Perception of Burnout and Its Impact on Academic Hospitalists During COVID-19 and Institutional Strategies to Combat Burnout and Improve Wellness

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ABSTRACT

Introduction: Physician burnout has been alarmingly high, particularly among general internal medicine, which displays some of the highest rates. A recent study of academic hospitalists reported a higher level of burnout (62%) than the rates found in similar studies, but with agreement about factors leading to burnout, consequences of burnout, and importance of steps to prevent burnout. This study seeks to expand upon these results by investigating the impact of COVID-19 on burnout among hospitalists and uncovering the perspectives of frontline clinicians to formulate effective mitigation strategies.

Methods: Academic hospitalists were recruited to participate in a series of focus group interviews. The questions focused on contributors to burnout, the impact of COVID-19, and strategies to improve wellness and reduce burnout. The focus groups were audio-recorded, transcribed, and coded for emergent themes using Taguette, an open-source qualitative data analysis software.

Results: Burnout-inducing themes included workload, bureaucratic hurdles, and lack of control. COVID-19-specific themes included fear of exposing family and social isolation. The most common mitigation strategy was to increase social interactions to foster a sense of community. Additional solutions included adhering to a census cap of patients, streamlining clinical work, and providing avenues for two-way communication between leadership and clinicians to share concerns and elicit feedback.

Conclusions: Streamlining clinical work allows more time for patient care. Enhancing community and fostering collaboration in decision-making allows clinicians to feel more empowered. A crucial first step to combat burnout is to encourage a work environment that values clinician well-being and proactively works to increase job satisfaction.

INTRODUCTION

The term burnout was first introduced in 1974 by psychologist Herbert J. Freudenberger, who described it as a state of mental exhaustion in one's career—particularly in the professions dedicated towards helping others, namely health care providers.[1] In 1981, social psychologist Christina Maslach expanded upon Freudenberger's work and conceptualized burnout into the 3 chief components: exhaustion, depersonalization (negative attitudes and cynicism), and reduced sense of personal accomplishment.[2-4] The term burnout is now recognized as an occupational hazard by the World Health Organization's International Classification of Diseases (ICD-11).[1]

Physician burnout is alarmingly high, with one study showing burnout documented in over 50% of practicing physicians and trainees in the United States.[3] Despite already high numbers of physicians experiencing burnout, the problem appears to be getting worse.[2] In a survey study of physicians in 2011 and 2014, 45% reported at least 1 symptom of burnout in 2011 compared to 54.4% merely 3 years later.[4] There is variability among medical specialties, with emergency medicine, general internal medicine, and neurology associated with burnout rates 3 times higher than other specialties.[3] This suggests that there are unique aspects to these disciplines that contribute to the variable rates of reported burnout.

A study of academic hospitalists surveyed in 2018 reported a higher level of burnout (62%) than rates found in similar studies.[5] Another recent study discovered a significant rise in burnout and decline in work-life integration satisfaction in US physicians between 2020 and 2021.[6] Measurements of depression were negligibly different, indicating the primary cause of physician distress was primarily work related. Relatively few pieces of research pro-

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vide comprehensive information about the impact of the COVID-19 pandemic on physician burnout in the United States; in fact, most studies on physician burnout have been conducted in countries outside of the United States.[7] We posit that the COVID-19 pandemic negatively affected provider well-being and requires the unique perspectives of frontline clinicians to formulate effective mitigation strategies to combat this rampant issue.

METHODS

Twenty practicing academic hospitalists at Froedtert Hospital were recruited to participate in a series of qualitative, semistructured focus groups. Froedtert Hospital is a 702-bed academic medical center affiliated with the Medical College of Wisconsin (MCW). All physicians who practice at Froedtert are MCW faculty dedicated to patient care, research, and teaching. Before participant recruitment, prior approval was obtained from the institutional review board.

