

Hard hits of distress¹

Wendy Dean^{a,*} and Simon G. Talbot^b

^a*Moral Injury of Healthcare, Carlisle, PA, USA*

^b*Division of Plastic Surgery, Brigham and Women's Hospital, Boston, MA, USA*

Physicians took two hard hits in May 2019. The first: the WHO will include a more detailed description of burnout as an occupational phenomenon in the International Classification of Diseases-11 (ICD-11) [1]. The second: physician burnout costs the healthcare system \$4.6 billion each year [2]. Each of these news items highlights the seriousness of distress – physician distress is real, and warrants additional detail in the ICD-11 and if left unattended, it is one of the factors driving up the cost of healthcare. Instead, what physicians see is another threat to their livelihood and undeserved blame for increasing healthcare costs.

Nearly half of physicians in the United States are suffering burnout and there is evidence that burnout impacts patient safety [3,4]. However, over the last year, clinicians have increasingly shifted the language of distress from the term ‘burnout’ to ‘moral injury’ [5,6]; the latter giving a better explanation of the *cause* of their *symptoms*. Burnout is a constellation of symptoms – fatigue, depersonalization, and a lack of accomplishment – suffered by the individual, which arises when occupational demands exceed resources. The subtle implication, to date, has been that the cause of this distress is a lack of resilience due to individual frailty [7]. But what if the emotional exhaustion and lack of accomplishment that define burnout result

from years of knowing what patients need and being unable to get it for them? What if depersonalization is the coping strategy physicians use to tolerate the pain of watching patients suffer unnecessarily when their clinician cannot implement a treatment plan? This is the crux of moral injury.

Moral injury – acting in ways that transgress deeply held moral beliefs – arises when clinicians are routinely frustrated in their attempts to get patients the care they need because of constraints imposed by the corporate framework of medicine. When leakage mandates preclude referrals outside one's own healthcare system [8], or when taking care of the electronic medical record distracts from, and takes longer than, taking care of the patient, or when the clinician feels they have to rush through a patient's appointment in order to meet their volume or RVU metrics, moral injury is a risk. This shift is important because it relocates the drivers of the epidemic away from individual frailty towards failures in the system of care; and it simultaneously shifts the responsibility for mitigation of the crisis from individual clinicians to healthcare organizations working collaboratively with clinicians.

The WHO's decision to add detail to the burnout categorization and embark on the development of evidence-based guidelines on mental well-being in the workplace may signal an approaching decision to make the condition a diagnosis. Will the attention alone be enough for the U.S. healthcare system to mandate that every physician identified as “burned out” must receive a formal assessment for functional capacity and potential danger to patients? Will physicians have a duty to report the episode to licensing boards? While such questions may seem hyperbolically over-reactive, acting in the interest of patient safety creates an unar-

¹ Authors note: Physician distress was a substantial concern prior to the arrival of SARS-CoV-2, as outlined in the article below, written in mid-2019. The realities of working in resource-constrained environments during the pandemic have magnified moral injury. It is critically important that organizations recommit to the social contract with their physicians now, to avoid an exodus in the wake of this crisis.

*Corresponding author: Wendy Dean, Moral Injury of Healthcare LLC, 1130 Creek Rd, Carlisle, PA 17015, USA. E-mail: wdean@moralinjury.healthcare.

guable rationale for policy or regulatory over-reach. Such a reactionary response could have chilling outcomes: physicians may self-protectively stop acknowledging burnout in any way – in surveys, to their colleagues, or to their institutions; survey responses could dramatically and erroneously improve, suggesting the epidemic of burnout was miraculously cured, when instead it just went below the surface. The number of physicians exiting from practice could further escalate (in 2018 almost 30% of physicians planned to retire or find nonclinical jobs, up from 20% in 2014 [9]). As we face an imminent shortage of physicians to treat the aging U.S. population [10], it seems regulators, policy makers, and physician leadership should carefully consider the impacts of any response to the WHO's signal.

Why does it matter that burnout costs \$4.6 billion to address? That is a sensational headline without the benefit of context. It is easy to lay blame at the feet of physicians, who may already be viewed as over-paid and highly privileged [11]. No matter that unnecessary spending in healthcare is estimated at more than \$500 billion per year, making the \$4.6 billion to address burnout seem a pittance in comparison [12]. No matter that healthcare executives saw their compensation increase nearly 200% between 2005 and 2015, a period during which physician pay increased roughly 10% (largely in keeping with inflation) [13]. No matter that administrative bloat in healthcare since the 1970s has been staggering. From 1975–2010, the number of physicians practicing in the U.S. increased by 150%, keeping pace with the increase in the U.S. population; during that same period, the number of administrators increased 3200% [14].

