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ANALYSIS

Burnout in healthcare: the case for organisational change

Burnout is an occupational phenomenon and we need to look beyond the individual to find effective solutions, argue **A Montgomery and colleagues**

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Burnout has become a big concern within healthcare. It is a response to prolonged exposure to occupational stressors, and it has serious consequences for healthcare professionals and the organisations in which they work.[1] Burnout is associated with sleep deprivation,[2] medical errors,[3-5] poor quality of care,[6 7] and low ratings of patient satisfaction.[8] Yet often initiatives to tackle burnout are focused on individuals rather than taking a systems approach to the problem.

Evidence on the association of burnout with objective indicators of performance (as opposed to self report) is scarce in all occupations, including healthcare.[9] But the few examples of studies using objective indicators of patient safety at a system level confirm the association between burnout and suboptimal care. For example, in a recent study, intensive care units in which staff had high emotional exhaustion had higher patient standardised mortality ratios, even after objective unit characteristics such as workload had been controlled for.[10]

The link between burnout and performance in healthcare is probably underestimated: job performance can still be maintained even when burnt out staff lack mental or physical energy[11] as they adopt "performance protection" strategies to maintain high priority clinical tasks and neglect low priority secondary tasks (such as reassuring patients).[12] Thus, evidence that the system is broken is masked until critical points are reached. Measuring and assessing burnout within a system could act as a signal to stimulate intervention before it erodes quality of care and results in harm to patients.

Burnout does not just affect patient safety. Failing to deal with burnout results in higher staff turnover, lost revenue associated with decreased productivity, financial risk, and threats to the organisation's long term viability because of the effects of burnout on quality of care, patient satisfaction, and safety.[13]

Given that roughly 10% of the active EU workforce is engaged in the health sector in its widest sense, the direct and indirect costs of burnout could be substantial.[14]

Shared problem

We need effective strategies for preventing and ameliorating burnout within healthcare settings. The most common responses have put the responsibility on healthcare professionals to take better care of themselves, become more resilient, and cope with stressors on their own. But such an individualistic approach can ignore the sources of chronic stressors in the workplace such as incivility, staff shortages, and austerity measures, which are often beyond an individual's control. The exhaustion, cynicism, and consequent feelings of inefficacy experienced by people with burnout are often a shared experience in response to shared job stressors, and we should frame it as a systems problem, and not simply as an individual one.[1]

Individually focused solutions are important to support overburdened staff but are less likely to have longevity and sustainability than solutions that are organisationally embedded.[15] They may even compound problems in the long run by reinforcing a dysfunctional coping approach that interprets failure as wholly personal. Locating solutions for organisational problems within individuals is common in healthcare, particularly with the physician culture that valorises inappropriate self care[16] and the avoidance of emotionally challenging events.[17-19]

The current focus on narrow definitions of burnout as a medical diagnosis and inadequate measurement approaches have hampered progress. Viewing burnout as a disease has hindered efforts to focus on the work place values that are driving burnout. In addition, a focus on the exhaustion component of burnout has overestimated some relationships and

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underestimated others, meaning that interventions are less evidence based. We discuss four practical steps to move us towards understanding burnout at a systems level and therefore implementing a systems approach to the problem: using burnout as an indicator of healthcare quality, assessing it at the departmental and the individual level, explicitly developing healthy workplaces, and including practitioners and patients in the process of articulating research questions.

Including burnout in assessments of healthcare quality

We need a different approach to integrate wellbeing as a quality marker within the healthcare system (such as the JAMA charter on physician wellbeing).[20] We can think of hospitals measuring safety in four categories: structure (eg, facilities, organisational culture), process (eg, consistency of care), outcome (eg, survival rates), and patient experience (eg, satisfaction).[21] In the UK, research among NHS staff indicates an almost universal desire to provide the best quality of care but also shows that organisations can find it difficult to obtain valid insights into the quality of the care they provide.[22] However, better quality, safer care for patients has been linked to higher rates of staff engagement.[23 24] In addition, staff satisfaction is weakly correlated with hospital standardised mortality ratios.[25] Medical departments reporting high levels of burnout could therefore be a signal of erosion of hospital safety. If burnout can be considered an indicator of organisational malfunctioning, it should be included in the assessment of healthcare quality. The World Health Organization's recent recognition of burnout as an occupational phenomenon (and not a medical disease) opens the way for policy makers to fund organisational strategies aimed at research and amelioration.[26]

Measuring staff experience of work may help to understand organisational drivers of poor quality care. Leiter and Maslach describe five profiles of work experience, each suggesting a different approach to tackling the drivers of burnout and thus a different intervention and solution.[27] There is a continuum from burnout (high on all three dimensions of dysfunction) to engagement (low on all three). The three intermediate profiles are disengaged (characterised by high cynicism only), overextended (high exhaustion only), and ineffective (high inefficacy only) (fig 1). Each profile reflects a different worklife crisis that would require a unique intervention strategy. The ineffective profile has been largely ignored, with most researchers focusing on exhaustion and cynicism. But feeling negatively about how well you are doing your job needs more than just a lighter workload and lunch with colleagues.

