

DISSERTATION

EXPLORING EXPERIENCES OF BURNOUT, ENGAGEMENT, AND SOCIAL SUPPORT
NETWORKS: A QUALITATIVE STUDY OF HOSPITAL MEDICINE PHYSICIANS

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ABSTRACT

EXPLORING EXPERIENCES OF BURNOUT, ENGAGEMENT, AND SOCIAL SUPPORT NETWORKS: A QUALITATIVE STUDY OF HOSPITAL MEDICINE PHYSICIANS

Studies on burnout and engagement for US physicians have resulted in few changes to improve the lives of affected physicians who suffer from the negative effects of burnout that include negative effects to patient care. Research has suggested that physician social support networks can provide protections against burnout that theoretically would lead to a more engaged physician. This qualitative study was conducted to understand the nature of hospitalist experiences of burnout, engagement and social support networks for 15 hospital medicine physicians (i.e., hospitalists).

Two sources of burnout related to hospitalist leaders and hospitalists (non-leader role) emerged: (a) lack of hiring authority, (b) lack of business support, and (c) disruptive peer behavior. Sources of burnout for hospitalists (non-leader) came from: (a) unrealistic expectations from a boss and (b) stress from the employment contracting process, and (c) enough time in the day to finish work. Sources of engagement came from: (a) time spent with patients during difficult diagnosis, (b) appreciation expressed from patients, and (c) meaningful connections with patients. Social support networks for hospitalists were represented by: (a) clinical support, (b) non-clinical support; and (c) leader support. Social support networks were influenced by the quality of relationships hospitalists had with their boss and degree of support received from their leaders. Implications from the study suggested burnout and engagement are

separate constructs; engagement is defined differently by hospitalists and their leaders, and sources of stress that lead to burnout need to be identified to enact effective interventions.

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There are some special people that have contributed to this study and provided pivotal experiences for me. Frank Becky, MD who practiced internal medicine, and brought me along on the hospitalist specialty journey was a source of inspiration for my study. He taught me about the human side of physicians; specifically, how they think, and why they act and say things that help them cope with the demands of patient care. I am forever grateful for his unfiltered view on life and healthcare.

In this study, I had the pleasure and privilege to interview 15 amazing individuals who practice hospital medicine. Without their willingness to share their experiences, this study would not have been possible. I appreciate their stories of struggle and happiness and the trust they instilled with me in this study.

I want to acknowledge my committee: Dr. Russ Korte (advisor), Dr. Meena Balgopal, Dr. Heeyoung Han, and Dr. Travis Maynard for their support and advice on my topic. Dr. Korte's insistence on rigor is appreciated now and will resonate and continue to shape my future career as a researcher. I acknowledge the commitment Dr. Korte had for me through his willingness to look at every 'new and improved' conceptual model and revision.

I also want to thank my son Hayden for being there for me and hopefully this experience will show him what happens when things don't go to plan in your life (squeeze some lemonade). Finally, my husband Peter has been an unshakable support and strength for me. Peter never complained when I had to read in the car, fulfill a compulsion to write at 1:30am, or defer numerous opportunities to choose between time with him, or my laptop. Time for a vacation for two (no laptop).

DEDICATION

I would like to dedicate this study to my parents Don, and my (late) mother Elaine Robinson. Their unwavering support in me through all of my academic pursuits can never be overstated. Although my mom passed during the time of my doctoral pursuit, I know she continued to watch over me from heaven.

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DEFINITION OF TERMS

Burnout: Prolonged response to chronic stressors that include exhaustion, cynicism, and decreased perception of personal accomplishment (e.g., inefficacy; Maslach et al., 2001).

Cynicism: Described as dysfunctional disengagement and a gradual loss of concern which develops negative attitudes toward the nature and the recipients of one's work (Leiter & Maslach, 2017, p. 81).

Engagement: The degree to which a worker has experiences of meaningfulness, psychological safety and availability at work (Kahn, 1990).

Exhaustion: Consequence of intensive physical, affective, and cognitive strain; that is, as a long-term consequence of prolonged exposure to certain job demands (Leiter & Maslach, 2017, p. 33).

Hospital medicine physician/hospitalists: Physician whose work involves >75% of patient care in a hospital setting (Roberts et al., 2013).

Inefficacy: Feelings of incompetence at work and feelings of poor self-esteem and insufficiency (Leiter & Maslach, 2017, p. 81).

Professional identity: One's adoption of a set of expected behaviors that suggests specific knowledge connected to a profession (Cruess et al., 2016).

Relationships: The way in which two or more people act, behave, and talk to or with one another or a group of people (Schaufeli et al., 2009).

Social support theory: Positive social environments that provide confirmation of social identity, instrumental, and emotional aid (Bliese & Britt, 2001).

Socialization: Refers to how newcomers learn about their new organizational role (Van Maanen & Schein, 1977).

Stress: A mental and physical response to unbearable demands in the workplace (Haslam, 2004).

CHAPTER ONE: INTRODUCTION

Physician burnout has been an impairment to practicing physicians since the observation of the phenomenon almost 40 years ago (Eckleberry-Hunt, Kirkpatrick, & Barbera, 2018; Freudenberger, 1974). Burnout syndrome occurs when individuals are exposed to “chronic interpersonal and emotional stressors” (Maslach, Schaufeli, & Leiter, 2001, p. 397) related to their work. More specific to physicians, three factors have been identified that contribute to burnout for physicians and they reside within repeated exposures of stressors. These stressors include factors like unachievable workload demands (Kavalieratos et al., 2017), loss of autonomy related to clinical decision making (Williams, 2018), clinical input into patient care plans (Sutinen, Kivim, Elovainio, & Virtanen, 2002), and unresolved interpersonal conflict (Georganta, Panagopoulou, & Montgomery, 2014). Emotional exhaustion, cynicism, and decreased personal accomplishment are the three recognized dimensions of burnout (Maslach & Jackson, 1981); however, cynicism has the potential to impact patient care the most because of physicians’ disconnection from work, lack of empathy, and loss of capacity to care for patients. In a qualitative study, physicians and their assistants described what burnout felt like from the perspective: ““It’s like heart failure. It’s chronic. And it will kill you”” (Kavalieratos et al., 2017, p. 1).

Background of Study

Burnout research for the past 40 years has been represented by an individual’s response to prolonged emotional and interpersonal stress in the workplace. Burnout research represents a set of responses observed originally by healthcare workers. Emotional exhaustion, the most widely studied symptom of burnout, is commonly felt and referred to as the first stage of burnout

(Schaufeli, Leiter, & Maslach, 2009); whereas, cynicism is reflected by an attitude towards work. Leiter, Bakker, and Maslach (2014) described cynicism as a “dysfunctional disengagement” from one’s work with “gradual loss of concern” about others (p. 81). Roberts, Cannon, Wellik, Wu, and Budavari (2013) defined the third dimension of burnout, inefficacy, as a feeling of incompetency and producing work that is no longer worthwhile to the individual performing the work. What has been considered less in the context of burnout and engagement research has been the role of situational contexts and the potential relationship of these three factors. Thus, there is a need for more organizational research that includes the social aspects of work that can effect changes at the individual and organizational levels (Leiter & Maslach, 2003; Leiter & Maslach, 2017; Schaufeli et al., 2009).

