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Organizational Change and Unintended Consequences: "Clinical Physician Burnout"

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ABSTRACT

Significant organizational changes result when physicians that had been predominantly clinical in their scope transition over to administrative or other non-clinical roles. Someone must pick up the additional clinical volume and continue the primary mission of directly caring for patients. Leadership must consider the myriad potential unintended consequences of moving someone away from clinical duties. Any large shift out of clinical practice must be undertaken with adequate anticipation of, and genuine concern for, the unintended consequences. Everyone that desires an opportunity to develop leadership skills should be granted that opportunity. Physician burnout is a "hot" topic in today's healthcare management literature. I propose it be renamed "Clinical Physician Burnout" to reflect the unintended consequences of burnout experienced mainly by physicians that directly care for patients (rather than predominantly physician educators, researchers or administrators). Patient satisfaction will always remain the primary focus of any successful health care institution. However, sustainability for world-class organizations means also working tirelessly to prevent burnout and maintaining a very high level of provider satisfaction.

INTRODUCTION

Major organizational change occurs when clinical physicians are offered, or actively seek out and receive, new institutional administrative, educational or research opportunities. While they advance their careers and achieve success, someone must pick up the additional significant clinical volume and care for our patients. These newly minted "administrators" schedule significant time off the clinical schedule far in advance, leaving limited options for everyone else. They, along with leadership, must consider the negative effects and unintended consequences of usurping so much available time away from clinical duties. Innovation, creativity and non-clinical efforts suffer as they become relegated to the rare, non–guaranteed protected day because the clinical days are much too busy. Each and every non-clinical day must be meticulously accounted for, and thoroughly justified, as net operating income and margins have become the primary metric, above all else.

DISCUSSION

Everyone feels they work harder than everyone else (1,2). The "clinical people" complain "my day was so intense caring for patients." The "administrative people" bemoan, "Oy vey, I have to go from one meeting to another." The "researchers" remind everyone; "I have to complete two 20-page NIH grants by Friday!" I've heard the administrators, researchers and educators call the others, "their clinical colleagues." Unless you got that MBA or PhD, everyone has had the same essential training and have the same basic credentials. The subtlety of claiming that someone has some additional unique qualifying skillset is often very vague and highly subjective rather than documented and objective.

As Heffernan (3) described, this situation is a classic "super chicken" scenario. She describes the story of how a group of the most productive egg-laying chickens on a farm achieved their success by pecking the others to death. One's gain is another's loss. This also fits well in Martennson's (4) theory of everyone advocating for their own position and becoming defensive of their position. His theory extrapolates to the analogy that in order to avoid scrutiny, those in power and utilizing non-clinical time keep their intentions and strategies somewhat secretive so as not to be opposed by their clinical colleagues, who they know may ultimately stand to lose. Transparency is eliminated. Misunderstandings occur. Trust is eroded. People speak negatively of others.

People don't always correctly interpret their own actions or the potential reactions. They don't always associate their own actions with the subsequent consequences. They may see the benefits, but not the unintended side effects. This prevents them from learning, changing their beliefs or adjusting their future actions. When problems occur elsewhere in the organization, they don't necessarily connect it to their actions. When negative consequences or effects reach them, they ascribe the problem to others. These factors compound to create significant barriers to a healthy work environment. The paradigms utilized are all internal, disconnected from the environment; from otherwise valued colleagues.

In the interest of fairness and to describe both sides of the potential debate, it is true that many, if not most large healthcare institutions are complex organizational systems where department members are interrelated, interconnected and interdependent. This dynamic complex relationship means that, despite our best efforts to work fairly and collaboratively, one person's gain may be another's loss. The situation is fluid, as we must change in response to the external environment around us including payor mix, declining reimbursements and other, as of yet unforeseen future challenges. Also in the interest of fair debate, increased involvement in non-clinical tasks can increase the visibility of your division and department within the institution, albeit at a significant cost to division cohesiveness. Leadership, however, must respond to negative feedback to find a better equilibrium. The current system organization often does not work to accomplish everyone's goals. Rather, it is often set up so as to be limited to addressing the goals of the "super chickens." This change may result in the ascribing of negative attributes upon others. Colleagues are seemingly more likely to speak ill of one another – something that had been relatively rare in health care, which for so long had enjoyed a sense of collegiality, mutual respect and civility.

