Addressing Burnout—Focus on Systems, Not Resilience

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Even before the coronavirus crisis, the topic of burnout dominated discussions about the state of our health professions workforce, particularly as it pertains to physicians but not limited to them. The preponderance of reports has been descriptive, focusing on symptoms and speculating widely on causes. Many health care systems have responded by implementing measures to improve the personal resilience of their workforce. Initiatives for health care workers range from work site drop-in rooms for emotional decompression to team meetings focused on improving mutual support. “Happiness” committees have been formed to sponsor social events; some even offer massage therapy and meditation classes. At issue is the extent to which the emphasis on boosting caregiver resilience represents the best strategy for dealing with burnout among physicians and other health care professionals. The acute and unprecedented stress on physicians during the coronavirus pandemic tests even the most resilient among us, but it does not obscure the question of whether burnout requires giving priority to boosting resilience or to correcting the practice environment.

To help inform the direction burnout alleviation and prevention should take, West and colleagues1 report results of a cross-sectional national survey study of more than 5000 US physicians and a probability-based sample of the US working population. Their objective was to assess the association between resilience and burnout among US physicians and how it compares with workers in other career fields. They used previously validated instruments to measure both resilience and burnout and found scores for resilience that were significantly higher among physicians than the general working population (mean (SD) score, 6.49 [1.30] vs 6.25 [1.37] on a 0-8 scale [higher scores indicate greater resilience]; adjusted mean difference, 0.25; 95% CI, 0.19-0.32; \( P < .001 \)). Although physician resilience was associated with risk of physician burnout (each 1-point increase in resilience score was associated with 36% lower odds of overall burnout), even physicians with the highest resilience scores still reported a disturbing 29% rate of burnout.

The take-home message from this study1 was that physicians are already highly resilient and that efforts to boost resilience might not be the most effective approach to managing burnout. These data lend support to the National Academy of Medicine's Action Collaborative burnout amelioration recommendations,2 which focus on correcting causative external factors through a systems-based approach. These recommendations contrast with the current emphasis on trying to boost physician resilience. The National Academy of Medicine’s recommendations derive from a comprehensive evidence review of available data on the causes of burnout. While exhaustive in diagnosis and underlying pathophysiology, the report lacks specific solutions to the factors identified, yet several potential etiologies lend themselves to consideration for concerted high-priority action once the coronavirus pandemic passes, particularly physician payment, electronic medical records, and threats to professionalism.

Modes of physician and practice payment play important roles in work environment, clinician behavior, and professional satisfaction.2 It has been long recognized that fee-for-service (FFS) payment, still the predominant mechanism of physician and practice payment in the US, encourages excessive volume of services—the more service provided, the greater the income. Those physicians who perform highly reimbursed procedures often find themselves enriched and enjoying high institutional status, but they are also under great pressure from their organizations to maximize the number of such procedures performed. Such strong incentives have been associated with questionable activities, such as concurrent surgeries, arthroscopic knee washouts, and arterial stenting of persons with stable angina, taking a toll on professional pride and standing. At the other
end of the FFS payment scale live those who deliver cognitive services, which are grossly underreimbursed, consequently engendering hamster-wheel practice environments of high volume and rushed visits detrimental to work life, morale, patient experience, and career choice. In both settings, burnout was prevalent in the West study and significantly elevated among those engaged in primary care.

Recognition of the importance of payment reform—“paying for value, not volume” has become the mantra for federal physician-payment reform initiatives—provides an opportunity to address FFS payment’s contributions to burnout, especially in primary care where it is highly prevalent. Large-scale reform initiatives are underway, particularly for primary care practices (eg, the Primary Care First program sponsored by the Centers for Medicare & Medicaid Service’s Innovation Center). These initiatives use a risk-adjusted, prospective comprehensive payment model, heeding the call for fundamental payment reform that frees primary care physicians and their teams from the pressures and adverse outcomes of high visit volumes and inadequate FFS reimbursement. Qualitative analysis of initial piloting suggests meaningful improvement in professional satisfaction. It will be essential to monitor professional satisfaction and rates of burnout in assessments of these large-scale implementation initiatives.

Much has been written about the frustrations associated with use of electronic medical records (EMRs). The advent of EMRs brought computerized physician order entry, which currently remains a frustrating and time-consuming manual process. Survey data report time spent on the EMR usually exceeds that of patient contact, impedes it, and typically necessitates an hour or 2 of data input at home each night, with the obvious adverse consequences. Purveyors of EMRs claim that much of the documentation burden derives from practices using their EMRs as billing instruments to maximize FFS payment. If one moves to a prospective comprehensive payment model, then the need to exhaustively document each visit should decline substantially, especially if patient-reported outcomes are used in place of process measures for accountability and measurement of quality. While this should help, it needs to be combined with improved search engines able to readily recognize and automatically order tests and drugs.

Factors that compromise professionalism deserve mention in any discussion of burnout remedies. At a time when health care professionals are stepping forward at great personal risk to care for others, it is disheartening to be referred to as a provider. The demeaning term innocently first entered the health care lexicon as a payer shorthand for health care delivery organizations but was subsequently picked up by Medicare to designate health care professionals who could bill independently for care. Simply substituting professional for provider would be much appreciated and send an important message of respect and recognition. Professionalism also suffers when physicians are treated as employees instructed to perform unprofessionally with regard to hospital admission, length of stay, and discharge. Such decisions should be the sole responsibility and province of emergency department and attending physicians. This needs to be codified in employment contracts.

The importance of the practice environment is underscored during the coronavirus pandemic by the consequences of acute shortages of respirators and personal protective equipment for physician well-being and morale. Attempts to boost physician resilience without correcting these shortages borders on the disingenuous.

Prioritizing attention to these powerful but eminently correctible external factors bearing down on US physicians today should help us reconnect with patients and experience the immense personal gratification that comes from their saying “thank you”—the very best cure for burnout. As noted in the National Academy of Medicine’s report: “Burnout comes from loss of connection to our patients...what our patients want and what we truly crave is to feel connected.”