Freudenberger’s (1974) initial observations on burnout suggested that burnout on the job can come from perceptions of relationships that contribute to stress on the job. For instance, Freudenberger’s research (1974) revealed that burnout starts with an employee’s perception of leadership which was contrary to the individual level approach (Leiter et al., 2014) that suggested the individual needs to change without regard to the environment. In an attempt to close the gap between a burned out employee versus an engaged employee, Kahn (1990) suggested that employees are capable of being at any given place on a continuum between being burnout and engaged at work, based on psychological states at work (Kahn, 1990). Thus, part of the challenge for burnout researchers has been an ambiguous definition of various phenomena as noted by Starrin, Larsson, and Styrborn (1990): “Some of the definitions [of burnout] are restricted, others unrestricted; some refer to experience, others to behavior; some describe a state, others a process; some include causes, others include effects” (p. 84). These aspects of the burnout phenomenon as explained by Starrin et al. (1990) suggest inclusion or exclusion of

different factors related to the phenomenon; suggesting the inherently complex nature of the phenomenon (Freudenberger, 1974).

Research on burnout has also explored a worker's engagement or disengagement at work (Eldor, 2016; Kahn, 1990; Leiter & Maslach, 2017). Some researchers studied the antithesis to burnout (e.g., engagement), a perspective that may provide rich insights into what the worker experiences (Maslach, Schaufeli, & Leiter, 2001b; Maslach et al., 2001). Other scholars have rejected the premise of burnout without consideration of social and local organizational factors (Farber, 1983; Kahn, 1990; Thunman, 2012). Thus, a continued focus of research is needed to better understand the phenomenon of burnout and engagement that include social contexts.

Leiter et al. (2014) suggested burnout is an individual response to a socially constructed workplace. The predominant tools used to measure individual levels of exhaustion, cynicism, and inefficacy have been the Maslach burnout inventory (MBI), developed by Maslach and Jackson (1981) to measure the negative dimensions of burnout, and the Utrecht work engagement scale (UWES; Leiter & Maslach, 2003) to measure the positive dimensions of engagement. The two scales each measure engagement on a spectrum of support and prediction related to the mediating organizational context of work outcomes. Results of research from these two survey instruments have relied on self-reported data and resulted in an estimated 6,000 books, book chapters, and dissertations (Schaufeli et al., 2009) but none have created successful burnout interventional methods. The focus on the individual is important; however, self-reports have shown to be shaped in relation to social contexts, or frame of reference (Brown, Novick, Lord, & Richards, 1992). Brown et al.'s frame of reference research context revealed that individuals respond to surveys based on their relationship to their social context(s); therefore, it

is logical to assume that understanding the social contexts of work can extend burnout research (Meyerson, 2017; Schaufeli et al., 2009).

Research that included social contexts, such as support in the healthcare workplace, was limited possibly due to variable factors of the concept. Research conducted in a hospital workplace revealed that strong social support can possibly provide a buffer to the effects of burnout and reduce stress (Meyerson, 2017). In addition, the strength of social support during challenging times in the workplace has not been considered in determining worker stress. Theoretically, social support is meant to provide a buffering effect to the “negative effects of stressors” (Rizzo, House, & Lirtzman, 1970, p. 426), but research lacks on what constitutes the quality of these relationships. Logically, employees would want to be part of a positive social environment with relationships to help them through difficult times. More specifically, little research addresses how individuals interact within social contexts and how social contexts contribute to mitigating burnout in relationship work.

Some assume that situations related to life and death in hospital contexts could contribute to higher rates of burnout among hospital-based physicians compared to office-based physicians; however, this has not been confirmed. Global research conducted on outpatient versus inpatient physician burnout revealed inpatient physicians are protected from the negative effects of burnout possibly because of availability of working in teams compared to their outpatient peers who cite lack of social support (Roberts et al., 2013) as a contributing factor to burnout. Regardless of the setting in which physicians practice, the consequences of untreated physician burnout to patients is shown through decreased patient satisfaction, decreased quality of patient care, and increased medical errors (Lemaire & Wallace, 2017; Panagioti et al., 2017; West, Dyrbye, Erwin, & Shanafelt, 2016)(Lemaire & Wallace, 2017; Panagioti et al., 2017; West et al.,

2016). It is plausible that as emotional exhaustion increases for physicians, the toll that burnout takes on the individual will affect the quality of care delivered by affected physicians. Hence, understanding the quality and function of social support will contribute to existing research and understanding of the phenomenon.

Purpose Statement and Research Questions

The purpose of this study is to explore the nature of hospitalist burnout, engagement and social support networks through lived experiences of hospitalists. It is plausible that a supportive, positive workplace is an asset for an organization allowing the employees to improve patient care; thus, a deeper understanding of what constitutes the nature of burnout, engagement and social support networks for hospitalists will add to existing knowledge.

The following three research questions guided the qualitative inquiry: (a) What is the nature of burnout experiences for hospitalists? (b) What is the nature of engagement experiences for hospitalists? (c) What is the nature of social support networks for hospitalists?

Problem Statement

Physicians have self-reported experiencing burnout at an increasing rate compared to non-healthcare occupations (Shanafelt et al., 2015). Burnout scholars have determined that all workers are susceptible to burnout, but those in the helping professions with a high degree of patient/client interaction are especially at risk (Freudenberger, 1974; Leiter et al, 2014; Maslach & Jackson, 1981; Shanafelt et al., 2015). Although there is a lack of research focused on hospital physicians (e.g., hospitalists; Roberts et al., 2013), one assumption is that hospitalists are perceived to experience higher rates of burnout compared to their peers because of the complex work environment of a hospital compared to a clinical office. It is possible, however, that hospitalists are experiencing burnout that is contextually based due to institutional norms and

expectations that dissuades hospital professionals from admitting to experiencing burnout symptoms (Meyerson, 2017).