Recruitment and Focus Groups

An invitation letter with details about the study was emailed to the entire hospitalist group. It highlighted the importance of the study, emphasized voluntary participation, and included the focus group questions. Written by the research team, the questions covered (1) contributors to burnout, (2) the influence of COVID-19 on wellness/burnout, (3) strategies to mitigate burnout and improve wellness, and (4) hospitalists' perceptions during COVID-19. Participants were divided into 4 focus groups composed of 4 to 5 individuals. Each interview was approximately 45 minutes and took place in January and February, 2022. All participants were blinded as to which colleagues would be participating. Focus groups were audio-recorded, deidentified, and transcribed. The researchers utilized Taguette, a validated, free, open-source qualitative data analysis tool, to code the transcripts.[8] The study utilized an inductive approach that allowed patterns and themes to emerge from the data. Each transcript was analyzed line by line in Taguette, and tags were assigned within the software to specific quotes that corresponded to a common theme across all transcripts. Participant quotes were later edited for clarity and brevity.

RESULTS

Discussion centered around 3 topics: (1) perceived contributors of burnout, (2) impact of COVID-19 on burnout, (3) suggestions for institutional wellness initiatives. We have highlighted the emergent themes in the Table.

Perceived Contributors of Burnout

The most common contributors to burnout reported were high workload, numerous bureaucratic hurdles, and lack of control. Participants reported having a high patient census that often required them to work extra shifts due to the increased demand for medical care. While their job hours and number of shifts seemed to increase over the years, job descriptions have remained the same, which is a source of frustration. Additionally, participants indicated that a lack of transparency from leadership contributes to their burnout and that they would like more two-way communication between the administration and health care providers.

> "There is no transparency from leadership…we are left unaware of decisions, which causes confusion and contributes to burnout."

In addition to the high patient census/extra shifts, participants reported having a high workload due to the abundant roles that they play within the academic setting—such as clinician, teacher, researcher, and administrator—while having little protected time to engage in learning activities outside of clinical duties.

> "The responsibility of teaching, taking care of patients, and coordinating care teams all contributes to physical and mental burnout...Even when you're not working, you feel like you are."

Participants also reported that extensive documentation is one of the biggest daily obstacles as they spend more time documenting and writing patient encounter notes than in direct face-to-face contact with patients.

> "Less time is spent with patient care and more time is spent writing the notes for the patient...The medical care of the patient is secondary to documentation as opposed to the primary issue."

Another bureaucratic hurdle that leads to burnout is the numerous additive requests from leadership and colleagues, such as writing a comprehensive discharge summary, discharging at a specific time, and having to consult specific committees about patients' medical histories.

> "Additive requests, such as writing a good discharge, discharging by 10 AM, and consulting a specific committee, take time away from the reason you came into medicine, which is to talk with and care for patients."

Participants further reported that they do not have control over instutional decisions, which further contributes to their feelings of burnout.

> "Burnout is all about how much control you have and your input in the sudden decision-making process."

Impact of COVID-19 on Burnout

Focus group participants reported that COVID-19 introduced new reasons for burnout, including emotional stress. They said they were afraid to expose their families to COVID-19 and took on extra shifts out of sympathy for colleagues who contracted COVID, although they did not have the mental capacity to work those extra shifts.

> "If you don't take the extra shifts, then you feel guilty for not helping the team, but if you overload your schedule, then you pay the price later down the road."

Participants also said that the impact of COVID made it dif-

ficult to find work-life balance—especially when their children were not able to attend school in person.

> "It was especially tough being a woman in hospitalist medicine as it has been difficult juggling clinical work, family, and virtual schooling for my children...My job was doubled both at home and at work."

Additionally, participants said the pandemic created a sense of social isolation, which further contributed to their sense of burnout as there was little face-to-face interaction among colleagues.

> "There was a degree of social isolation that everyone has experienced worldwide...I really miss seeing people and now I work mostly alone when I'm at the hospital."

Table. Themes From Focus Groups

Topics	Emergent Themes
Perceived contributors of burnout	1. High workload/patient census 2. Bureaucratic hurdles 3. Lack of control/transparency 4. Extensive documentation
Impact of COVID-19 on burnout	1. Emotional stress 2. Fear of exposing family 3. Overworked/scheduling demands 4. Difficult work-life balance 5. Social isolation 6. Patient skepticism regarding COVID-19 7. Witnessing patient suffering/dying
Suggestions for institutional wellness initiatives	1. Have a better workroom/space for social interactions at work 2. Increase social gatherings outside of work (retreat, holiday parties, interest groups, etc) 3. Provide avenues for bidirectional communication with leadership and clinicians to better understand and elicit feedback 4. Have a wellness officer 5. Census caps/improved scheduling 6. Better financial incentives

Interestingly, participants reported that the pandemic made them skeptical of patients. They questioned their empathy for patients who were not immunized against COVID despite evidence-based research and available information about vaccinations and treatment.

