes me for a job well done[a]
Keeps me informed about changes taking place at Mayo Clinic[a]
Encourages me to develop my talents and skills[a]
I would recommend working for (name of immediate supervisor)[a]
Overall, how satisfied are you with (name of immediate supervisor)[b]

A summary of a number of common burnout drivers and solutions as described by West, et al can be found below:

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Figure 4. Common drivers of provider burnout and solutions

Table 2 *Common drivers and selected solutions for physician burnout*

Driver	Organization-level solutions	Individual-level solutions
Excessive workload	Fair productivity targets Duty hour limits Appropriate distribution of job roles	Part-time status Informed specialty choices Informed practice choices
Work inefficiency and lack of work support	Optimized electronic medical records Nonphysician staff support to offload clerical burdens Appropriate interpretation of regulatory requirements	Efficiency and skills training Prioritize tasks and delegate work appropriately
Lack of work–home integration	Respect for home responsibilities in setting schedules for work and meetings Include all required work tasks within expected work hours Support flexible work schedules, including part-time employment	Reflection on life priorities and values Attention to self-care
Loss of control and autonomy	Physician engagement in establishing work requirements and structure Physician leadership and shared decision-making	Stress management and resiliency training Positive coping strategies Mindfulness
Loss of meaning from work	Promote shared core values Protect physician time with patients Promote physician communities Offer professional development opportunities Leadership training and awareness around physician burnout	Positive psychology Reflection/self-awareness of most fulfilling work roles Mindfulness Engagement in physician small-group activities around shared work experiences

Conclusion

Burnout is an epidemic affecting healthcare providers driven by a combination of organizational policies and a set of unchallenged cultural behaviors that create burdensome operational processes, excessive workplace pressure and expectation, and perverse incentives. In turn, these cause individual care providers to lose their sense of coherence, agency, and camaraderie in their work. This can have devastating effects for patients, health systems, and providers themselves. The solution to provider burnout involves (1) Addressing the sources of burnout; (2) Building a positive workplace environment; and (3) Strengthening individual resiliency. Importantly, the senior leadership of healthcare organizations must understand the impact of professional burnout within their ecosystem and intentionally steer their organization toward a meaningful workplace culture.

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Discussion Questions

Every industry has some level of burnout. What level of healthcare provider burnout is acceptable?

Is provider burnout a health*care* issue or a *health* issue? Put another way, from the patient perspective, how significant is provider burnout?

What is the "low-hanging fruit" when it comes to reducing provider burnout?

Business questions aside, what are the *cultural* elements of the US healthcare system that contribute to burnout? How do we address these?

If provider burnout is a systemic problem, who then – individually – is responsible for addressing it?

Could we better address provider burnout by promoting leaders based on different criteria (e.g., "soft skills" over – or in addition to – quantitative measures like revenue generated, quality metrics, etc.)?

One potential cause of burnout is when providers are tasked with responsibilities beneath the top of their training level. Physician groups often describe the time spent on tedious record-keeping as a contributor to burnout: the subtext being that doctors go to medical school for more than data entry. Likewise, nursing associations have called for nurses to be able to practice at the top of their training level. Does the debate around scope of practice reform relate to provider burnout?

While there has been some discussion about the financial costs of provider burnout, the solutions proposed also seem expensive. Is reducing provider burnout likely to raise healthcare spending? If so, will it be worth it?

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