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Physician Burnout and Career Fatigue Part I

The Growth of Physician Workload and Workplace Violence in Healthcare

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Prior to the onset of the COVID-19 pandemic, the issue of career fatigue was already a growing concern for physicians and healthcare systems. In 2018, a survey conducted by The Physicians Foundation reported that 31% of physicians indicated they often have feelings of burnout. [1] Fast forward a few years into the pandemic, and in the 2022 edition of this survey, this number has jumped to 62% of respondents indicating that they often have feelings of burnout. [2] This growth in burnout is a major concern as physician burnout negatively impacts physicians' well-being, decreases the quality of care physicians provide, and contributes to older physicians retiring earlier than anticipated and younger physicians leaving the field altogether. [3] While many of the reasons for these results were present before COVID-19, the pandemic has brought this discussion into new context and importance.

This is the first in a three-part series on physician career fatigue and mental health issues. This article will examine four of the major causes of career fatigue for physicians: administrative burdens, including those created by the advent of electronic health records (EHRs), the increase in violence in the healthcare setting, the continued industry-wide staffing shortages, and the persisting stigma associated with seeking treatment for a mental health condition or substance use disorder. While there are no simple answers or quick fixes for these issues, this article will include a discussion of potential solutions that various stakeholders around the country are adopting in an attempt to positively address physician career fatigue and burnout.

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Administrative Burdens

Over the past decade, the adoption of EHRs, increased prior authorization [4] and other administrative requirements imposed by payers, and the focus on shifting from fee-for-service models to valued-based care compensation structures have thrust increased administrative burdens on physicians. This growing workload has not been a welcome addition for physicians, and for many, these demands have become an impediment to caring for patients. While the aim of these new technologies and payment methods is to improve productivity and efficiency and decrease costs, many physicians feel these new requirements have negatively impacted their profession. [5]

"Click Fatigue" and the "Inbasket"

Many physicians cite "click fatigue" and their "inbasket" as constant sources of frustration. They feel that they are spending the majority of the patient visit clicking through different parts of the EHR and inputting information instead of directly interacting with their patients. [6] The burden of EHR "task baskets" or "inbaskets" has also been well documented. [7] The inbasket's role increased with the adoption of EHR patient portals and data sharing with patients under the 21st Century Cures Act. [8] Message types in a physician's inbasket can include laboratory or imaging results, messages from other physicians, staff members, or patients, and system-generated messages regarding incomplete progress notes, system maintenance, and more. [9] Additionally, the COVID-19 pandemic may have contributed to larger inbaskets for physicians, with a recent study showing that the number of task basket messages increased 157% over the course of the pandemic. [10] To put this in perspective, physicians spend between 17 minutes and 217 minutes per patient in the EHR, resulting in up to 33 hours per month in the EHR after work hours. [11] These longer hours were found to be "highly attributable to symptoms of

burnout." [12] Physicians frequently ask that the EHR be re-designed to, in part, reduce task repetition, number of clicks per task, and inefficient data entry.

Solutions to Reduce EHR Administrative Burdens

Industry stakeholders are committed to finding solutions to decrease physicians' administrative time associated with seeing a patient. Usability, workflow, and documentation time have all been targeted as areas that can be improved. In conversations with physician clients and in much of the literature, there seems to be a great deal of agreement that EHRs need an overall redesign to increase their efficiency and decrease the amount of time a physician needs to interact with the EHR to achieve the same result. Usability needs to be addressed by the EHR creators, however, workflow and documentation time can be addressed by providers and health systems. The American Medical Association (AMA) has published a Saving Time Playbook to provide solutions to some of these workflow and documentation time issues. [13]

Addressing physician burnout and supporting physician wellness is an industrywide goal, with some recent changes showing potential to lessen physician administrative burden. Beginning in 2019, the Centers for Medicare and Medicaid Services (CMS) implemented several changes to documentation requirements to help ease the strain faced by physicians, minimize errors, and eliminate redundancies. Under the 2019 fee schedule, physicians are only required to document interval changes from a previous encounter instead of requiring physicians to import prior histories on each encounter. [14] Additionally, it is acceptable for ancillary staff to enter patient history information for a physician, as long as the physician ultimately takes responsibility for the documentation being submitted. [15] Finally, any chief complaint information or history provided by a patient through a patient portal does not need to be re-entered by a physician; the physician only needs to indicate that these were verified. [16] In 2021, documentation requirements for evaluation and management codes changed to require medically appropriate documentation for the history and exam portion only to the level that supports the medical decision-making process, instead of requiring a physician to report a full history and exam to support the billing for that code. [17] At first, these changes were only in effect in the office setting, but in 2023, these changes were applied to all settings. [18] In addition to reducing time spent in EHRs, organizations like the AMA believe that engaging more physicians in the design process will result in improvements to quality of care. [19] This will hopefully result in more proactive solutions that reduce physician headaches with EHRs before they occur.

