Health Care Harmonics: Fine Tuning the Tension Between Stakeholders

In this issue of Mayo Clinic Proceedings, Shanafelt et al present the third triennial report on physician burnout in the United States. Burnout peaked in 2015 at 54% and dropped to 44%. Improvements might be attributed to physician wellness initiatives and the system settling after health care reforms.

This landmark series of surveys revealed that a majority of American physicians were experiencing burnout. Burnout was dynamic, rising and falling in unison across all specialties throughout the country, from year to year, and proportional to hours spent at work. In contrast, the baseline level of burnout in other US workers was nearly half the levels experienced by physicians and static. These findings point to a faulty health care system to which all physicians are exposed. Related research found that burnout portends grave personal and professional consequences for physicians and adverse effects on patient care (eg, quality and safety, access and cost, and the patient experience). In response to these surveys, health care executives declared physician burnout a public health crisis, and medical societies convened stakeholders to take action.

LOST VOICE (LOST ENGAGEMENT)

Shanafelt et al provide a sense that physicians’ perspectives regarding health care delivery have been absent in the consolidation of hospitals, practices, and markets. For the first time in American history, a majority of physicians are employed rather than self-employed. More often, “good doctor” connotes completion of mandated tasks on the electronic health record (EHR) tied to billing and productivity, a yardstick that reflects “imperfect” measures of quality and patient satisfaction. Thus, physicians spend half of their workday entering data into the EHR, with additional hours after work to comply. Physicians’ professional societies have raised their voices calling for an end to the excessive administrative burden and complexity.

Lacking value alignment with the system, physicians might question whether the time spent on the EHR is the best use of their training and worth sacrificing work–life balance. According to Shanafelt et al, physicians were less satisfied with their work–life balance than other Americans were (43% compared with 61%, respectively). Physicians work 12 hours longer each week than the average American worker; and 39% of physicians work more than 60 hours per week compared with 6% of the general population. However, as cited by Shanafelt et al, physicians tend to withdraw from the clinical workforce in response to burnout, which may exacerbate existing physician shortages and compromise access to care.

LOST EFFICACY (LOST EMPOWERMENT)

As employees in large organizations, physicians have given up aspects of control enjoyed in private practice. As this trend has accelerated, the notion of physician autonomy has shifted. Some argue that physicians were willing to give up their professional autonomy for administrative simplicity, work–life balance, and job stability. Some argue that professional autonomy had been compromised by the administrative complexity of private practice, and physicians increasingly sought large organizations with the attendant benefit of administrative support and economy of scale. Yet others argue that physicians should not have autonomy and should follow the dictates of organizational management and clinical guidelines. Some hospitals and newly formed Accountable Care Organizations strategically have wanted to limit autonomy to control quality, costs, prices, and productivity—by employing and controlling their competition. Loss of control (autonomy) is tied to burnout.
These philosophies on physician autonomy are part of a larger debate regarding how to bend the cost curve and ensure reliable quality care uniformly for all Americans. Gross regional variations in care and the number of deaths attributable to medical errors were reported by the Dartmouth Atlas Project in 1996 and the Institute of Medicine in 2000, respectively. Dysfunctional communication, coordination, and collaboration among stakeholders in orchestrating care was most culpable. In response, comparative effectiveness researchers sought consensus regarding the standards of care to reduce physician’s discretionary decision making and unnecessary spending, thus limiting physicians’ freedom.

Control over how quality is arbitrated and reimbursed raises tension between stakeholders (eg, cost and quality, payers and providers, individuals and society), and it affects the patient–physician relationship through which rational care is established. A pioneer in Health Services Research, Donabedian explained in 1966 that “care can be good in many of its parts and disastrously inadequate in aggregate.” Although outcomes are more easily measured and reliably reproduced, an outcome is not rational if it is not perceived as valid and “good” for a particular patient’s circumstance. Given the innumerable possible patient presentations, the process of collecting sufficient data and shared decision making generates rational care for a quality result—a customization that requires a degree of autonomy. Artificial intelligence might eventually collect and process sufficient data to judge the situation in aggregate, given the amount of data in EHRs. Until perfected, physicians will still require authority to correct course to ensure that target outcomes are meaningfully good.