Moreover, including burnout as a quality metric can signal problems that are difficult to capture. For example, there is evidence that compassion fatigue and depersonalisation from staff burnout is associated with caring neglect.[28] Although insufficient to trigger current institutional procedures (and unlikely to cause immediate harm), caring neglect can lead patients, family, and the public to believe that staff are unconcerned about the emotional and physical wellbeing of patients.

Burnout should be assessed at departmental or unit level

Evaluation of burnout is limited by inadequate measurement. The best available measure is the Maslach burnout inventory, but researchers often use it improperly—for example, focusing only on the exhaustion part with a single item—or using it as a tool for diagnosis, for which it was not designed. Research efforts to link the burnout and patient safety research agendas have counterintuitively focused on the performance of individuals rather than the department or practice in which they work. However, some recent research has examined the differences between organisations within healthcare,[29-31] and our suggestion is to go further and examine the levels of burnout in each unit within an organisation to understand key systems drivers.

Organisations are designed and managed around work teams, and managers are held accountable for large groups of people. The relevant data for evaluating these teams are typically aggregated indicators, such as productivity or turnover or patient safety rates for the entire team. This suggests that burnout assessments should also be aggregated measures. This is especially relevant for any decisions about implementing interventions across work teams or entire departments. Outside of healthcare, there is evidence that burnout is more meaningful if measured at the team level.[32 33] This is because burnout is a social phenomenon rooted in the relationships that people share in work teams.

Focus on development of healthy workplaces

A meta-analysis of interventions to reduce physician burnout suggests that approaches that promote healthy individual-organisation relationships are the key to preventing burnout.[34] At the same time, another meta-analysis found few examples of rigorously implemented and evaluated structural interventions.[35] We need more research to identify the key stressors driven by the organisation that put people at risk of burnout and what changes could be made to reduce their impact.

Models of the "fit" or "match" between the workplace and the worker provide a useful framework for identifying possible ways to improve the job environment. For example, the areas of worklife model specifies six areas in which the job-person match is critical: workload, control, reward, community, fairness, and values.[36] Burnout, in contrast to simple chronic exhaustion, arises from workload problems combined with mismatches across the other five areas of worklife.[36] Mismatches in these areas affect an individual's level of experienced burnout, which in turn determines various outcomes, such as job performance, mental health, and health services delivery. The greater the mismatch between the person and the job, the greater the likelihood of burnout; conversely, the greater the match, the greater the likelihood of resilience and engagement. The challenge is to identify some of the important factors from one or more of the six areas and then use this information to design possible interventions. Obviously, a practice or department may be experiencing problems in multiple areas that may be outside the control of that team, but it may be possible to identify a problem that people care about and are willing to work on, until there is animprovement. For example, organisations where staff have set their own working patterns (affecting the areas of fairness and control) have shown improved recruitment and staff satisfaction.[37] One successful intervention can inspire more hope and willingness to fix other problems.

Measuring the attributes of an organisation before an intervention (box 1) can provide a foundation on which to monitor its health and enable the selection of appropriate tools to change work practices.

Box 1: Strategies to reduce burnout in healthcare using the areas of worklife model[36]

***Workload*—**Overload is a feature of frontline care that means there is little opportunity to rest, recover, and restore balance. Managing workload and recognising boundaries can provide opportunities that can help staff feel effective in their work

***Control*—**Experiencing a lack of control has been a consistent predictor of burnout. Conversely, the perception of having the capacity to influence decisions and exercise professional autonomy is more likely to lead to resilient and engaged physicians

***Reward*—**Insufficient recognition and reward (whether financial, institutional, or social) increases people's vulnerability to burnout because it devalues both the work and the workers, and it is closely associated with feelings of inefficacy. Feeling that you are appropriately and consistently rewarded is associated with intrinsic satisfaction, which is the optimum state for healthcare staff. This is an area where patients can contribute

***Community*—**Regardless of their size, healthcare organisations are social communities. The area of community has to do with the ongoing relationships that people have with others on the job. Whether it is a rural general practice or a large university hospital, relationships that are characterised by a lack of support and trust, and by unresolved conflict, all mean a greater risk of burnout

***Fairness*—**Fairness is the extent to which decisions at work are perceived as being fair and equitable. This factor is the one most directly relevant to patient care. Patients and health staff will experience feelings of cynicism, anger, and hostility if they don't feel they are being treated appropriately

***Values*—**Values are the ideals and motivations that originally attracted people to their job, and thus they are the motivating connection between the worker and the workplace. Feeling that the work that you have to do is far away from what you want to do can lead to greater burnout.

