Making an Evidence-Based Case for Urgent Action to Address Clinician Burnout

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More than half of all clinicians throughout the United States experience symptoms of burnout.[1-4] The constellation of burnout, depression, and suicide in clinicians is now a public health epidemic that is having adverse effects on the quality and safety of healthcare. Burnout manifests itself by emotional exhaustion, no longer finding work as meaningful, and feelings of ineffectiveness, as well as a tendency to view patients, students, and colleagues as objects rather than as human beings.[5]

The Problem

Burnout has many adverse consequences, including lower job satisfaction, higher turnover rates, increased rates of alcohol and drug abuse, and suicide, in addition to higher rates of medical errors and decreased patient satisfaction.[6-11] Although clinicians work to provide the highest quality of care for their patients, they often do not prioritize their own self-care. As a result, physicians, nurses, and other healthcare providers are often plagued by chronic conditions and mental health problems. Findings from a recent national study of nearly 1800 practicing nurses from 19 healthcare systems throughout the United States indicated that more than 50% reported being in suboptimal mental or physical health.[3] Compared with nurses in better health, those in poorer health were 26% to 71% more likely to have made medical errors. Depression affected approximately one-third of the nurses and was the leading cause of medical errors. Further, those who worked 12-hour shifts had poorer health and made more errors than those who worked fewer hours. Nurses who perceived their work site as supportive of their health and well-being reported better health.

Although registered nurses comprise the largest healthcare workforce, they have higher levels of depression, fewer healthy lifestyle behaviors, and poorer physical health than physicians and the general population.[12,13]

Not only is burnout detrimental to clinician population health and the quality and safety of healthcare, but it also contributes to huge financial losses. It is estimated that $500,000 to $1 million in revenue is lost when a physician leaves a practice.[5] The loss of a newly licensed registered nurse (NLRN) in the first year of practice costs the organization up to 3 times the nurse's annual salary when taking into consideration the cost of recruitment, training, and orientation.[14] Nearly 60% of NLRNs leave their first professional position within the first 24 months, often due to high stress and burnout.[15]

The Causes

There are multiple causes of burnout in clinicians, including both personal and system factors. Personal factors include not engaging in good self-care and healthy lifestyle behaviors, such as making time for regular physical activity, engaging in healthy eating, getting adequate sleep, and practicing daily stress reduction. Malalignment of a clinician's role with their purpose and passion also leads to issues with presenteeism and burnout. However, multiple factors within the healthcare system also contribute to clinician burnout and depression. These include poor staffing patterns that result in imbalanced clinician–patient ratios, long shifts, ongoing challenges with electronic health records that result in less time with patients, and pressure to increase caseloads.[5] Loss of autonomy and a sense of powerlessness are other sources of burnout, along with

inadequate leadership support and work cultures that do not support clinician well-being. A lack of trust in, connection to, or support from coworkers also leads to social isolation and dissatisfaction and contributes to the problem of burnout.

Solutions

First and foremost, it is important to implement a multicomponent comprehensive strategy that entails building a culture of well-being in which healthy choices are the norm within a system.[16] There is a longtime saying that "culture eats strategy for breakfast, lunch, and dinner." Healthcare systems must build a culture of wellness in which leaders "walk the talk" and provide resources along with an infrastructure that supports it.[17] If leaders and supervisors do not role model and support wellness, it is unlikely that their clinicians will engage in healthy behaviors. Wellness for clinicians needs to be built into the mission and values of the organization and made visible, as well as highlighted as important, throughout the onboarding of new clinicians to a system. Evidence-based interventions must be targeted to individual clinicians, the community of practice, the workplace culture and environment, and institutional policies. All clinicians should be made aware that their well-being is an important priority for the organization, and they should be made knowledgeable of wellness resources within the institution that are available to them. It is critical to have a "menu of options," as not all interventions will resonate with everyone. Grassroots tactics, such as wellness champions (individuals who volunteer a few hours every month to help build a culture of well-being in a system), are a low-cost but very effective strategy in helping to create a culture of well-being throughout an organization.[18]

