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Going Down in Flames: Provider Burnout, The Cost of Burnout to the Provider, Medical Industry, and Patients

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The Cost of Burnout to the Provider, Medical Industry, and Patients

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Abstract

Burnout is identified as a combination of emotional exhaustion, depersonalization, and a sense of decreased personal achievement. In a perspective article Bianchi, Schonfeld, and Laurent (2015) argue that burnout is not a separately identifiable condition, but simply a depression that is caused by work (Bianchi, et al, 2015). Regardless of whether one defines burnout as a separate condition or depression from occupational stresses, burnout has negative consequences for the individual experiencing the symptoms, as well as the medical industry as a whole.

Although professional burnout is not unique to the PA profession, there is a need for better understanding of the magnitude of burnout in the profession, and the effects of burnout on PAs both personally and professionally. Each member of the healthcare team provides unique contributions and responsibilities in the delivery of health care services resulting in differing stressors that might contribute to the risk of burnout. Available research studies specific to burnout in the PA profession are not as prevalent as studies of burnout in physicians. While there are differences in professional roles, there are enough commonalities between physicians and PAs in stressors that may lead to burnout that some data from physician burnout studies can be extrapolated to address burnout in PAs.

This study evaluates available research on burnout in PAs. This study will analyze the causes and extent of burnout within the PA profession, the negative effects of burnout for PAs, and the interventional modalities that might minimize the risk of burnout for PAs.

Keywords: provider burnout, interventions to prevent burnout, cost of provider burnout to healthcare industry, causes of burnout.

Introduction

In a presentation on the effect of EMRs on provider burnout, Steven Strongwater, MD, President and CEO of Atrius Health relates that Daniel Pink author of the book *Drive*, relates the professional satisfaction is driven by three things: purpose, autonomy, and mastery.[1,2] The drivers of burnout according to Maslach and Leiter are work overload, loss of control, insufficient reward, a breakdown of community, absence of fairness, and conflicting values.[3] The ability of healthcare providers to perform at their optimum capability is paramount for patients to receive the highest quality medical services. It is vital that medical providers are not overly stressed and feeling overwhelmed which can lead to "burnout." Burnout is defined in multiple ways; however, most researchers use some form of the definition of burnout provided by Christina Maslach. Dr. Maslach defined burnout as a psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment that occurred among various professionals who work with other people in challenging situations.[4]

The Maslach Burnout Inventory (MBI) is the most commonly used instrument for measuring burnout.[4] Multiple variations of the MBI have been adapted to address the job-specific qualities of different professions. The Maslach Burnout Inventory captures three dimensions of burnout: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA).

Review of the Literature

While studies vary regarding the extent of provider burnout as relating to specific specialties, employment models, the gender of providers, point in career, etc. there is little debate that provider burnout is a significant problem and methods to prevent and relieve burnout in providers is vital. A review of the literature does not appear to provide clear indications of specific methods or interventions to prevent or relieve burnout. A better understanding of the role of burnout in provider job satisfaction, provisions of services, and costs to the industry will serve to provide guidance for strategies to improve the experience of individual medical providers and thereby seeking to relieve the provider's suffering and improve the medical outcomes for their patients.

Provider burnout is an insidious process that can be devastating to the individual provider's personal well-being, career, and family. However, burnout is not just detrimental to the individual provider, it is also detrimental in many aspects of the healthcare industry. The healthcare industry is affected negatively by provider burnout financially by decreased productivity, increased turnover rates of personnel and the associated costs of replacing and retraining staff, increased legal risks from medical errors and the associated cost of litigation and malpractice insurance coverage. There are potentially increased costs associated with decreased patient satisfaction. Healthcare leaders are becoming more aware of the negative effects caused by burnout on both the individuals who are experiencing burnout and the financial costs to the industry as a whole resulting from employees who are experiencing burnout and have begun to implement strategies to address the issue.

