Caution Urged Regarding Role of Free Clinics in US

Dear Editor:

The commentary in the latest issue of the *WMJ* by Zellmer et al[1] discussing the possible role of free clinics in health care in the United States should raise a number of cautions. There are certainly free clinics, such as the St Clare Health Mission, which are staffed, designed for continuity of care and partnering with health systems in the region to provide referrals and follow-up. They do serve a useful, but limited role in health care. However, experience with free clinics, particularly those run or staffed by medical and other health sciences students who change frequently, may represent a failure of good intentions unless the clinic leadership takes responsibility to assure continuity of care and have guaranteed arrangements to get patients additional care as needed.

As the authors point out, chronic disease is a burden for many low-income Americans, and free clinics are often not helpful in treating chronic illnesses. They have records that are not available when patients show up in emergency departments or urgent care centers, and often confuse patients more than help them. A few centers, such as Bread of Life and Walker's Point Health Center sponsored by Aurora Health Care in Milwaukee are examples of clinics that provide chronic care management and social services for uninsured patients. But they also strive to get patients insurance access and assignment to a primary care medical home as part of their mission.

Well-meaning free clinics that cannot assure continuity and arrange secure handoffs to community health centers or other sources of care or guarantee access to consultants and testing as needed do not help the safety net or patients. I worked as a student and resident in free clinics in Chicago, but the community itself ran the clinic and took responsibility for the process of care. We as volunteers played specific roles.

Many services for unhoused people, immigrants and refugees, and the working poor are embedded in public health or teaching programs but remain the responsibility of all health systems in a state as well-endowed as Wisconsin. In the end, working for universal coverage in our state and country is what is needed.

—John J. Frey, III, MD

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Mitigating Burnout Imperative for Retention of Hospitalists

Dear Editor:

We were interested to read the article by Vazirnia et al, "Perception of Burnout and Its Impact on Academic Hospitalists During COVID-19 and Institutional Strategies to Combat Burnout and Improve Wellness."[1] The authors surveyed academic hospitalists on their perceived contributions to burnout, strategies to mitigate burnout in academic medicine, and the impact of COVID-19. Some of the perceived contributions to burnout for hospitalists included high workload, bureaucratic hurdles, extensive documentation, and lack of control over administrative decisions. Suggestions to mitigate burnout included improving open communication between leaders and clinicians and providing opportunities for social gatherings within and outside of work. One of the most important strategies was "to increase social interactions to foster a sense of community."[1]

Survey participants' focus on community building highlights their need for belonging. Belonging has been defined as, "everyone is treated and feels like a full member of the larger community and can thrive."[2] In medicine, belonging has been associated with increased physician retention.[2] In one study, women clinicians who reported a higher sense of belonging were less likely to leave their institution within 2 years.[2] Retention is critical for the sustainability of the physician workforce and the financial health of the institution. Attrition is costly; the direct and indirect costs have been estimated to range from $250,000 to $1 million, where the variability is dependent on specialty and other factors.[2] If creating a work environment that fosters belonging increases physician retention, then hospitals and other health care organizations have a compelling reason to invest in efforts that improve physician belonging.

Solutions are imperative – especially given the high levels of burnout in hospital medicine and the current inpatient workforce shortages[1] – and should focus on mitigating burnout, enhancing community, and facilitating communication. Previous suggestions to foster workplace belonging include empowering professional thriving.[2] For academic hospitalists, this may include streamlined clinical care, support for career advancement, and promoting open, effective, and safe communication.[3] These strategies are aligned with the initiatives suggested by Vazirnia et al, which may not only decrease burnout but also promote belonging and retention. As we continue to evaluate burnout, we should consider the topic of belonging and its potential benefits on physician burnout and hospital retention.

—Amarilis A. Martin, MD; Adaira Landry, MD, MEd; Meridith Englander, MD; Jessica M. Allan, MD

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