> "The trickiest part was the strong public perception that the standard quality of care was suspicious...The public often thought we were up to no good even though we are dedicated and committed to serve our patients."

> "This is taking a huge psychological toll…I go to patient rooms and they are not immunized…I'm losing empathy due to so much information available regarding immunizations."

At the same time, participants reported that it was difficult for them to witness many patients dying and suffering from COVID. The combination of patients dying and patients who did not trust health care providers further affected their own mental states.

> "Seeing COVID patients who are dying is not a good feeling and gave a sense of hopelessness, especially at a certain time when there were no treatment options besides oxygen and steroids to just blunt the immune response."

Suggestions for Institutional Wellness Initiatives

The most common suggestion for improving wellness was increasing social interactions to allow clinicians to relax, share feelings, and create more community. This included a better workroom and increasing social gatherings outside of work. There was a desire for a workroom with windows, more space, snacks, coffee, and a couch. It also was noted that existing space constraints have resulted in new hires being scattered—increasing isolation and loneliness.

> "I would love if there was a place for all the providers working that day to have a place to come together and have a cup of coffee for 5 minutes and talk about cases where you need advice…That will let us provide better care and would really brighten our day."

Suggestions for social interactions outside of work included a retreat, arranging activity groups for people to join based on their interests, and holiday parties. It was suggested that these gatherings would make people more comfortable talking to each other and go a long way to help relieve stress.

Another suggestion was to provide avenues for two-way communication between leadership and clinicians to share concerns and elicit feedback; increasing bidirectional communication would allow clinicians to feel more control.

> "It would be helpful, before our administration made decisions, to involve the physicians at the onset so that they can actually be a part of the decision-making and feel as though they have some control."

Additionally, it was suggested that it would be beneficial to have a wellness officer to help clinicians navigate wellness resources.

> "There might be a need to have someone from our section to provide that information to us in a better way so that we know how we should approach those resources…There is info out there, but clarity about resources will be needed… just sending an email doesn't mean that you have completed your responsibility."

Other suggestions included streamlining clinical work, as small tasks by management are burdensome and do not improve quality of care; introducing census caps; improved scheduling; and providing better financial incentives.

DISCUSSION

The key findings in our focus group interviews were consistent with Maslach's interpretation of burnout (exhaustion, depersonalization, and reduced personal accomplishment).[2-4] We found hospitalist exhaustion was exacerbated during the pandemic as they took on extra shifts to cover for colleagues who became ill, while simultaneously having increased duties at home (ie, childcare/home schooling). The pandemic further took a toll on participants' mental health by causing fear of infecting loved ones and inducing social isolation. They experienced depersonalization as they struggled to feel empathy for unvaccinated patients and felt reduced personal accomplishment due to the public's negative perception of health care providers during the pandemic.

Our study also highlighted several strategies hospitals can take to alleviate the causes and consequences of burnout. Focus group participants reported a desire for increased social activities, improved work spaces that foster community, increased communication with leadership, census caps, and streamlined clinical work. They are vulnerable to exhaustion that comes from the combination of a high workload, bureaucratic hurdles, and comprehensive documentation, which were made worse by COVID-19 due to increased scheduling demands, difficult work-life balance, and no time for self-care.

