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CONCEPTS

Physician Wellness

Beyond the Maslach burnout inventory: addressing emergency medicine burnout with Maslach's full theory

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Abstract

Burnout, a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job, remains a substantial problem for emergency physicians, leading to decreased quality of care and attrition from the workforce. The majority of prior work on burnout in emergency medicine has focused on individualized solutions, which have demonstrated modest efficacy for ameliorating burnout. However, recent studies suggest that burnout in medicine is primarily caused by workplace factors (eg, unmanageable workloads, unreasonable time pressures) and therefore requires solutions at an organizational level. In her decades of research across industries, Christina Maslach identified 6 domains of organizations that can either promote engagement or lead to burnout. In this article, we apply Maslach's 6 domains to emergency medicine to provide a systematic framework for alleviating burnout and promoting engagement among emergency physicians. By considering the domains of workload, reward, control, fairness, community, and value congruence, emergency medicine leaders can develop and deploy more effective interventions aimed at improving the experience and longevity of physicians across our specialty.

KEYWORDS

burnout, Maslach burnout inventory, moral injury, physician experience

1 | INTRODUCTION

Burnout is "a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job."[1] The emergency medicine community has used Christina Maslach's burnout inventory[2] extensively to identify the prevalence of burnout in emergency physicians, but has been limited in applying Maslach's full model[3] in identifying potential solutions. The high prevalence of burnout in emergency medicine relative to most other specialties[4] requires novel approaches for bolstering clinician well-being. Using decades of research data gathered across a range of industries, Maslach described burnout as a condition resulting from organizational stress in multiple identifiable domains amenable to organizational solutions. However, most burnout work in emergency medicine has focused on solutions that require individual physician action (eg, mindfulness or yoga), suggesting that providers can and should address burnout on their own.[5,6] Although prior research suggests that individualized interventions such as mindfulness and mental health programs can be modestly

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helpful across various fields,[7,8] it is essential to closely examine organizations and systems for meaningful solutions.

There is ample evidence of the detriments of burnout, ranging from lost revenue to poor quality of care.[9–13] Fortunately, Maslach noted that burnout has an opposite state: engagement. As such, interventions to reduce burnout would ideally facilitate the transition from alleviating exhaustion and de-personalization towards improving self-efficacy and engagement. We suggest that it is time to shift our focus to how promoting satisfied and energized clinicians can improve the care provided in our emergency departments. Although the personal accomplishment component of burnout is often left out of medical burnout surveys,[5] feelings of low personal effectiveness among physicians are common and may be worsening.[14] Interventions to improve the physician experience may also improve patient outcomes and department operation—both patients and physicians are happier when department flow is smooth and care is effective.[15] Augmenting the provider experience may be a significant opportunity for emergency departments (EDs) to improve their overall performance while also reducing provider burnout.

Emergency physicians have previously identified specific emergency medicine workflow and clinical issues that contribute to burnout.[6] Experts in other specialties have created useful frameworks for considering burnout at the level of the health care organization.[16] We believe there is a clear and present need for a systematic approach to improving the provider experience and career longevity of emergency physicians for emergency medicine leaders. Applying Maslach's full burnout framework to emergency medicine reveals the steps we can take to promote engagement over burnout in EDs across the country.

2 | THE FRAMEWORK

Maslach described 6 domains of organizational life that determine whether workers will be engaged or burned out by their work: workload, reward, control, fairness, community, and values.[3] Below, we explore each of the 6 domains, highlighting conflicts within current emergency medicine practice and offering potential solutions. We cite data where they exist but also explore areas with little prior study, because past literature cannot provide answers for problems not yet solved.

2.1 | Workload

The ideal workload is not always less work; research suggests that optimal work experience occurs when people are challenged but also have the capacity to meet the challenges they face.[17] Overwork is clearly far more common in emergency medicine than boredom, however. With worsening crowding, increasing documentation expectations, and decreasing reimbursements, workload expectations in most ED settings are rising.[18] Workload encompasses factors including patients seen, tasks completed, and procedures performed in a given shift, as well as total schedule, day–night balance, and flexibility for balancing work with other needs.

2.1.1 | Solutions

Many providers are decreasing their own workload by cutting back on hours[19]; this attrition has contributed to physician shortages in many areas.[20,21] For EDs, funding more robust staffing when patient volumes stress physician capacity may outweigh the costs of hiring and training new staff when burnout inevitably leads to turnover.[22] Optimizing staffing levels for fluctuating but predictable ED demand is also essential.[23] Scheduling improvements have decreased burnout for attendings in other specialties, and may do the same in emergency medicine.[24] Unburdening clinicians from non-essential tasks can decrease workload without reducing hours or even patient loads; scribes, more efficient electronic health records, more effective clinical environments, and physician extenders can all improve physician experience, and are particularly powerful in busy ED settings where cognitive load is high.[25,26] Additionally, workload stress can be ameliorated through circadian scheduling and more flexibility in schedule creation, as the deleterious effects of diurnal switching are particularly pronounced in emergency medicine.[27]

2.2 | Reward

The simplest reward is, of course, monetary compensation; unsurprisingly, Maslach found that feeling underpaid and undervalued is associated with burnout across industries. However, for most individuals, rewards extend beyond finances. Recognition and prestige are potent rewards. Shift buy-downs, increased work flexibility, growth opportunities, and support for individual endeavors may also serve as rewards. Ideally, much of the reward of emergency medicine should also come from the work itself; satisfaction from providing quality care to the acutely ill, gratitude from patients and families, and status in the community are all potential rewards that are variably present depending on the particular ED environment.

