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Sources of Clinician Burnout in Providing Care for Underserved Patients in a Safety-Net Healthcare System



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BACKGROUND: Burnout among clinicians is common and can undermine quality of care, patient outcomes, and workforce preservation, but sources of burnout or protective factors unique to clinicians working in safety-net settings are less well understood. Understanding these clinician experiences may inform interventions to reduce burnout.

OBJECTIVE: To describe clinician perspectives on sources of burnout in a safety-net healthcare system.

DESIGN: Semi-structured interviews were conducted with clinicians from multiple disciplines who provided care at a safety-net healthcare system from October 2018 to January 2019. Transcripts were analyzed using thematic analysis.

PARTICIPANTS: Forty clinicians (25 female and 15 male; mean [SD] age, 41 [9.1]) participated, including physicians, social workers, advanced practice providers, nurses, psychologists, physical and occupational therapists, and other healthcare professionals.

MAIN OUTCOMES AND MEASURES: Themes and sub-themes that reflected clinician experiences, burnout, and workload expectations.

KEY RESULTS: Five themes emerged: limited resources (entrenched social injustices, brokenness of the US healthcare system, precarious discharge options, and “revolving door” readmissions), barriers to building trust with patients (chasm of communication, addressing fear and mistrust, and being exposed to threats), administrative requirements (criticism hampering meaningful care, assuming extra workloads, bureaucratic burden), compassion fatigue (confronting traumatic situations, persistent worry about patient safety and welfare, witnessing mistreatment and stigmatization, overextending and overinvesting, withdrawing and shutting down, blaming self and career crisis), and advocacy as a counterbalance to burnout (solidarity when helping underserved communities, fervent advocacy, and patient gratitude).

CONCLUSIONS: Among clinicians who provide care in a safety-net healthcare system, sources of burnout included limited resources, barriers to building trust with patients, administrative requirements, and compassion fatigue, but clinicians remained driven by their desire to advocate for patients. Policy-level interventions which increase funding to safety-net healthcare systems to bolster existing resources and staffing, create peer-support and wellness programs, and support advocacy efforts may mitigate burnout.

KEY WORDS: burnout; wellness; health policy; underserved; safety net; qualitative research.

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INTRODUCTION

Professional burnout is a syndrome comprising loss of enthusiasm for work (emotional exhaustion), feelings of cynicism (depersonalization), and a low sense of personal accomplishment.¹ Burnout is common among healthcare professionals and has increased over time.^{2,3} Burnout is associated with job dissatisfaction, depression, fatigue, suicidal ideation, substance use, reduced productivity, and lower workforce retention.^{4–15} Clinician burnout can decrease quality of care, increase medical errors, and reduce patient satisfaction and adherence to medical advice.^{5,16–29}

Safety-net healthcare systems (SNHS) are hospitals and clinics which provide care to poor and underserved communities and often face unique challenges in providing high-quality care with limited resources.³⁰ (Note: “Underserved” is defined as patients who experience health disparities.)³¹ There is limited research on sources of burnout in SNHS.³² SNHS provide care to patients who experience a disproportionate burden of complex medical, mental health, and social needs.^{33–36} As a result, clinicians who work in these systems may experience unique factors that might drive burnout or

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serve to counteract it. We hypothesized that one such factor may be a more prominent role of the social determinants of health (SDoH) on health outcomes in this population. The SDoH are the conditions in which people live that contribute to health outcomes, such as safe housing, education, and income.³⁷ We conducted a qualitative study to answer the question, “What are the sources of burnout and protective factors experienced by clinicians providing care to underserved patients?”

METHODS

Study Design, Participants, and Settings

This study was conducted at a SNHS in Denver, Colorado, which includes one main hospital and multiple clinics. Each clinician participated in a semi-structured interview. Interviews were conducted from October 2018 to January 2019 by author E.B. The consolidated criteria for reporting qualitative health research (COREQ) was used to report this study.³⁸ Clinicians³⁹ from multiple clinical disciplines with at least 1 year of experience working with underserved populations participated. Purposive sampling was used to achieve diversity of demographic characteristics (age, sex, years of experience) and clinical disciplines, and to include both inpatient and outpatient clinicians. The University of Colorado Denver multi-institutional review boards approved this study.

