

VIEWPOINT

Improving the System to Support Clinician Well-being and Provide Better Patient Care

Pascale Carayon, PhD
Wisconsin Institute for Healthcare Systems Engineering, College of Engineering, University of Wisconsin, Madison.

Christine Cassel, MD
Department of Medicine, University of California, San Francisco.

Victor J. Dzau, MD
National Academy of Medicine, Washington, DC.



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Twenty years ago, the Institute of Medicine (now the National Academy of Medicine) published 2 important reports^{1,2} in response to a crisis in patient safety that led to significant reform and improvements in quality and patient safety. It is time for another major system improvement in response to the crisis of clinician burnout. Numerous changes with health information technologies, accountability frameworks, and payment models have substantially affected the patient-clinician relationship and the work demands placed on health care professionals. Physicians, nurses, and other clinicians are experiencing mounting system pressures that contribute to occupational stress, including burnout, which has been defined as emotional exhaustion, depersonalization, and a low sense of personal accomplishment from work.³ Students and trainees also experience pressures and similar degrees of occupational stress.

In 2017, in response to concerning rates of depression, stress, and burnout among US medical students and clinicians, the National Academy of Medicine launched the Action Collaborative on Clinician Well-Being and Resilience, a network of more than 200 organizations committed to reversing clinician burnout. A consensus study evaluated the evidence on clinician burnout and well-being and the resulting report⁴ emphasizes that opportunities exist to improve work and learning environments at all system levels.

Health care training and practice have always been stressful, and place emotional, psychological, and physical demands on individuals. Given the limited longitudinal data, it is unclear whether the currently reported rates of mental health problems and occupational distress have increased over time. But that does not diminish the importance of recent findings from numerous national studies that used the validated Maslach Burnout Inventory (MBI) (or its emotional exhaustion subscale),⁵ and found, based on physician study samples ranging from 25 000 to 35 000 and nurse study samples ranging from 10 000 to 95 000, that between 35% and 54% of US nurses and physicians report symptoms of burnout.⁴ Similarly, between 45% and 60% of medical students and residents report symptoms of burnout based on the MBI and its subscales involving samples ranging from 50 to 16 000 students and residents.⁴

Studies show that clinician burnout is associated with an increased risk of errors and malpractice claims, reduced patient satisfaction, and diminished communication with patients and families. There is also evidence that burnout strains organizations by increasing clinician absenteeism, presenteeism, and turnover and reducing productivity.⁶ These associations are important, although these studies do have limitations.

Recent trends in the clinical environment include shifts toward industrialization of health care delivery, greater accountability and transparency through measurement without regard to the negative consequences on clinicians and patient care, rapid pace of change, greater influence of information technology on the patient encounter, and changing expectations of patients as consumers. These changes may create an imbalance in which the demands of a clinician's job are greater than the resources available to complete the job effectively (eBox in the [Supplement](#)). This imbalance contributes to clinician burnout. Within this strained work environment, the emotional distress experienced by many clinicians as a result of the disconnect between avowed ethical principles and the values and incentives in the work environment further adds to burnout.⁷ Because of this complex web of multilevel factors and influences, the committee took a systems approach to clinician burnout, incorporating input from experts in human factors and systems engineering and health informatics, as well as medical, nursing, pharmacy, and dentistry experts and educators.

The committee's systems model for professional well-being and clinician burnout has 3 levels: frontline care delivery, health care organization, and external environment, which together influence the work system factors that contribute to clinician burnout and professional well-being (eFigure in the [Supplement](#)). These interacting factors produce imbalances in job demands and resources experienced by clinicians at all stages of their professional development and career. Among clinicians, job demands relate to workload and time pressure, intrinsic aspects of clinical work (eg, clinical uncertainty), and work inefficiencies (eg, administrative burden, inadequate technology usability). Job resources include tangible and intangible resources within the work environment, such as meaning in work, job control, and the availability of social support from peers and supervisors. The main drivers for burnout among students stem from the learning environment, and include grading schema, suboptimal clinical experiences, inadequate preparation and support, supervisor behaviors, peer behaviors, and lack of autonomy. Other factors, unique to each individual (personality, coping strategies, resilience) mediate the effect of these work system factors on clinician and student burnout and professional well-being, which have consequences for both patients and clinicians, health care organizations, and society at large.

The work system factors often extend across more than 1 system level (care delivery, health care

organization, and external environment), and improvement can occur at every level to relieve workplace stress. The recommendations from the report,⁴ organized under 6 overarching goals, reflect the crosscutting nature of the identified factors contributing to clinician burnout and professional well-being. Overall, the intent of the recommendations is not to create additional system burden, but rather to encourage health care leaders to prioritize the actions, procedures, and policies that deliver the greatest value to direct patient care, which includes eliminating unnecessary clinician burden and promoting professional well-being.

1. Create positive work environments:

- Health care organizations should develop, pilot, implement, and evaluate organization-wide initiatives to reduce the risk of burnout, foster professional well-being, and enhance patient care.
- They should adopt and apply systems design principles to balance job demands and job resources.
- They should routinely measure clinician burnout and ameliorate the work system factors that erode professional well-being.

2. Create positive learning environments:

- Educational institutions and clinical training sites for health professions should develop, pilot, implement, and evaluate initiatives to improve the learning environment and support professional well-being.
- They should routinely assess the learning environment and factors that erode professional well-being and contribute to student burnout to guide systems-oriented efforts.
- Accreditors, regulators, national educational organizations, health professions educational institutions, and other related entities should partner to support the student well-being.

3. Reduce administrative burden:

- Health care policy, regulatory, and standards-setting entities at the federal and state levels should systematically assess laws, regulations, policies, and standards to determine their effects on clinician job demands and resources as well as the effects on patient care quality, safety, and cost.
- These entities, in conjunction with health care organizations, should adopt approaches to documentation and reporting that incorporate human-centered design, human factors, and technology-enabled systems engineering approaches.

4. Enable technology solutions:

- Health care leaders and information technology vendors should engage clinicians in the design and deployment of health information technology using human-centered design and human factors and systems engineering approaches to ensure the effectiveness, efficiency, usability, and safety of the technology.
- Federal and state policy makers should facilitate the optimal flow of useful information among all members of the health care community through regulation and rulemaking.
- Federal policy makers, in collaboration with private sector health information technology companies and innovators, regulators, health care organizations, and clinicians, should develop the infrastructure and processes for a truly patient-centered and clinically useful health information system.

5. Provide support to clinicians and students:

- State licensing boards, health system credentialing bodies, disability insurance carriers, and malpractice insurance carriers should either not ask about clinicians' personal health information or else inquire only about clinicians' current impairments due to any health condition.
- State legislative bodies should create legal protections that allow clinicians to seek and receive help for mental health conditions as well as to deal with the unique emotional and professional demands of their work without the information being admissible in malpractice litigation.
- Educational institutions for health professions, health care organizations, and affiliated training sites should identify and address those aspects of the learning environment, institutional culture, infrastructure and resources, and policies that prevent or discourage access to professional and personal support programs for individual students and clinicians.

6. Invest in research:

- Federal agencies should develop a coordinated research agenda to examine best measures of occupational stress, burnout, and workplace well-being in the health care environment, health care system factors that contribute to distress, and testing system-level interventions.
- These agencies should pursue and encourage public-private partnerships to support research on clinician and student professional well-being and burnout.

ARTICLE INFORMATION

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