Physician and Nurse Well-Being: Seven Things Hospital Boards Should Know

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America's medical centers, hospitals, and healthcare organizations form the foundation of our healthcare delivery system. Typically, each is guided by a board of directors charged with helping the organization achieve its mission. Although not involved in day-to-day management, the board hires and monitors the CEO, oversees strategy, ensures that the organization is providing high-quality medical care to its community, and applies sound financial supervision. It must allocate sufficient resources to both measure and improve the safety and effectiveness of care (Centers for Medicare & Medicaid Services, 2003), and thereby help the organization achieve its mission.

Most board members are experienced senior executives who bring a deep understanding of organizations and a familiarity with leading people, identifying internal and external threats to organizational health, and mitigating risks. Although many do not have an extensive background in healthcare, they can cultivate sufficient expertise to challenge, advise, and guide the organizations' leaders. Indeed, members of healthcare boards often develop a fluent understanding of safety and quality, patient satisfaction, and healthcare economics (including payer mix, contracting, and service lines).

Board members generally are grounded in the fundamentals of human resources but typically have a less nuanced view of the specific challenges associated with recruiting, developing, and retaining engaged, fulfilled, and loyal healthcare professionals. Evolving challenges related to this aspect have coalesced to threaten the ability of healthcare organizations to achieve their missions. Professional burnout is one such challenge. Extensive evidence indicates that professional burnout jeopardizes the delivery of the safest and highest-quality care—the paramount priority of board members (Wallace, Lemaire, & Ghali, 2009). The CEOs of 10 of the nation's leading healthcare institutions have identified burnout in healthcare professionals as a public health crisis (Noseworthy et al., 2017), and the National Academy of Medicine has launched a major initiative to engage payers, regulators, professional societies, healthcare organizations, and other stakeholders in efforts to increase awareness and address this problem (Dzau, Kirch, & Nasca, 2018).

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SEVEN THINGS HOSPITAL BOARDS SHOULD KNOW

To face the magnitude of the threat that burnout presents for healthcare professionals, board members must attain a sufficient understanding of the issues to serve as effective stewards of their organizations' mission. Here are seven things board members should know.

1. Burnout Is Prevalent Among Healthcare Professionals

Research suggests that half of America's physicians and nurses have symptoms of professional burnout (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011; Shanafelt et al., 2015b). They suffer from exhaustion, cynicism, and a loss of commitment to work. Burnout is markedly more common in physicians than in U.S. workers in other fields, and the gap is widening (Shanafelt et al., 2015b). Perhaps most disturbing is the fact that individuals experiencing burnout begin to view people as objects and exhibit less compassion and empathy. In healthcare, this syndrome negatively affects the patient experience, clinical outcomes, and the cost of care (McHugh et al., 2011; Windover et al., 2018).

Various factors contribute to healthcare professional burnout, including production-based compensation, inefficient processes and workflows, and overly strict interpretation of regulatory requirements (Shanafelt et al., 2016; Welp, Meier, & Manser, 2014). Electronic health records (EHRs), in particular, have changed providers' work by increasing the clerical burden and distracting caregivers from the human interactions at the center of the healing process. The average physician now spends at least 50% of each work day on desktop medicine (charting, entering electronic orders, responding to electronic messages, and completing preauthorization forms) rather than interacting directly with patients (Sinsky et al., 2016). The average physician also spends 28 hours per month interacting with the EHR during off-hours. Much of the burden associated with the EHR is attributable to mandates and requirements added by payers, healthcare enterprises, the legal system, public health entities, measurement entities, and government regulators rather than the EHR tools themselves.

Ineffective first-line leadership also appears to be a major factor contributing to poor well-being of healthcare professionals. This deficit is likely due, in part, to a lack of attention to leadership development for physicians and nurses (Shanafelt et al., 2015a).

2. The Well-Being of Healthcare Professionals Affects the Quality of Care

The well-being of physicians and nurses affects the quality of patient care (Wallace et al., 2009). Multiple studies have indicated increased mortality for patients cared for in hospitals whose physicians and nurses have higher levels of burnout (e.g., Welp et al., 2014). Nurse burnout is correlated with the risk of developing hospital-acquired infections (Cimiotti, Aiken, Sloane, & Wu, 2012). Burned-out physicians are more likely to make errors and less likely to provide compassionate, humanistic care (Wallace et al., 2009). In fact, care provided by a burned-out physician appears to be more closely associated with an increased likelihood of errors than is the overall quality of the hospital or unit in which the care is provided (Tawfik et al., 2018). This fact is staggering when one considers the billions of dollars invested to improve quality scores and the minimal attention organizations have paid to the well-being of their physicians and nurses.