Other scholars have suggested that social support and relationships within their workplace provided a protection against burnout (Roberts et al., 2013). Using this context, a deeper understanding surrounding the quality of hospitalist relationships in the workplace could further enhance organizational knowledge around what is meant by protections against burnout. Hence, some suggested that social support in the hospital work environment includes: (a) relationships with supervisors, peers, and patients (Glasheen et al., 2011; Hoff, Whitcomb, & Nelson, 2002); (b) absence or presence of conflict (Georganta, Panagopoulou, & Montgomery, 2014; Leiter & Maslach, 2003); and (c) opportunities to exchange/elicit advice from peers (Humphrey, Nahrgang, & Morgeson, 2007; Meyerson, 2017) contributing to an environment where burnout symptoms are less likely to exist. Furthermore, there are no known empirical studies on the quality of social support contexts related to burnout and physician engagement in hospitals. Burnout has been framed in the literature as an antithesis to engagement (Anthony-McMann, Ellinger, Astakhova, & Halbesleben, 2017), a concept that suggests workers are on a continuum between burnout and engagement; however, this commonly held conceptualization that posits workers are in an either/or burnout/engaged status has been challenged (Leiter & Maslach, 2017) and suggests engagement is independent from burnout. **The problem is that little is known about how hospitalists experience burnout, engagement and what constitutes their social support networks.**

Significance of Study

This study is significant because it will further the understanding of how hospitalists experience burnout, engagement and social support networks. Furthermore, this research will

deepen the understanding of who hospitalists include in their social support networks. Additionally, the intent of this study is to provide future organizational, individual, or a combination thereof of interventions that will support a healthy hospital workplace. The intended contribution is to gain greater understanding of individuals' interactions within the social support contexts in hospitals by using qualitative methods for hospitalists. Hospitalists, provide inpatient hospital care to patients >75% of their work day (Wachter & Goldman, 1996) and their work environment is similar to a medical resident because of the hospital environment; however, there are inherent differences in responsibilities between a medical resident who is a student and a hospitalist who is an employee of a hospital system, corporation or privately owned medical practice.

A hospital workplace is complex and different from other settings where patient care delivery happens. Patient care in outpatient office settings are in a bounded environment with respect to the physician and nurse (if present and part of the office staff). It is reasonable to assume that the social roles that different people have in a medical office setting would be different than that in a hospital setting. To this end, Roberts et al. (2013) suggested that favorable social relations protect hospitalists from experiencing burnout; and Glasheen et al. (2011) found that support from supervisors was a stronger predictor of career satisfaction than relationships with one's hospital (organization), although, the definitions of these two constructs were not clear. Thus, the support people received in their networks, could possibly mitigate the exhaustion from working with difficult patients that could lead to depersonalization of patient. Attention to depersonalization is important because when physicians start to feel detached concern for their patients due to stress (Maslach et al., 2001), the quality of patient care could decrease. Patient care in hospital settings is highly complex due to the level of patient sickness,

and the results of this study will help understand how people could mitigate depersonalization that could lead to decreased quality of patient care (Leiter & Maslach, 2003, p. 93).

Healthcare work contexts are unique to other workplace environments because the decisions made can affect the health of others. In a rare study that compared US occupations to all physician specialties, 67% of surveyed physicians ($n=4476$) continued to be satisfied with their chosen profession and 54% of this same population also reported experiencing burnout (Shanafelt et al., 2015). In the same study by Shanafelt et al. (2015), US physician burnout rates compared to non-healthcare occupations had risen (from 45% to 54%) between 2011-2014 with no significant increase in non-healthcare occupations (28.4% to 28.6%). Shanafelt and Noseworthy (2017) found that physicians who practiced medicine and simultaneously reported burnout symptoms were more likely to make medical errors, more likely to become emotionally detached from patients, and more likely to have patients that reported decreased satisfaction related to their care (Shanafelt & Noseworthy, 2017). The reasons and context for why physicians experienced these dual experiences are unknown.

Assumptions and Limitations of Study

This study circled back to the original discovery that burnout was a social and leadership problem observed in the human services (Freudenberger, 1974; Maslach, 2003). Although many healthcare workers provide care directly to patients, including physician assistants, nurse practitioners, nurses, and medical residents; this study focused on physicians in a hospital setting. Setting delineations were important because of the variable research findings that combined inpatient and outpatient settings.

Hospital-based physician burnout research has commonly been grouped together with outpatient primary care physicians (Linzer et al., 2015, 2016; Panagioti et al., 2017). For

instance, medical students and inpatient physicians (i.e., physicians who have graduated with a medical degree) share similar workplaces (e.g., hospital based); however, overall responsibilities differ due to the trajectory a medical student is on compared to a fully credentialed physician (i.e., physician with a medical degree). Isolation in the workplace does not reflect the complexity of social contexts in a hospital. For example, there are factors connected to responsibilities or sources of possible stress reflected by student status that may not be present for a fully licensed physician.

Although physician burnout has been measured in all specialties (Shanafelt et al., 2015), there is a small amount of research on burnout for hospital medicine physicians (Roberts et al., 2013). For instance, medical student burnout was measured at 60-76% (Holmes et al., 2017), yet in hospital medicine physician burnout research, there was no known baseline assessment of burnout rates. In a rare hospitalist specialty survey article, respondents self-reported multiple overlapping factors that contributed to job and specialty satisfaction: (a) organizational climate; (b) patient care; (c) compensation; (d) relationships with peers, patients, co-workers, and leaders (Hinami, Whelan, Wolosin, Miller, & Wetterneck, 2012). In the only known article separating hospitalists from their outpatient peers, Roberts et al. (2013) suggested the lack of baseline assessment was partially due to a lack of heterogeneity of survey instruments. Furthermore, there are no known studies on social support conceptualized as an individual network or strength for individuals who work in stressful workplace. This study adds to the current knowledge on empirical social support in stressful settings.

Background of Study

The metaphor of “burnout” was used by Freudenberg (1974) in reference to observed behavior found in drug addicts. Burnout was described as “the smothering of a fire or the

extinguishing of a candle”(Schaufeli et al., 2009, p. 205). Burnout is a response to continued stressors in the workplace that over time cause the worker to exhibit burnout symptoms. If prolonged, the combined chronic and consistent workplace stressors contribute to increased absenteeism, turnover, and low morale (Maslach & Jackson, 1981) that renders the worker unable to offer emotional or psychological support to patients (or clients).

Burnout was first observed by behaviors exhibited by physicians in a health clinic context (Freudenberger, 1974). Physicians continue to report increased rates of burnout compared to non-healthcare worker populations; within the physician population, burnout rates differ among medical specialties. Research that compared burnout and work-life balance rates across medical specialties (e.g., emergency room physicians, pediatricians, dermatologists) from 2011-2014 found differences among specialties. Of note, physicians as a collective population from the same study revealed a rise of 9% in self-reported burnout to 54%, compared to US population of 28.6% (Shanafelt et al., 2015). Burnout research that includes data based on medical specialty (i.e., Shanafelt et al., 2015) is rare, so research that compared physicians’ burnout to the US population provides a reference point for what specialties appear to be affected in comparison to their peers in other specialties relative to the non-clinical population.

Individuals who work in hospitals work in a complex environment. Haslam (2004) defined complexity in organizations as a social system that “coordinates people’s behavior by means of roles, norms and values” (p. 286). Complex environments without normative lines of communication and understood responsibilities can contribute to ambiguity and confusion (Rizzo et al., 1970). Hospitals reflect complex environments due to overlapping responsibilities of the professions responsible for patient care; however, complex organizations are prone to ambiguity if workers are not aware of their specific roles within their organization. Specifically, the

physical layout of a hospital requires physical demands unique to the hospital medicine physician because of varying patient locations spread throughout the hospital, like in the emergency room or the intensive care unit, for example. In a hospital context, hospital medicine physicians engage in varying subgroups in differing physical locations that constitute small groups of people throughout the hospital. Emotional exhaustion adds another layer of individual complexity for hospital physicians because of frequent, challenging social interactions and conversations with families of sick patients (Hinami et al., 2012).

