

Perceptions of Burnout Among Academic Hospitalists

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ABSTRACT

Introduction: There is a paucity of data on burnout among academic hospitalists in Wisconsin.

Objective/Methods: To evaluate perceptions on burnout among academic hospitalists at an academic center in Wisconsin, a survey was distributed to academic hospitalists at the Medical College of Wisconsin. Questions addressed job satisfaction, factors contributing to burnout and its consequences, and various preventive steps. A section was included for respondents to provide any additional comments.

Results: Out of 52 academic hospitalists surveyed, 43 (83%) responded. Sixty-two percent of participants reported feeling burnout. Burnout rates did not differ by gender (males vs females, 58% vs 73%, respectively; $P=0.65$), career length as a hospitalist ($P=0.28$), or satisfaction as a hospitalist ($P=0.11$). High patient census (94%) and unrealistic workload (83%) were the most commonly cited factors for burnout. Possible consequences of burnout included lack of enthusiasm (95%) and mental exhaustion (93%). A majority of respondents (81%) indicated that high clinical demands interfered with their ability to teach medical students. Improving the structure of work (88%) and incorporating respect, care, and compassion as a group culture (88%) were the most common themes reported to prevent burnout.

Conclusion: This study shows a high prevalence of burnout among academic hospitalists and highlights various opportunities to reduce burnout risk.

INTRODUCTION

The term burnout was first coined by psychologist Herbert Freudenberger and recently has been recognized as an occupational phenomenon in the World Health Organization's (WHO) 11th revision of the International Classification of Disease (ICD-

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11).^{1,2} Dr Freudenberger ran a practice on New York City's Upper East Side and also started a free clinic on the Bowery, where he cared for young clients who abused drugs.³ He observed that many of his clients held cigarettes, watching as they burned out – thus the inspiration for the term “burnout.”

In recent years, burnout has been a topic of big concern among physicians. Burnout is a work-related syndrome involving 3 chief dimensions: emotional exhaustion (losing enthusiasm for work), depersonalization (treating people as if they were objects), and a sense of low personal accomplishment (having a sense that work is no longer meaningful).⁴ Numerous studies involving nearly every medical and surgical specialty indicate that approximately 1 out of 3 physicians is experiencing burnout at any given time.^{5,6} Physician

burnout may affect core domains of health care delivery, including patient safety, quality of care, and patient satisfaction. However, this evidence has not been systematically quantified. Salyers et al conducted a meta-analysis of 82 studies on 210,669 health care providers that showed consistent relationships with perceived poorer quality health care, reduced patient satisfaction, and lowered safety for patients.⁷ Further investigation of burnout is critical given its association with increased physician turnover, poor quality of care, and adverse personal consequences for physicians and their families.^{8,9}

Physician burnout has been increasingly studied and recon- gized over the past several decades; however, few studies have specifically examined how burnout affects academic hospital- ists.^{10,11}

Table 1. Demographic Information and Perceptions of Hospitalists Regarding Job Satisfaction and Burnout

Variables	n (%)
Sex (N=43)	
Male	26 (61%)
Female	16 (37%)
Prefer not to respond	1 (2%)
Time as hospitalist (N=43)	
0-3 years	18 (42%)
4-6 years	11 (26%)
7-9 years	9 (21%)
≥10 years	5 (12%)
Are you satisfied with working as a hospitalist? (N=42) ^a	
Extremely dissatisfied	2 (5%)
Somewhat dissatisfied	3 (7%)
Neither satisfied nor dissatisfied	6 (14%)
Somewhat satisfied	28 (67%)
Extremely satisfied	3 (7%)
Have you experienced burnout as a hospitalist? (N=42) ^a	
Yes	26 (62%)
No	7 (17%)
Not sure	9 (21%)

^aOne missing response

Hospital medicine is a relatively new specialty with a unique aspect of work-life balance. It includes various clinical and non-clinical responsibilities like medical education and research, which possibly can place hospitalist physicians at high risk of burnout. We conducted a survey-based project with academic hospitalists at the Medical College of Wisconsin regarding job satisfaction, perceptions on burnout and its consequences, and approaches to improve burnout.