3. Healthcare Professionals' Distress Costs Organizations a Lot of Money

Extensive evidence indicates that burnout in physicians and nurses is costly. Burned-out physicians have a turnover rate that is twice that of non-burned-out physicians (Windover et al., 2018). Depending on specialty, the cost of replacing a physician (recruitment, on-boarding, lost revenue during transition) is $500,000 to $1,000,000. The cost of nurse turnover is lower, but the collective cost is substantial because hospitals typically employ 4 to 5 times as many nurses as physicians.

Burned-out physicians and nurses are also more likely to prematurely leave their profession altogether (Sinsky et al., 2017). This consequence compounds the large projected shortages of physicians and nurses over the next decade, which will make recruiting and retaining healthcare professionals even more difficult.

Burnout also decreases productivity, erodes patient satisfaction, and may increase the risk of malpractice suits (Windover et al., 2018). Recent studies suggest that the average collective cost of burnout to organizations from all these factors is exceeds $12,000 per employed physician each year.

4. Greater Personal Resilience Is Not the Solution

Physicians and nurses enter their professional training with lower burnout and better mental profiles than their peers who pursue other occupations (Brazeau et al., 2014). This pattern is reversed shortly into the training process, revealing the important contributions of professional culture and environment to the problem. Excessive work hours and sleep deprivation, for example, are the professional norm during physician training. Once established, these unhealthy habits are perpetuated in practice, and they communicate the expectation to physicians that they must somehow be impervious to normal human limitations.

Although providing opportunities for physicians and nurses to cultivate personal resilience skills is a worthy endeavor, it is an inadequate approach to this organizational problem (West, Dyrbye, Erwin, & Shanafelt, 2016). As noted, excessive clerical tasks, inefficient practice environments, and regulations and policies make it difficult to provide patients the care they need. Suboptimal teamwork, role ambiguity, and hierarchical working relationships further undermine the promise of team-based care. Ineffective leadership, lack of voice and input in decision-making, and erosion of community also all contribute to the problem. For academic clinicians, it is often unclear how they are expected to prioritize clinical revenue generation, the research and publications necessary for promotion, and teaching commitments. Leaders must address this uncertainty and establish realistic expectations.

The aspiration for healthcare organizations should go beyond the eradication of burnout; they must embrace the broader vision of cultivating an engaged, productive, and professionally fulfilled team of healthcare professionals. The Stanford Model for Professional Fulfillment and Worksite Wellness (Figure 1) proposes that efficiency of practice and organizational culture—in addition to personal resilience—are needed if optimal well-being for healthcare professionals is to be achieved (Bohman et al., 2017).

FIGURE 1
Stanford Model for Professional Fulfillment in Healthcare Professionals

Source: Board of Trustees of the Leland Stanford Junior University. Used with permission.

5. Different Occupations and Disciplines Have Unique Needs

Modern medicine is a team sport. In a multidisciplinary collaboration, physicians, nurses, pharmacists, technologists, social workers, and other professionals with complementary expertise all work in partnership to meet the needs of a given patient. Although burnout and distress are prevalent among all healthcare professionals, the nature of the problem and the primary drivers are not the same for all specialties or occupations. Some contributing factors, such as poorly functioning teams, misalignment of values, and ineffective leadership, affect healthcare professionals broadly, but the impact of other factors differs widely by occupation. The primary challenges for an intensive care unit nurse attending to critically ill patients and working nights and weekends are different from those of a public health nurse who has a traditional workweek but is under-resourced to meet the needs of patients in the face of their social determinants of health. Radiologists, family physicians, and neurosurgeons have very different work, and the degrees of isolation, clerical burden,

control, and excessive work hours differ. The aspects of workflow (e.g., triage, scheduling, operating room turnaround times, documentation, care team consistency) that need to be improved to enhance efficiency vary dramatically for these specialists.