Definition of Terms

The challenge in exploring the phenomenon of burnout connects to agreement on a definition. For instance, Freudemberger (1997) defined burnout as “becoming exhausted by making excessive demands on energy, strength, or resources” (p. 159). Maslach et al. (2001) considered burnout as “a prolonged response to chronic emotional and interpersonal stressors on the job” defined by the three dimensions of exhaustion, cynicism (e.g. depersonalization), and inefficacy (e.g., self-accomplishment (p. 397). Others suggested burnout is the result of a complex set of relationships workers experience so closely related that they are considered intertwined between individual and organizational goals (Thunman, 2012). Thunman (2012) claimed burnout is the result of an existing duality and friction when workers seek to be authentic to themselves and to the organization. This occurs when the organization communicates freedom and autonomy to achieve goals but requires organizational conformity on how to achieve the goals. Although different conceptions and definitions exist. The following definitions of terms will be used in this study:

Burnout: Prolonged response to chronic stressors that include exhaustion, cynicism, and decreased perception of personal accomplishment (e.g., inefficacy) (Maslach et al., 2001).

Cynicism: Described as dysfunctional disengagement and a gradual loss of concern which develops negative attitudes toward the nature and the recipients of one's work (Leiter & Maslach, 2017, p. 81).

Engagement: The degree to which a worker has experiences of meaningfulness, psychological safety and availability at work (Kahn, 1990).

Exhaustion: Consequence of intensive physical, affective, and cognitive strain; that is, as a long-term consequence of prolonged exposure to certain job demands (Leiter & Maslach, 2017, p. 33).

Hospital medicine physician/hospitalists: Physician whose work involves >75% of patient care in a hospital setting (Roberts et al., 2013).

Inefficacy: Feelings of incompetence at work and feelings of poor self-esteem and insufficiency (Leiter & Maslach, 2017, p. 81).

Professional identity: One's adoption of a set of expected behaviors that suggests specific knowledge connected to a profession (Cruss et al., 2016).

Relationships: The way in which two or more people act, behave, and talk to or with one another or a group of people (Schaufeli et al., 2009).

Social support theory: Positive social environments that provide confirmation of social identity, instrumental, and emotional aid (Bliese & Britt, 2001).

Socialization: Refers to how newcomers learn about their new organizational role (Van Maanen & Schein, 1977).

Stress: A mental and physical response to unbearable demands in the workplace (Haslam, 2004).

The next chapter will provide a foundation of literature that will help guide the study and provide relevant scholarly input.

CHAPTER TWO: LITERATURE REVIEW

The overall intent of this literature review was to discover what historical and current literature was available on the concept of burnout, burnout in healthcare workplaces, and hospitals. In addition to an overview on burnout, literature was reviewed on work design and social support to inform the theoretical and conceptual framework for the study. The structure of this chapter is (a) definition of burnout, (b) occupational findings, (c) brief history of work design, and (e), theoretical and conceptual framework.

After refining the keywords for the literature review, studies from the following three databases were used: *Google Scholar*, *Academic Search Premier* and *Business Source Complete*. Hospitalists have stressful daily responsibility for patients that includes life and death situations situated in the hospital context (Tziner, Rabenu, Radomski, & Belkin, 2015) and patient care occurring in different locations. Every attempt was made to obtain literature taking place in a hospital setting, because there are two general work environments for healthcare: clinical settings and a hospital.

Some of the pressures unique to physicians in hospitals are embedded in the work context that include long working hours and providing care for patients with severe or incurable illness sometimes leading to death (Khamisa, Peltzer, Ilic, & Oldenburg, 2016; Tziner et al., 2015). Another workplace stressor is due to the liability physicians have related to patient care. Physicians can be sued for malpractice, and commonly are responsible for the final plan of care for patients but rely on other teams or individual professionals to provide the care they co-manage. Nurses and other clinical staff do not have the same liability pressure in hospitals

because their liability is covered by their employer (e.g. the hospital system) and thus covered by the hospital system that employs them (Khamisa et al., 2016).

It is important to note that literature for this review will include other medical specialties and work occupations that have responsibility for patient care in facilities that are open 365 days of the year and cannot turn away patients or clients for any reason. The work setting (i.e., hospital) is relevant; therefore, scrutiny of where the study took place was considered carefully. Conversely the work setting alone does not imply that the responsibilities are equal. For example, hospital nursing research found a relationship to higher mortality on hospital floors as nursing staff ratios decreased (Koy, Yunibhand, Angsuroch, & Fisher, 2015). Nurse staff is typically controlled by hospital supervisors which contrasts with physician staffing unless employed by the hospital.

Burnout

Burnout is a feeling that results from cumulative stresses in the workplace. Emotional exhaustion, depersonalization, and lower personal accomplishment are all recognized as the hallmarks of burnout and have been the focus of burnout research. The following section will discuss the origins of burnout in the workplace.

Defining Burnout

The concept of workplace burnout was adopted by Freudenberger (1974), a clinical psychologist, during observed behaviors of clinical staff working in a free health medical clinic. During the time spent in the clinic, Freudenberger (1974) observed clinical staff becoming emotionally exhausted and exerting negative behaviors towards work and the patients being treated, and although more hours were spent in the clinic working, less was done. Freudenberger (1974) noted the idealistic, positive attitudes that the workers started with, was not sustainable

over time after caring for patients who are ill, have high emotional needs, and do not recover from illness. Sometimes answers for ill patients are unknown or ambiguous. These situations over time can contribute to feeling burned out especially in the healthcare sector (Maslach & Jackson, 1981). The definition of burnout in the early conceptualization, has been referred to an “overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment” (Maslach et al., 2001, p. 399).

The Maslach burnout inventory (MBI) was created to specifically measure the dimensions of burnout, in the workplace and has been used predominantly for more than 30 years (Theorell et al., 2015). Using the burnout dimensional framework, it appeared burnout was the result of consistent interpersonal stressors shown by specific individual behaviors identified as emotional exhaustion, depersonalization (sometimes referred to as cynicism), and lowered personal accomplishment (sometimes referred to as inefficacy), (Maslach & Jackson, 1981, p. 99). Figure 2.1 illustrates the three commonly held dimensions that describe burnout in the workplace.

