

# Organisational support of physician well-being: A survey of healthcare executives

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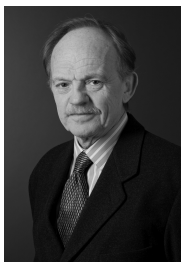


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for Health Information Technology (ONC) to measure the adoption rate of the use of electronic health records in the nation's hospitals. The most current version of the survey addresses issues of interoperability, especially with public health agencies and others related to COVID-19.

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**Abstract** Physician burnout has reached epidemic proportions in the United States, and COVID-19 has only exacerbated the strain on the physician workforce. To gather data on organisation-level support for physician burnout prevention initiatives, the American Hospital Association, AdventHealth, and the Coalition for Physician Well-Being collected responses from more than 500 top-level executives from healthcare systems across the United States, documenting the current state of organisation-level interventions to support physician well-being. The findings revealed that organisational initiatives to curb physician burnout vary in scope and degree, but the need for organisation-level interventions appears to be widely recognised.

**KEYWORDS:** physician burnout, healthcare administrators, survey, organisational initiatives

### INTRODUCTION

With heavy patient loads, long work hours, administrative demands and the stressful nature of clinical work, physicians are experiencing burnout in epidemic proportions. The burnout rate in US physicians is estimated to be above 40 per cent, and physicians are at a significantly increased risk of burnout compared with the general workforce.<sup>1</sup> It is projected that the cost of physician burnout due to turnover and lost productivity is US\$4.6bn a year in the United States.<sup>2</sup>

Burnout is a work-specific phenomenon characterised by emotional exhaustion, depersonalisation and a diminished sense

of personal accomplishment.<sup>3</sup> Emotional exhaustion is marked by the depletion of emotional resources and a feeling of being 'spent' to the point of not having anything left to give to patients.<sup>4</sup> Depersonalisation is a feeling of cynicism and detachment from patients, viewing them as clinical problems rather than as individuals. Decreased personal accomplishment encompasses the perception that despite positive intentions, professional efforts are ineffectual.

Factors that contribute to physician burnout include workload, efficiency, flexibility/control over work, work-life integration, alignment of individual and organisational values, social support/

community at work and the degree of meaning derived from work.<sup>5</sup> Among the workload-related factors contributing to clinician frustration is time spent on administrative, non-clinical tasks that detract from face-to-face time with patients.<sup>6</sup> Physicians are three times more likely to be burned out if they spend less than 20 per cent of their time on meaningful activities.<sup>7</sup> Physicians who were burned out were significantly less likely to regard their work with a sense of calling.<sup>8</sup>

The ramifications of physician burnout include quality and safety implications, as well as personal quality of life issues. One study reported that burnout is associated with twice the odds of patient safety incidents, lower professionalism and lower patient-reported satisfaction.<sup>9</sup> Burnout is also associated with self-reported medical errors and physician perceptions of lower quality of care.<sup>10</sup> Dewa (2014) reviewed physician productivity, such as the number of sick leave days, intent to continue practising, intent to change jobs and work ability, and reported a significant negative relationship between these outcomes and burnout.<sup>11</sup> On a personal level, burnout is associated with depression, suicidal ideation and despair in physicians.<sup>12</sup>

Efforts to prevent and mitigate burnout include both physician-directed and organisation-directed interventions. Physician-directed interventions include mindfulness-based stress reduction, communication skills training and physical activity.<sup>13–16</sup> Meta-analysis indicates a small, significant reduction in burnout as a result of interventions targeted directly at physicians.<sup>17</sup> More effective in reducing burnout are organisation-based interventions, which were associated with a medium, significant reduction in both emotional exhaustion and depersonalisation.<sup>18–20</sup> These interventions typically address a reduction in workload, scheduling changes and team composition in both primary and tertiary care.<sup>21,22</sup>

The literature offers few examples of organisation-directed interventions to address physician burnout. In the primary care setting, some reports suggest that transitioning from work dyads to a team-based system improved workload and decreased emotional exhaustion in providers.<sup>23</sup> Another study leveraged an array of interventions, including group discussions, workflow changes and quality improvement projects to decrease burnout among primary care clinicians.<sup>24</sup> In the tertiary care setting, Garland (2012) reported less stress and burnout in intensivists after transitioning to a shift staffing model versus a standard model of taking calls from home.<sup>25</sup> A study of inpatient attending physicians compared two- and four-week rotations and reported that overall burnout and high emotional exhaustion scores were lower in the shorter rotations.<sup>26</sup> Interventions targeted towards residents included shift-duration variations<sup>27</sup> and protected sleep time,<sup>28</sup> neither of which demonstrated a statistically significant effect on burnout.