Breaking down the stigma of mental health disorders for clinicians is important so that those at risk can receive evidence-based treatment. For healthcare systems that do not offer annual personalized health or wellness assessments for all employees, clinicians should be offered the opportunity to be screened for depression, anxiety, and burnout without concern regarding risk to their employment should they screen positive for mental health problems. Those at risk with symptoms should be offered evidence-based interventions, such as cognitive-behavioral therapy or cognitive-behavioral skills building, which have been shown to be effective in reducing these symptoms with clinicians.[3,19] The Healer Education Assessment and Referral Program is a useful system that provides anonymous encrypted risk screening in partnership with the American Foundation for Suicide Prevention. Although mindfulness interventions with clinicians tend to be time intensive, findings from studies indicate that they have resulted in improvements in stress and anxiety.

Healthcare system issues that are known to cause burnout must be addressed. Staffing patterns must be improved where patient–provider ratios are high, and 12-hour shifts should be eliminated. Changes to the electronic health record system also are necessary so that clinicians can spend more time with their patients. Scribes should also be considered, as they could decrease the data entry workload of healthcare providers.

Return on Investment and Value of Investment

For every $1 that is invested in wellness, findings from studies have indicated a $3 to $4 return on investment (ROI) for organizations that invest in building robust wellness programs for their employees.[20,21] As an example, The Ohio State University, a large land grant university with a large academic health center comprising 7 hospitals, accelerated its wellness initiative and was the first institution of higher learning to appoint a chief wellness officer (CWO) in 2011 to spearhead a comprehensive integrated strategy designed to enhance the well-being of faculty, clinicians, staff, and students. At Ohio State, interventions are targeted to individuals, the social and family network, the culture and environment, and policy. For every dollar invested in wellness, the university has a $3.65 ROI and is in a negative trend for healthcare spend for the third year in a row, whereas other institutions have been experiencing upward trends of 4% to 6% annually in healthcare spend. Value of investment is now being assessed beyond ROI and includes factors such as better morale, higher job satisfaction, less presenteeism and less absenteeism, and higher patient satisfaction.

An Urgent Call for Action by the National Academy of Medicine

Because of the disconcerting rate of clinician burnout, depression, and suicide, the National Academy of Medicine (NAM) launched an Action Collaborative on Clinician Well-being and Resilience in 2017 to enhance visibility on this issue and to develop evidence-based solutions to tackle this public health epidemic.[1] As a key strategy to address this problem, the NAM collaborative has emphasized the urgent need for healthcare systems to prioritize the hiring of CWOs whose responsibility is to spearhead a culture of well-being and implement strategies to create a healthier workforce.[22] CWOs should have a role within the C-suite to elevate the importance of the position and be equipped with the needed resources to effectively build cultures of well-being and implement evidence-based interventions, as described here, to enhance well-being in clinicians.

Conclusions

It takes numerous years, even decades, to translate evidence generated from research into real-world practice settings.[23] The time gap between what is known and what is done is lethal.[24] We must not wait decades to place high priority on preventing and reducing clinician burnout, depression, and suicide. Urgent attention and action on this public health epidemic will not only improve clinician well-being and save lives, but it will also improve the quality and safety of the US healthcare system, which the public and health of our nation rightly deserve.

REFERENCES

1. Dzau VJ, Kirch DG, Nasca TJ. To care is human—collectively confronting the clinician-burnout crisis. *N Engl J Med*. 2018;378(4):312-314. doi: 10.1056/NEJMp1715127.

2. McHugh MD, Kutney-Lee A, Cimiotti JP, Sloane DM, Aiken LH. Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Aff (Millwood)*. 2011;30(2):202-210. doi: 10.1377/hlthaff.2010.0100.

3. Melnyk BM, Orsolini L, Tan A, et al. A national study links nurses' physical and mental health to medical errors and perceived worksite wellness. *J Occup Environ Med*. 2018;60(2):126-131. doi: 10.1097/JOM.0000000000001198.

4. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014 [erratum in *Mayo Clin Proc*. 2016;91(2):276]. *Mayo Clin Proc*. 2015;90(12):1600-1613. doi: 10.1016/j.mayocp.2015.08.023.

5. Fred HL, Scheid MS. Physician burnout: causes, consequences, and (?) cures. *Tex Heart Inst J*. 2018;45(4):198-202. doi: 10.14503/THIJ-18-6842.

