'I'll Never Be Your Beast of Burden': Physician Burnout and Moral Injury

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It was a typically busy Wednesday night. We had 22 people in the waiting room, with admitted patients boarding in the emergency department (ED) due to difficulties with bed availability and staffing. At 3:40 a.m. an 80-year-old woman arrived from a skilled nursing facility after staff found her unresponsive. Emergency Medical Services (EMS) discovered her to be pulseless and in asystole, and after 4 rounds of epinephrine in the field, she arrived in room 2 of my ED. As she was a "full code," I intubated her and initiated resuscitation measures. A bedside echo revealed cardiac standstill and after 2 more rounds of epinephrine, calcium chloride, and bicarbonate infusion, she was pronounced dead. After a moment of silence, I attempted to contact family members, called the medical examiner and the organ bank, and began entering data required by our electronic health record (EHR).

I next turned my attention toward the completion of the death certificate. On paper, the death certificate takes about 4 minutes to complete and is self-explanatory. However, more than a year ago, the Rhode Island Department of Health instituted and now mandates use of the Rhode Island Vital Events Registration System (RIVERS), an electronic web-based application from Genesis Systems, Inc., to register and record deaths. RIVERS required a 90-minute tutorial, which I dutifully undertook, reviewed, and forgot. Deaths in the ED are high-acuity, but fortunately, low-frequency events, and I had never completed an electronic death certificate previously. I bumbled my way through the program, and after 65 minutes I completed the information and certified the patient's death. My active patients waited, and during that hour I received 4 "new" patients, all of whom had been waiting 3–4 hours to be seen by a physician.

Clerical storm halts funeral plans

Meanwhile, a storm was brewing. I usually sleep after working an overnight shift and I awoke to a torrent of secure chat messages and texts from the medical records department and the director of the ED. The family and funeral home could not move the patient's body until I completed the certificate, which I naively thought I had done. Panicked, I contacted colleague after colleague asking questions about the program, but none could help – they said the program was so opaque and obtuse that most had never completed it successfully. Over the next 2½ days I spent many waking hours attempting to rectify the problem. Thankfully, the body was taken by the funeral home despite the missing "paperwork," but the messages and calls continued. Finally, on Saturday afternoon, a troubleshooter from the help desk at Genesis Systems called me on my cell phone. My help desk savior was able to efficiently walk me through the program over the next 15 minutes until we came to a road block. I had answered one question "wrong" about my office location. My office is on Claverick Street with Brown Emergency Medicine – but the program was looking for a different answer. It wanted the hospital name. Because of this error, my help desk friend was unable to complete the program, and so, after 3 days and rising tensions, it was referred to someone at the state level, who sent me an automatic reply that he was unavailable. What was formerly a 4-minute process had dragged out over 3 calendar days.

I worked the entire weekend after this event – it is the nature of emergency medicine – and so the following Monday I took time to catch up on notes and "paperwork." I completed about 50 charts, and I attempted to renew my Massachusetts Physician License for $600. All went well until I found that I needed to complete an hour of mandatory CME on Alzheimer's disease. My choices were to spend $149 to take the Massachusetts Medical Society course, $49 for another course, or I could register for Medscape and take its course. I did the latter. The courses were fairly meaningless to my practice – no one is suffering from acute Alzheimer's in the ED – but I like to learn, and so, after an hour, I was able to renew my license, which took about 5 minutes. What struck me was that after each mini course (two 15-minute courses, followed by a 30-minute course), I had to complete three separate 16-question modules regarding the value of the courses. The questionnaires on satisfaction were 8x longer than the course questions! Fortunately, I had another hour left in my morning so I could complete the learning modules on corporate compliance and HIPAA (for the nth time) mandated by my health care system prior to going for a run on my day off.

I am a relatively resilient physician. I have completed two residencies, survived (thus far) three pandemics (AIDS, H1N1, and SARS-CoV-2), taken care of about 100,000 ED patients during my career at the Massachusetts General Hospital (MGH) and Brown, and I have endured multiple

EHR iterations. I have made errors and have been insightful; I have been prickly, and I have been magnanimous – in short, I have been human. And as a human, and as a physician, I feel exasperated by a chaotic system that purports to revolve around patient safety, but impedes it by extracting every ounce of my creativity and energy. There is a reason the literature on physician burnout has exploded over the past several years, and even the United States Surgeon General Vivek Murthy, MD, has recognized that burnout is a public health care crisis.[1]

Defining burnout and moral injury

Burnout has been defined as "a syndrome of emotional exhaustion, loss of meaning in work, feelings of ineffectiveness, and a tendency to view people as objects rather than as human beings."[2] But the usual ingredients associated with burnout – time spent on non-clinical tasks, information technology demands, loss of autonomy, organizational/systems factors – do not entirely explain my exasperation.[3,4] I, along with many colleagues, work in a system that contributes to what is now defined as moral injury, a precursor to burnout. First used to describe veterans returning from the Vietnam War, moral injury has been extended to the health care field to help further explain and refine causes of burnout.[2] Burnout suggests individual deficit. Moral injury stems from deficiencies in the system.[5] As Dean notes, "Moral injury is the consequence of the ever-present double binds in health care: Do we take care of our patient, the hospital, the insurer, the EMR, the health care system, or our productivity metrics first?"[5] The answer should be straightforward (the patient!), but unfortunately, physicians and other health care workers are pulled in competing directions.

I am a late-career physician and the data suggests that I am less vulnerable to the factors associated with burnout.[6] I still love seeing patients, interacting with colleagues, and uncovering the daily puzzles presented to me. But I am not a beast of burden, to be saddled with every ancillary project that detracts from my life, and adds limited value or benefit to my practice. Like Howard Beale from Paddy Chayefsky's brilliant and caustic screenplay "Network" (for those under 50, you may wish to YouTube this), I want to scream, "I am mad as hell, and I am not going to take it anymore."

But I can't – I need to complete the Med-IQ modules for our Quality and Safety Department so I can participate in my department's risk mitigation program. ❖

References

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