It is evident that individual institutions have initiatives in place to address physician well-being; however, to date, no study has examined what comprises these efforts nationwide. This project marks a unique partnership between the American Hospital Association (AHA), AdventHealth and the Coalition for Physician Well-Being to survey healthcare executives across the United States and determine the nature and scope of their physician well-being initiatives.

### COVID-19

Reports from the international community indicate that healthcare workers can suffer from depression, anxiety, insomnia and trauma as direct consequences of contending with the COVID-19 pandemic.<sup>29–31</sup> In addition to the normal stressors of caregiving, there are the burdens of potential exposure to oneself, concerns regarding

possible endangerment of family members, lack of protective equipment, lack of clear treatment plans in the face of a new disease, patient morbidity and mortality and social isolation. In light of the pandemic, it is especially important to support the psychological, emotional and spiritual needs of the healthcare workforce to prevent the adverse effects of COVID-19 from further depleting their personal resources. The imbalance between demands and resources can lead to professional and personal fatigue and burnout, which may consequently impact safety and patient outcomes.

This survey was administered before COVID-19 arrived in the United States. The pandemic, however, has highlighted the now increased need for burnout prevention resources and the amplified responsibility of healthcare organisations to address physician well-being. This survey focuses on the existing state of physician burnout resources across hospitals in the United States. The added strain of the COVID-19 crisis will magnify both the benefits of these programmes and deficits where they are lacking. Ideally, this crisis will incite healthcare organisations to enhance their current physician well-being offerings further or to create new support resources for clinicians at risk for burnout.

## METHODS

### Survey

Physicians and administrators from the AHA, AdventHealth and the Coalition for Physician Well-Being collaborated to create a ten-question survey administered to healthcare executives across the United States. The survey focused on organisational initiatives targeted towards physician well-being and burnout prevention, including questions about the formal assessment of burnout, existing programmes and opportunities and turnover rates. The survey took place between October 2019 and January 2020 and was administered

electronically to over 5,000 AHA member-institutions. From 5,279 total institutions in the AHA database, surveys were sent to the 5,153 institutions with available e-mail addresses for the CEO. Reminder e-mails were sent four times to encourage survey participation.

### Participants

Representatives from 538 hospitals belonging to more than 150 healthcare systems responded to the survey invitation — a 10.4 per cent response rate. Most participants were top-level executives in their organisations, including 185 chief executive officers (CEO), 24 presidents, 30 president/CEOs, 65 chief medical officers (CMO) and 44 chief wellness officers/physician-specific wellness executive. Many answered simultaneously on behalf of several hospitals within their systems, so although this is hospital-level data, some reflect trends within hospital systems.

The majority of responses represented hospitals with up to 200 beds (68.3%). In this surveyed sample, the hospitals are classified by size into small (fewer than 100 beds) — 52.4 per cent, medium (100–399 beds) — 34.4 per cent and large (400+ beds) — 13.2 per cent. This size distribution is generally representative of all organisations within the AHA database (55.9%, 35.1%, 8.9%, respectively). In terms of system affiliation, 56 per cent of this sample are system-affiliated hospitals, whereas 67 per cent of total hospitals in the AHA database are system affiliated (Table 1).

Approximately 56 per cent of the hospitals in this sample are non-teaching hospitals, 36 per cent are minor teaching hospitals and 8.4 per cent are major academic medical centers. Minor teaching hospitals in this survey sample represented a slightly larger percentage than minor teaching hospitals in the AHA database (overall percentages: 68.8% non-teaching, 26.1% minor teaching and 5% major teaching hospitals). This sample included

42.75 per cent rural hospitals versus 57.35 per cent urban hospitals, indicating a slightly higher representation of rural hospitals than those in the entire AHA database (35% rural versus 65% urban). Of the responding hospitals, 8.7 per cent were for-profit, 27 per cent are government (non-federal) hospitals and 64 per cent are from non-profit hospitals. Overall, in the AHA database, the breakdown is 24.9 per cent for-profit, 18.6 per cent government (non-federal) and 57 per cent non-profit organisations (Table 1).

## RESULTS

### Assessment of burnout

Approximately two-thirds of participants indicated that there had been no formal

assessment of physician burnout within the organisation (63.1%, 343 hospitals). Of those who did perform an assessment, 67.240 per cent (135 hospitals) performed the survey in 2019. The most frequently utilised survey instrument was the Press Ganey survey (22.6%), followed by the Maslach Burnout Inventory (16.9%). Other survey platforms included the Physician Well-being Index and internally constructed questionnaires.

### Turnover

As turnover is one of the primary outcomes of concern in healthcare organisations, participants were asked to estimate turnover rates for physicians and advanced practice providers and the dropout rate for residents (Table 2). Nearly 9 per cent of participants reported a greater than 10 per cent turnover rate among employed physicians in the previous calendar year, and, similarly, 10.6 per cent reported a greater than 10 per cent turnover rate in advanced care practitioners. The resident dropout rate was significantly lower, with 29.3 per cent (146) of participants reporting turnover rates between 0 and 5 per cent.

