Organisational causes of physician burnout

Abstract

It has become common for physicians to practice within healthcare organizations as employees, instead of within the more traditional independent contractor role. Concurrent with this transition in care model has been a progressively increased rate of physicians experiencing classic symptoms of burnout, particularly emotional exhaustion and professional disengagement. The culture and climate of an organization may serve to exacerbate these symptoms if dysfunctional and/or frankly toxic. Physicians represent a unique role in the healthcare system, and may be predisposed to being more acutely affected by negative cultural or climate models than other employees due to their traditionally-independent role, high level of education and training, and commitment to the patient as their primary allegiance over that of the organization itself. Increasingly burned-out physicians are more likely to give suboptimal clinical performance and more likely to make errors. Efforts to engage employed physicians by first understanding the difficulties with respect to their somewhat unnatural fit within the organization, and the unique challenges they face will enable development of productive pathways towards increased resilience, and overall improved patient care.

Introduction

The role of physicians within thetypical healthcare organization has changed drastically over the last fewdecades from that of respected independent professionals who contracted withhospitals and care organizations to bring in patient volume and thus revenue, to that of employees representing but one

“ cog in the wheel” amongst midlevelhealthcare providers and nurses, as well as ancillary clinical, support, andadministrative staff.

The dissatisfaction felt by physicians, especially those who are employed and/or in academic direct patient care practices is multifactorial, and can lead to symptoms of exhaustion, withdrawal, and overall disengagement. Physicians respond differently to the organizational environment than do other employee types, due to unique aspects of subculture and perhaps to differences in ideology with respect to management philosophy and allegiance (e. g., organization first vs. patient first). It has been shown that a majority of physicians suffer from burnout symptoms in today’s healthcare climate, and that burned-out physicians are more likely to provide suboptimal care and/or make errors. Burnout, and provider wellness in general has been recognized as a significant problem, and has been incorporated into the broad, ongoing national conversation regarding healthcare reform as an additional goal to be achieved in the quest to meet the spirit of the Quadruple Aim described below.

The primary goals of this paper are to briefly define and explore the factors leading to dysfunction (i. e., “ toxicity”) within organizational culture and its subsequent negative effect on physician well-being, job satisfaction, and clinical performance, a. k. a. “ burnout”. Additional goals will be to further describe the relationship of burnout to issues of patient safety, and to briefly introduce the concept of increasing physician resilience as one component of a more comprehensive plan to decrease burnout.

Organizational Culture and Climate

The culture of an organization can be thought of as the collective set of behavioral norms and attitudinal expectations held by employees, and promoted by leadership with respect to the organization's core values. It is an outward expression of an organization's implicit or explicit Mission Statement– the manifestation of shared understanding regarding how things are to be done, how leadership and management should relate to employees, and how employees should relate to one another. An organization's culture is primarily driven by its top-level leaders and managers.

An organizational culture need not be uniform; the degree of uniformity can however determine its strength. The more broadly and deeply the organization's core values are shared by employees, the greater will be the influence on shaping behaviors in the workplace [1] . A strong organizational culture acts as a stabilizer, similar to a buffer in acid-base chemistry, or to the keel of a sailboat; it provides a stabilizer and a " righting force" to keep an organization on track vis à vis its stated mission and community role.

To the extent that an organization's culture is uniform, it can use that strength to create either a positive or a negative workplace climate. The climate of an organization represents the shared *perceptions* of both formally and informally published policies, procedures, and practices/routines by its employees. The organization's culture in contrast defines the underlying values and ideologies that gave rise to the subjects of these perceptions.

While there are multiple dimensions of climate, three primary aspects have been defined by Ostroff [2] . Carr et al. surveyed the impact of these three separate *affective* , *cognitive* , and *instrumental* aspects of climate on an employee's performance at work, mental state of wellness, and engagement (i. e., organizational commitment and job satisfaction) [3] . There is not one defining characteristic that is in and of itself sufficient to define a culture as toxic. It represents the sum total of organizational culture characteristics which contribute to the whole in a negatively synergistic manner.

