American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

July 30, 2025

Mamatha S. Pancholi, M.S.
Acting Director
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

RE: Predictors, Consequences, and Interventions for Burnout Among Healthcare Workers: A Systematic Review

Dear Acting Director Pancholi:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, we appreciate the opportunity to provide comments on the draft systematic review, "Predictors, Consequences, and Interventions for Burnout Among Healthcare Workers: A Systematic Review."

We appreciate AHRQ's acknowledgement of the gravity of the prevalence and negative effects of healthcare worker (HCW) burnout. Rates of burnout have serious consequences for the capacity of the U.S. health system, particularly in regard to employee retention. From 2019 to 2024, the average U.S. hospital turned over 107.1% of its workforce.[1] According to the 2024 Medscape Physician Burnout and Depression Report, 49% of physicians reported experiencing burnout.[2] Furthermore, almost two-thirds of nurses reported experiencing burnout during the COVID-19 pandemic, driving a significant number of them to leave the profession entirely and exacerbating a historic workforce shortage.

For physicians and other clinicians that remain in medicine, burnout can lead to decreased job satisfaction as well as increased medical errors, impacting the quality of care that patients receive as a result. In addition to the rise in burnout, the same Medscape study reports that 20% of physicians are suffering from depression. With suicide rates among physicians, particularly female physicians, higher than the general population and higher than physicians in other countries and with female nursing suicide rates 8.5 times higher than the general female population, the mental health crisis among health workers is at a crisis level.

Burnout is particularly prevalent among emergency physicians, with 63 percent of emergency physicians reporting it – the highest rate by a wide margin among the physician specialties surveyed.[3] The causes of burnout among emergency physicians are multifaceted, including high work demands and administrative burdens, limited resources, understaffing, workplace violence, and boarding.

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[1]https://www.nsinursingsolutions.com/documents/library/nsi_national_health_care_retention_report.pdf
[2] https://www.medscape.com/slideshow/2024-lifestyle-burnout-6016865#2
[3] Ibid.

In 2022, ACEP was grateful for the passage of the bipartisan Dr. Lorna Breen Health Care Provider Protection Act, which has supported over 250,000 health care workers through initiatives aimed at reducing stigma and promoting mental health for clinicians. As burnout and mental health challenges remain a growing problem, we strongly support the "Dr. Lorna Breen Health Care Provider Protect Act Reauthorization" (H.R. 929/S.266) to help fund programs aimed at addressing drivers of burnout.

Boarding in the Emergency Department as a Factor Causing Burnout

The issue of patients "boarding" in the emergency department (ED), a scenario where patients are placed in a holding pattern for extended periods of time while waiting for an inpatient bed after admission to the hospital or transfer to another facility, is overwhelming emergency physicians, non-physician clinicians, nurses, and other staff who are doing all they can to treat or stabilize every patient that needs care.

Boarding in the ED has become its own public health emergency. Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed. And this breaking point is entirely outside the control of the highly skilled emergency physicians, nurses, and other ED staff doing their best to provide equitable, high quality and safe care.

Boarding is a systemic problem that hinders patients' access to care. Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Patients in need of intensive care may board for hours in ED beds not set up for the extra monitoring they need. Those in mental health crisis, often children or adolescents, can board for months in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. Patients may delay or avoid emergency care and risk their physical and mental health because of these systemic bottlenecks.

ED boarding and crowding are not caused by ED operational issues or inefficiency; rather, they stem from broader health system dysfunction. This dysfunction also leads to negative patient outcomes, as a substantial body of evidence has shown that ED boarding and crowding lead to increased cases of mortality related to downstream delays of treatment for both high and low acuity patients.[4, 5] It also leads to increased ambulance diversions, increased adverse events, preventable medical errors, lower patient satisfaction, higher overall health care costs, and clinical staff burnout. While the causes of ED boarding are multifactorial, growing staffing shortages throughout the health care system have recently brought this issue to a critical point, and the resulting added stress and burnout are leading to an exodus of physicians and nurses – further exacerbating the crisis and spiraling the system towards a very real risk of collapse.

We are grateful to the Administration for acknowledging the severity of boarding and taking steps to alleviate the boarding crisis, including AHRQ's report, "AHRQ Summit to Address Emergency Department Boarding," and the recent proposal in the Calendar Year (CY) 2026 Outpatient Prospective Payment System proposed rule to incorporate the "Emergency Care Access & Timeliness Measure" into the Hospital Outpatient Quality Reporting program and the Rural Emergency Hospital Outpatient Quality Reporting program. Addressing the root causes of boarding will in turn alleviate the stress on emergency clinicians, therefore potentially reducing burnout.

ACEP supports legislative efforts that complement AHRQ's work to reduce emergency department boarding. The bipartisan "Addressing Boarding and Crowding in the Emergency Department Act" (ABC-ED) (H.R. 2936/S. 1974) modernizes infrastructure and expands transparency by supporting the development and implementation of real-time, statewide and regional hospital bed tracking systems—leveraging existing CDC public health data modernization grants. It would also promote innovative care models by authorizing CMS innovation Center to pilot imporved care transitions for older adults and patients with acute psychiatric needs. This effort aligns with AHRQ's objectives and

[4] Hsuan C, Segel JE, Hsia RY, Wang Y, Rogowski J. Association of emergency department crowding with inpatient outcomes. Health Serv Res. 2023 Aug;58(4):828-843. doi: 10.1111/1475-6773.14076. Epub 2022 Oct 12. PMID: 36156243; PMCID: PMC10315392.
[5] do Nascimento Rocha HM, da Costa Farre AGM, de Santana Filho VJ. Adverse Events in Emergency Department Boarding: A Systematic Review. J Nurs Scholarsh. 2021 Jul;53(4):458-467. doi: 10.1111/jnu.12653. Epub 2021 Mar 31. PMID: 33792131.

would help relieve some of the burden that contributes to clinician burnout in emergency departments across the country.