### Suicide

As physicians are noted to have higher suicide rates than the general public,<sup>32</sup> participants were asked to estimate the rate of suicide attempts and suicides in their organisations in the previous 12 months. Of 510 and 515 responses, respectively, 33 hospitals (6.5%) reported attempted suicides and 39 (7.6%) reported suicides. Note that these are percentages of organisations reporting suicide attempts and completed suicides, not suicide rates.

### Culture of wellness

One of the most effective ways to engage physicians in self-care is by establishing a

**Table 1:** Organisational Descriptions of Survey Respondents

	Survey Sample	AHA Database
<b>Size</b>		
Small (Less than 100 beds)	52.4%	55.9%
Medium (100–399 beds)	34.4%	35.1%
Large (400+ beds)	13.2%	8.9%
<b>System Status</b>		
System-affiliated	56%	67%
Non-system-affiliated	44%	33%
<b>Teaching Status</b>		
Minor teaching hospital	36%	26.1%
Major teaching hospital	8.4%	5%
Non-teaching hospital	56%	68.8%
<b>Location</b>		
Rural	42.75%	35%
Urban	57.35%	65%
<b>Financial Status</b>		
For profit	8.7%	24.9%
Not-for-profit	64%	57%
Government (non-federal)	27%	18.6%

**Table 2:** Previous Year Turnover Rates % (N)

	Turnover 0%–5%	Turnover 6%–10%	Turnover 11%–15%	Turnover 16%–20%	Turnover 21%+	N/A
Employed physicians	61.9% (322)	16% (83)	3.8% (20)	2.5% (13)	2.5% (13)	13.3% (69)
Residents	29.3% (146)	2% (10)	0.2% (1)	0	0	68.5% (341)
Advanced practice providers	47.8% (239)	26.6% (133)	7% (35)	2.2% (11)	1.4% (7)	15% (75)

culture of support through peer relationships. Thus, participants were asked whether there were physician-led efforts to enhance well-being and prevent burnout among colleagues. Approximately two-thirds (63.5%, 345 hospitals) responded that they indeed had physician spearheaded wellness programs in place, while 198 hospitals did not.

Open, candid communication with an organisation's administration is a component of a healthy work environment. Formal assessments are one way for leaders to receive valuable feedback from physicians within the organisation. When asked if physicians have the opportunity to formally assess administrative leadership, over 75 per cent of participants responded that physicians were able to assess their leadership.

Organisational initiatives to promote physician well-being and prevent physician burnout vary among organisations. Participants were presented with a list of organisationally based initiatives and asked to identify which occurred in their organisations. Those with the highest percentages of participant agreement included: (1) written code of conduct and process to address code infractions (75.4%), (2) formal physician onboarding process (65.5%), (3) formal process/system of two-way communication between physicians and administration (65.5%), (4) social, networking and family events (62.4%), (5) physician leadership training (60.4%), (6) physician well-being committee (40.9%), (7) peer-mentoring for physicians (39.3%), (8) organisationally funded physician coaching

or counselling (38.9%) and (9) education for physicians regarding organisational stress management resources (29.9%).

Other examples volunteered by participants included programmes such as second victim (secondary trauma) counselling, employee assistance programmes (EAP), mindfulness training, an annual physician well-being conference, courses on burnout and employee wellness programmes.

Of 522 responses, 66.5 per cent of hospitals had implemented system-level changes to address physician burnout. Participants were asked to describe these initiatives, and several trends emerged from their responses. Many had enacted the examples offered in the question, including medical scribes, order sets and scheduling changes/flexibility.

Among the other strategies offered, the most common were electronic medical record (EMR) optimisation/upgrade, the addition of staffing (advanced practice professionals, hospitalists, assistants), dictation and/or voice recognition software and specific councils or committees dedicated to physician well-being (Figure 1). Other comments included the creation of a chief wellness officer's position, perks like access to gyms and lounges, educational classes, leadership access and access to EAP (employee assistance programmes)/counselling. Additional themes emerging from the question of initiatives to address physician burnout include administration of surveys, peer-mentoring and regular communications/rounding, maintaining physician well-being as a standing item with

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*"We regularly review our EHR use and attempt to streamline and adapt the process to create better efficiencies and minimize redundancies. We have created a Physician/AP group to "Get Rid of Stupid Stuff" and have identified several projects to address decreasing administrative burdens."*

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— System Professionalism and Provider Experience Officer

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*"We allow for a very flexible schedule that the physicians help to develop. We are a family-oriented organization and want our physicians to be able to attain a strong work-life balance."*

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— Chief Executive Officer

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*"We saw a rise in MD belief that the organization cared about their professional development and overall MD engagement."*

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— Chief Medical Officer

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*"We have added Advanced Practice Providers to cover many duties previously held by physicians, particularly at night. This has reduced the number of calls at night by nearly 75%."*

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— Executive

**Figure 1:** Hospital administrator statements regarding organisational initiatives to support physician well-being

physician committees and connection points with administrative leaders/focus groups/discussion groups (Figure 1).