Culture, Management and the Employed Physician

Although physicians may on paper be employees of an organization, they differ on whole or moreover as a class from other individuals due to their inherent *subculture* which includes an emphasis on autotomy. As such, cultural factors which would be predictably toxic to other employee groups may affect physicians differently, and manifest in different responses such as burnout instead of classically " dark side" behaviors, (e. g., workplace violence). Indeed, it may be considered that the concept of " physician employees" is in a sense oxymoronic, and an artificial artifice that belies an underlying predisposition to dysfunction.

Leaders and managers are the primary drivers who set the tone of an organization's culture and climate. Stress levels of organizationally-employed physicians are inversely related to alignment regarding between organizational leadership and physician interests [4] . One can consider an inherent conflict of interest between organizational leadership and/or management having as its primary interest that of reducing costs, where the

primary interest of employed physicians is on maintaining highest-quality care. Obviously, both interests are valid and important for the long-term success of the organization, but the perspectives and perceived loyalties of each party can in some cases differ substantially. This paradox has been referred to as one of “ administrative theory” versus that of “ occupational theory” [5] . More colloquially, this can be envisioned as a struggle between the “ business of medicine” versus the “ practice of medicine”.

Another potential incongruence between physicians and organizational management is the perception of from where one derives personal value and identity. For many physicians, their personal and professional identities are not separate. Most physicians, especially those in clinical medicine, derive a significant component of their identity from working with patients and improving their lives. Although technically employed, as part of a unique subculture set apart by the uniqueness of shared experiences obtained through extensive training and socialization, they do not view their role as a “ job”, but more that of a public service.

Beyond issues of approaching healthcare problems from the perspective of administrative versus occupational theory, managers and physicians are also often set apart by intrinsic differences in criteria for promotion. Managers typically follow a hierarchical and progressive *advancement* through the ranks of an organization based on performance and merit. Promotion for physicians in contrast often takes the form of increasing levels of *achievement* through acquiring recognition by improved professional

reputation, advancing skillsets, prestige, and social standing amongst one's peers [5] .

Thus, although technically employees of the healthcare organization, physicians have a different set of drivers and interests than that of other employees and in particular managers and non-physician leadership. To the extent that these conflicts are present is not in and of itself the primary factor in dysfunction but rather the extent to which they are effectively negotiated. Poorly negotiated and persistently unresolved conflict can contribute to an environment perceived by the employed physician as " toxic", more so than by other employees, and may further predispose to emotional exhaustion, depersonalization, and burnout.

Essential Components of Burnout

" *It'sbetter to burn out than to fade away* " [6] .

Neil Young penned that lyric in 1979 as a lament to the egoic risk and fear of being lost to obscurity as times change. Although Neil was not a physician, the conceptual elements of his lament are nevertheless germane and partially extensible to the practice of medicine. The concept of " burning out" implied by Mr. Young references engaging in doing what one loves " full throttle" for the simple sake of the love of doing it (n. b., author's personal interpretation). While this is a different sense of the word than that typically used in reference to employee burnout as described below, it nevertheless conveys a common appeal that is applicable to physicians trying to do their best at what they love to do, within an environment that is perhaps not perfectly conducive to such endeavors.

The term “ burnout”, with respect to Organizational Behavior, is classically defined by Maslach as having three conceptually distinct but interrelated components: Emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment [7] . Of the three, emotional exhaustion is most commonly recognized and referred-to symptom of burnout. The concepts and etiologies of depersonalization and decreased sense of personal accomplishment are more nuanced. Depersonalization stems from emotional exhaustion as a protective mechanism via social and professional “ withdrawal” from the occupational stressor. Individuals can acquire a flattened affect, which in severe cases can manifest as callousness and/or cynicism. The “ decreased sense of personal accomplishment” reflects an affected individual’s feeling of inefficacy and/or decreased competence.

The etiology of burnout is considered tobe related more to the individual’s particular environment (i. e., organizational culture/climate), and not necessarily to any particular fault ordeficiency based on personality or demographic characteristics [8] .