Importance of staff and patient input

We need more input from everyone in healthcare settings, including physicians, nurses, and other staff as well as patients and their families. For example, most research on the intersection between quality and burnout has focused on nursing.[38] Physician and (especially) patient experiences are largely absent, although recent evidence indicates that patients' perceptions of physician wellness affect the doctor-patient relationship.[39]

Patients and relatives also have an important role in driving or preventing burnout. The perspective of patients and carers on organisational problems and stress among healthcare staff can be an indicator of organisational wellbeing.

The accumulated evidence points towards prevention strategies that emphasise building staff engagement.[40] Questions such as, "What working conditions would need to change in this hospital to make people want to work here and be fully engaged with their job?" may be easier to answer than, "How do we improve the quality of healthcare in this hospital?" and be more likely to allow clinicians and patients to feel ownership of some of the answers. Initial evidence suggests that involving patients through experience based co-design can result in better service delivery,[41] and patient feedback can help improve services and build morale among staff.[42] Given the symbiotic relationship between physician burnout and patient outcomes,[43 44] and the evidence that positive reinforcement from patients helps build partnerships,[45] meaningful patient involvement has the potential to ameliorate staff burnout.

Conclusions

We need to widen our approach to tackling burnout. The challenge for health systems in an increasingly complex health environment, with the twin pressures of limited resources and increasing levels of burnout, is to develop interventions to counter the factors that are leading to burnout. The problem is not the workforce but the way that the environment is becoming toxic. Measurement of burnout can provide an early signal of a problem. Prevention, which is more desirable than treatment, will be enabled by a healthy workplace approach that includes both continuous evidence based assessment of burnout and action on the structural drivers of burnout tailored to staff experience and co-designed with input from the users of the health service.

Key messages

Burnout is an occupational problem not a medical diagnosis

Healthcare organisations should assess burnout at departmental level and use it as a metric of safety of care

More focus is needed on developing healthy workplaces

Staff and patients must be included in developing actions to reduce and prevent burnout

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Figure

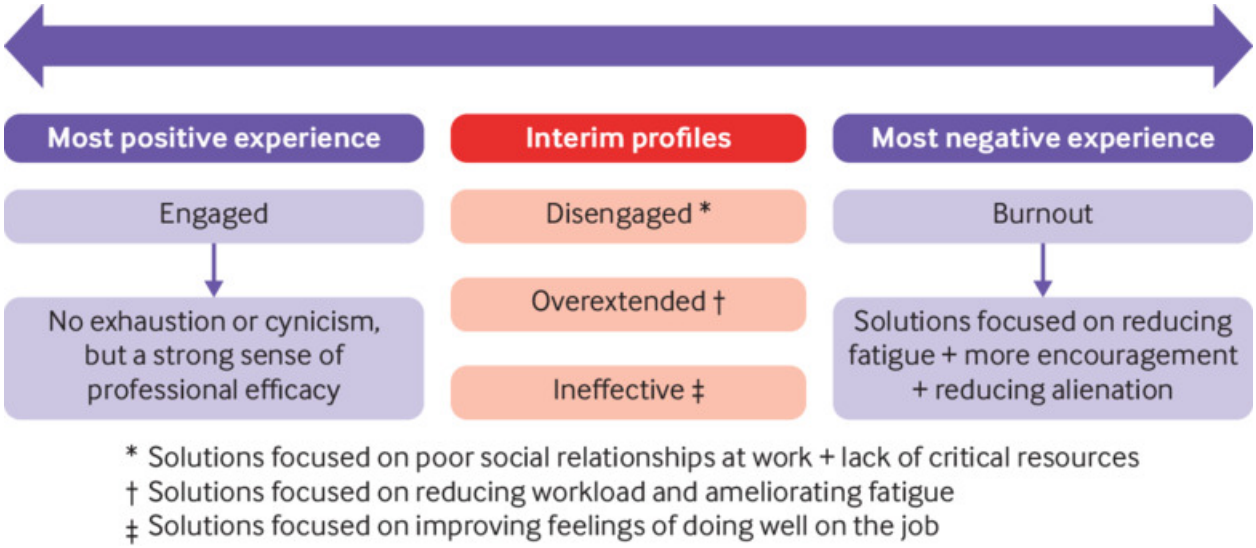

Fig 1 Maslach burnout inventory profiles of work experience and possible solutions