METHODS

Study Design and Survey Elements

Froedtert Hospital and the Medical College of Wisconsin (MCW) is an academic tertiary care center based in Milwaukee, Wisconsin, with 607 beds and over 31,000 inpatient admissions annually. A web-based Qualtrics survey (www.qualtrics.com) was emailed to all 52 academic hospitalists based at Froedtert Hospital and MCW. All responses were anonymous. In addition to collecting demographic information and general perceptions of burnout, the survey also aimed to capture information regarding several elements related to burnout, including job satisfaction, factors leading to burnout, the effects of burnout, and preventive steps. The responses were obtained either on a dichotomous (yes/no) or a 5-point Likert scale (strongly disagree, disagree, neutral, agree, strongly agree). A section to solicit anonymous, open-ended comments also was included. The study was approved by the MCW institutional board review.

Statistical Analysis

Data were analyzed as respective frequencies and percentages. Association between the variables, which were essentially categori-

Table 2. Perceptions of Hospitalists Regarding Possible Contributors to Burnout

Possible Factors Leading to Burnout	Agree/ Strongly Agree n (%)
High patient load/census (N=42)	39 (93%)
Unrealistic work load/feeling over worked (N=42)	35 (83%)
Caring for complex and demanding patients (N=42)	34 (81%)
Feeling pressured by higher expectations (teaching, providing excellent patient care, meeting provider performance metrics, administrative duties, scholarly projects, etc) (N=42)	33 (79%)
Unpredictability in the work structure and patient volume (N=42)	33 (79%)
Lack of transparency/communication between leadership and hospitalists (N=42)	31 (74%)
Pushback from the consult services on the requested consults: hesitation or refusing to see patients (N=42)	31 (74%)
Not feeling valued as a hospitalist by the residents and other subspecialty peers (N=42)	29 (69%)
Lack of recognition/reward/incentive for your performance (N=42)	27 (64%)
Dissatisfaction with compensation/incentives despite increased clinical duties (N=42)	26 (62%)
Feel unsupported by leadership (N=42)	24 (57%)
Lack of flexibility/work life balance/amount of control over work schedule (N=42)	23 (55%)
Do not feel as a part of a group/poor group dynamics (N=42)	21 (50%)
Lack of protected time for scholarly projects (N=42)	19 (45%)
Lack of structured mentorship for career guidance/professional development/scholarship (N=42)	18 (43%)
Uncertainty about your career as a hospitalist (N=42)	18 (43%)

cal, was analyzed using the chi-square test. All tests were 2-sided and *P* values <0.05 were considered statistically significant. All analyses were performed using SAS 9.4.

RESULTS

Forty-three Medical College of Wisconsin hospitalists (83%) responded, although some did not complete all questions. Twenty-six (61%) were male and 18 (42%) had been working as a hospitalist for ≤3 years (Table 1). Only 3 (7%) said they were extremely satisfied working as a hospitalist, whereas 28 (67%) said they were somewhat satisfied. Twenty-six (62%) reported experiencing burnout, while 7 (17%) did not, and 9 (21%) were unsure. Factors that respondents said most contributed to burnout were high patient census (n=39, 93%), unrealistic workload or feeling overworked (n=35, 83%), caring for complex and demanding patients (n=34, 81%), feeling pressured by higher expectations (n=33, 79%), unpredictability in work structure and patient volume (n=33, 79%), and lack of transparency or communication between leadership and hospitalists (n=31, 74%) (Table 2).

Hospitalists reported the most common consequences of burnout were lack of enthusiasm and energy to work (n=39, 95%), followed by mental exhaustion (n=38, 93%), doubt that their work made a difference (n=33, 83%), physical exhaustion (n=33, 81%), feeling their personal life has been affected negatively

Table 3. Perceptions of Hospitalists Regarding Possible Consequences of Burnout

Possible Consequences of Burnout	Agree/ Strongly Agree n (%)
Lack of enthusiasm and energy to work (N=41)	39 (95%)
Mental exhaustion (N=41)	38 (93%)
Doubt that your work really makes any difference or question the quality of your work (N=40)	33 (83%)
Physical exhaustion (N=41)	33 (81%)
Feeling that your personal life has also been affected negatively (N=40)	31 (78%)
Feeling that the quality of your life has been compromised (N=40)	31 (78%)
Feeling detached/depersonalization/cynicism (losing your ability to interact, empathize, and connect with your patients and coworkers) (N=41)	31 (76%)

Table 4. Perceptions of Hospitalists Regarding Various Possible Steps That Can Prevent Burnout