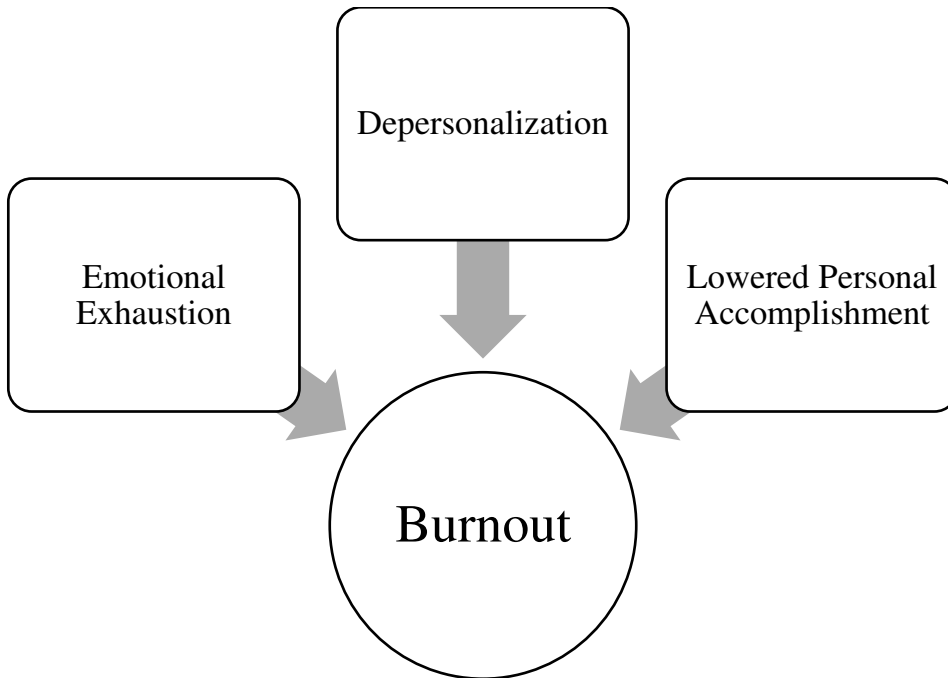


Figure 2.1. Workplace burnout framework defined as emotional exhaustion, depersonalization, and lowered personal accomplishment based on Maslach’s model of burnout (Maslach & Jackson, 1981).

Burnout has been conceptualized in other ways in addition to exhaustion, cynicism and inefficacy. Leiter and Maslach (2003) reconceptualized burnout as levels of engagement comprised of energy, involvement and effectiveness and the UWES has been used widely (Christian, Garza, & Slaughter, 2011) for measurement. Extending the reconceptualization of burnout as engagement led to other scholarly work seeking to measure engagement that reflected a positive side of work that included values such as personal life and community (Eldor, 2016), The areas of work life (i.e., areas of work life scale; Leiter & Maslach, 2003) concept was the result of burnout results that continued to suggest social issues, or levels of engagement were a contributing factor to burnout. Despite this turn of attention to define the phenomenon more narrowly, the definition widened.

Burnout measurement. The predominant burnout inventory used to measure workplace burnout dimensions in healthcare is the Maslach burnout inventory human services survey (MBI-

HSS). Two additional surveys, the Maslach burnout inventory-educators survey (MBI-ES) and the Maslach burnout inventory-general survey (GS) were created that focused on education specific contexts and the GS survey is used for all occupations (Maslach et al., 2001). The MBI consists of 25 items where participants rate their perceptions and feelings related to exhaustion, cynicism and inefficacy. Over time, the reliability, validity, convergent validity including test/re-test provided a burnout measurement tool that is still in use today (Maslach, 2003; Maslach & Jackson, 1981). The importance the MBI survey serves in healthcare is the results are used as a predictor of the level of quality of care rendered by the healthcare worker who is affected by burnout symptoms (Maslach & Jackson, 1981). In other words, the MBI-HSS can be used in conjunction with patient care quality outcomes, but the predictor rating is difficult to assign to any one provider of care in a hospital, due to multiple caregivers involved in patient care.

In summary, the predominant conceptualization and measurement of burnout has consisted of disengagement from work with alternative concepts that have suggested workers also experience engagement. Research on both sides of the phenomenon is informative, but still lack the clarity for what burnout is in different workplace situations. Attempts to clarify burnout led to other scientific inquiries that will be discussed in the next sections.

Burnout and depression. Initial burnout research focused on individuals in the human services and research was somewhat split between social and mental health practitioners because the behavior mirrored depression (Freudenberger, 1974; Maslach et al., 2001) and these behaviors led practitioners to treat individuals for burnout syndrome. Psychologists ascertained, however, that workplace burnout is related to the workplace, specific to the work environment; whereas, a diagnosis of burnout syndrome is a medical condition present in every aspect of a

person's life and not isolated to the individual's workplace (Leiter et al., 2014). Further confirmation by scholars reported that the presence of depression in the workplace or extreme exhaustion by itself is not representative of burnout and all three dimensions; emotional exhaustion, depersonalization and personal accomplishment, must be present in some form to conclude the individual is suffering from burnout (Maslach, 2003; Maslach & Jackson, 1981).

Additional studies further explored burnout specific to hospital medicine physicians. Similar dimensions of burnout in the research revealed burnout symptoms having negative relationships to job satisfaction (Hinami et al., 2012), control over workload (Glasheen et al., 2011) interactions with colleagues (Hoff et al., 2002) and social support (Saijo et al., 2013) and will be discussed later in this review.

Burnout Interventions

Interventions for burnout in the workplace are sparse. As Maslach et al. (2001) point out, [the] primary reason for the small number of such studies has been not a lack of interest, but the major difficulties involved in designing an intervention, finding an opportunity to implement it and being able to do longitudinal studies on it. (p. 192)

Related scholars found burnout interventions fall into two distinct areas. The first is prevention and the second is to alleviate burnout when it arises (Leiter et al., 2014). Connected to these approaches, burnout interventions are designed and delivered at either the individual, organizational and/or system level. Discussion of the two approaches will follow and how they are connected to the topic of physicians experiencing burnout.

Overall, most intervention studies have not been able to provide generalizability, validity and longitudinal successes. This lack may be partially due to a general lack of consensus on what constitutes a success in interventional burnout reduction design (Leiter et al., 2014). For instance, is a successful burnout intervention reduction successful if burnout is reduced in one or

all three dimensions (e.g. emotional exhaustion, cynicism and inefficacy)? Leiter et al. (2014) suggested categorizing burnout into organizational or individual-centered interventions. Similarly, in Panagioti et al.'s (2017) meta-analysis on physician burnout interventions separated literature into hospital (e.g., organizational) or physician targeted interventions. Organizational interventions are identified where there are attempts to change the resources, working environment, intensity or schedule (Panagioti et al., 2017) versus individually-centered interventions that have for example, consisted of various coping strategies such as mindfulness and communication workshops (Leiter et al., 2014). Despite a lack of agreement on success measures and whether the individual or the organization need to be the focus of interventions, it appears that a combination of two approaches may be needed.

Based on Figure 2.2, it appears organizational and individual interventions impact one another. For instance, the individual could be affected by schedule intensity through teamwork and individual communication with members on one's team. Alternatively, the ability to control one's workload could involve communication with others and mindful reflection utilizing internal cognitive coping strategies. Thus, separating individual and organizational interventions presents challenges and supports Panagioti et al.'s (2017) findings that combining individual and organizational physician interventions tended to be the most effective method. However, there is a lack of research on what combination of individual and organizational interventions are the most effective to reduce burnout. Figure 2.2 illustrates the levels of focus between the individual and organization based on Panagioti's (2017) report.