Manifestations and Detrimental Effects of Burnout

The negative effects of burnout can be observed with respect to at least 3 dimensions: individual, organizational, and patient. Each level can be manifested on a scale of high to low severity. On the individual level, manifestations of severe burnout could include a myriad of maladaptive psychosocial behaviors including worsened interpersonal relationships, substance abuse, depression, and in a worse-case scenario workplace violence including harm to oneself or others.

The experience of burnout amongst healthcare providers in general, and more specifically among physicians has been observed to differ in some respects from that of other employee types. These differences include both the overall prevalence of burnout, the ability to recognize burnout symptoms, and the severity of symptoms expressed on the different components of the Maslach model. The prevalence of physicians burnout has recently been estimated to be at least 46% amongst employed physicians, and upwards of 50% amongst those in an academic setting and in particular those who practice in high-risk specialties [9, 10] . Compared with physicians, members of the general population were shown to report burnout symptoms at a statistically lower rate (27. 8% vs. 37. 9%, p <001) in a survey by Shanafelt et al., using a validated 2-question abbreviated version of the Maslach Inventory [10] .

The depersonalization and withdrawal symptoms typically observed as a consequence of emotional exhaustion may be harder to detect in physicians due to standard practice of otherwise healthy baseline professional detachment required within the doctor-patient relationship in order to maintain objectivity and quality medical practice. A more concrete difference in burnout symptoms displayed by physicians over that of other employees is a reduced manifestation of Maslach's 3 [rd] component– ' decreased sense of personal achievement'. Compared with non-physician population controls whom displayed generally high scores on all 3 components, physicians who otherwise scored high with respect to symptoms of emotional exhaustion and depersonalization tended to not display statistically-significant scores reflecting a decreased sense of personal achievement [8] . The prevalence of

burnout is highest in those medical specialties having the largest component of clinical exposure; the highest rates being seen in academic physicians whose practice includes 80% or greater time in direct patient care. The primary risk factors were found to include a perceived lack of professional respect, appropriate clinical resources, staff support, and unacceptable balance between work requirements and home responsibilities (i. e., “ work-life-balance”). It is thought that the professional satisfaction felt by physicians in providing direct patient care may serve to blunt the negative effects of emotional exhaustion and depersonalization resulting from environmental stressors on their sense of personal accomplishment. Direct patient care can therefore be considered ironically to both increase risk for, and an act as an ameliorating factor against physician burnout.

Impact of Physician Burnout on Patient Safety

A primary recommendation of the landmark Institute of Medicine “ To Err is Human”, and the subsequent “ Crossing the Quality Chasm” reports was the creation and maintenance of healthcare organization cultures that support patient safety and medical error reduction [11, 12] . Although it has been shown that health care providers are strongly influenced by organizational culture on several levels, few papers have investigated the *direct* impact of organizational healthcare culture on outcomes and patient safety. One such endeavor was the longitudinal Minimizing Error, Maximizing Outcome (MEMO) study, which was sponsored by the Agency for Health Care Research and Quality (AHRQ) [4] . This study approached the issue using a two-part question to determine (a) “ Which cultural conditions effect physician stress, dissatisfaction, and burnout?”, and (b) “ Do stressed, dissatisfied and

burned-out physicians deliver poorer quality care” (i. e., commit an increased number of medical errors)? While the study results indicated that culture played a lesser role than expected, it also confirmed that physicians who exhibited characteristic symptoms of burnout including high levels of stress/exhaustion, and dissatisfaction did report a statistically-significant increased likelihood of medical errors and deviations from best medical care practices.

The specific etiology of how physician burnout affects the rate of medical errors is felt to follow the progression from emotional exhaustion, to depersonalization and withdrawal. In clinical encounters, patients may sense this “ disengagement” and consciously or subconsciously express a perception of dissatisfaction with their care. This could then form part of a negative-feedback loop whereby the physician responds further with even deeper withdrawal, and therefore more likely to commit errors. A study of internal medicine housestaff by Shanafelt in 2002 demonstrated that seventy-five percent met criteria for at least one measure of burnout, and the self-reported rates of “ suboptimal care practices” were more than double the rates for colleagues not exhibiting burnout (53% vs. 21%) [13] . The takeaway is a positive correlation between high levels of physician burnout symptoms with subsequent disengagement and increased proclivity towards less-than-optimal care.