Possible Steps to Prevent Burnout	Agree/ Strongly Agree n (%)
Improving the structure of the work/manageable workload (N=41)	36 (88%)
Incorporating respect, care and compassion among the hospitalist as a group culture (N=41)	36 (88%)
Improving coordination/support from other sub specialists and consult services (N=41)	34 (83%)
Increased or more competitive compensation, incentives, acknowledgments, rewards, or awards (N=41)	34 (83%)
Protected time for scholarly pursuits (N=41)	34 (83%)
Transparency in policy and communication within the group (N=41)	31 (76%)
A strong mentorship program to support personal and professional development (support to achieve goals including promotion, leadership, scholarship and overall career development) (N=41)	28 (68%)
Increased leadership role in monitoring and preventing burnout issues (N=41)	27 (66%)
A wellness program or faculty resilience training to support the hospitalists (N=41)	24 (59%)

(n=31, 78%), and feeling that the quality of their life has been compromised (n=31, 78%) (Table 3).

Among proposed means to prevent burnout and increase wellness, hospitalists cited improving the workload (n=36, 88%); incorporating respect, care, and compassion among the hospitalists as a group culture (n=36, 88%); improving support from subspecialists and consult services (n=34, 83%); introducing increased or more competitive compensation, incentives, acknowledgments, rewards, or awards (n=34, 83%); and ensuring protected time for scholarly pursuits (n=34, 83%) (Table 4). The burnout rates experienced between males and females were not statistically significant (58% vs 73%, respectively; $P=0.65$). Burnout rates were 50%, 55%, 88%, and 80% in hospitalists with career length 0-3 years, 4-6 years, 7-9 years, and 10 or more years, respectively

($P=0.28$). Burnout was not associated with job satisfaction as a hospitalist ($P=0.11$). In total, 34 (81%) hospitalists surveyed felt that the high demands of clinical work interfered with their time and interest to teach medical students.

Of the 42 hospitalists who completed the survey, 11 (26%) provided open-ended comments about burnout. Common themes on possible reasons for burnout included increased workload and lower financial compensation. Perceived consequences included interference in the hospitalists' teaching ability and work-life balance issues, whereas suggested prevention strategies included the leadership's willingness to commit to address burnout. Multiple respondents mentioned workload, with some citing "uncertainty in the amount of work" and also "absence of NP (nurse practitioner)/PA (physician assistant)." Several respondents commented on teaching in the clinical setting, including one who said, "I find it almost impossible to provide good teaching to medical students rotating with me on the hospitalist service." Another said, "Service is busy, and it is hard to be a consistent good teacher." Some comments suggested capping a non-house staff team at 15 patients a day when working with a student or having students work only with the house staff teams. Several respondents expressed their desire to be valued and not considered "just as workforce." Respondents also expressed concerns about the effect of work on their physical health and interpersonal relationships, and multiple respondents proposed that leadership should address burnout and well-being in the hospitalist group.

DISCUSSION

In this study of academic hospitalists at a single tertiary care center, more than half of the respondents reported experiencing burnout. Academic hospitalists are a unique group of physicians with many responsibilities; thus, there are many triggers for burnout. Increasing numbers of non-house staff clinical services and high patient census were cited as the most common contributors to burnout. These escalating clinical demands discouraged hospitalists' interest and effectiveness in teaching medical students and residents.

Two studies examining burnout among academic hospitalist medicine showed burnout rates of 23% and 30%, respectively.^{10,11} Our study demonstrates a higher burnout rate of 62%. Based on the survey results, the strongest contributors to this higher burnout rate were higher volume of clinical work and higher expectations (teaching, provider performance metrics, administrative duties, scholarly activities). Challenges unique to academic medicine also were identified, such as pushback from consult services and a lack of protected time for scholarly projects. This is consistent with a prior study by Glasheen et al, which found that academic hospitalists had inadequate amounts of protected scholarly time due to high demands for non-house staff clinical work.¹⁰

In our study, the rate of burnout increased with the duration

of practice as a hospitalist. Hospitalists who had worked in the group 3 years or less composed 42% of the study group, while 33% of respondents had served in the hospital for 7 years or more.