2.2.1 | Solutions

Paying people what they are worth is optimal. Although emergency medicine salaries appear to be rising overall, increasing salaries may be impossible for most departments.[28] When financial levers are not available, augmenting non-financial rewards may decrease burnout. The structure of emergency medicine can often preclude providers from experiencing the full rewards of providing great care; we seldom see patients get dramatically better during the short periods we treat them, and the patients we do the most for frequently cannot even speak, let alone express gratitude. We often never learn the ultimate outcomes of patients for whom we perform intensive and invasive interventions; in some settings, the only formal outcomes

feedback received may be through safety reports and quality committees. Therefore, efforts to specifically recognize good work and highlight excellent outcomes can create potent rewards for emergency medicine providers and help overcome cultures of negativity.[29]

In addition, crowded ED environments full of patients in hallway stretchers reduce the likelihood of satisfied patients, making patient interactions more stressful and less rewarding. Improving the experience of patients flowing through the ED can therefore augment the rewards of providing excellent care. Ensuring adequate ED resources, call panels, and transfer agreements is also paramount for providers feeling good about the care they can provide. Although boarding is not likely to disappear any time soon, operational improvements that improve flow and reduce crowding almost certainly improve emergency physician satisfaction.[30]

2.3 | Control

Emergency physicians are never fully autonomous; we always work in teams during shifts, and function as part of a physician group in covering a department. Feelings of control therefore depend on team functioning, employment structure, and organizational culture. Rigid practice protocols may make physicians feel less in control of their medical decisions. Additional administrative tasks during patient care may decrease a sense of control over one's time during shifts. The ability of emergency physicians to suggest changes and affect the practices of their departments can also impact feelings of control, as can the ability to design one's own schedule.

2.3.1 | Solutions

Some changes that decrease physician autonomy such as clinical pathways and guidelines have benefits manifested through standardization of best practices. However, allowing emergency physicians to follow their own practice preferences—when there is clinical equipoise or a paucity of data—may improve feelings of control. This balance requires careful consideration of which protocols and procedures truly improve care; for example, many would argue that some ED sepsis measures force actions without proper evidence.[31] For scheduling control, hiring nocturnists at higher salaries, or having an overnight shift buy-out option, can benefit both daytime and nighttime providers. Decreasing administrative tasks during clinical time is also likely to create a more robust sense of autonomy. The manner in which decisions are made at the department level is also important—leadership teams eliciting provider feedback and empowering employees to drive change can increase feelings of control among staff.[32] Providing coaching that helps physicians maximize personal efficacy may be helpful as well.[33]

2.4 | Fairness

Fairness and transparency are essential for promoting engagement. Fairness concerns can range from how patients are allocated to providers during individual ED shifts to how end-of-year bonuses are calculated. A subjective and opaque promotion or partner track process is likely to potentiate burnout, as will departmental decisions that do not match the reality of the front lines. A lack of fairness and transparency in our malpractice system almost certainly contributes to burnout[34]; emergency clinicians have a 2% risk of being sued each year, with increased years of practice and more patients seen the only reliable predictors of risk.[35] Local cultures around mistakes and blame can affect engagement levels as well; lack of due process and transparency in disciplinary matters is both common and stressful.[36]

2.4.1 | Solutions

Making clinical and non-clinical expectations, promotion pathways, and pay structures explicit and/or public can improve transparency. Ensuring that night, weekend, and holiday shifts are distributed fairly and transparently is simple but important since EDs must be open at many undesirable times to work. It can be particularly difficult to assemble the full staff of an ED simultaneously given 24-hour coverage schedules, but good leadership that promotes engagement still requires finding ways to elicit input and publicize rationales for major decisions. In addition, cultures of safety where failure is expected and accepted—and errors are used to spur systematic improvement rather than blame—can promote engagement over burnout.[37,38]

2.5 | Community

Sense of community at work is crucial for engagement. People can transcend great hardship when they work with people they care about and who care about them. Community encompasses the physician group, advanced practice providers, residents, nurses, other ED staff, and consultants. Environments with high tensions between providers—including friction between emergency physicians and consultants—are common[39,40] and almost certainly contribute to burnout. Emergency medicine is also notable for the frequency with which teams change; physicians may work with new nurses, techs, and/or advanced practice providers each shift. Particularly in larger departments with many part-time employees or high turnover, it may be difficult for employees to get to know one another deeply through only their shifts.

