"Seeing the Patient Is the Joy:"
A Focus Group Analysis of Burnout in Outpatient Providers

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BACKGROUND AND OBJECTIVES: The increased demand on providers from health care systems combined with the complex and difficult practice of medicine contributes to provider stress and burnout. In order to develop effective, sustainable interventions for provider burnout, it is important to understand the lived experiences of providers and their perceptions of its causative factors. We describe focus group findings that explore provider perceptions and offer suggestions for future actions.

METHODS: We convened six focus groups in five clinics involving 44 participants and used a common set of questions for each group. Real-time follow-up questions varied as needed to clarify or explore specific themes. We asked for descriptions of providers' daily work, their ability to complete that work, and the frustrations associated with accomplishing their tasks. In addition, providers were asked about transparency of decision making and their perceptions of control in the workplace.

RESULTS: Three major themes evolved from these focus groups: the perceived impact of the work environment, work tasks, and "e-stress."

CONCLUSIONS: Our findings suggest three competing tensions contribute to provider burnout, none of which were attributable to patient volume or complexity. These tensions were described as originating from clinician experience of management practices and new requirements in the work environment, tension between direct patient care and non-direct patient care work tasks, and "e-stress" caused by the digital presence in providers' work lives.

"Seeing the patient is the joy" is a sentiment expressed by many providers and is often the primary reason they chose a health care profession. Professional managers of health care systems increasingly require activities and tasks that are perceived to take time away from "seeing the patient." The resultant increased demand on providers from health care systems combined with the complex and difficult practice of medicine contributes to stress and burnout. A substantial body of literature describes causes of burnout, behaviors attributed to burnout, and interventions to alleviate burnout. Providers' personal experiences and perceptions of burnout are less well documented. In order to develop effective, sustainable interventions for provider burnout, it is important to understand their lived experiences. Against this background of burnout, health care systems are confronted with a need for rapid, comprehensive redesign to improve population health and patient experience while decreasing the total cost of care, referred to as the Triple Aim. These transformational challenges are often being met by healthcare administrators and managers, whose training and expertise may not include direct patient care experience, and clinicians, whose training and expertise may not include practice management experience. The resultant tension can hinder success in achieving these goals. In addition, the introduction of electronic documentation and communication tools has dramatically altered providers' work and work load. For many, these applications are difficult to learn and assimilate into already established work patterns. Maslach's work on burnout in the 1970s defined burnout as three separate but related experiences: emotional exhaustion describing the personal experience of burnout, depersonalization (or cynicism) describing the interpersonal experience of burnout, and diminished
perception of personal accomplishment—describing the work experience of burnout. An important principle of this model asserts that burnout is primarily a function of workplace stress. The Maslach Burnout Inventory (MBI) provides a measure of burnout prevalence, but understanding the causes of burnout is more complex. Linzer describes the contribution of workplace chaos to burnout. Suchman and a Rand/AMA Research Report speak to organizational influences on well-being. Others define contributing factors ranging from descriptions of the workplace to identification and quantification of various domains of work that are associated with burnout. The search for predisposing personality characteristics has likewise been elusive. Proposed solutions for burnout include suggestions for organizational and operational changes and the power of a supportive workplace. Others suggest intervening directly with burned-out providers and improving work-life balance. These differing intervention models, while potentially complementary, were constructed with a view toward doing something to or for providers. The voice of the provider is frequently absent; when it is reported, it often describes how they personally manage burnout and does not ask about their perceptions of causation. Our early efforts to better understand provider burnout and contributing factors started with measurement using the MBI and the Areas of Worklife Survey (AWS). The survey did not explore providers’ personal experiences or their perceptions of the causal factors related to burnout. In this paper, we report on the results of a series of follow-up focus groups in which we asked providers to tell us their stories about burnout and reflect on their perceptions about its causes.

Methods

Study Design

In 2011 and 2012, our health care system surveyed eight outpatient clinics in the midst of a major work process redesign. In Phase 1, clinics were assigned to be either an intervention clinic (implemented the work process change) or a comparison clinic (received no process change). We asked providers (n=196) in both sets of Phase 1 clinics to complete the MBI and the AWS. These surveys quantify burnout prevalence and contributing work domain associations; however, the broad nature of the workplace domains offered insufficient insight into providers’ personal experiences of work life to be actionable. To further clarify providers’ experiences, we conducted six focus groups (90 minutes each) in five Phase 1 clinics (three intervention and two comparison clinics) between December 2011 and March 2012. The sites were suburban and rural primary care clinics of a large Midwestern non-academic health care system, all had a specialty provider presence, and system leadership approved participation by all providers and clinics. We convened the focus groups in clinic conference rooms at midday during the work week to maximize participation and convenience for the participants. Questions explored providers’ descriptions of daily work, ability to complete that work, and frustrations associated with accomplishing their tasks. In addition, we asked providers about decision making transparency and their perceptions of workplace control. We used a common set of questions for each group, but real-time follow-up questions varied as needed to clarify or explore specific themes. Discussions were recorded and transcribed for analysis.