The responses to both of the challenges mentioned at the outset of this article can be coordinated. Addressing the drivers of moral injury would mitigate clinician distress and in doing so, prevent or greatly reduce burnout and its associated costs. Our recommendations follow:

1. Identify and address the double binds that constrain clinicians' autonomy and latitude to practice: prior authorizations, leakage constraints, productivity quotas, and countless situations where physicians are forced to choose between their patients and the myriad others to whom they are accountable.
2. Build bridges between administrators and clinicians. When we better understand each others' responsibilities and challenges, we can more effectively make meaningful changes.
3. Carefully consider the utility of satisfaction scores. If clinicians are held responsible for patient satisfaction, administrators should be responsible for clinician satisfaction.
4. Reestablish our community of clinicians to support the 50% of physicians who are struggling with moral injury and to work toward better work environments for ourselves and better treatment for our patients.
5. Realign healthcare so that serving our patients' needs is unquestionably the top priority. What does not facilitate patient care must be reconsidered, redesigned, restructured, or replaced. This will require a concerted approach from clinicians, administrators, hospital systems, and payors; and likely needs regulatory input to break the conflicting incentives and allegiances. Our patients deserve clinicians working only in their best interests. They deserve thoughtful, engaged conversations with focused clinicians. Physicians deserve the autonomy and latitude to take care of patients the way they are under oath, and were trained, to do.

References

- [1] World Health Organization [https://www.who.int/mental_health/evidence/burn-out/en/] Geneva: ICD-11; 2019 (accessed August 18, 2019).
- [2] Han S, Shanafelt TD, Sinsky CA, et al. Estimating the attributable cost of physician burnout in the United States. *Ann Intern Med.* 2019; 170: 784. doi: 10.7326/M18-1422.
- [3] Medscape National Physician Burnout and Depression Report. 2018 (January 17, 2018; cited August 28, 2019). Available from: <https://www.medscape.com/slideshow/2018-lifestyle-burnout-depression-6009235#1>.
- [4] Panagioti M, Geraghty K, Johnson J, et al. Association between physician burnout and patient safety, professionalism, and patient satisfaction: A systematic review and meta-analysis. *JAMA Intern Med.* 2018; 178(10): 1317–1331. doi: 10.1001/jamainternmed.2018.3713.
- [5] Talbot SG, Dean W. Physicians aren't burning out. They're suffering from moral injury. *STATNews.* July 26, 2018. Available from: <https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/>. Accessed August 18, 2019.
- [6] Dean W, Talbot SG, Caplan A. Clarifying the Language of Clinician Distress. *JAMA.* Published online January 31, 2020. doi: 10.1001/jama.2019.21576.
- [7] Nedrow A, Steckler NA, Hardman J. Physician resilience and burnout: Can you make the switch? *Fam Pract Manag.* 2013 Jan-Feb; 20(1): 25–30.
- [8] Crowley T. How to have a high-performing employed medical group without a hospital subsidy. *NEJM Catalyst.* November 22, 2017. Available from: <https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0318>. Accessed December 29, 2019.

- [9] Norbeck T. 2018 Survey of America's Physicians: Practice Patterns & Perspectives. Merritt Hawkins, on behalf of the Physicians Foundation. September 2018. Available from: <https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf>. Accessed February 18, 2020.
- [10] American Association of Medical Colleges report. The complexities of physician supply and demand: 2017–2032 (2019 Update). April 2019. Available from: https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf. Accessed December 29, 2019.
- [11] Sibert KS. Privilege and entitlement in work-life balance. August 23, 2015. Available at: <http://apennedpoint.com/privilege-and-entitlement-in-work-life-balance/>. Accessed February 18, 2020.
- [12] Berwick DM, Hackbarth AD. Eliminating waste in U.S. healthcare. *JAMA*. 2012; 307(14): 1513–1516. Published online March 14, 2012. doi: 10.1001/jama.2012.362.
- [13] Du JY, Rascoe AS, Marcus RE. The growing executive-physician wage gap in major US nonprofit hospitals and burden of nonclinical workers on the US healthcare System. *Clinical Orthopaedics and Related Research*. 2018; 476(10): 1910. doi: 10.1097/CORR.0000000000000394.
- [14] Cantlupe J. The rise (and rise) of the healthcare administrator. November 7, 2017. Available from: <https://www.athenahealth.com/insight/expert-forum-rise-and-rise-healthcare-administrator>. Accessed December 18, 2019.