Moral distress and mistreatment by other members of the care team may be non-issues for physicians but are major issues for many nurses. Conversely, the impact of malpractice suits and the pressures of academic appointment and promotion are major drivers for many physicians but largely irrelevant for other healthcare professionals. Role ambiguity (a lack of clarity and a wide variability in role and responsibility) is rarely an issue for physicians or nurses, but is a major challenge for advanced practice providers (Shanafelt et al., 2018).

Oversimplifying the problem serves no one and typically leads to offering healthcare professionals the same generic human resources programs seen in every industry (e.g., mindfulness, personal resilience training) rather than addressing the unique aspects of the healthcare-related challenges that are the underlying problem. To make meaningful progress, organizations must not only address the issues that affect all healthcare professionals but also identify and address the distinct and major contributing factors that differ by practice setting, occupation, or specialty.

6. Evidence and Tactics Are Available to Address the Problem

A road map has emerged to address this issue (Shanafelt et al., 2018; Shanafelt & Noseworthy, 2017). The first step is an organization-level assessment to establish the baseline, identify hot spots, and prioritize where to begin. The assessment includes a survey using validated instruments with national benchmarks along with existing organizational measures related to the efficiency of the practice environment. This information can be used to define the organizational cost of caregiver burnout and to determine appropriate investment (Shanafelt, Goh, & Sinsky, 2017). A leadership structure to develop and coordinate approaches should then be established. An appropriately positioned leader with authority to drive progress should be appointed, a team assembled, and sufficient resources allocated to address the problem. The team must begin by diagnosing the opportunities to improve at both the organization and work unit (division, department, clinic) levels.

Shanafelt and Noseworthy (2017) suggest that the baseline assessment helps define the problem and identify hot spots but does not diagnose the primary contributing factors (which vary by organization and work unit) or the most actionable opportunities to address them. The drivers typically relate to one of eight dimensions: workload, efficiency, control and flexibility, work–life integration, meaning in work, fairness and equity, collegiality, or values alignment between individuals and the organization or unit. The drivers that pose the greatest problem vary by work unit, and determining the greatest opportunity for improvement involves asking the healthcare professionals in the work unit. A number of established processes can be used to engage work units in this dialogue, define the nature of the local issues and opportunities, and give healthcare professionals a voice in creating the solutions (Shanafelt & Noseworthy, 2017). Once the diagnosis is made,

tactics relevant to the local issue can be selected (or developed) and deployed. Metrics are available to measure progress; some leading organizations incorporate measures of healthcare professional well-being as part of the CEO's annual performance scorecard (Shanafelt & Noseworthy 2017).

7. Interventions Work

Evidence indicates that organization-level interventions work (West et al., 2016). Both organization- and individual-focused approaches are effective and, indeed, complementary. Organizations that have prioritized the problem and implemented system-level interventions have reduced burnout and improved professional fulfillment at the system level (Shanafelt & Noseworthy, 2017). Like efforts to improve quality, organizational efforts to cultivate well-being and engagement for healthcare professionals are a journey. Making progress requires prioritization and a leadership infrastructure to drive organizational improvement (Shanafelt et al., 2018).

CONCLUSION

Burnout among healthcare professionals has become a major threat to the ability of most healthcare organizations to deliver quality care and effectively serve their communities. An understanding of the importance of this strategic concern is critical for board members because they play an important role in supporting organizational leaders as they address the problem. The board's role should include asking the organization's officers for regular updates on objective, organization-specific data on burnout and well-being among healthcare professionals, and on specific plans for improvement. Board members should also recognize the strategic importance of allocating time, attention, and resources to address this challenge.

REFERENCES

Bohman, B., Dyrbye, L., Sinsky, C., Linzer, M., Olson, K., Babbott, S., ... Trockel, M. (2017, August 7). Physician well-being: The reciprocity of practice efficiency, culture of wellness, and personal resilience. *New England Journal of Medicine Catalyst.* Retrieved from https://catalyst.nejm.org/physician-well-being-efficiency-wellness-resilience/

Brazeau, C. M., Shanafelt, T. D., Durning, S. J., Massie, F. S., Eacker, A., Moutier, C., … Dyrbye, L. N. (2014). Distress among matriculating medical students relative to the general population. *Academic Medicine: Journal of the Association of American Medical Colleges*, *89*(11), 1520–1525.

