Supporting the Healthcare Workforce:

Understanding Burnout, Its Impacts, and What Can Be Done About It

The Illinois ACEs Response Collaborative

Health & Medicine
POLICY RESEARCH GROUP

Introduction

Burnout in health care is a widespread problem with profound implications for patients, professionals, and health care systems. While some promising strategies have been identified to address burnout, much more work is necessary, especially on a system and policy level.[1] This brief provides an overview of burnout, including its prevalence, consequences, drivers, and costs. It then delves into strategies to mitigate the impact of burnout and suggests areas for further research and policy change.

Defining Burnout

Burnout describes the consequences of severe stress in professions that require intense involvement with people, such as medicine, social work, and teaching. Specifically, it describes a state of physical and mental exhaustion related to caregiving that consists of three key elements: physical and emotional exhaustion; depersonalization, or a cynical or detached response in relationships; and inefficacy, or a sense of low personal accomplishment leading to decreased effectiveness at work.[2]

Compassion fatigue, moral distress, and secondary trauma are distinct but related to burnout. Most health care providers hear painful stories and witness horrific events, yet the majority have little to no training on how to process such experiences. This can result in the following:

- **Compassion fatigue** is experienced by professionals helping people in distress, and it is characterized by an extreme state of tension and preoccupation with the suffering of those being helped.[3]
- **Secondary trauma**, also known as vicarious trauma, is emotional stress experienced when an individual hears about the firsthand trauma experiences of others.[4]
- **Moral distress** occurs when one knows the right thing to do, but institutional constraints make it difficult to impossible to pursue that course of action.[5]

Experiencing compassion fatigue and secondary trauma can result in symptoms that mimic post-traumatic stress disorder (PTSD): hyper-arousal, avoidance, and re-experiencing events such as clinical encounters with suffering patients.[6] All three take a serious toll on provider wellbeing.

Burnout is a pervasive problem cutting across classifications and specialties. Approximately half of all physicians experience burnout, with the prevalence in some types of specialties—especially those considered the front line of access to care (i.e., family practice, general internal medicine, and emergency medicine)—as high as nearly 65%.[7] Physicians are not the only health care practitioners that are affected. Roughly 40% of emergency nurses and palliative care nurses experience at least one aspect of burnout, and almost 30% of social workers report burnout.[8, 9, 10]

Alarmingly, this phenomenon has worsened over time. Between 2011 and 2014, burnout increased by 9% among physicians, while it remained the same among workers in other professional fields.[11] The prevalence increased among physicians again between 2013 and 2017 from 40% to 51%.[12] These trends should be a call to action to systems and policy leaders that more must be done to support healthcare practitioners.

Costs of Burnout

Burnout has significant consequences for all those involved in the health care system, impacting patients and providers alike. It takes an enormous toll on the health and wellbeing of physicians, as it is linked to headaches, fatigue, marital difficulties, cardiovascular disease, alcohol use, and depression.[13, 14, 15] Perhaps most distressing, burnout is associated with a 200% increase in the odds of suicidal ideation and has been linked to shorter life expectancy for physicians.[16, 17]

Burnout also impacts physicians professionally. Unprofessional conduct and less altruistic values are more common in physicians with burnout, and burnout is a stronger predictor than depression of lower satisfaction with career choice. [18, 19] Not surprisingly, burnout is also associated with reduced hours worked and a loss of productivity, as well as with early retirement and leaving clinical practice—all things that put more strain on the already burdened health care system. [20, 21, 22]

Patients also suffer when providers experience burnout. Patient satisfaction has been correlated with physician and nurse job satisfaction, and burnout has been linked to worse patient outcomes. [23, 24, 25] Additionally, burnout is associated with major medical errors, medical malpractice suits, and healthcare-associated infections, all of which have consequences for care quality and health care system costs. [26, 27, 28]

Perhaps the best quantified cost of burnout is the high price of provider turnover. There is well-established evidence that burnout is a strong cause of physician turnover.[29] Replacing a physician places a large financial burden on a hospital, as it generally costs two to three times a physician's salary to hire a new one. Other reports have quantified the cost to replace a physician to be between $500,000 and $1,000,000, and this amount could be even higher for procedurally-based physicians.[30] Moreover, these are the direct costs of turnover; they do not take into account the impact on the quality of care delivered to patients or on other members of the care team who are more likely to experience burnout after a colleague leaves.[31] Some have estimated the cost of physician burnout

alone to be $200,000,000 annually across the whole healthcare system.[32]

Drivers of Burnout

Many believe that burnout is due to an individual's characteristics or choices, but evidence shows that organizational and systems level issues are the primary drivers.[33] On the organizational level, excessive workplace demands—such as unsustainable work hours, frequency of overnight call, and time spent working at home—and lack of support create workplace cultures that breed burnout. [34] Almost half of physicians work at least 60 hours per week—compared to just 10% of U.S. employees in other fields—and physicians are twice as likely to be dissatisfied with their work-life balance as other employees.[35]

Excessive demands are exacerbated by workplace cultures that provide inadequate support to providers. Factors like low levels of social support, collaboration, and mentorship contribute to burnout, as does a sense of powerlessness or lack of control. However, leadership that values transparency and demonstrates a commitment its employees can lessen the impact of burnout.[36]

Many of these organizational factors which contribute to burnout are influenced by systems level issues. Excessive productivity demands are associated with the fee-for-service model in health care, in which providers are reimbursed for each service delivered. Many health care systems have responded to fee-for-service by utilizing productivity-based compensation models to incentivize providers to meet productivity goals. These models encourage providers to maintain unsustainable workloads with long hours so they can achieve financial rewards.[37]