These themes were shown in previous research on how the pandemic exacerbated physician burnout. A May 2021 news article in *BMJ* reported that approximately 6 in 10 physicians reported higher levels of fatigue and exhaustion while working in the pandemic.[9] A *BMJ* tracker survey revealed that more than half (58%, n = 2834 of 4876) of its respondents had worked extra hours relative to the previous month, and 44% (n = 2086) said they felt pressured by their employer to work extra hours.[9] As work demands increased, physicians also had increased demands at home. A 2021 survey of academic medicine faculty at the University of Texas Southwestern reported that faculty had increased time spent on household and childcare duties by an additional 27 hours per week.[10]

This feeling of pressure to take on extra work while already having a full workload also was expressed by our study cohort. A suggested solution to this problem is to cap the number of patients assigned to each team. A 2012 study on internal medicine residents at Mayo Clinic revealed that having a census cap on the number of patients admitted improved resident workload while benefiting their learning.[11] Streamlining clinical work also may help alleviate clinician exhaustion. It has been reported that for every hour spent on patient interaction, a physician spends an additional 1 to 2 hours finishing progress notes, administrative requirements such as ordering labs, prescribing medications, and reviewing results.[4] Thus, by reducing hours spent on nonclinical administrative work, clinicians can spend more time on patient care, which is associated with increased personal accomplishment and reduced burnout.[3]

All of these contributors to burnout, exacerbated by the emotional stress of COVID-19, created a unique burden on hospitalists. During the state of social isolation, the stress of the burden that the hospitalists in our study faced was heightened. In population studies, social support and community belonging have a well-established association with improved mental and physical health.[12] The same principle should be applied to the health care workplace to improve wellness. A survey of Mayo clinic internal medicine hospitalists in 4 states showed that 27% "felt isolated from others" and 2.6% "felt like a stranger to those around me" compared to 0% for both categories prior to the COVID-19 pandemic.[13] Our study suggests that creating spaces for dialogue between colleagues with shared experiences to discuss challenges can alleviate some of this stress. Both increasing workplace social interactions through a better workroom experience as well as gatherings outside of work were persistently highlighted during our focus groups. These findings are consistent with previous research suggesting the importance of cultivating workplace relationships to improve wellness in resident physicians and the importance of social connectedness among health care staff.[14,15]

Leadership and organizations can play a significant role in mitigating burnout in health care workers. Seeking input, informing constituents, and recognizing individuals for their contributions help decrease feelings of burnout and increase career satisfaction among those they lead.[3] Studies have shown that when organizations and leaders provide physicians with increased control over the workplace, lower levels of work-related stress and subsequent burnout are more likely.[3] In a cross-sectional study conducted across 3 emergency departments (ED), frontline employees reported feeling more supported and experiencing less stress and burnout when local leadership communications were effective, consistent, and bidirectional.[16] These results were similar to our findings in that participants wanted avenues for two-way communication between clinicians and leadership to better understand concerns and elicit feedback. Health care organizations previously have prioritized self-resilience and stress management education, which is a tactic that places the perceived blame on physicians.[1] Organizations must foster a culture of wellness and effective procedures that can reduce health care stressors rather than attempting to fix the clinicians.[17] However, a well-being oriented culture can only be established with leadership support. It is necessary for institutional transformation to start at the top. A crucial first step is to encourage a work environment that values clinician well-being and proactively works to increase job satisfaction by lowering burnout.[18]

Our study has a few limitations. Our qualitative data were derived from multiple focus groups. Although widely utilized, this method of data collection has the potential pitfall of groupthink. We attempted to avoid this outcome by having a different participant be the first to answer each question to prevent the conversation from being dominated by a particular person or

idea. Additionally, participation was voluntary, and the topic of the focus groups was disclosed in the invitation letter. Thus, it is likely that hospitalists who were disproportionately affected by factors leading to burnout were more inclined to participate. Furthermore, all study participants belonged to a single academic center, which limits the generalizability of our findings. Our analysis also was limited by the level of detail provided by participants, as some were more detailed in their responses than others.

Future studies can be done that randomly select individuals to participate. Participating sites should include multiple academic centers in order to create universal institutional strategies to mitigate burnout. They also can standardize the level of detail in interviewee responses by asking more follow-up questions targeted towards specific statements.

CONCLUSIONS

Physician burnout remains alarmingly high and should be of concern to academic institutions. The COVID-19 pandemic further increased physician burnout, while both maintaining traditional views and creating unique perceptions of physician burnout. Social isolation and lack of effective communication between clinicians and leadership contribute to fatigue and frustration and worsens burnout. This can be mitigated by enhancing community and fostering collaboration in decision-making, which may alleviate stress and reduce burnout. A crucial first step to combat burnout is to encourage a work environment that values clinician well-being and proactively works to increase job satisfaction.

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