The concept of professional burnout is not unique to medical providers. Burnout can be experienced by any person in a high-stress occupation. Maslach's research was not restricted to the healthcare industry, but the MBI provides a commonly utilized tool to quantify the condition of burnout within the healthcare industry. The Maslach Burnout Inventory, or variations of the MBI, is frequently used to identify those providers who are experiencing symptoms of burnout. The Medscape Lifestyle Report 2017,[5] a survey of more than 14,000 physicians in thirty specialties, reveals a range of burnout, as self-reported by physician providers through the survey, from a rate from 59% in Emergency Medicine physicians to a "low" rate of burnout symptoms of 42% in Psychiatry physicians. According to the survey, more than 40% of all physicians are experiencing some level of burnout. In addition, it is estimated that over 400 physicians commit suicide each year in the United States, this is the equivalent to the loss of two medical school classes each year.[6] Just these two statistics indicate that provider burnout is a significant issue that needs to be addressed in a proactive manner.

The financial costs of provider burnout are significant. A study done at Stanford Medical revealed that a major predictor of physician turnover is burnout and that the cost to replace a physician who resigns due to burnout is approximately $250,000 for each provider that has to be replaced.[7] The study also showed that physicians who are experiencing burnout are twice as likely to leave their position. The estimated annual cost to Stanford Medical is approximately $7.5 million dollars to recruit and hire physicians to replace those who have left. With narrow profit margins in many healthcare corporations, addressing provider burnout to minimize provider turnover is financially prudent. While the Stanford Medical survey is

specific to physicians, given the similarities in job expectations, other medical providers probably are experiencing similar rates of burnout in this and similar institutions. Extrapolating from the experience of Stanford Medical, the additional costs related to replacing physicians who are experiencing burnout and with the additional costs related to other providers and healthcare workers who are also experiencing burnout, the costs to the health care industry in the United

States could easily be in the billions of dollars each year.

It is estimated that for every one-point increase in the emotional exhaustion component of the Maslach Burnout Inventory, the likelihood of reduction of professional effort is increased by 43% in the subsequent 24-month period as reported in the Mayo Clinic Proceeding.[8] The report extrapolated that this likely resulted in a 1% decrease in national work effort by physicians. While 1% may not sound significant, the net loss in productivity is equivalent to losing the work production of seven medical school graduating classes each year. Again, extrapolating this estimate to include other medical providers and staff the estimated loss of productivity due to burnout is extreme.

The CEOs of 10 leading healthcare delivery organizations held a summit meeting at the American Medical Association (AMA) headquarters in Chicago in September 2016 and agreed that provider burnout is an issue of national importance and needs to be addressed urgently.[9]

Many researchers have studied interventions that could limit the causal factors that lead to burnout among providers and to also look at methods to alleviate burnout in those providers who are already experiencing symptoms of burnout. Multiple factors have been indicated for

increasing the likelihood of provider burnout. A survey of physicians done in 2015, indicated that paperwork and administration were the reported leading causes of burnout.[10] Another survey done in 2013 found that electronic health records (EHR) has decreased professional satisfaction and interfered with patient care.[11]

Specific interventions such as revising EHRs, using scribes, decreasing the clerical load on providers, wellness programs, stress management strategies, and multiple other strategies have been proposed to address the issue of provider burnout.

A study evaluating addition of scribes to decrease the documentation burden of providers revealed that scribes improved all aspects of physician satisfaction, including overall satisfaction with clinic (OR = 10.75), having enough face time with patients (OR = 3.71), time spent charting (OR = 86.09), chart quality (OR = 7.25), and chart accuracy (OR = 4.61) (all *P* values <.001). Scribes had no effect on patient satisfaction. Scribes increased the proportion of charts that were closed within 48 hours (OR =1.18, *P*=.028).[12]

A systematic review and meta-analysis study reported in JAMA Internal Medicine looked at studies of interventions to address issues of provider burnout. The studies reviewed included interventions that were both individual provider-driven and organizationally driven interventions. The provider driven interventions included mindfulness-based stress reduction programs involving a 45-minute mindfulness exercise, a weekly 60-minute group reflection, and mindfulness exercises, contemplation-meditation exercises involving contemplation nonjudgmentally bodily sensations, breathing, sounds and thoughts. Other studies looked at communications skills training and stress management skills training, training courses involving