Resilience and the Quadruple Aim

The balance struck between the demands and rewards of medical practice can determine whether a physician will thrive as an engaged member of an organization, or become one of the majority suffering from systemic burnout.

As primary manifestations of burnout, the symptoms of emotional exhaustion and depersonalization can result in decreased empathy and professionalism, reduce job satisfaction and performance, and affect a myriad of interpersonal relationships both in the workplace as well as at home. Burnout can indeed have devastating effects on both the individual physician as previously described, and on the organization. On an organization level, burnout can result in decreased employee retention, customer/patient satisfaction scores, and benchmarked quality outcomes as well as increased propensity for medical errors.

In response to the “ To Err is Human” and “ Crossing the Quality Chasm” reports referenced above, hospital administrators have gone to great lengths to improve the patient experience of healthcare, and to reduce medial errors. These goals are embodied as the “ Triple Aim” framework of healthcare: Improve the patient experience, improve the health of populations, and reduce costs [14] . The implemented processes however, including the introduction of Electronic Health Records, and pursuit of quality metrics while at the same time striving to both reduce costs and maximize profits has had the secondary effect of increasing administrative demands on clinical providers, and reducing professional satisfaction at work. Thus, the seeds of burnout were planted.

Clearly, an effective healthcare organization should have in place a mechanism to address the problem of physician and moreover, all-employee burnout as part of an overarching wellness initiative. To do so is in the best interest of both the employee and the organization. An expansion of the Triple Aim framework was proposed by Sikka in 2015, acknowledging that

the current framework did not directly acknowledge the role of an productive and engaged organizational workforce as a critical component to achieving and maintaining the desired transformations in healthcare. The additional goal of enabling healthcare professionals to “ find joy and meaning in their work” was added, and the Triple Aim was thus rebranded as the “ Quadruple Aim”, and serves as a pathway towards ameliorating physician burnout through development of resilience [15] .

Strategies for increasing physician resilience are varied, and are designed to address the primary dissatisfactions leading to burnout and in short strive to reintroduce joy and meaning to one’s work environment, and improve the work-life balance. Specific implementations that have been shown to be effective include the restructuring of physician call schedules to allow more time away from work, the reinduction of physician lounges within hospitals, the provision of wellness “ coaches”, and exercise facilities convenient to work [16] .

Conclusion

Physician burnout is a significant problem afflicting healthcare organizations, and leads to decreased efficiency and increased medical errors, in addition to the human toll on the afflicted individual. The etiology of burnout is complex, consisting of personal, environmental, and institutional factors. The role of dysfunctional organizational culture, and the climate experienced by the employed physician in theory should therefore be a significant a risk factor, but has in fact been shown to play a minimal role. Physicians appear to respond somewhat differently to organizational stressors, varying

significantly from non-physicians in reporting symptoms of ‘ decreased sense of personal accomplishment’. Indeed, it is somewhat of a paradox that is both exacerbated and ameliorated by the experience of direct patient care. Through increased understanding of this problem, and the implementation of appropriate organizational structures to improve resilience, healthcare organizations can affect positive changes to improve overall employee wellness and hopefully, patient safety. We should strive to achieve a collaborative environment for employed physicians and other healthcare professionals wherein the inherent structural differences extant between the proponents of administrative vs. occupational theory (i. e., physicians vs. organizational management) are reduced such that rates of burnout and job dissatisfaction are decreased, and the spirit of the Quadruple Aim can be achieved. In contrast to Neil Young’s above-referenced lamentation, for physicians and other healthcare professionals, it may in fact be better to “ fade away” following a rewarding professional career rather than to “ burn out” along the way.

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