Why is this significant practice change so concerning? Physician burnout. Olson (5) suggested that approximately 50% of practicing clinical physicians are experiencing some degree or manifestation of burnout. These may include emotional exhaustion, cynicism, depersonalization, disengagement, reduced effectiveness (6). These physicians may withdraw from clinical practice, reduce work hours, take more unpaid and sick time, retire early, leave medicine, shift to non-clinical work, limit their practice, or constantly seek new opportunities (7). If burned-out physicians can't step away from clinical practice to affect a change, they may withdraw psychologically, manifest as less empathy, more errors, slower effort, less efficiency, reluctance to engage, reduced productivity, resistance to incentives to

work, rebelling and manipulating situations, disengaging from organizational initiatives or innovations and decreased vigilance (8).

The significant human toll of burnout may include substance abuse, broken relationships or even suicide (9). In addition, patient care suffers. Quality, safety, ordering patterns, access, patient satisfaction and malpractice are all at risk, making a very strong business case for organizations to reduce burnout. Compensation models linked to productivity encourage decreased time with patients, ordering more tests or working longer hours; thus, increasing burnout. Salaried compensation models solve this by providing protected non-clinical time (research, education, administration) as the reward, allowing physicians to shape their work to be more meaningful and fulfilling (10).

While there are clearly external considerations to consider, the workplace plays a significant contributory factor in burnout. This includes increased workloads, greater inefficiencies, misaligned individual and organizational values, the loss of meaning derived from work, and the loss of flexibility and control over work (7). Organizations love metrics; defining, measuring, analyzing, improving, controlling and scrutinizing everything deemed critical to achieving their mission. This includes patient visits, payer mix, outcomes, quality, safety, patient satisfaction and financial performance (11,12). Lean management systems in place throughout so many healthcare organizations risk stifling innovation and creativity. Protocols and other work-flow is standardized to increase throughput and consistency while reducing waste, variability and risk. Productivity, predictability, efficiency and profitability are the valued goals so as to maximize cost-effectiveness. Our clinical colleagues describe they are left with standardized, homogenous, assembly line work; all contributing to burnout.

Physician well-being is an important yet often overlooked quality metric, and one that must be monitored even more now that so many physicians are employed in large institutions where complex organizational structures diminish autonomy (5). The Institute for Healthcare Improvement instituted a framework describing the optimization of health system performance, stating that three mutually reinforcing dimensions must be simultaneously pursued. They promoted the "triple aim" construct of: a) improving the patient care experience (quality and satisfaction), b) improving population health, and c) reducing costs. (13,14). A "quadruple aim" is now described where the fourth component is provider well-being. Improving the experience of providing care, increased job satisfaction, increased work engagement and reduced burnout must be addressed with the same effort as that devoted to

enhancing quality and outcomes for patients and organizations(15). Our emphasis on patient-centered care remains steadfast, but the conversation has been expanded to include a renewed emphasis on the importance of provider satisfaction and well-being.

Disruptive changes in large organizations, even when conferring a competitive business advantage, can result in misunderstandings and loss of trust and transparency. Departmental changes may result in a culture shift contributing to inhibited creativity and innovation, diminished morale, and burnout. Physician burnout rates indicate health system dysfunction and warrant careful monitoring and prompt management. Changes are needed to improve performance before the situation threatens patient care, as well as to avert a wider range of potential crises (6, 8).

Burnout, engagement, professional fulfillment, fatigue, and emotional health should all be assessed. While they are potentially more difficult to measure, these are all extremely important metrics. Patient care involves long hours and important decisions. Exposure to clinical work hours demonstrates a dose effect with burnout, suggesting a cause and effect(16). Withdrawal from clinical work protects against individual burnout but potentiates burnout in the remaining physicians by shifting work. This is currently the concern in many organizations that allow many individuals in their groups to leave clinical work. Everyone's perspective and contribution must be equally valued.

CONCLUSIONS

Physician burnout is a very important topic in the current healthcare management literature. It should be renamed "Clinical Physician Burnout" to reflect the consistent pattern in literature studies that describe the unintended consequences of burnout to physicians that care for patients, rather than those that have become predominantly educators, researchers or administrators later in their careers.

Care must be taken that a large shift out of clinical practice is undertaken with adequate anticipation of (and genuine concern for) the unintended consequences. Questions of transparency, fairness, equity and actual or perceived slights on the team must be carefully considered in order to avoid physician burnout. It behooves leadership to optimize aligning the myriad career paths of the various stakeholders in their departments.

I recently asked a nationally renowned champion of alleviating physician burnout, "why can't non-clinical time be more equitably distributed? Wouldn't that go a long way toward

diminishing burnout? Why do so few have so much protected time while most have so little?" The response; "well, everyone doesn't have the skillsets that I have." I say …. give everyone that wants a chance, a chance. Let them develop those skillsets, just like you were given the opportunity to do. Otherwise, you risk even more burnout in your department. Successful and sustainable high quality organizations have no room for "super chickens."

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