The interview guide was based on a literature review,^{29,40–43} and due to the qualitative nature of the study, burnout was self-defined (see Supplementary Table 1). Self-definition of burnout has previously been validated against the emotional exhaustion component of burnout; therefore, our study likely reflects burnout as measured by emotional exhaustion. Interviews were conducted face to face, audio-recorded, transcribed, and analyzed. Additional interviews were conducted until thematic saturation was achieved.⁴⁴ Transcripts were imported into HyperRESEARCH (version 4.0.1 ResearchWare Inc. Randolph, MA). Author A.T. read transcripts and inductively identified preliminary concepts, grouping similar concepts into initial themes and subthemes. These were reviewed with L.C. and E.B. who also read the transcripts. A.T. coded the transcripts line by line and identified conceptual links within the data. Investigator triangulation helped ensure the findings reflected the full range and depth of the data. Member checking was also performed to ensure the accuracy of the data.

RESULTS

Participants and Characteristics

The 40 participants included attending physicians ($n = 13$), social workers ($n = 5$), registered nurses ($n = 4$), nurse practitioners ($n = 4$), psychologists ($n = 4$), physical therapists ($n = 3$), physician assistants ($n = 3$), an occupational therapist ($n = 1$), a dietician ($n = 1$), a dentist ($n = 1$), and an emergency medical

technician ($n = 1$) (Table 1). Of the participants, 68% were female ($n = 25$) and 32% male ($n = 15$). The mean (SD) age was 41 (9.1) years. These individuals had provided a mean of 12 (6.76) years of care to underserved patients. The mean (SD) duration of the interviews was 40 (15.9) min. We identified 5 themes, each with subthemes and supporting quotations, outlined below and in Table 2.

Limited Resources

Powerlessness in the Face of Entrenched Social Injustice.

Participants felt “powerless” in “combatting the entire societal reason” that patients were underserved. The SDoH were “stacked against people.” One participant described, “The most distressing aspect is that healthcare is a poor tool to ameliorate many of the problems that I see. A lot of the problems are outside of the scope of prescription medicine or procedures. It’s education, poverty, culture, language, homelessness, health literacy.”

Brokenness of the United States (US) Healthcare System.

Resource limitations were a constant frustration because “you can’t give patients the standard of care.” The US healthcare system was “strapped and in a lot of ways pretty broken,” which perpetuated inequities in access to care. One participant noted, “We will take care of anyone, which is one of the things I love about this hospital, but for an undocumented population, if they need any kind of specialized care or rehab or anything, we can’t get it for them.”

Precarious Discharge Options.

Homelessness was “the number one” challenge to timely and safe discharge and a source of “moral distress” because “it’s always really hard to discharge to the street.” Participants also recognized that arranging for follow-up appointments and equipment such as wheelchairs and oxygen was “impossible” for patients without insurance.

Table 1 Characteristics of the Participants

| Characteristic | Participants ($n = 40$) |
|---|---------------------------|
| Mean age (SD), y | 41 (9.1) |
| Female, n (%) | 25 (68) |
| Mean years working with underserved (SD), y | 12 (6.8) |
| Mean time of interview, min | 40 (15.9) |
| Discipline, n (%) | |
| Physician | 13 (33) |
| Clinical social worker | 5 (13) |
| Nurse practitioner | 4 (10) |
| Clinical psychologist | 4 (10) |
| Registered nurse | 4 (10) |
| Physical therapist | 3 (8) |
| Physician assistant | 3 (8) |
| Occupational therapist | 1 (2) |
| Dietitian | 1 (2) |
| Dentist | 1 (2) |
| Emergency medical technician | 1 (2) |