With a high burnout rate observed in the hospitalist group, these findings possibly suggest a high likelihood of hospitalists leaving the job as a consequence of burnout, among other reasons. Rapid workforce turnover has important implications on the health care organization's finances.¹²

In the open-ended comments section, several respondents expressed that the high volume of nonteaching clinical work made them feel as if they were working in a community hospitalist (nonacademic) group. Since the Accreditation Council for Graduate Medical Education initiated resident duty hour restrictions in 2003, there has been a growth in non-house staff services required to care for hospitalized patients at most academic medical centers.¹³ Unless solutions are proposed, the expansion of these non-house staff teams will continue to pose logistical challenges and contribute to burnout. Additionally, a heavier clinical burden leads to a lack of protected nonclinical time, hindering early career hospitalists from developing academic interests, such as teaching or research.¹⁴ Protected nonclinical time may be a vital step to improving burnout rates in academic hospitalist medicine while cultivating scholarly activity.

There is a need for both individual-focused and organizational solutions to address burnout among academic hospitalists. Physician-centered approaches include mindfulness, stress reduction, resilience training, and communication skills training. Organization-level changes are typically much harder to implement and sustain.^{4,15,16}

Several studies with interventions to mitigate burnout have been published; the results are best summarized by a systematic review and meta-analysis that showed both individual and organizational-focused strategies may be able to reduce burnout among physicians.¹⁷ Based on our survey data, high patient volume is perceived as the strongest contributor to burnout and, thus, requires serious attention. Strategies that can be effective include increasing the number of hospitalist teams available, capping the number of patients per hospitalist, arranging coverage for predictable life events, and giving hospitalists more control of their schedule. In addition to addressing work conditions, other steps to improve or prevent academic hospitalist burnout include incorporation of mindfulness and teamwork practices, decreasing the burden of the electronic health record, providing protected time for scholarly activities and teaching, making self-care a larger part of medical professional culture, improving mentoring systems, advocating for academic promotion, scribes, and wellness programs.^{3,18,19}

Academic hospitalists play an important role in educating medical students and residents. In this study, 81% of hospitalists indicated that high demands of nonteaching clinical work interfered with their time and interest to teach medical students. This finding strongly suggests that rigorous clinical demands negatively affect

the academic hospitalist's role as a teacher. This is consistent with a prior study that found lower teaching scores for academic hospitalists associated with higher amounts of clinical work.²⁰ Perceived consequences of burnout on the teaching role are perhaps best captured by the study respondent who said, "Some days I resent having them [medical students], and I didn't go into academics to feel that way." Respondents proposed several solutions to improve teaching, including a 15-patient cap for hospitalists working with a student or moving all students to the resident teaching teams. These comments and proposals reflect the frustration of hospitalists who want to teach but are also extremely busy on non-house staff services. These findings add to prior research that described benefits and barriers to learning experienced by medical students during the hospital rotation,²¹ including being on a busy service, limited interaction with the attending physician, and variability in rounding methods.

One strength of this study was the high percentage of survey participation (83%). Because the survey was anonymous, another strength was the transparency of comments by hospitalists about how burnout affects medical education. The study was limited in that it was a single-center design, and there may be factors related to burnout that are specific to our institution. Further, this study did not use the most widely accepted burnout scale—the Maslach Burnout Inventory (MBI)—but relied upon hospitalists to define their own burnout.¹⁵ Previous studies have shown that the single-item measure of burnout served as a reliable substitute to MBI across occupations. Such measure also assisted in abbreviating survey material and potentially increasing response rates.²²⁻²⁴ Our study used dichotomous responses incorporating hospitalists' perceptions of burnout rather than using various levels of burnout, so it is possible that the burnout rates observed in our study could represent overestimation or underestimation.^{8,9}

As newer studies consolidate our awareness and advance our understanding of the causes and consequences of burnout and its solutions, the current era demands more rigorous investigation of contributing factors and delineation of strategies more specific to the local practicing environment, which our study has attempted to accomplish at an academic medical center in Wisconsin. While a recent study reported a burnout rate of 46% among Wisconsin physicians, our study is the first to describe burnout among academic hospitalists in Wisconsin.²⁵

CONCLUSIONS

Our survey-based study on academic hospitalists showed that more than half of the group experienced burnout. Academic hospitalists are uniquely positioned to serve in a heavy clinical workload environment and fulfill several responsibilities including educator and researcher, in addition to the clinical care of patients. While it is generally accepted that both individual-focused and organizational solutions can help prevent and mitigate burnout, further studies are needed to determine which combinations of interventions are

effective for the hospitalist population. Burnout research on academic hospitalists remains meager; therefore, longitudinal studies exploring the contributing factors and interacting variables need to be conducted to further refine our understanding of the causes and consequences of burnout in this group.

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