Workplace Violence

Violence in the ED is a serious and growing concern, causing significant stress to ED staff and to patients who seek treatment in the ED. According to a survey conducted by ACEP in 2022, two-thirds of emergency physicians report being assaulted in the past year alone, while more than one-third of respondents say they have been assaulted more than once.[6]

This issue has profound effects on the health care workforce shortage. Beyond the immediate physical impacts and injuries, the risk of violence increases the difficulty of recruiting and retaining qualified health care professionals and contributes to greater levels of physician and emergency provider burnout. In fact, 87 percent of emergency physicians report a loss of productivity from the physician or staff as a result, and 85 percent of emergency physicians report emotional trauma and an increase in anxiety because of ED violence. Most importantly, patients with medical emergencies deserve high-quality care in a place free of physical dangers from other patients or individuals, and care from staff that is not distracted by individuals with behavioral or substance-induced violent behavior.

These stresses have significantly contributed to attrition among health professions, especially within the nursing workforce. The Emergency Nurses Association notes that workplace violence is "…increasingly seen as a contributing driver of poor nurse retention and recruitment, further exacerbating the nursing shortage and its costly consequences for healthcare organizations and their patients."[7]

And unlike the significantly more visible violence against airline employees and other travelers that has become more ubiquitous over the last several years, violence against health care workers often is not seen or addressed because of inadequate reporting and tracking of violent incidents, and other systemic barriers that do not hold violent individuals accountable for their actions.

As a result of the inability to prosecute those who are arrested, many health care workers are discouraged from even pressing charges and being forced to accept that it's "just part of the job." Violence is not accepted in any other workplace, and it must not be accepted especially in a setting focused on improving the health and well-being of individuals.

ACEP supports multi-pronged legislative efforts to address various aspects of health care workplace violence prevention. During the 118th Congress, ACEP supported two bipartisan bills to address workplace violence: the "Workplace Violence Prevention for Health Care and Social Service Workers Act" ((H.R. 2531/S.1232); as well as the "Save Health Care Workers Act," (H.R. 3178/S.1600). The Workplace Violence Prevention for Health Care and Social Service Workers Act would ensure that health care workplaces implement violence prevention plans and techniques and are prepared to respond to acts of violence, while the Save Health Care Workers Act would establish federal legal penalties for individuals who knowingly and intentionally assault or intimidate health care workers and provide grants to help hospitals and medical facilities establish and improve workplace safety, security, and violence prevention efforts. We are hopeful Congress will consider these and other efforts to reduce the threat and incidence of violence against emergency physicians and other health care workers.

Consolidation

Emergency physicians work in a variety of employment models. While some are employed by or contract with hospitals directly, many are employed by independent entities that contract with the hospital to provide 24/7 ED coverage. These independent entities range in size, from small, independent democratic (i.e., owned by the physicians)

[6] https://www.emergencyphysicians.org/siteassets/emphysicians/all-pdfs/acep-emergency-department-violence-report-2022-abridged.pdf
[7] Emergency Nurses Association Position Statement: Violence and Its Impact on the Emergency Nurse. https://stopedviolence.files.wordpress.com/2019/11/violence-and-its-impact-on-the-en-final-board-draft.pdf

groups that serve only one or two local hospitals to larger groups that staff EDs (and sometimes service lines of other specialties) nationwide. While some of these larger groups may still be physician owned and run, more are owned by private equity investment companies, large hospitals and health systems or insurance companies, who have acquired these practices.

Consolidated markets and unchecked mergers that substantially lessen competition in the labor market for emergency physicians, in which the employer is the buyer, and the physician is the seller, can impact physicians directly by lowering wages or slowing wage growth, worsening benefits or working conditions, or contributing to other degradations in workplace quality, which may contribute to the high rate of burnout among emergency physicians. In an anonymous questionnaire completed by ACEP members, many emergency physicians cited the current working conditions at large national groups as reasons for quitting medicine altogether, for they feel that they are trapped in a system that does not respect their autonomy or mental well-being and that there are no other options for their employment in the emergency medicine sector.

As the trend towards horizontal and vertical consolidation continues to accelerate, emergency physicians are experiencing labor-related impacts for themselves, their livelihood and their patients. They need and deserve to be protected from business practices that jeopardize their quality of life as a physician and their duty and responsibility as safety net clinicians to provide the highest quality of patient care.

Conclusions

ACEP appreciates the opportunity to comment on this draft systematic review. We agree with AHRQ's assertion that societal conditions, organizational factors, job and task-specific factors, and individual factors can all impact the prevalence of burnout in HCWs, and that burnout in turn has downstream effects on patient care, HCW family health and wellbeing, healthcare organization performance, and ultimately societal outcomes. Thus, the causes of HCW burnout must be addressed in order to relieve the negative downstream effects. When health care professionals have the care they need and deserve they are able to continue to provide high quality care to the individuals, families, and communities they serve.

Thank you for the opportunity to comment on this draft. If you have any questions, please contact Erin Grossmann, ACEP's Manager of Regulatory and External Affairs, at egrossmann@acep.org.

Sincerely,

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