Table 2 Themes and Subthemes

| Theme and subthemes | Illustrative quotes |
|--|---|
| Limited resources <i>Powerlessness in the face of entrenched social injustice</i> | <p>"It's the discrepancies in the type of care someone can have access to ... just the fact of having private insurance versus Medicaid versus a discount program... it really dictates the type of discharge planning we can do."</p> <p>"There's an element of feeling powerless in helping a population that's under-resourced. We work with a lot of undocumented people and people that are in jeopardy of losing a lot of benefits."</p> <p>"Because at the end of the day what matters to them is basic needs and you're not meeting their basic needs. So, it doesn't really matter what you've done medically, because they don't walk out of here with a home."</p> |
| <i>Brokenness of the US healthcare system</i> | <p>"... when you know you would offer them a different treatment if they had insurance. Especially surgical specialties where we do essentially ration care."</p> <p>"Even Medicaid puts a lot of limitations on us."</p> <p>"Folks who come in who can't care for themselves and yet don't have that financial piece from the insurance to cover that; and so, then we're kind of in between a rock and a hard place."</p> |
| <i>Precarious discharge options</i> | <p>"... there's more distress when you send someone back to a place that you know might be outside, or in a shelter..."</p> <p>"They don't have a place to go, we're just going send them to the street? When they're here for a pneumonia and they're just going to sit on the sidewalk and be cold, and have trouble breathing and not be able to get any medication?"</p> |
| <i>"Revolving door" readmissions</i> | <p>"... the homeless population is huge. They don't have resources to follow up with their care, and I see them readmit multiple times."</p> <p>"... people feeling burnt out about patients that they see over and over again."</p> <p>"There would always be different doctors saying the same thing and I had to explain why we couldn't do anything for this poor guy."</p> |
| Barriers to building trust with patients <i>Chasm of communication</i> | <p>"...the worst is [when] you're saying something - trying to have empathy through a translator and you pour yourself into it and the translator is like, "I'm sorry, can you repeat that? I didn't hear it."</p> <p>"...because our patients get evicted and lose addresses and their phone numbers change three times in a month and it can be really challenging to try and follow up with critical results."</p> |
| <i>Addressing fear and mistrust</i> | <p>"...many women fear being reported to social services and worry about losing custody of their kids. Fear of social services is a huge barrier to getting medical care."</p> <p>"I use a lot of medicines that have higher risks, and even though I do the best I can to explain those risks to patients, I think they're still kind of fearful of using medicines, fearful of the whole system."</p> |
| <i>Being exposed to threats and assault</i> | <p>"... a patient was verbally attacking me ... that's a bad day when you're rejected and attacked and you're just trying to help."</p> <p>"Security had to be called and he was yelling in the waiting room that he was going to come back with a gun to shoot me."</p> |
| Administrative requirements <i>Criticism hampering meaningful care</i> | <p>"... it is exhausting. You have high productivity expectations on top of increasing EMR demands that leave out the ability to make eye contact with your patient."</p> <p>"[Being told] you have to discharge people; we have 17 boarders in the emergency room - I'm not even being a doctor anymore. I'm not even doing what it is that I want to do with medicine in those moments."</p> |
| <i>Assuming extra workloads</i> | <p>"We were short-staffed for psychologists and behavioral health. I had three weeks in a row I got to the third week, I got to the point that I was like, "I can't even think about going back."</p> <p>"I often double-book patient appointments because I don't have any other room to see people. And sometimes it works out okay but sometimes it just ends up being chaos."</p> |
| <i>Bureaucratic burden</i> | <p>"Medicaid decides how they're going to reimburse for visits that I do... so [I'm told], 'make sure that in your visit you definitely cover these 17 different things every time.'"</p> <p>"I feel more affected emotionally and energy-wise by things like having an overwhelming number of tasks in my inbox. It's the admin and clerical stuff that is like a never-ending wave."</p> |
| Compassion fatigue <i>Confronting traumatic situations</i> | <p>"There for probably a good four months...I often nightly was getting called on child abuse cases and multiple child deaths. I [felt] like I can't see a kid die again; I just emotionally can't do this."</p> <p>"there's just such a higher rate of the stories that people tell you which are absolutely horrific, of humans doing horrible things to each other."</p> |
| <i>Persistent worry about patient safety and welfare</i> | <p>"...it was definitely not a good feeling, because I didn't feel hopeful that he was going to get what he needed..."</p> <p>"You go home thinking about them, worrying about them. It's troubling, it's disturbing, it takes a lot out of you."</p> |
| <i>Witnessing mistreatment and stigmatization</i> | <p>"So, a lot of times what bothers me is people... being treated differently because of a substance use history. Sometimes people just don't get taken seriously and it can lead to poor health outcomes."</p> <p>"I try to not blame her or shame or for what she's doing. She is overly blamed and shamed for her alcohol use."</p> |
| <i>Overextending and overinvesting</i> | <p>"I feel like there's not a lot of callousness, it's more, 'I'm just going to keep giving of myself until I fall apart.'"</p> <p>"I feel like I'm functioning pretty close to my maximum capacity to take care of patients in a way that's safe and responsible, but it doesn't feel like it's enough access."</p> |
| <i>Withdrawing and shutting down</i> | <p>"People are bending over backwards all the time and I think eventually that just gets to be too much."</p> <p>"I'd cry a lot. I would come and I would sit in my car and be like, "I don't know if I really want to go in."</p> <p>"I think sometimes that I'm like, how long can I do this?"</p> <p>"I left for 7 months.... when I came back, I came back at part time intentionally, because I was burnt out and I was like, 'I can't sustain it.'"</p> |