Value-Based Care Impacts on Physicians

With the healthcare industry's continued push toward value-based care, the potential for physician administrative burdens continues to grow. Value-based care is heavily data driven and requires a large commitment from physicians and other healthcare providers to put in the time and effort to report and record this data. Thoughtful and targeted solutions will be needed to continue to promote the benefits of EHRs and value-based care programs while not unintentionally increasing the administrative and other burdens that factor into fatigue or burnout.

In the push towards value-based care, CMS has recently made changes to its Merit-Based Incentive Payment System (MIPS) by implementing a new voluntary framework. This framework, called the MIPS Value Pathways (MVPs), is meant to improve patient care and outcomes, as physicians have expressed concerns regarding the original aspects of the MIPS program, including the confusing nature of the reporting requirements and large choice and complexity in reporting measures and activities. MIPS participants will be able to begin using MVPs beginning in the 2023 performance period, which spans from January 1 to December 31, 2023. [20] MVPs aim to align a subset of measures and activities to a given specialty or medical condition. CMS believes this shift from the siloed approach under MIPS will result in measures and activities that are clinically related, relevant to a clinician's practice, and pertinent to patient care. [21] Although MVPs will be voluntary through 2027, they may become permanent after 2028. [22] Balancing the need for information to implement value-based care programs and the effort this will require of physicians will be important as value-based care arrangements continue to grow in the market.

Workplace Violence

As many physicians have experienced firsthand, there is an alarming nation-wide trend of violence against healthcare workers since the beginning of the COVID-19 pandemic. The Bureau of Labor has published statistics indicating that 10.4 in 10,000 workers in healthcare experience some sort of workplace violence, compared to 2.1 in 10,000 across all industries. [23] Specifically, the American Hospital Association (AHA) has reported in a recent study that 44% of nurses have reported experiencing physical violence and 68% reported verbal abuse during the COVID-19 pandemic, while 24% of female physicians and 22% of male physicians report they have been harassed on social media, with such harassment consisting mainly of death threats. [24]

Workplace violence and intimidation makes it even more difficult for doctors, nurses, and staff to treat patients and provide quality care.

Federal Initiatives

Federal and state legislators are beginning to address this very real issue. At the federal level, multiple bills have been introduced to attempt to curb workplace violence in healthcare settings. (25) The AHA, through its Hospitals Against Violence initiative, has been actively lobbying in collaboration with other industry stakeholders in support of the Bipartisan Solution to Cyclical Violence Act of 2023. (26) This bill would establish a grant program to support trauma center violence intervention and violence prevention programs.

Louisiana Violence Prevention Laws

At the state level, many state legislators have introduced and passed bills to address the rise in violence in the healthcare setting. As an example, the Louisiana legislature passed two new laws that went into effect August 1, 2022, to help address violence in healthcare. Act 129 makes battery or assault of a healthcare professional a felony in Louisiana and increases the penalties for a second offense against a healthcare worker. Additionally, the new law expands the prior definition of "healthcare professional" to include patient transporters, dietary workers, patient access representatives, security personnel, patient relations advocates, or any other person who otherwise assists in or supports the performance of healthcare services. The law also creates a new criminal offense, the crime of unlawful disruption of the operation of a healthcare facility, which is the "intentional communication of information that the commission of a crime of violence is imminent or in progress, or that a circumstance dangerous to human life exists or is about to exist." (27)

In the same legislative session, the Louisiana legislature passed Act 461, also effective August 1, 2022. Act 461 applies to regulated entities, which the legislation defines broadly and includes nearly all healthcare facilities in Louisiana and creates new requirements for these entities to help reduce workplace violence. These requirements include: (1) posting signage in a conspicuous and publicly accessible location at the facility explaining that violence against healthcare staff will not be tolerated and could result in a felony conviction, (2) developing and maintaining a workplace violence prevention plan that requires in-person training for staff, and (3) reporting all workplace

violence to the appropriate authorities. [28] Importantly, the law prohibits retaliation against employees who report instances of workplace violence. [29]

To supplement the above Acts, the Louisiana Department of Health drafted and posted information on their website as guidance to help providers implement their own workplace violence prevention plans, including: a listing of resources on the issue of healthcare workplace violence; actions healthcare facilities can take to prevent, respond to, and mitigate healthcare violence; a checklist of items that healthcare facilities should consider when developing a workplace violence prevention plan; and a downloadable example of the signage required to be displayed in healthcare facilities. [30]

Violence Prevention in Other States

This trend towards enacting laws to help prevent workplace violence is not isolated to Louisiana. On May 24, 2023, Florida Governor Ron DeSantis signed a bill into law to increase the penalties for assault or battery of hospital personnel. [31] The law will take effect October 1, 2023, and similar to the Louisiana law, broadly describes "hospital personnel" to include personnel who "perform duties directly associated with the care and treatment rendered by any department of a hospital or with the security thereof." [32]

Only time will tell if any of these laws will prove effective at decreasing and preventing violence in the healthcare setting. However, the breadth of different approaches to address these issues, including the grants for violence prevention programs, implementation of workplace training for healthcare workers, and increased penalties for violence against healthcare workers, is encouraging.