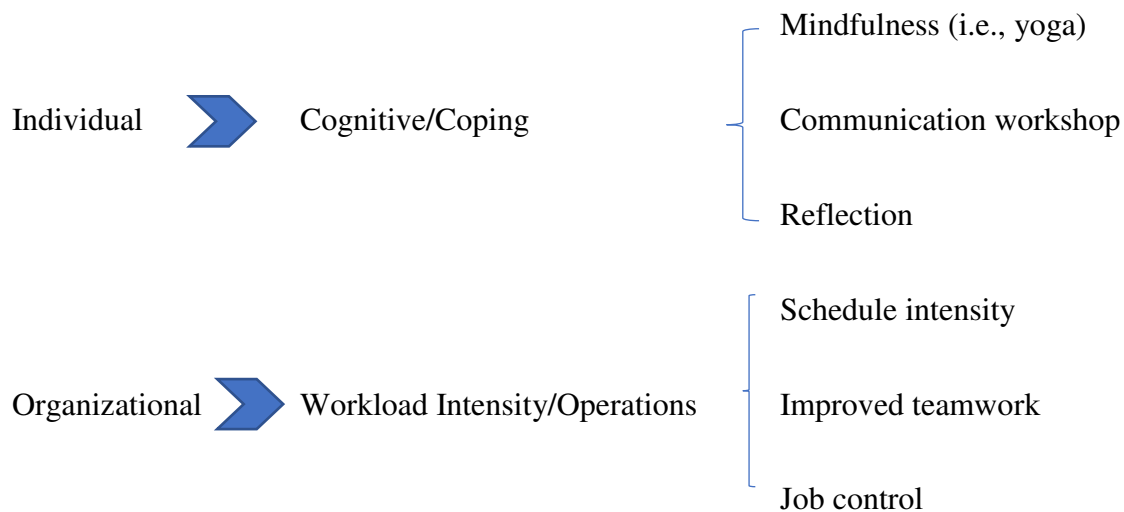


Figure 2.2. Potential impact for individual and organizational interventions based on Panagioti et al.'s (2016) meta-analysis.

Burnout symptoms appear before physicians earn their medical degree. Signs of burnout during medical school and subsequent medical residency vary from 27-75% (Montgomery, 2014). Methods to mitigate burnout at the physician/individual level varies. Back et al.'s (2016) research utilized individual training in resilience and coping strategies to physician work environments. West, Dyrbye, Erwin, & Shanafelt (2016) found in their meta-analysis of burnout interventions that excluded medical students revealed mixed results in individual interventions. Methods included yoga, mindfulness and discussion groups. The authors suggest targeting specific populations to interventions with considerations given to organizational structure and note the amount of individual intervention studies exceed organizational interventions.

In response to mixed results on individual burnout interventions, some scholars have suggested burnout could be considered as an indication of a functioning (or a dysfunctional) organizational system (Maslach et al., 2001; Montgomery, 2014); where an absence of burnout symptoms are considered a measurement of fulfilled workers and organizational systems working together. Going back to the engagement and disengagement literature, fulfilled workers could be considered engaged. In response to the proliferation of interventions for individuals,

Maslach (2003) suggested a possible reason why individual focused interventions have fallen short on results by stating, “individual strategies are relatively ineffective in the workplace, where people have much less control over stressors” (p. 192). Conversely, if measurement of burnout scores are low, some positive assumptions about the workplace can be made and can lead to investigation into what systems are working that support the worker.

Methods that reduced individual levels of burnout include mindfulness (such as meditation or yoga), stress reduction workshops, and communication skills workshops (West et al., 2016); however, there was no agreement on what individual intervention works best or if certain physician populations make a difference as to which interventions are more likely to provide reduced burnout measurements beyond what was measured in the study. Despite the lack of overall clarity matching individual interventions, West et al. (2016) found an overall reduction in burnout scores (measured by the MBI) of up to three-points mainly in emotional exhaustion scores, however longitudinal studies are lacking. Panagioti et al. (2016) concurrently found in their meta-analysis of physician-directed versus organizationally-directed interventions that the majority ($n=20$) focused on emotional exhaustion. The approach to continually try different methods that range from yoga to communication training is evidence of the wide range of methods and the inherent challenge in determining which individual method works best with the best outcome.

Organizational and/or Hospital Burnout Interventions

The degree of control a worker has over workload has been found to be predictive of burnout (Leiter et al., 2014; Maslach et al., 2001). Control over workload in hospital medicine versus outpatient and/or office-based practices differs. Hospital medicine physicians admit patients for the hospital, consulting with other physicians (e.g. cardiology, obstetrics, oncology)

during their prescribed schedule. In contrast to a hospital medicine physician counterpart, the primary care physician, scheduling of and flow of patients are controlled by either the physician or office staff. Therefore, physicians practicing exclusively in the hospital can be relatively compared to medical specialties who do not have outpatient responsibilities such as hospital faculty in an academic hospital, and medical interns (physicians who are in their final year of training) who practice general or internal medicine.

Results from Panagioti et al.'s (2017) meta-analysis included (n = 20) 13 individual focused studies that took place in hospitals. The remaining seven intervention studies were considered organizational focused consisting of either workload or schedule changes. Meta-analysis of physician burnout interventions (Panagioti et al., 2017) confirmed Maslach and Leiter's (2003) recognition regarding the limitations related to scholars staying solely focused on individual burnout interventions. Studies on organizational burnout interventions in the hospital setting focused on workload variances (Garland, 2012; Lucas, 2012) and protected time for physicians to sleep (Shea, 2014). In a related study, (Linzer et al., 2015) scholars sought to confirm increased burnout scores related to work control, chaos in the workplace and clinician outcomes in patients. Results revealed no significant group effect, however other results found attention to communication and control over workflow contributed positively to individual burnout measurement, satisfaction and intention to leave.

The interdisciplinary nature of work within hospitals coupled with the possibility of relational disconnections between physicians, their work and the organization have been recognized by hospital burnout scholars suggesting the need for organizationally supported burnout interventions. One reason cited for a possible lack of intervention research at the organizational level, is due to the related costs associated with large-scale system changes. Due

to scarcity of organizational interventions it has been suggested that large-scale systems could benefit from a combination of interventions that include physical space to foster individual collaboration (Panagioti et al., 2016; Shanafelt et al., 2015). Burnout scholars in the fields of psychology and medicine recognize that future studies are needed that include individual/situational, organizational (Maslach, 2003), or a combination of system and individual interventions (West et al., 2016).