(continued on next page)

Table 2. (continued)

| Theme and subthemes | Illustrative quotes |
|---|--|
| <i>Blaming self and career crisis</i> | “There’s always still I think a little piece of me that’s just like, did I not try hard enough? Or if I had had more time with this patient, I could have looked at A, B and C, even though they probably wouldn’t have made a difference.” “I go home feeling like something turned out sub-optimally and I could have caused it to turn out better.” |
| Advocacy as a counterbalance to burnout <i>Solidarity when helping underserved communities</i> | “I love taking care of patients who otherwise may not get what they need. That makes me feel like I’m spending my time the best way that I can.” “The fact that everybody is kind of focused on the mission makes you go to work in the morning and feel like you’re all there for the same reason.” |
| <i>Fervent advocacy</i> | “You have to have individuals that really want to take this job on and fight all the time – you see situations and issues and you personally have a desire to make it better.” “I’m interacting with people when they’re their most vulnerable. They’ve gone through a tragedy; sometimes there’s been a death or their life’s changed forever. And I’m really there to advocate for them.” |
| <i>Patient gratitude</i> | “It’s very rewarding to provide care for people who don’t have access to resources and there are times you always feel very appreciated. You always get a sense that you’re doing something useful.” “People are so grateful for the services that we provide. And we have a great team here. I feel like I get a lot out of providing these services. I want to give back.” |

“Revolving Door” Readmissions. Participants recognized, “you’re seeing the same patients over and over again that through proper healthcare options after discharge, proper housing, and proper medication availability may be avoided.” Participants felt discouraged by discharging patients who were medically stable but whose SDoH seemed to portend inevitable readmissions: “It feels like their discharge will just lead to failure and returning to the hospital.”

Barriers to Building Trust with Patients

Chasm of Communication. Communication was complicated by language barriers, health literacy, and difficulty reaching patients for follow-up. One participant explained, “Some of these conditions are really complicated... these aren’t quick visits - there’s a lot of limited health literacy and if we’re really trying to make sure that people understand what we’re talking about, it takes a long time.”

Addressing Fear and Mistrust. Some clinicians were sensitive to patients’ fears of being reported to the US Immigrations and Customs Enforcement or social services and losing custody of their children. Social workers had to reassure patients about their role—“social workers have a negative stigma ... people shut down; people become defensive when I’m actually there to help.” More generally, some recognized that “working alongside somebody from a different culture” would require time to establish trust.

Being Exposed to Threats and Assault. Participants reported being verbally abused and physically assaulted by patients. They attributed this to patients feeling “disenfranchised” and being frustrated by the “system, or with healthcare, or with their life.” Some worried about becoming victims of gun violence, which they felt is “getting worse” and “creating more stress in our job.”