Centers for Medicare & Medicaid Services. (2003, January 24). Medicare and Medicaid Programs; Hospital Conditions of Participation: Quality Assessment and Performance Improvement [Final rule]. *Federal Register*, *68*(16). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms3050f.pdf

Cimiotti, J. P., Aiken, L. H., Sloane, D. M., & Wu, E. S. (2012). Nurse staffing, burnout, and health care-associated infection. *American Journal of Infection Control*, *40*(6), 486–490.

Dzau, V. J., Kirch, D. G., & Nasca, T. J. (2018). To care is human: Collectively confronting the clinician-burnout crisis. *New England Journal of Medicine*, *378*(4), 312–314.

McHugh, M. D., Kutney-Lee, A., Cimiotti, J. P., Sloane, D. M., & Aiken, L. H. (2011). Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs (Millwood)*, *30*(2), 202–210.

Noseworthy, J., Madara, J., Cosgrove, D., Edgeworth, M., Ellison, E., Krevans, S., . . . Harrison, D. (2017). Physician burnout is a public health crisis: A message to our fellow health care CEOs. *Health Affairs Blog.* Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20170328.059397/full/

Shanafelt, T. D., Boone, S., Tan, L., Dyrbye, L. N., Sotile, W., Satele, D., . . . Oreskovich, M. R. (2012). Burnout and satisfaction with work-life balance among us physicians relative to the general US population. *Archives of Internal Medicine,* 172(18), 1377–1385.

Shanafelt, T. D., Gorringe, G., Menaker, R., Storz, K. A., Reeves, D., Buskirk, S. J., … Swensen, S. J. (2015a). Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clinic Proceedings*, *90*(4), 432–440.

Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., & West, C. P. (2015b). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings*, *90*(12), 1600–1613.

Shanafelt, T. D., Dyrbye, L. N., Sinsky, C., Hasan, O., Satele, D., Sloan, J., & West, C. P. (2016). Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clinic Proceedings*, *91*(7), 836–848.

Shanafelt, T. D., Goh, J., & Sinsky, C. (2017). The business case for investing in physician well-being. *JAMA Internal Medicine*, *177*(12), 1826–1832.

Shanafelt, T. D., & Noseworthy, J. H. (2017). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clinic Proceedings*, *92*(1), 129–146.

Shanafelt, T. D., Trockel, M., Ripp, J., Murphy, M., Sandborg, C., & Bohman, B. (2018). Building a program on well-being: Key design considerations to meet the unique needs of each organization. [Epub ahead of print.] *Academic Medicine: Journal of the Association of American Medical Colleges*. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/30134268

Sinsky, C., Colligan, L., Li, L., Prgomet, M., Reynolds, S., Goeders, L., … Blike, G. (2016). Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties. *Annals of Internal Medicine*, *165*(11), 753–760.

Sinsky, C. A., Dyrbye, L. N., West, C. P., Satele, D., Tutty, M., & Shanafelt, T. D. (2017). Professional satisfaction and the career plans of US physicians. *Mayo Clinic Proceedings*, *92*(11), 1625–1635.

Tawfik, D. S., Profit, J., Morgenthaler, T. I., Satele, D. V., Sinsky, C. A., Dyrbye, L. N., ... Shanafelt, T. D. (2018, July 9). Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. [Epub ahead of print.] *Mayo Clinic Proceedings*. pii: S0025–6196(18)30372-0.

Wallace, J. E., Lemaire, J. B., & Ghali, W. A. (2009). Physician wellness: A missing quality indicator. *Lancet*, *374*(9702), 1714–1721.

Welp, A., Meier, L. L., & Manser, T. (2014). Emotional exhaustion and workload predict clinician-rated and objective patient safety. *Frontiers in Psychology*, *14*(5), 1573.

West, C. P., Dyrbye, L. N., Erwin, P. J., & Shanafelt, T. D. (2016). Interventions to prevent and reduce physician burnout: A systematic review and meta-analysis. *The Lancet*, *388*(10057), 2272–2281.

Windover, A. K., Martinez, K., Mercer, M. B., Neuendorf, K., Boissy, A., & Rothberg, M. B. (2018). Correlates and outcomes of physician burnout within a large academic medical center. *JAMA Internal Medicine*, *178*(6), 856–858.