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Addressing palliative care clinician burnout in organizations: a workforce necessity, an ethical imperative

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Abstract

Clinician burnout reduces the capacity for providers and health systems to deliver timely, high quality, patient-centered care and increases the risk that clinicians will leave practice. This is especially problematic in hospice and palliative care: patients are often frail, elderly, vulnerable and complex; access to care is often outstripped by need; and demand for clinical experts will increase as palliative care further integrates into usual care. Efforts to mitigate and prevent burnout currently focus on individual clinicians. However, analysis of the problem of burnout should be expanded to include both individual- and systems-level factors as well as solutions; comprehensive interventions must address both. As a society, we hold organizations responsible for acting ethically, especially when it relates to deployment and protection of valuable and constrained resources. We should similarly hold organizations responsible for being ethical stewards of the resource of highly trained and talented clinicians through comprehensive programs to address burnout.

Keywords

burnout; moral distress; ethics; hospice; palliative care

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Introduction

Burnout causes harm to hospice and palliative care (HPC) providers, patients, and organizations, in part by compounding a growing workforce shortage.(1) Recent estimates suggest 6,000-18,000 palliative care physicians were needed to staff existing hospital-based and hospice programs in the United States.(2) The number of hospice (3), hospital-based and community-based palliative care programs (4) have grown rapidly. Yet research to characterize burnout in American HPC clinicians finds that nearly one-quarter are considering leaving the field within 5 years (5) with higher rates of burnout occurring among those who are younger than 50.(6) Efforts to expand the HPM workforce and improve access to care – as recommended by the U.S. Institute of Medicine (IOM) report *Dying in America* (7) – will be seriously hampered unless organizations and policy makers address burnout.

Harms and Causes of Burnout

Burnout is characterized by emotional exhaustion, depersonalization and cynicism, and negative evaluation of competence or personal accomplishment.(8) Clinician burnout causes harm to providers, patients, and health care systems. Its consequences for clinicians include anxiety, depression, substance abuse, and suicide.(9–12) Evidence also suggests that clinician burnout results in measurable differences in quality of care.(13) Patient and family care is adversely affected by burnout-related reductions in professionalism and quality of care.(13–17) Health care organizations suffering from burnout are noted to have higher rates of medical errors (18,19) and declines in productivity (20) such as reductions in work hours and pursuit of early retirement.(21,22) High turnover also diverts resources allocated for patient care towards hiring new staff.

The existential and emotional challenges intrinsic to the care of the dying increase the vulnerability of HPC providers to burnout. A recent assessment of HPC clinicians suggests a higher incidence of burnout (62%)(6) relative to hospitalists (52.3%)(23) and oncologists (44.7%).(24) Predictors of burnout among HPC clinicians include working over 50 hours per week or working on weekends, less experience, and practicing in isolation from peers.(5,6) Other predictors of HPC burnout include lack of self-confidence in communication skills with patients and families, time pressures that hinder effective communication, communicating bad news, and addressing pain, suffering, dying, and death.(25)

Structural factors and moral distress as components of burnout

Given the emotional intensity of working with dying patients, these challenges may not be unexpected individually. However, systemic causes of burnout can also prompt higher rates of feelings of loss of autonomy and practice control that compound the emotional drain.(9) For example, certain organization structures may require clinicians to work long hours in relative isolation. The rapid growth and consolidation of HPC organizations over the past 10 years in the United States have resulted in high levels of regulatory oversight. HPC clinicians may chafe at bureaucratic requirements and its erosion of professional autonomy, despite the benefits of consolidation. Yet systemic structures of growth and consolidation may contribute to feelings of powerlessness, system unfairness, and conflicts between