Maslach & Goldberg (1998) posited one reason interventions have focused on the individual is based on the belief that it is easier to change the individual instead of the organization. Hospital medicine physicians work within complex workplaces with interdependent departments (i.e., radiology, surgery, emergency rooms) and rely on the strength of these interdependencies to treat patients effectively; therefore, changing one system in a hospital could directly or indirectly effect other systems a physician works in. There is an implied assumption of change in people a hospital medicine physician is forced to work with daily in a hospital setting; rendering them dependent on the hospital to hire and train staff to treat mutual patients without input in personnel choices. Thus, there is a distance and possible disconnection of the physician to the hospital and the people who work there. How hospital medicine physicians interact with others, their peers, patients and supervisors can possibly impact the perspective of the organization itself. Therefore, the design of hospital medicine physician burnout interventions could benefit from a deeper understanding of what systems affect the individual related to what contributes to emotional exhaustion, cynicism and inefficacy.

In summary, the literature on individual and organizational burnout interventions revealed mixed results. Scholars recognize that individual measurements are indicative of

further research and burnout intervention design, however there is a lack of agreement on what successful interventions should include. Organizational interventions are lacking and scholars in general burnout and physician burnout communities suggest a need for either organizational or organizationally supported interventions.

Occupational Findings

The population and corresponding occupation for this study is hospital-based physicians. To further explain and compare the chosen population to other occupations, the following section will provide further context. Location of care and work hours are connected in healthcare. For example, hospitals and nursing homes are open seven days a week, 24 hours a day and receive patients with varying degrees of patient care needs. Although there are other occupations requiring 24-hour worker availability, such as firefighters, 9-1-1- operators, police force personnel, and the like, there is a requirement that the facility (e.g. nursing home, hospital) is connected to the physician in order to provide patient care. Hospital medicine physicians are restricted in providing care at a hospital due to the need of support staff for the physician and patient clinic. Palliative care physicians are included in occupational reviews due to the similar scope of medical responsibility shared by internal medicine physicians that target adult care.

Burnout in hospitalists. Hospital physicians encounter daily life and death responsibility decisions contributing to a complex work environment. Before explaining specific factors that have been found within the hospital physician medicine literature contributing to burnout, it may be helpful to understand how physicians compare with other occupations in general in the United States. Utilizing the MBI, Shanafelt et al. (2015) conducted a comparison study during 2011 to 2014 with a cross-section of occupations that focused on well-being and satisfaction with work-life balance. Occupations included military personnel, clerical workers,

sales workers, and farmers were included in the study alongside physicians (Shanafelt et al., 2015, p. 1609). The results revealed physicians in all specialties across the country reported experiencing one of three burnout symptoms: emotional exhaustion, cynicism and inefficacy ($n=3310$, 48.5 vs 40.9%, $p<0.001$). This study is unique because it compares all physician specialties to other occupations in a cross-sectional approach, validating physicians (all specialties grouped together) are twice as likely to experience burnout compared to the general population.

Turning to related research specific to hospital medicine physicians, Hinami et al. (2012) measured work life balance and satisfaction of career choice for hospital medicine physicians ($n=864$) utilizing the hospital medicine physician work life survey. Concurrent research conducted in an academic medicine setting with hospital medicine participants (Glasheen et al., 2011) confirmed the role of relationships related to career satisfaction. Hinami et al. (2012) found hospital medicine physicians are most satisfied with patient care and relationships with peers and patients, however 29.9% ($n=816$) reported experiencing burnout indicated by intent to leave the profession or reduce their work effort. One possible weakness in the Hinami et al. (2012) study was the measurement instrument used for burnout. Burnout questions were embedded in the work life balance survey; therefore, the results present possible convergent validity challenges when compared to similar research (i.e., Shanafelt et al., 2015).

Burnout in nursing home providers. Nursing homes are defined as facilities providing around the clock care for patients who cannot care for themselves at home. The assumption is nursing home patients do not require enough care to be admitted to a hospital, nor can they live safely by themselves at home and approximately 68% of all nursing home patients have some type of mental health disorder (Ferrara, 2013.). In a quasi-experimental dissertation study

(Ferrara, 2013), based on the assumption that nursing home caregiver burnout rates would be decreased if they had more knowledge and training of mental health disorders, it was found there was no statistical difference ($n=15$, $p<.88$) between the control and experimental group after training. Of note, the highest pre/posttest correlation to the training was the feeling of support the participants felt through sharing among their peers particularly with difficult experiences they had with patients. Knowledge scores had measurably increased in the control group; however, the knowledge and additional training did not contribute to lower levels of burnout (Ferrara, 2013). It is possible the sharing of difficult experiences creating a social support environment as was more important in mitigating burnout than additional training.

Burnout in palliative care physicians. Palliative care and hospice physicians are sometimes mistaken for being the same specialty. Palliative care physicians specialize in working within teams of healthcare workers, that typically include a social worker who works with patients that have a chronic or incurable illness, while hospice physicians treat patients with incurable diseases. It has been suggested that the time and complexity associated with the aging demographic coupled with an increase in demand for palliative care physicians in the hospital absent of clear role expectations in the hospital is possibly reasons for burnout (Back et al. 2016).

Back et al.'s (2016) study suggested a burnout prevention model based on resilience training at the individual level. Even though the resilience model targets work demands and personal resources for resilience in the individual, scholars acknowledged that intervention at the system level may be needed (Back et al., 2016, p. 2). In a follow-up qualitative study that addressed the lack of “rich respondent-driven narratives that support or challenge constructs in conceptual models and related interventions” (Kavalieratos et al., 2017, p. 6), participants were asked about the specific sources and potential outcomes of untreated burnout symptoms. The

study suggests resilience training for participants and a partnership between the palliative care physician community and the organization it serves for strategies to protect these physicians and the increasing workload demands

In summary, this section provided occupational differences as a contrast to hospital medicine physicians and to provide the reader a context for the hospital medicine physician occupation compared to the general workforce. The literature found that healthcare workers and other occupations such as palliative care physicians and nursing homes are similar in work hours, however facilities provide variability regarding staff and acuity (e.g., level of sickness). The following section discusses work design theory and practice at the individual and organizational levels to further explore the complexities associated with hospital medicine physician work and challenges.

Engagement

Individuals' relationships with their work, especially in relation to job burnout and stress, are an important dimension that needs attention (Anthony-McMann et al., 2017); however, researchers have not agreed on what these relationships mean. Leiter and Maslach (2003) suggested that with burnout, workers are in a relational state of engagement or disengagement with work. After many years of burnout research that focused on the negative affects burnout has on the worker, scholars turned to measurements of engagement of a worker to explain attributes of a worker who was not experiencing burnout (Leiter & Maslach, 2003). Rather, burnout scholars posited that workers were on a burnout or engagement spectrum. For example, Leiter and Maslach initially conceptualized and measured engagement as an antithesis to burnout and defined engagement as energy, involvement, and effectiveness; however more recently questions remain whether engagement and burnout are on individual constructs, but

related in a different way (Leiter & Maslach, 2017). Christian, Garza, and Slaughter (2011) found that the self correlates more closely to engagement than job satisfaction (Christian et al., 2011). These findings led to the recognition that job satisfaction and engagement are not necessarily the same construct, and the concept of engagement can have multiple definitions (Anthony-McMann et al., 2017). Finally, Saks' (2006) multidimensional model drew a distinction of job and organizational engagement. An individual's job correlates to the employee's role and that role within the organization.