Recruitment

All providers (n=131) in the five clinics received a personal email soliciting participation in the focus groups. Follow-up emails reminding participants of the focus group time occurred 1 week in advance of the meeting. We accommodated all interested physicians; however, confidentiality promised to participants in the study design limits comparative demographics. Forty-four providers (33.6% response rate) participated in focus groups ranging in size from three to 15 members. Thirty-six of the 44 providers (18 male, 26 female) were primary care physicians or advanced care practitioners (81.8%); eight were specialist providers (audiology, chiropractic, surgery, and mental health). This approximates the clinics’ 65.7% primary care provider mix. Four participants had part-time (≤20% FTE) administrative responsibility (Table 1). A free lunch was the only incentive offered.

Analysis

Focus group recordings were de-identified, transcribed, and organized using NVivo 10. Our analytic approach was based on identifying themes emerging from the statements of the focus group participants. The first author and a second reader, who was not present at the focus group sessions, coded a single focus group transcription. Emergent codes and sub-codes were identified and organized. After agreeing on a coding scheme, the same transcription was re-read and re-coded to confirm inter-rater agreement. Further coding of the remaining focus groups was then divided between the readers. The readers met repeatedly during this process to clarify codes and emerging themes, review each coder’s work, and confirm inter-rater agreement. We resolved discrepancies in coding by consensus selection of the best appropriate code or sub-code category and used field notes to specify participant gender, practice specialty, and to add contextual clarity. Approval was received from Allina Health Institutional Review Board, #3482-1E, June 2, 2011.

Results

Focus group results are organized into three emergent themes: perceived impact of the work environment reflecting the organizational environment in which providers work, work tasks reflecting providers’ daily activities, and “e-stress” reflecting the digital presence in providers’ work lives. We found no
difference in responses between process change and comparison clinics (Table 2).

Perceived Impact of the Work Environment

Participants frequently described their work environment as a major contributor to burnout. They specifically described erosion in professionalism, an increase in expectations from patients and leaders, barriers to teamwork, and decreased appreciation for their work. The evolving tension between direct and indirect patient care responsibilities challenged providers’ professional roles and values. They expressed a sense of diminished commitment to direct patient care activities by leadership and an increased commitment to indirect patient care activities, such as electronic documentation, managing quality of care and patient experience reports, and increasing provider productivity. They perceived these requirements to perform per organizational dashboard metrics as distracting them from their patient care role.

“Part of it is that our professionalism ought to help us do things above and beyond what we get directly paid for. Yet when we start feeling pressured by this rule and that rule, this task and that task, it starts to feel overwhelming and then the professionalism loses some of its impetus.” (Focus Group 4)

Participants described management-driven practices interfering with work flow and team performance. Stability of the provider and clinical assistant dyadic relationship contributed to daily work efficiency, and disruption of this relationship led to increased work as providers completed tasks usually performed by their clinical assistant. “We’re done at 5:00 or 5:30 seeing patients. Unfortunately, our nurses can’t work overtime, so they’re clocking out at 5:00 or 5:15, so the time when I need them the most they’re not available, so I can’t get that help after I’m done seeing patients, when they could be used.” (Focus Group 1)

Participants also reported frustration with performance expectations from leaders and patients. They described continually escalating organizational demands for increased productivity and patient access.

“The expectation for our productivity keeps going up. It’s like the United Way fund target. It doesn’t matter how much money you make, next year it’s always, ‘Come on, try a little harder.’” (Focus Group 1)

Relationships with patients were further strained by expectations for services or treatments considered to be inconsistent with best practice by the providers.

“It’s those expectations that really wear on me because I’m not satisfying them. They come back and complain, and it really burns me out. I’m doing the right thing. If I did the wrong thing they would be happy and life would go on and be beautiful, but I am actually choosing the right care, and they are not appreciating it.” (Focus Group 4)

Finally, they expressed receiving minimal or no recognition from managers for their work other than an occasional complimentary patient letter. More often they felt criticized and unappreciated.

“We try to thank our nurses every night, but who does that for the physicians?” (Focus Group 4)

Perceived Impact of Work Tasks

The contribution of work tasks to burnout was notable when participants spoke about decreased control of their work day, an increasing volume of non-direct patient care responsibilities, and the escalating presence of computers.

Providers described how medical training taught them that their primary work was direct patient care and while interacting with patients in the exam room, they reported work to be satisfying. Their inability to control the kind and volume of indirect care tasks they were required to perform outside of the exam room was dissatisfying. “We’re getting

Table 1: Descriptive Characteristics of the Sample Base

<table>
<thead>
<tr>
<th>Characteristic*</th>
<th>Invitation Recipient (n=131)</th>
<th>Focus Group Participant (n=44)</th>
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<tr>
<td>Age, years (mean, SD)</td>
<td>47.9 (9.6)</td>
<td>36 (81.8)</td>
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<tr>
<td>Primary care provider, n (%)</td>
<td>86 (65.7)</td>
<td>26 (59.1)</td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>26 (59.1)</td>
<td>26 (59.1)</td>
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<tr>
<td>Tenure, years (mean, SD)</td>
<td>13.0 (8.6)</td>
<td>13.0 (8.6)</td>
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</tbody>
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* Gender and specialty were the only characteristics collected from focus group participants.