personal/professional and organizational values known to be associated with burnout.(26) Organizations that prioritize revenue and adherence to regulatory restrictions (as described in recent reports from the U.S. Office of the Inspector General(27,28) and the Medicare Payment Advisory Commission) drive distress.(29,30) Conflicts between professional and organizational values can arise in other settings too. Like the general tensions between bureaucratically-imposed responsibilities to manage overall population health while doing what is best for an individual patient, HPM clinicians face this with life and death regularly.(31) This is especially apparent in U.S. hospices with "open access" policies, where the majority of patients enroll in the Medicare Hospice Benefit (MHB) and its associated flat-rate per diem reimbursement, but may request resource-intensive services like chemotherapy, radiation, antibiotics, or inotropic therapy that far exceed the MHB per diem.(32,33) Clinicians are often torn between commitment to align patient-centered plans of care that promote optimal symptom management but may include resource-intensive services, and a commitment to their organization to help ensure aggregate expenditures for their patients do not exceed the Medicare or insurance reimbursements. These kinds of concerns will likely become more prevalent as more providers participate in shared risk contracts. These modern managed care payment models, such as accountable care organizations, require consideration of the *value* of the services rendered – the appropriateness and effectiveness of the treatment compared to the cost.

These organizationally-mediated ethical tensions may result in moral distress – an inability to act in accordance with one's ethical beliefs due to institutional constraints.(34) Some have suggested that unrelieved moral distress might result in burnout, stress, and eventually deficiencies in ethical appraisal and discernment among HPC clinicians.(35) Moral distress is most commonly described among HPC clinicians encountering a host of common clinical dilemmas such as balancing a duty to minimize patient harm (nonmaleficence) while facilitating patient autonomy, honoring advance care preferences including decisions to resuscitate or not, or withholding or withdrawing of life-sustaining treatments.(36) The prevalence of moral distress among practitioners is worrisome when examined in light of system-based ethical practices as a whole. The fact that moral distress is prevalent among interdisciplinary clinicians (37) suggests unethical system mediators of these outcomes. At the very least, moral distress should be identified and addressed to aid clinicians in reconciling their feelings of providing unethical care. Ideally, these realities should prompt reflection on troublesome patterns, incentives, and barriers within organizational structures that together engender moral distress, burnout, and attendant declines in HPC workforce capacity.

Systemic factors leading to ethical tensions can be subtle and unintentional. Institutional cultures or policies might inadvertently influence how physicians communicate and offer choice to patients and families in ways that might be counter to HPC best practices. For example, institutional norms may promote therapeutic inertia that encourages a mindless "honoring" of autonomy without reflection or consideration of medical appropriateness.(38) This in turn might lead to offering therapeutic options which may not be in the patient's best interest, inappropriately approaching life's end and leading to moral distress.(39) Like burnout, researchers often treat moral distress as an individual-level problem; however,

examining organizational factors that serve both financial or regulatory ends may expose the collective conscience of clinicians within the organization.

Interventions to address burnout

Despite the well-documented magnitude of the problem of burnout and the plausible role of organizational mediators, interventions to address or prevent HPC clinician burnout remain small, infrequent, and often focused on individual actions. For example, researchers recommend that clinicians at risk for burnout pursue art,(40,41) build strong professional relationships, focus on transcendental perspectives,(42) engage in exercise programs,(43) or improve personal resilience.(44,45) These interventions implicitly suggest that the individual clinician retains primary responsibility for preventing, identifying and mitigating burnout. While individual-level interventions are necessary, in light of the structural causes of burnout described in this commentary, they are neither sufficient nor fair distributions of the burden of responsibility.

If system-level issues contribute to burnout, then health care organizations must take a portion of responsibility to address HPC clinician burnout.(45) The culture of a health care organization impacts its ability to deliver high-quality, high-value care and effect positive patient outcomes; misalignment between mission, values, and everyday practices may indicate an ethics gap in need of transformation.(46) Organizations seeking to foster a positive and ethical culture as part of their pursuit of the Triple Aim – enhanced patient experience, improved population health, and reduced costs (47) – must attend to the alignment between mission and values, decisions, and practices in a manner that honors the agency and dignity of its clinicians. Recognizing the direct threat that burnout poses to Triple Aim Care, advocates have proposed that an equal emphasis be placed on systematically assessing and improving the professional lives of clinicians.(48)

Addressing burnout is a matter of organizational mission and ethics. Ethically responsible organizations will first systematically measure burnout alongside other metrics of quality of care.(49,50) While a number of initiatives are seeking to better measure HPC quality of care,(51–53) few quality measures focus on the well-being of the clinicians themselves. One effort to longitudinally measure burnout, satisfaction, and their impact found that each 1-point decrease in satisfaction or increase in emotional exhaustion was associated with a greater likelihood of reducing full time-equivalent effort (54). Adding a measure of clinician burnout to routine institutional quality measures could aid in the continuous evaluation of care quality by assessing the effectiveness of the processes in place and the capacity of the workforce delivering the care.