modeling ideal behavior with role play and practice. Organizationally driven studies reviewed included changes in scheduling and workload, debriefing sessions exploring themes of work-related stressors, coping mechanisms, communication improvement, improving teamwork, and changes in workflow. This analysis of twenty independent comparisons from 19 studies were included in this meta-analysis (n = 1550 physicians; mean [SD] age, 40.3 [9.5] years; 49% male). Interventions were associated with small significant reductions in burnout (standardized mean difference [SMD] = −0.29; 95% CI, −0.42 to −0.16; equal to a drop of 3 points on the emotional exhaustion domain of the Maslach Burnout Inventory above change in the controls). Subgroup analyses suggested significantly improved effects for organization-directed interventions, (SMD = −0.45; 95% CI, −0.62 to −0.28) compared with physician-directed interventions (SMD = −0.18; 95% CI, −0.32 to −0.03). Interventions delivered to experienced physicians and in primary care were associated with higher effects compared with interventions delivered in inexperienced physicians and in secondary care, but these differences were not significant. The results were not influenced by the risk of bias ratings.[13]

A study evaluating the implementation of patient-centered medical home (PCMH) showed that this project lowered staff burnout as measured by the emotional exhaustion subscale of the Maslach Burnout Inventory, 2.29 vs 2.80; *P*=.02.[14] A cluster randomized trial of interventions that grouped diverse interventions into three categories: improved communications, changes in workflow, and targeted quality improvement projects targeting provider concerns, concluded that organizations may be able to improve burnout, dissatisfaction, and retention by addressing these issues.[15]

Conclusions

The best clinical outcomes for a patient cannot be achieved if their medical providers are not struggling with the burdens of burnout. To be actively engaged with their patients, medical providers need to feel that their work is meaningful, that they have adequate time to address their patient's needs, and that they have a supportive administration who is concerned about their wellbeing.

In order to deliver the highest quality of medical care, decrease costs of rehiring and retraining of medical providers, and to ensure that patients are receiving the best medical care possible, any factor that negatively affects the medical provider needs to be addressed in a proactive manner to alleviate the stress or distress being experienced by medical providers. Addressing burnout in an effective way results in improved job satisfaction of medical providers, a higher likelihood of improved quality of medical care, and potential cost savings to the medical provider's employer and the medical industry as a whole.

There are many factors that influence the level of burnout felt by providers. Factors such as productivity expectations, practice location, methods of compensation, payer mix, quality and quantity of support staff, workflow processes, matching of talents to job duties, organizational culture, EMR systems, opportunities for involvement, opportunities for professional development, personal values, level of altruism, moral ethics, commitment to the organization, personality, length of service, call schedule, collegiality of co-workers, restrictions on referrals, limitations set by practice policies, etc.[7] The list of factors that can influence burnout of any individual provider is endless making if very difficult to assign attribution to specific factors as

causal or to find interventions that are widely beneficial. However, both individuals and organizations need to be aware of what can be addressed and controlled and take effective steps at intervention.

Interventions have to be tailored to the organization. The stressors of a large organization may overlap considerably with smaller organizations or may be significantly different. Unfortunately, the implementation of interventions and resources available to address those issues may also vary considerably. Leadership at Mayo Clinic began measuring physician satisfaction in 1998 and have recommendations of nine strategies to promote physician wellbeing.[7,16]

1. Acknowledge and access the problem
2. Harness the power of leadership
3. Develop and implement targeted strategies
4. Cultivate community in work
5. Use rewards and incentives wisely
6. Align values and strengthen the culture
7. Promote flexibility and work-life integration
8. Provide resources to promote resilience and self-care

9. Facilitate and fund organizational science

(List) [7]

While the strategies mentioned above may be organizational goals, the recommendations do not address the effectiveness of any specific stated goal. Due to the nature of burnout, the difficulty in quantifying the exact definition of burnout, the personal variations of those who are experiencing burnout, and that research is heavily reliant on survey data and not objectively measurable points, defining which interventions are effective in preventing or relieving burnout is a complicated problem. While there is much more study needed to determine the most significant factors leading to burnout and the most effective interventions to affect the progression from job stress to burnout, both individuals and organizations need to be willing to acknowledge that burnout is a significant problem and is not a personal failing of the individual experiencing burnout. Both individual and organizations need to recognize the problem and take steps to intervene and those interventions should be ongoing, nonjudgmental, and continually evaluated for effectiveness.

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