Additionally, workplace inefficiencies are in large part created by electronic health records (EHRs) and computerized order documentation. EHRs were intended to streamline processes, but the reality is that they often interrupt traditional workflows and create tedious documentation procedures—resulting in physicians and nurses spending up to 50% of their time on documentation. Some have argued that EHR systems were designed to meet the needs of payers

and regulators and not primarily to support the delivery of care. Billing codes and processes are extremely complex and require extensive documentation, leading to bloated EHRs. Spending so much time entering data into EHRs reduces the amount of time providers can spend with patients and contributes to challenges with work-life balance, as many providers find themselves completing their EHR documentation at home.[38]

Mitigating Burnout

Clearly, the epidemic of burnout in health care is a critical issue that must be addressed with multi-level change. The good news is that the health care field has begun shifting its perspective to include provider wellbeing as a priority. In 2014, Bodenheim and Sinsky proposed expanding the Triple Aim to the Quadruple Aim. The Triple Aim was first introduced in 2008 by Don Berwick and colleagues at the Institute for Healthcare Improvement, and included 1) improving population health, 2) enhancing patient experience, and 3) reducing costs, which became hallmarks of the Affordable Care Act.[39] The Quadruple Aim proposed adding the goal of improving the work life of healthcare providers as an essential part of any plan to improve care and cut costs.[40] These expanded goals provide a platform for improving the balance of provider workload, providing adequate resources, and increasing provider satisfaction.

Some major national organizations have taken notice of the Quadruple Aim and the problem of burnout. The National Academy of Medicine convened the Action Collaborative on Clinician Well-Being and Resilience in 2017, with a focus on improving the understanding and raising the visibility of burnout, as well as elevating evidence-based solutions to reduce burnout.[41] The Accreditation Council for Graduate Medical Education also revised some of its program requirements to address resident wellbeing; one major change is to require programs to adhere to the 80-hour maximum weekly limit for residents.[42] The growing national attention to this issue provides hope that real change occur.

Hospitals and health care systems often recognize burnout as a problem, but many are unsure how to address it or are concerned with the cost of intervention. Those that do address burnout often implement programs aimed at individual-level change, such as increasing provider self-care which is important in minimizing the harm from burnout, compassion fatigue, and moral distress, and in promoting personal and professional wellbeing. [43, 44] Strategies used by hospitals include dedicating space to become a wellness center for yoga and mindfulness; implementing stress management programs; and offering onsite art classes and performances.[45, 46]

While encouraging self-care is a positive step, hospitals should think beyond individual-level interventions and critically examine how institutional policies and practices drive burnout. A number of organizational change strategies have been implemented by a few health care systems. These include:

- *Acknowledging the problem:* Leadership should acknowledge the problem of burnout and stress the importance of provider wellbeing. Provider wellbeing should be included in organizational values to further demonstrate a commitment to reducing burnout.[47]
- *Measure/assess the problem:* Institutional success should include metrics for provider satisfaction and wellbeing. These can include pace of work, sense of control, values alignment with leadership, as well as satisfaction, stress, and burnout.[48]
- *Tailor interventions:* Organizations should use metrics to identify high-risk departments, and engage staff to develop interventions tailored to their needs.[49]
- *Implement trauma-informed care:* Systems should begin the organizational change process of becoming trauma-informed, which is intended to promote healing and reduce the risk of re-traumatization for both patients and staff.[50]
- *Build community:* Leadership can reduce isolation and build support by creating physical space for providers to congregate and encouraging them to spend time together.[51]

- *Address EHR stress:* Lengthen appointment times to account for burden of EHRs, or add daily blocks that allow provider to complete documentation.[52]
- *Compensation models:* Incorporate dimensions of self-care as part of productivity-based pay, or transition to salaried compensation models.[53]
- *Flexibility:* Provide more flexible work schedules by allowing providers to work reduced hours and/or to shift their hours to better meet their personal needs.[54]

On a systemic level, more research is necessary to examine the role of care delivery models, payment models, licensing requirements, and malpractice liability on burnout. Additionally, resources should be directed to developing EHR systems that better support the delivery of care, rather than simply meeting the billing requirements of payers. Ultimately, these actions will help create policy change that will reduce health care professional burnout and improve health outcomes for patients.[55]

Conclusion

Health care provider burnout is a critical issue with devastating costs to providers, patients, and health care systems. While systems change to address the issue of burnout is happening slowly, more can be done. A macro-level approach is particularly critical since burnout is an issue that affects every aspect of health care. We must advocate for additional energy and resources to support the health and well-being of both providers and the populations they serve. Real policy change addressing care delivery and payment models, as well as health IT systems and licensing requirements, is required to address the depth and breadth of health care provider burnout.

Acknowledgments

About Health & Medicine Policy Research Group

Health & Medicine is a Chicago based non-profit working to improve the health of all people in Illinois by promoting health equity. Founded in 1981 by Dr. Quentin Young, it was formed as an action-oriented policy center—nimble, independent, and focused on regional health issues. Health & Medicine's mission is to promote social justice and challenge inequities in health and health care. It conducts research, educates and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people. Health & Medicine has successfully developed health policy recommendations and implementation strategies for different public and private entities, earning the trust of the legislature, advocates, the media, researchers and policymakers at all levels of government in Illinois to become the region's "honest broker" on healthcare policy matters. Learn more at www.hmprg.org.

About the Illinois ACEs Response Collaborative

Established in 2011, the Illinois ACEs Response Collaborative (the Collaborative) represents a broad range of organizations and agencies committed to expanding and deepening the understanding of the impact of childhood trauma and ACEs on the health and well-being of Illinois families and communities. The Collaborative works to develop education, policies, and responses to assist those who have experienced a high level of adversity, while simultaneously developing strategies to reduce the frequency and impact of ACEs as well as preventing their transmission to the next generation.

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