Reactions to consolidations, such as those noted by Shanafelt et al, have been described by Barr, who built on the work of Donabedian in the 1990s. Ever larger health care organizations are prone to manage complexity with standardizations and strict enforcement of rules and regulations. Responsibilities may be fragmented, compromising teamwork. Communication and coordination can be more challenging. Bureaucratic inefficiency can erode quality, clinician well-being, patient satisfaction, and economy of scale. Barr concluded that efforts to preserve physician autonomy and the patient–physician relationship might mitigate some risks, perhaps owing to the authority to correct course to prevent harm.

**RESTORE VOICE (ENGAGE)**

Increasingly, health care organizations seek physician input through their annual physician wellness survey and correlate findings with causes and consequences. In response, organizational leadership has the opportunity to provide meaningful structures and processes to better support physicians’ implicit motivation to provide quality patient care. A systematic approach to identifying these opportunities would specifically explore 3 domains: (1) culture and climate, including leadership and control; (2) workplace efficiency, including clinical teamwork; and (3) personal resiliency, including work–life balance and rejuvenation. Consequences can be monitored using the quadruple aim model of quality and safety, cost and access, the patient experience, and physician well-being.

The Job Demands Resource model has been used to demonstrate that physicians experience burnout when they have poor control and lack of resources to manage their job demands. When the effort to meet demands is exceedingly high, the physician will withdraw from work physically and psychologically to preserve their well-being and existing resources. Evidence suggests that this process can be mitigated by engaging and empowering physicians, such that they feel heard and supported, and to the extent they are most effective in their work. The annual physician wellness survey is one method of engaging their input.

**RESTORE EFFICACY (EMPOWER)**

Lack of self-efficacy (poor sense of personal accomplishment) is 1 of the 3 domains of burnout, along with emotional exhaustion and depersonalization, and it could be the primary feature of physician burnout. A recurring theme echoed throughout the literature
regarding physician burnout is the sense that physicians have lost control over practice management and medical decision making, thus straining their ability to perform at their best within the patient–physician relationship. The lack of control and the fact that their perspectives are not taken into account leads to a feeling of powerlessness within a dysfunctional system that does not reflect their professional values. This domain of self-efficacy is not included in the conventional assessment of physicians (as the Maslach Burnout Inventory was not designed for physicians; physicians tend to cluster on an extreme of the scale).

This series of surveys by Shanafelt et al1 reinserts physicians’ perspectives into the reimagining of what a reliable, well-orchestrated, high-quality health care system looks like. The research sparked by this survey series illustrates that when the perspectives of frontline physicians are not included in designing the health care system, the health care system is not designed to support their work on the frontlines.

HARMONIZE (ENGAGE, EMPOWER, COLLABORATE, COMMUNICATE, COORDINATE)

An orchestrated health care system might tune to the question “What goes on here?” Donabedian recommended this method to orient the stakeholders toward a common mission to provide patients and communities with affordable access to satisfying, high-quality care from high-performing clinicians. Those in power might be tempted to control, rather than collaborate, communicate, and coordinate, because these three actions take time. However, cognitive short cuts to save time are fraught with biases that are detrimental over the long term. The tensions between stakeholders can create great harmonics when stakeholders listen to one another and align efforts. The whole is greater than the sum of its parts. Shanafelt et al1 exemplify how surveys can engage and empower to bring harmony to health care.

Kristine Olson, MD, MSc
Yale New Haven Health
Yale School of Medicine
New Haven, CT

Potential Competing Interests: The author reports no competing interests.

Correspondence: Address to Kristine Olson, MD, MSc, 20 York Street, New Haven, CT 06510 (kristine.olson@yale.edu).

REFERENCES