6. Shanafelt TD, West C, Zhao X, et al. Relationship between increased personal well-being and enhanced empathy among internal medicine residents. *J Gen Intern Med*. 2005;20(7):559-564. doi: 10.1111/j.1525-1497.2005.0108.x.

7. Firth-Cozens J, Greenhalgh J. Doctors' perceptions of the links between stress and lowered clinical care. *Soc Sci Med*. 1997;44(7):1017-1022. doi: 10.1016/S0277-9536(96)00227-4.

8. Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med*. 2002;136(5):358-367. doi: 10.7326/0003-4819-136-5-200203050-00008.

9. Williams ES, Skinner AC. Outcomes of physician job satisfaction: a narrative review, implications, and directions for future research. *Health Care Manage Rev*. 2003;28(2):119-139.

10. Gardiner M, Sexton R, Durbridge M, Garrard K. The role of psychological well-being in retaining rural general practitioners. *Aust J Rural Health*. 2005;13(3):149-155. doi: 10.1111/j.1440-1854.2005.00677.x.

11. Wetterneck TB, Linzer M, McMurray JE, et al; Society of General Internal Medicine Career Satisfaction Study Group. Worklife and satisfaction of general internists. *Arch Intern Med*. 2002;162(6):649-656. doi: 10.1001/archinte.162.6.649.

12. Blake H, Chambers D. Supporting nurse health champions: developing a 'new generation' of health improvement facilitators. *Health Educ J*. 2011;71(2):205-210. doi: 10.1177/0017896910396767.

13. Bass K, McGeeney K. U.S. physicians set good health example. Gallup website. gallup.com/poll/157859/physicians-set-good-health-example.aspx. Published October 3, 2012. Accessed April 30, 2019.

14. Unruh LY, Zhang NJ. Newly licensed registered nurse job turnover and turnover intent. *J Nurses Prof Dev*. 2014;30(5):220-230. doi: 10.1097/NND.0000000000000079.

15. Twibell R, St. Pierre J. Tripping over the welcome mat: why new nurses don't stay and what the evidence says we can do about it. *Am Nurse Today*. 2012;7(6).

16. Melnyk BM, Gascon GM, Amaya M, Mehta LS. A comprehensive approach to university wellness emphasizing Million Hearts demonstrates improvement in population cardiovascular risk. *Building Healthy Academic Communities J*. 2018;2(2):6-11. doi: 10.18061/bhac.v2i2.6555.

17. Melnyk BM, Szalacha LA, Amaya M. Psychometric properties of the perceived wellness culture and environment scale. *Am J Health Promot*. 2018;32(4):1021-1027. doi: 10.1177/0890117117737676.

18. Amaya M, Melnyk BM, Buffington B, Battista L. Workplace wellness champions: lessons learned and implications for future programming. *Building Healthy Academic Communities J*. 2017;1(1):59-67. doi: 10.18061/bhac.v1i1.5744.

19. Sampson M. *Intervention Effects of a Cognitive Behavioral Skills Building Program on Newly Licensed Registered Nurses* [PhD thesis]. Columbus, OH: The Ohio State University College of Nursing; 2019.

20. Baicker K, Cutler D, Song Z. Workplace wellness programs can generate savings. *Health Aff (Millwood)*. 2010;29(2):304-311. doi: 10.1377/hlthaff.2009.0626.

21. Sparling PB. Worksite health promotion: principles, resources, and challenges. *Prev Chronic Dis*. 2010;7(1):A25.

22. Kishore S, Ripp J, Shanafelt T, et al. Making the case for the chief wellness officer in America's health systems: a call to action. *Health Affairs* Blog website. healthaffairs.org/do/10.1377/hblog20181025.308059/full. Published October 26, 2018. Accessed November 1, 2018.

23. Melnyk BM, Fineout-Overholt E. *Evidence-Based Practice in Nursing & Healthcare: A Guide to Best Practice*. 4th ed. Philadelphia, PA: Wolters Kluwer; 2019.

24. Melnyk BM. The difference between what is known and what is done is lethal: evidence-based practice is a key solution urgently needed. *Worldviews Evid Based Nurs*. 2017;14(1):3-4. doi: 10.1111/wvn.12194.