Administrative Requirements

Criticism Hampering Meaningful Care. Participants felt pressure to discharge patients rapidly and described that the need to justify their discharge decisions detracted from their clinical role. Participants felt loss of “control because of performance expectations ... [that] start to erode into their personal mission.”

Assuming Extra Workloads. Due to workforce shortage, some clinicians absorbed additional work—“I was doing the work of four people on my own and did not have enough time or energy to adequately meet all of the patient’s needs.” Some felt that a lack of awareness about the different roles of clinicians in the hospital meant that they took on additional duties beyond their own job responsibilities and were left “feeling like a failure even though it’s not supposed to be a part of my role.”

Bureaucratic Burden. The regulatory environment was seen as “onerous.” Participants explained, “There’s just so many I’s to dot and T’s to cross because of the regulations and compliance issues that the SNHS are so tied to in terms of their funding.” Providers described having to do extra paperwork, stating “so, about 30% of the admin work I do could be done by clerks or nurses, but it’s not; the providers do it.”

Compassion Fatigue

Confronting Traumatic Situations. Participants were distressed when faced with traumatic events including child abuse, domestic violence, murder, and suicide. One participant reflected, “There’s a lot of sadness that I see ... sadness about what humans do to each other. I think there’s more of that in

underserved populations ... so even though I feel very heartened by that work, at the same time, I'm exposed to a lot of really awful things."

Persistent Worry About Patient Safety and Welfare.

Participants continued to worry about patients' wellbeing even after death or discharge—"you go home feeling super-anxious...whether it's families that couldn't arrive in time to be with their loved ones before they died or whether it's hoping a patient is going to get the follow-up he or she needs." Participants also worried about the consequences of their decisions, such as calling Child Protective Services.

Witnessing Mistreatment and Stigmatization. It was disheartening to observe the "subconscious bias" of others towards patients with mental health or substance use issues. Some voiced frustration that "there still persists a lot of stigma around substance use, and so that can kind of get me down ... hearing about the barriers my patients are facing because of their history of substance use."

Overextending and Overinvesting. Some recognized the tendency for clinicians to "go the extra mile" by double-booking appointments, helping patients complete forms, and making phone calls to access support for patients. They realized it was easy to end up "working harder" and that "some clinicians aren't able to set internal boundaries" and thus lack the "ability to create the healthy distance that's needed." Some observed colleagues "making ongoing sacrifices of their own personal wellbeing."

Withdrawing and Shutting Down. Navigating the complexities in the patient population "eventually wears on you and makes things just difficult to see." Participants reported an emotional toll whereby some withdrew from work, cried, and wanted to give up. Some felt "broken" and reported panic attacks.

Blaming Self and Career Crisis. Participants harbored a "sense of culpability" and questioned if their "work was up to par." The stress of "feeling like so much is at stake" led to burnout, and some considered pursuing a different career. Some articulated it as "an identity crisis, where you become so enmeshed with this idea of helping that a potential misstep is devastating to who you are as a person."

Advocacy as a Counterbalance to Burnout

Solidarity When Helping Underserved Communities.

Participants were driven by a passion to help the "most voiceless and vulnerable people in our society" because "people here truly need our help." They were "doing

something worthwhile." This opportunity also united them as colleagues in resilience and strength—"we're all in this together and doing the best we can and having some kind of greater purpose to providing healthcare."

Fervent Advocacy. Participants had to "fight all the time" to advocate for their patients. Participants described engaging community and health policy stakeholders to change health policies. They also appealed to foreign consulates to grant access for family members in other countries to visit their patients, identified sources of "food, housing, and other support outside of the general social services system," and sought to keep patients safe—"we go to bat and there are times where I've really pushed back ...I'm the one who says this is dangerous to let this person go."

Patient Gratitude. The appreciation expressed by patients motivated participants to help even more, and seemed to counteract some of the negative interactions and threats described by participants—"the rewards are very high... they are really thankful. You can see the smile on their faces, their body mannerisms that they're really happy that you care about them."

DISCUSSION

Clinicians working in a SNHS identified four major sources of professional burnout, including limited resources, barriers to building trust with patients, administrative requirements, and compassion fatigue. Despite these challenges, clinicians expressed a strong sense of solidarity with their colleagues and institution to advocate for health care equality for their patients.