Organisational commitment to physician well-being may be reflected by resources specifically allocated for these efforts. Participants were asked whether there were specific funds and C-Suite executive time earmarked for physician burnout prevention initiatives. Approximately one-quarter (26.4%) of the responses indicated that funds were specifically budgeted for physician well-being initiatives, and about one-third (35.4%) allowed C-suite executive time to be dedicated to physician burnout prevention efforts.

In a little less than half of the organisations (46.9%), there are specific individuals whose job roles include accountability for physician well-being. These include the CMO, chief wellness officer/physician-wellness specific position and CEO.

When questioned as to methods utilised to assess the effectiveness of physician burnout prevention efforts, participants reported the use of surveys, group discussions and targeted education event evaluation. Additional strategies included looking at turnover and retention data and monitoring anecdotal information from exit interviews. Participants also reported



regular engagement and communication between clinical and administrative leaders, including through existing groups/committees as well as informal dialogues with leadership.

## DISCUSSION

The surveys were done pre-COVID, and those returned were completed predominantly by an executive, indicating that physician well-being has visibility, and importance, to the leadership of these hospitals. Surprisingly, only 37 per cent of organisations surveyed their staff regarding burnout in the previous year, resulting in a lack of baseline data for assessing the success of ongoing and future physician well-being initiatives.

Mirroring previous data, many of these facilities had a turnover rate among employed physicians and mid-level practitioners, each over 10 per cent. This may result in a significant financial burden to the organisation as it is estimated that replacement costs for physician turnover is two to three times the physician's annual salary.<sup>33</sup> The turnover rate among residents was significantly lower, at 5 per cent. There is some evidence that working in physician/advanced practitioner teams reduces burnout and improves job satisfaction and patient outcomes.<sup>34,35</sup> It may behoove organisations to implement this model of care to reduce the work burden on individual practitioners and potentially reduce turnover rates among these essential healthcare workers.

This survey collected organisational-level and not individual-level data; thus, the physician suicide rates reflect the number of institutions that experienced a physician suicide in the previous year. The percentage of facilities reporting suicide of a practitioner in the past year was 7.6 per cent. It is reported that 300–400 physicians commit suicide annually,<sup>36</sup> underlining the importance of providing support to medical practitioners.

The good news is that to address these issues, 63.5 per cent of facilities had a peer-led support programme to support a culture of well-being, and 77.2 per cent allowed physicians to formally assess administrative leadership and established a process for two-way communication between practitioners and administration. Other practices reported to be in place included a diverse set of resources such as formal physician onboarding, social networking events for physicians and families, physician leadership training, physician well-being committees, peer support programmes, physician coaching or counselling and organisational stress management programmes.

Areas for opportunity remain, with only 26.4 per cent of organisations dedicating a budget to physician burnout prevention and 35.4 per cent having dedicated C-suite time to burnout prevention. Areas for future study would include the effect on burnout and turnover scores related to C-suite time, budget and specific interventions to help all work together to address this growing concern. As COVID remains a national concern and reports continuing to emerge of front-line burnout as well as added stress to executive teams and budgets, finding workable solutions that are low cost and that help both administrators and physicians alike to support one another would be an important next step in this journey to wholeness and work satisfaction. Experience and the literature demonstrate that facilitated discussions of the impact of this pandemic on the entire team, excellent two-way communication to create workable solutions to the inherent challenges of healthcare process changes, and simple communications of gratitude for the work being done by so many are simple ways to improve culture and relationships for administrators and clinicians alike. In addition, transparency and truth-telling are paramount to maintaining any relationship. The need to be candid

about the reality of the situation, and the reasoning behind decisions, is imperative to creating trust (Figure 2).

### CONCLUSION

This report of a survey of healthcare executives summarises current initiatives targeted towards physician burnout prevention at the organisational level. Several of the administrators who responded to this survey acknowledged that physician well-being is a priority but that organisational interventions were still in their initial stages and that there was significant

room for growth. Other organisations have invested heavily in physician burnout prevention and have implemented multifaceted programmes, including dedicated staff, peer-to-peer counselling and targeted educational and therapeutic sessions. With all the pressures associated with dealing with COVID-19, organisations face the challenge of meeting the psycho-emotional needs of the physician staff. This survey confirms that administrators across the United States recognise that organizationally driven physician burnout prevention is pivotal to stabilisation of the healthcare workforce.



Figure 2: Physician burnout summary infographic

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