Table 2: Focus Group Themes and Subthemes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-Themes</th>
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<tbody>
<tr>
<td>Work environment</td>
<td>Professionalism</td>
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<td></td>
<td>Teamwork</td>
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<td>Expectations</td>
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<td>Appreciation</td>
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<td>Work tasks</td>
<td>Volume</td>
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<td></td>
<td>Control</td>
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<td>Computers</td>
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<td>“e-stress”</td>
<td>Time</td>
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<td></td>
<td>Skills</td>
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<td></td>
<td>Volume</td>
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<td></td>
<td>Patient relationship</td>
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The Perceived Role of “E-Stress”

Many providers spoke of the frustration that arose from the ubiquitous digital presence in their work life, “e-stress.” Confronted with electronic health records (EHR), email, electronic patient messaging, online visit projects, smartphones, pagers, and the associated frequent weekly updates from information technology services, providers considered escape from work to be impossible. Compounding this was the difficulty participants reported in learning new computer skills. Some described work becoming organized around technology rather than patients.

“We’re getting emails numerous times a month about this update and that update. I don’t even read them anymore.” (Focus Group 4)

“I really struggle with how you get excellent results during the day when you’re face-to-face with people and you’re looking at that computer and typing and then look back, and you’re doing this (computer work).” (Focus Group 6)

In an interesting paradox, as health care has become increasingly dependent on technology for patient care, participants reported frustration with the application and volume of non-direct patient care technology. The increasing complexity and sophistication of the digital environment, the amount of time necessary to complete patient electronic health records, and the need to stay current with software system changes made it possible for them to always be “at work.” “When I’m at home and I’m not on the computer, I’m thinking about when I’m going to get on the computer.” (Focus Group 6)

Discussion

In this focus group analysis of 44 providers, our findings suggest three competing tensions contribute to burnout, none of which were attributable to patient volume or complexity. These tensions were described as originating from the clinicians’ experience of management practices and new requirements in the work environment, the tension between direct patient care and non-direct patient care tasks, and the “e-stress” caused by the digital presence in providers’ work lives. Several authors have reported on the impact of workplace stressors on provider burnout. Linzer described the effect of chaos in the workplace, and others have spoken about loss of control and work/life balance as contributing forces. A 2014 Rand Corporation/AMA Research Report concluded that understanding and developing skills for internal organizational improvement that address EHR functionality and interface, practice organization and structure, and health care system and payment reform can increase provider satisfaction. Bodenheimer and Sinsky have shown how a variety of practices adapt to the changing environment by introducing work flow changes. Our work adds to this literature by describing the perspectives of providers who are experiencing and living with these stressors. Clinicians know that without understanding symptoms and diagnosis, creating a treatment plan is impossible. Quantifying burnout provides a framework for understanding the magnitude of the problem, the symptoms; documenting the voices of those challenged by burnout adds insight into the complexity of the problem, the diagnosis; identifying potential leverage points for targeted interventions allows for creation of a treatment plan. Many current intervention models focus on individual tactics such as resiliency training, mindfulness, and narrative practice models, meditation, and exercise. Given what we have learned about the multiple inputs into provider burnout, it is unlikely that these tactics alone will alleviate persistent burnout. Individuals who regain a personal sense of balance and well-being are at significant risk of recidivism if they are re-introduced to the same challenging work environments and troubling tasks. Combining individual restorative practices with work environment changes intentionally designed to account for well-being offers greater opportunity for success in decreasing burnout and increasing satisfaction and will likely advance organizational vitality.

Including leadership, teamwork, and change management theory in medical education curricula and providing exposure to direct patient care in management education curricula may provide a better understanding of the struggles each professional faces as they design new models of care delivery. Finally, the extra work hours necessary to complete “e-tasks” is exacerbated by the steady stream of new applications, updates to old applications, and requirements to use new digital tools. While this may seem by some to be a generational problem, technology is constantly evolving, and new technological challenges will confront each generation of practitioners. Continuing efforts to refine the interfaces and functionality of the electronic environment offer long-term promise; furnishing workplace assistance for data entry and documentation demands can decrease providers’ dissatisfaction in the short term.

Our results are limited by the potential for investigator bias. The principal investigator (and focus group facilitator) is a physician practicing in the organization. We
Faced with workplace disruptors that, for many, result in an increase in expressed burnout and a diminishment in the joy of work. Changed work environments that attend to provider well-being, responsiveness to the stress caused by the increasing volume and content of non-direct patient care activities, and improved digital interfaces for providers may alter this trajectory.

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