2.5.1 | Solutions

Interventions to improve community can increase wellness and satisfaction.[26,41] Finding ways for staff to spend time together outside of work may be helpful for establishing relationships that would take much longer to build only through work. Managing staff relationships and solving workplace conflict is particularly important for the team-based work of emergency medicine; efforts to build relationships with consultants so they become more than a disembodied voice on the phone are also likely to be fruitful. Pre-shift huddles

with team introductions have not been formally studied in emergency medicine but may improve communication and promote relationship-building. Leadership styles, departmental systems, and incentive structures that facilitate a collegial and cohesive culture will certainly foster more engagement as well. Formal programs that encourage group discussions of work difficulties have also been shown to decrease burnout.[42]

2.6 | Values

Incongruence of the work environment with the espoused values of an organization causes burnout.[43] This is related to the increasingly discussed concept of moral injury.[44] If emergency physicians feel that their environment precludes the provision of quality care, or that decisions of department leadership run counter to core values, they are more likely to disengage. When administrative tasks slow down patient care while the waiting room fills up, emergency physicians feel value discordance. When an emergency physician is asked to transfer patients without private insurance despite an official hospital policy that all patients can be admitted, they feel value discordance. When emergency physicians wish to provide the right care for the right patient but face financial incentives that encourage doing as much as possible—or as little as possible—they cannot help but experience value discordance. Moreover, our health system makes EDs responsible for patient populations for whom treatment resources are inadequate and quick interventions are unlikely to be successful, such as those with homelessness, psychiatric illness, and substance use disorders. Although serving these patients is often a core reason that emergency physicians choose emergency medicine, trying to provide useful care without effective treatment options or heath system support is a recipe for burnout and moral injury.

2.6.1 | Solutions

Our healthcare system is full of value conflict; crowded EDs and underinsured patients make it difficult to fulfill many core physician values.[31] Programs that help provide effective care options for challenging care populations—such as medication-assisted treatment and addiction clinic follow-up for those with opiate use disorder[45]—can improve provider self-efficacy and decrease value discordance as well as depersonalization. Employing social workers, case managers, addiction counselors, translators, and other clinical support resources that allow for better care and disposition planning can help emergency physicians feel more effective in their care. Providing more EDs and hospitals with access to acute psychiatric resources could improve the emergency physician experience of treating patients with behavioral health needs. Clinical environments that promote patient dignity and appropriate care—with incentives that do not conflict with what providers believe is best for patients—are most likely to promote engagement and decrease burnout.

TABLE 1 Potential solutions for promoting engagement and alleviating burnout in the 6 categories of Maslach's burnout framework

Category	Potential solutions
Workload	• Reduce patient load per provider in the busiest care areas • Decrease documentation demands when feasible • Off-load administrative tasks to unit coordinators and other staff • Reduce operational inefficiencies that create extra work with little value • Optimize scheduling for volume, with allowance for provider preferences
Reward	• Increase payment when feasible • Recognize excellence publicly and highlight positive patient outcomes • Provide more individual feedback to providers on case outcomes • Promote gratitude for physicians' work among patients and staff • Create growth opportunities for staff outside of clinical work
Control	• Elicit frontline feedback and incorporate it into department decisions • Allow autonomy in practice style when feasible and safe • Promote physician-led improvement efforts • Decrease administrative burdens
Fairness	• Make salary, promotion, and funding structures explicit and transparent • Make processes for schedule requests and holiday coverage fair and transparent • Elicit participatory decisionmaking when feasible • Publicize rationales for major decisions through media that all providers can access • Utilize formal and transparent processes for disciplinary proceedings.
Community	• Promote community-building activities outside of the ED • Improve communication and familiarity among team members • Cultivate positive relationships with consulting services • Create a culture of teamwork and iterative improvement rather than blame • Retain staff and employ locals when possible • Staff the ED at levels that allow for some socializing while at work
Values	• Prioritize provider well-being and care quality over administrative/financial concerns • Align financial incentives with core values of the department • Provide adequate resources for treating challenging patient populations • Create adequate call panels and transfer policies to ensure high quality care • Address social determinants of health with extra-clinical resources

3 | CONCLUSION

Maslach's 6 domains of burnout represent a framework for understanding how many components of modern emergency medicine may potentiate physician burnout. Many of the root causes are daunting and require system level change for improvement; however, considering all 6 domains can provide a comprehensive lens through which potential options for improving the work experience for emergency physicians can be identified (Table 1). Further, the very process of eliciting broad feedback and implementing burnout solutions can itself improve engagement. Such efforts are likely to improve feelings of control, fairness, community, and value-congruence among staff. Not surprisingly, centers that have implemented broad, collaborative strategies for improving provider experience have successfully decreased burnout.[46] If we view fully engaged providers as an asset worth cultivating, rather than burned-out and disengaged physicians as problems to be solved, we have the chance to substantially improve the practice of emergency medicine for both patients and physicians.

CONFLICT OF INTEREST

The authors report no conflicts of interest.

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