

Ch. III-21 Provider Burnout

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ISSUE: Key team members tell you that they feel ‘burned out.’**Are there potential legal and quality implications related to ‘burnout’ for your practice?****WHAT IS PROVIDER BURNOUT?**

The notion of ‘burnout’ was first introduced by Freudenberger in 1974 to describe the perceived gradual emotional depletion, loss of motivation, and reduced commitment among volunteers of the St Mark’s Free Clinic in New York’s East Village. Despite the years through which the entity has been studied, there is still no standard definition of ‘burnout’ for example, as in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). There is debate about whether ‘burnout’ is a medical or psychiatric diagnosis; the outcome of that debate has significant legal implications.

The Agency for Healthcare Research and Quality (AHRQ) generally defines ‘burnout’ as a ‘long-term stress reaction’ that is comprised of (a) emotional exhaustion; (b) depersonalization, and, (c) a sense of reduced personal accomplishment. However, many argue that burnout includes classical symptoms of clinical depression including anhedonia, depressed mood, and even suicidal ideation. Diagnostic tools such as the Maslach Burnout Inventory are available but not specific. Schaufeli used neurasthenia (F43.8) as a surrogate or diagnostic equivalent of burnout under the International Classification of Diseases (ICD-10) based upon: (a) persistent and increased fatigue or weakness after minimal (mental) effort; (b) at least two out of seven distress symptoms including irritability and inability to relax; and, (c) the absence of other disorders such as mood disorder or anxiety disorder; where symptoms are causally-related to work.

The causes of burnout are similarly poorly defined but are generally considered a consequence of work-related stress. Some argue that the syndrome can be traced to (a) the de-professionalization, in favor of regulatory bureaucratization of health care providers; (b) impaired sense of professional community; and, (c) a trend toward technology at the risk of depersonalization of the patient care setting.

The incidence and prevalence of burnout are reported as increasing but exact data remains largely unknown. Prevalence across all providers is estimated to exceed 50%. Data suggests a burnout prevalence of: (a) 30% in nursing; (b) 41% among clinical pharmacists; and Medscape 2018 data reports provider burnout in 48% each among providers in critical care and neurology.

WHAT ARE QUALITY IMPLICATIONS OF BURNOUT?

The AHRQ opines that burnout can compromise patient access to continuity of care when practitioners leave practice due to burnout; and, burnout may affect patient safety quality of care when depersonalization impairs practitioner-patient empathy or interactions; or, when symptoms of impaired attention, memory, and executive function are present. Accumulating evidence suggests that practitioner burnout is a causal factor in medical errors and disruptive behavior; and contributes to poor patient satisfaction scores.

A key pending issue is whether practitioners who suffer from burnout can meet their patient care obligations in an ethical fashion; some have addressed this issue as a cause of moral distress among practitioners.

WHAT ARE LEGAL IMPLICATIONS OF BURNOUT TO THE PROVIDER?

From a legal perspective, the evolving issues will involve: (a) whether a provider who is diagnosed with ‘burnout’ can be considered an impaired, or disabled, provider; and (b) what regulatory or legal liabilities or protections might attach. These issues are not settled at present.

Shanafelt reported in 2010 that “major medical errors reported by surgeons are strongly related to a surgeon’s degree of burnout and their mental quality of life.” In a study of 7900 surgeons, Shanafelt concluded that (a) major medical errors were strongly related to the degree of burnout; (b) on a 33 point scale of depersonalization,

each incremental increase was associated with an increase in self-reported error by 11%; and, (c) on a 54 point scale of emotional exhaustion, each incremental point was associated with a 5% increase in self-reported medical error. The link between provider communication skills, patient satisfaction and the risk malpractice liability is well established. It is not surprising that non-systematic reviews suggest that burnout is associated with an increased risk for malpractice and disciplinary liability.

WHAT ARE LEGAL IMPLICATIONS OF BURNOUT TO THE INSTITUTION?

Institutions are increasingly aware that burnout adversely affects liability risks, provider productivity, and the workplace environment. Burnout creates financial and legal liabilities directly impacting the health care institution.

Almost all states have enacted legislation regarding impaired providers. The Federation of State Medical Boards defines 'impairment' as "the inability of a licensee to practice medicine with reasonable skill and safety as result of: (a) mental disorder...; or, (b) physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or (c) substance-related disorders including abuse and dependency of drugs and alcohol... ." Numerous publications have addressed 'cognitive impairments,' and research by Golonka has demonstrated neurophysiological correlates of cognitive impairment in burnout subjects. Jonsdottir *et al* demonstrated that burnout significantly affected executive function including aspects of speed, control and working memory, when tested with a multidimensional test.

The liability of institutions for the negligence of their independent practitioners through the doctrine of vicarious liability is well-established. The doctrine of *respondeat superior* imputes liability on a hospital for the

negligent acts of its agents, servants, and employees acting within the scope of their employment.

The World Health Organization and the U.S. Centers for Disease Control define work-related stress similarly as the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker. The U.S. Department of Labor notes that "when employees are injured or disabled or become ill on the job, they may be entitled to medical and/or disability-related leave under two federal laws: the Americans with Disabilities Act (ADA) and the Family and Medical Leave Act (FMLA)." Thus, if burnout becomes classified as a work-related disability, it may involve labor law related implications for a substantial portion of the U.S. health care labor force.

The legal and regulatory impact of the health care practitioner burnout 'epidemic' remains in its infancy and has significant potential liability implications which remains largely undefined.

SUGGESTED READING/REFERENCES

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