

CLINICAL PERSPECTIVE

Do No Harm: Health Systems' Duty to Promote Clinician Well-BeingAnish K. Agarwal MD, MPH, MS^{1,2}; Thea Gallagher PsyD³¹Department of Emergency Medicine, Perelman School of Medicine, University of Pennsylvania, Philadelphia²Center for Health Care Innovation, University of Pennsylvania, Philadelphia³Department of Psychiatry, Grossman School of Medicine, New York University, New York City

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Burnout and mental health disorders plague the health care workforce. Since the pandemic began, there has been an uptick in symptoms of anxiety, depression, and suicidality among health care professionals.¹ These threats to the workforce existed before the pandemic, have been exacerbated by the pandemic, and are likely to persist for years ahead.²

The attention toward clinician well-being was heightened during the initial surges of COVID cases.³ The nation watched as these individuals struggled with patient acuity, volume, lack of resources, and difficult clinical and personal life decisions. The subsequent surges during various iterations of the pandemic only heightened these issues.

Sadly, these problems only intensified with hiring freezes, a lack of salary increases, and a higher emotional burden for practitioners and patients.⁴ As a result, clinicians became more vocal (and were sometimes heard) across the globe as they discussed moral injury in allocating care, the dangers of bringing COVID home with you, and frustrations around public policy and behavior, to name a few poignant

topics. Due to the initial hiring freeze policies, the system became overburdened at a time when it needed the most support. Many providers are now stressed by the lack of resources and the ultimate threats to their patients and their license to practice.

The inherent "occupational hazards," in medicine otherwise known as burnout and co-occurring mental health conditions, such as depression and anxiety, were elevated to a new level. Public appreciation took the form of crowd-sourced supply donations and an influx of meals for clinical teams. These acts were thoughtful but not sustainable nor required any real sacrifice from institutions. In addition, health systems acted by launching or expanding approaches geared toward clinician wellness or employee assistance programs. For many, this was too little, too late and continued to send the message to clinicians, that they needed to fix these issues and seek support on their own. The system didn't acknowledge its role in failing people, which led to people feeling used and bred a deep mistrust of leadership.

Two years later, we find ourselves crossing 1 million deaths in the United States with a crisis in clinician staffing.

Droves of nurses are leaving the workforce, and national polls reveal a distressing amount of physicians are considering leaving the profession.⁵ Unsurprising when you look at the aforementioned problems.

As society trudges forward throughout the pandemic, health systems must take a fresh and new perspective in supporting and sustaining clinicians before they are burnt to a crisp. For too long, the approach has been reactionary and delayed, antiquated, reductive, and static. Health systems have an obligation to sustain their workforce. To make progress, they must look inward and proactively act to design a culture of well-being that mitigates burnout and supports individual mental health early and often. Like all good relationship rebuilding, this begins with acknowledgment, empathy, remorse, and real, sustainable change interventions.

First, systems must acknowledge that the current culture in medicine, including medical training, is fraught with a perverse notion that prioritizing well-being or admitting mental health strain is a weakness. Indeed, this is problematic at the individual level. Still, if the system can set a better example, it is likely also true that individuals will feel safe and supported to change their notions. Changing toxic work culture starts from the top down. Too long have we glorified working more hours, seeing more patients, or performing more procedures at the expense of sleep, nutrition, time with loved ones, or personal time off. The expectations only increase year after year, with a greater focus on money and productivity as primary goals. Moreover, the stoicism inherent to medicine hinders our progress and reinforces the deep stigma in identifying and accessing mental health services or resources.

These systemic barriers lead to significant costs; to the clinicians themselves, worse patient outcomes, and a

shrinking workforce – in size and experience. To truly invoke a commitment to bringing fulfillment back into clinical careers as outlined by the Quadruple Aim, health systems must place clinician well-being squarely next to patient safety and quality on their priority lists and budgets. The status quo has been designed to pick clinicians up once they've fallen, but the future must design and develop systems that prevent them from falling.

Next, conceptual frameworks across health care outline a multi-layer and complex range of issues ranging from the practice environment, organizational and personal factors, and the business or payor environment. Health systems often attempt to conduct annual burnout assessments of staff to achieve some clarity on these issues across domains. Though important, these approaches lack the depth and focus needed for local leaders to be action-oriented and often relay information in a one-way fashion (e.g., clinician to leadership).

An alternative strategy would supplement these annual surveys with a continuous and open mechanism feedback loop between clinicians, local leaders, and system-based leadership. For example, many institutions already employ and encourage anonymous reporting safety mechanisms related to patient safety. A similar yet distinct platform could allow clinicians to report or highlight well-being concerns in a democratizing fashion. A continuous influx of content could help identify issues early, provide focus areas for administration to address, and engage the workforce. Timely acknowledgment and attention would reinforce such a system and help normalize reporting burdens.

Finally, health systems must realize a need for structural change in clinician capacity. A goal of maximizing efficiency for clinicians may equate to maximizing burnout and distress. Inherent to the practice

of medicine and providing clinical care are a combination of profoundly fulfilling and emotionally exhausting moments. Witnessing disease progression, injury, morbidity, and mortality are difficult and real aspects of the profession. To provide compassionate, comprehensive, and quality care, clinicians need to be equipped with the resources to treat their patients and time to rest and recover adequately.

In the early weeks of the pandemic, many in health care found inspiration and energy in the word "resilience." As pots and pans rang out across the streets, we persisted in caring for our communities. Today, tone-deaf "resilience sessions," "wellness seminars," and lunch gatherings fall exceedingly short and send the message that the clinicians must heal themselves. Instead, clinicians need mechanisms that give them their time back to focus on daily recovery. This can take many shapes but could begin with decreasing administrative tasks, hiring more support personnel, reducing charting from home, and providing dependent or elder care resources. In short, an overhaul is needed, but small action steps that help relieve the burden in real ways might be that overhaul.

Health systems need to be more in touch, supportive, and clear with their workforce. The pandemic has highlighted the structural problems that contributed to clinicians' burnout and distress. The time is now for systems to double down on upstream strategies to decrease stigma in identifying mental health strains, identify issues early, and build mechanisms for clinicians to recover. Without these, costs will rise, clinicians will suffer, and patient care will falter.

Let's begin by acknowledging how broken the system is and rebuilding it to protect the clinicians and their patients. No one wants to talk about reducing expectations and hiring more people to support the work, but if this doesn't happen, the future of healthcare looks grim. Further exploration through directed study of the experiences of nocturnists and residents and of patient outcomes. This research provides groundwork for such studies.

Notes

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