These findings have several implications. First, our findings highlight the central role of SDoH in caring for underserved populations. Clinicians reported feeling powerless because the health of their patients was so often jeopardized by the ramifications of social and economic inequality. These results align with prior findings that physicians whose patients have more resource limitations experience greater burnout.^{45,46} Fortunately, providing support to address patients' social challenges reduces burnout.^{47,48} Potential solutions include policy-level interventions that increase funding for SNHS to address SDoH by hiring additional personnel (e.g., community-health workers, social workers) to assess social risks and provide resources. SNHS could also consider partnering with community-based organizations and other stakeholders to address upstream drivers of health disparities such as food and housing insecurity, under-resourced schools, and other SDoH.^{49,50}

Clinicians also described distress due to limitations in the care they could provide for patients without insurance coverage. However, they felt fortunate to work for an institution that

does provide care to uninsured and under-insured patients, considering the fact that many other healthcare systems in the US do not. SNHS also provide vital but unprofitable service lines, such as psychiatric and substance use services, when not-for-profit or for-profit institutions often close such service lines.^{51–53} Though this creates a difficult financial position for SNHS, they continue to provide these services because it is their mission. Clinicians in our study described a sense of solidarity and pride in working for an institution with these values. However, they also expressed the desire to be able to do more and felt frustrated when observing the toll that the SDoH, healthcare inequality, and the overall brokenness of the US healthcare system were taking on their patients. Potential solutions include policy-level interventions to improve access to healthcare and reduce health care inequalities. While awaiting more definitive policy-level solutions, studies have shown that systems-level interventions such as routine measurement of clinician burnout and wellness and peer-support programs to combat burnout are effective.^{54–56}

Clinicians in our study also described advocacy on behalf of their patients as a vital counterbalance to burnout. Clinicians in SNHS are uniquely positioned to witness how SDoH and access to care affect health outcomes⁵⁷ and therefore are well positioned to advocate for the wellbeing of underserved communities.⁵⁸ The literature reports many examples of clinicians who have encountered situations they felt were unjust and engaged in advocacy pertaining to gun violence,⁵⁹ racial inequality,⁶⁰ climate change,^{61,62} LGBT rights,^{63–65} and access to care for undocumented immigrants.^{66,67} Feelings of helplessness and disempowerment are hallmarks of burnout; therefore, advocacy efforts to reform healthcare policies may counter burnout by affording clinicians a sense of empowerment.^{40,68}

Our study included clinicians across multiple disciplines, which allowed us to obtain a broader, institutional perspective about health care teams. However, it also reduced our ability to learn more about discipline-specific burnout. Future research is needed to understand whether different types of clinicians have similar or different burnout assessments. Another strength of our study was the involvement of practicing physicians as investigators, which increased our capacity to understand and interpret clinician language, responses, and cultural factors.

Our study has limitations. We recruited clinicians from one SNHS; therefore, the generalizability of our findings may be limited. Clinicians who have experienced more burnout may have been either more or less inclined to participate. Finally, this study of clinician burnout, which is a clinical phenomenon, was led by practicing physicians. Therefore, reflexive bias of these clinicians could have been introduced during the data collection, thematic analysis, or interpretation of results, including the potential for unidimensional framing of problems and solutions.³⁸ To reduce any potential reflexive bias, only non-clinical investigators enrolled participants, conducted interviews, and performed transcriptions. Member checking was performed. Investigator triangulation (by two

non-clinical investigators and one physician investigator) was also performed to reduce the potential for reflexive bias during the thematic analysis.

CONCLUSION

Clinicians across multiple disciplines who provide care in a SNHS identified several sources of burnout, including limited resources, barriers to building trust with patients, administrative requirements, and compassion fatigue. Despite these challenges, they felt a strong desire to advocate for their patients, which was protective against burnout. Policy-level interventions which increase funding to SNHS to bolster existing resources and staffing, create peer-support and wellness programs, and support advocacy efforts may mitigate burnout.

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1007/s11606-022-07896-5>.

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