Staffing Shortages

While the healthcare industry is facing shortages across many positions, the major trends related to the physician shortage include a high demand for healthcare services by an aging population, an increase in physician retirements, and lack of sufficient residency positions for physicians. By 2032, the U.S. Census Bureau expects there to be more seniors in this country than persons 17 and under, which will be the first time in U.S. history that this demographic mix will be experienced. [33] According to the Centers for Disease Control and Prevention, seniors account for an

outsized portion of both diagnostic tests and inpatient procedures, which will continue to strain the physician workforce as seniors increase in number in the U.S. population. [34]

Residency Training Slots

The physician population is also facing an increase in older physicians, with approximately 30% of the physicians in the U.S. over the age of 60, or two of every five active physicians being 65 or older within the next decade, which means many may retire in the near future. [35] In addition, the strain and fatigue imposed on the profession, as well as the COVID-19 pandemic, has resulted in many physicians, including relatively young physicians, contemplating retirement. Unfortunately, the supply of new physicians entering the profession does not appear sufficient to handle the current physician shortage or replace departing physicians, not to mention expected increases in the demand for healthcare over the coming decades. The federal funding available for graduate medical education has been subject to caps established in 1997 by Congress. As part of COVID-19 relief payments, an additional 1,000 residency positions over a five-year period were funded. [36] However, this is far short of the number that the Association of American Medical Colleges (AAMC) has indicated is necessary to deal with current and future shortage. [37]

To this end, the AAMC issued a statement applauding the efforts of the U.S. Senate for their introduction of The Resident Physician Shortage Reduction Act of 2023. [38] This bill would potentially increase the number of Medicare-supported residency positions by 14,000 over the next seven years.

It's clear that long-term investments are needed, but solutions that focus on increases in supply are not the only ones available. As this article has discussed, there are many struggles faced by physicians in the healthcare industry today, from technology and administrative burdens, to increasingly unsafe working environments, to a lack of resources to address a growing mental health problem in the physician workforce. Few industry-wide changes can be made overnight to address these issues. However, a continued focus by hospitals, health systems, and state and federal government on addressing and minimizing these burdens could ease the strain faced by physicians, allowing them to spend more time on patient care. These changes will ideally improve patient interactions and allow physicians to focus on the aspects of this profession that they value the most, hopefully reducing the outflow of physicians from the industry.

As physicians are not the only part of the staffing shortages being experienced in the healthcare industry today, the next article in this series, "The Healthcare Staffing Crisis and Operational Challenges" by Gregory Fliszar, Marcus Hughes, and Vinila Varghese, will explore staffing shortages from a hospital and health system operational perspective, including a discussion of the increased use and cost of travel nurses and temporary workforce, and the cultural and cohesion challenges created by leaning heavily on a temporary workforce.

Mental Health and Substance Use Disorder Treatment Stigma

In light of the COVID-19 pandemic and the burdens it has placed on physicians, there has been a renewed focus on dismantling the stigma associated with treatment for mental health conditions and substance use disorders by physicians. The medical community is sometimes at odds with itself by promoting mental health psychotherapies and pharmacological treatments to the general population, while at the same time attributing stigma to, and penalizing, members of its own community for seeking the same treatment.. [39] Physicians frequently admit that they do not seek help for anxiety, depression, or other mental health conditions because of the licensing questions the state medical boards ask, which require physicians to disclose any mental health conditions or treatments they have received, no matter how situational or temporaneous. [40] The tragic consequence of this fear of seeking treatment is that 300 to 400 physicians die by suicide in the United States every year—roughly a doctor per day. [41]

To combat the stigma of mental health treatment, physicians are speaking out. There are many physicians and healthcare industry stakeholders seeking changes to medical licensing, hospital and health system credentialing, and other applications physicians must complete. The general thrust of the effort is to remove questions calling for disclosure of past diagnosis or treatment of a mental illness or substance use disorder and ask instead whether the applicant has a "current impairment" that if not appropriately treated, would adversely affect the health and safety of a patient or otherwise prevent the physician from safely and competently practicing medicine. [42] The movement to change these licensing application questions is a conversation in its own right. To give voice to this conversation, the third article of this series, "Mental Health Stigma and Impact on Physician Licensing, Credentialing, and Privileging," authored by Daniel Blaney-Koen, Sun Vega, and Tyler Cowart, will be solely dedicated to this topic.

Conclusion

Physician burnout is being driven by a variety of issues in the healthcare industry today. From the stress caused by increased administrative tasks and the higher workload resulting from staffing shortages to the fear caused by the rise in violent patient interactions and the stigma associated with physicians accessing mental healthcare, physicians are feeling the pressures of their profession continue to mount. With so many causes, the industry will need to implement a multitude of solutions to address the rise in physician burnout.

Recent efforts by CMS, state and federal governments, and industry stakeholders are attempting to turn the tide on physician burnout with solutions focused on minimizing physician administrative tasks and creating a safer working environment in healthcare. It is hoped that bringing awareness to the causes of physician burnout and career fatigue will initiate conversations and promote widespread adoption of solutions to the issues discussed in this article series.

Endnotes

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