Next, high integrity organizations will implement programs to address burnout that do not inadvertently worsen outcomes. For example, despite the evidence that more hours per week devoted to direct patient care is associated with greater risk of burnout,(55) one study found a reduction in work hours actually increased physician burnout, which the authors hypothesized was a result of the intensity of working hours increasing to accomplish the same volume of work.(56) This is one example of why structural interventions are needed that address the mid-level causes of burnout.

In recent years, U.S. health systems have been increasingly rewarded by payers for the quality of care rather than the volume of care provided to patients. Additionally, the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) and associated regulations unify and expand various outpatient practices to financially incentivize reporting of health care quality measures and achievement of baseline quality “thresholds”.(57) As a result, quality measures are being developed and implemented in hospice (52), palliative (53), and home-based medical care (58,59). In addition to the typical patient-oriented process and outcome measures, it may be increasingly important to organizations to measure burnout as a key factor impacting care quality and outcomes.

Organizations can also foster interventions focused on health system leaders, as evidence suggests that the quality of leadership at multiple levels in an organization impacts physician burnout.(60) Values-based leadership models (61–64) involve eliciting the core personal and professional values of clinicians (and other stakeholders) and developing organizational values in alignment with them. Leaders can also incorporate front-line clinician perspectives on organizational policies to review them for ethical concerns or conflicts, such as those perceived between reimbursement incentives and best interests of patients. If those conflicts cannot be resolved, leaders can help develop ways that clinicians can ethically respond when such tensions arise, such as the use of ethics committees with special expertise in organization-level concerns.(65) In addition, organizations should utilize fair processes for institutional policy-making that incorporate clinician perspectives to improve perceptions of procedural and distributive justice and therefore reduce exhaustion, absenteeism, and burnout.(66)

Health care organizations with an explicit commitment to fostering an ethical culture would be hypothesized to have lower rates of clinician burnout. Clinicians in organizations that develop such cultures are more likely to feel engaged, enabled, and energized about their work,(67,68) and willing to speak up to identify problems that should be addressed systematically throughout the organization. Clinicians who feel invested in the organization’s core mission are less at risk for burnout than clinicians who do not.(69) As such, organizations should ensure their mission and values align with those of hospice and palliative care, including equitable access, comfort and quality of life, teamwork and collaboration, excellence, stewardship, transparency, and integrity.(70) Organizations looking to implement a system-level intervention to improve ethical culture could begin with IntegratedEthics®, developed within the United States Veterans Affairs Health System.(71–73) This intervention aims to enable every level of a health care system to identify, address and improve ethical practices, including stewardship and perceptions of fairness. IntegratedEthics® includes tools and models to improve ethical culture as well as surveys to monitor outcomes.

Conclusion

HPC clinicians have tremendous responsibility to care for vulnerable patients in need. As a society and a field, we must do more than simply advise clinicians to take individual steps to prevent their own burnout. HPC clinicians struggle to balance the good of the patient and the good of the organization, which is echoed by the tension between clinicians’ struggle to

balance self-care and self-sacrifice for patient care. While clinicians do bear responsibility to set limits and engage in protective activities, organizations also bear responsibility for developing structures and processes that facilitate clinicians long-term thriving and mitigate workforce shortages due to leaving the field. Routinely measuring and reporting clinician burnout along with other organizational quality metrics would help to monitor whether changes to the practice patterns mitigates or intensifies burnout and its concomitant impact on care quality. Fostering ethical organizational cultures may help address the root causes of burnout and moral distress. Taking a systems-level approach to burnout and improving the professional lives of clinicians will allow organizations to ensure access to high quality hospice and palliative care for patients and families.

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