Much work has been done on employee engagement, such that some assume burnout is the alternative state to engagement. Some of this research has resulted in considering if the meaning of disengagement includes the presence of all three states of burnout (e.g., emotional exhaustion, depersonalization, and personal accomplishment), and thus, presenting differing approaches to explain how employees work in varying states of engagement. Not all scholars (Heinemann & Heinemann, 2017; Kahn, 1990; Thunman, 2012) have adopted burnout as an explanation for a disengaged worker. Kahn's (1990) theory of employee engagement stated that individuals will choose to engage or disengage from work based on how they see themselves in specific roles. Kahn's theory of employee engagement also suggested that three psychological conditions need to be present for engagement: meaningfulness, safety, and availability. Kahn's needs-satisfaction theory defined employee engagement as connection to self and work through roles expressed through physical, cognitive, and emotional states, and disengagement explained an individual's uncoupling from the role at work expressed by withdrawing and defensive behaviors (p. 694). More specifically, Kahn suggested that healthcare workers can theoretically meet criteria for burnout yet be engaged in and complete their work. Kahn's needs-satisfaction theory explained how physicians practice under these circumstances, but not necessarily why

physicians are able to stay in their jobs. In light of Kahn's research, results of this study sought to explain the supporting practices, relationships, and processes in place to prevent one from disengaging from work to prevent decreased quality of patient care. The following section will discuss the assumptions and limitations of the study.

Brief History of Work Design

The beginning of work design research traces its roots to understanding the relationship between the worker and productivity through simplification and breakdown of work into tasks that could be accomplished through a division of labor by skill and training (Smith, 1776/2003). It is possible the method of division of labor may have served a purpose to achieve manufactured goods in a controlled fashion, however even this early method ignores input from the worker. Smith (1776/2003) believed the work output of a worker needed to be constructed by an individual within a hierarchical industrial system using a top down management approach. Simplification of work, however, did not produce motivated workers, but encouraged theorists to further understand what motivated workers.

Over time, manufacturing jobs decreased, and gave rise to service jobs comprising 80% of all work (Grant, 2007). Service workers are identified as workers who have exposure to and work with the public versus manufacturing of goods. Work design authors associated with the service sector sought to understand motivation of work and the individual (Hackman & Oldham, 1976) and what conditions needed to be present for the individual to consistently be motivated. Although motivational work designs have made large contributions to explain motivation for workers, these theories have also neglected social influences for manufacturing and service sector jobs (Oldham & Hackman, 2010). Thus, with the movement of the workforce from manufacturing to service, work design theorists became more interested in observed phenomena

of these workers, one of which was burnout (Maslach & Jackson, 1981). Thus, the early beginnings of work design was largely based on an environment of manufacturing and as the workforce evolved, work design research and practice lagged behind (Parker, Morgeson, & Johns, 2017).

Adam Smith's, (1776/2003) work published in his book *The Wealth of Nations* proposed the division of labor into smaller, controllable facets of work, which fed into the industrial thinking of Taylor's (1911) approach in applying science to work. The approach during this time did not consider any intrinsic motivations of human nature and resulted in an inability to apply theory of simplification to work in industrial times; nonetheless, these early scholars provided a platform for 20th century researchers. An understanding of work in the 19th century provided work design researchers two seminal models that continue to inform work design research: two-factor theory (Herzberg, 1966) and the job characteristics model (Hackman & Oldham, 1976). While some of the building blocks of work design (i.e., a clean and safe environment and fair pay for a days' work) can motivate workers to produce products or services, scholars also underestimated the motivational role and importance of social characteristics (Oldham & Hackman, 2010).

Work design literature is included in this review because of the location of the proposed study. Work design is interrelated to the worker, work related social situations, engagement and burnout. Usage of the term job design versus work design is sometimes used interchangeably in the literature and varies in definition. For clarity and usage in this paper the definition provided by work design scholars will be referenced. Definitions of job versus work refer either to the tasks assigned to a worker or a definition that includes the context, environment, and individual (Parker et al., 2017). I have chosen to use the definition provided by Parker et al. (2017) of work

design as “the content and organization of one’s work tasks, activities, relationships and responsibilities” (p. 404) because the definition includes an overall loop of tasks associated with one’s work, relationships, and work accountability. The role of relationships is ill-defined. For example, are relationships a peer to peer relationship, or is relationship referring to the relationship a worker has with his work or clients and/or patients?

The relationship(s) a worker has with work seems to matter more in contemporary research than before. The previous assumptions that workers and the company were best served from a top down approach to management (Oldham & Hackman, 2010) neglected the social aspects of work that included co-worker and supervisor relationships, meaningful work and the impact of technology on the way work is accomplished.

Social Support and Work Design

The commonly used term social support will be used in this study because there is not a unified definition of social characteristics. Work design theory treats social support as an environment that includes the capacity to develop friendships, initiate and receive interdependence foster interaction from outside of the organization, and collect feedback from peers or supervisors (Oldham & Hackman, 2010). In an absence of a consensus on social support definitions in the workplace, awareness led to a relation work design model, recognizing the importance of relationships through a worker’s job, role, and/or tasks with workplace uncertainty (Grant, 2007). Grant (2007) suggested that the social context of work is framed and influenced by interpersonal interactions necessary for accomplishing and fulfilling the job roles and tasks. Through these interpersonal interactions and feedback from the client or patient, the worker is theorized to feel motivated by making a difference in others’ lives. The relational model will be discussed more thoroughly later in this chapter.

The location of physician work happens in different locations (e.g., office, nursing home, etc.); however, the location for this study is situated in hospitals. An office setting has a fixed amount of space to practice; whereas, hospital medicine physicians' patient care can be geographically located throughout an entire hospital, from the emergency room to various patient floors. The context of patient care in a hospital requires hospital physicians to interact professionally and socially with a variety of people, such as nurses, pharmacists, other physicians connected to patient care, family and patients. Engagement in work in a hospital setting isn't necessarily linear and with relationships requires a network of multiple and varying interactions between the physician to patient, families, technology and medical staff connected to care.

Work design scholars posit that inclusion of social support factors are possibly related to motivation in the workplace (Humphrey et al., 2007). Similar hospital medicine physician workplace research found physician job satisfaction studies aligned with work design scholars research that social support and workplace context helped explain turnover intentions, job satisfaction, and organizational commitment more than other factors such as compensation or fiscal incentives (Glasheen et al., 2011; Hinami et al., 2012). These findings support the idea that other motivations are possibly embedded in social support specific to workplace context.

Hackman and Oldham's (1976) five-factor theory was the predominant work design theory for over 30 years but attention to tasks and motivation were given more attention than social contexts of work. Despite the wide adoption of the theory, there were two aspects of the theory that led to academic critique. The first is the theory focused on skill, variety, and autonomy, but neglected any social aspects of work design (Oldham & Hackman, 2010). Saturation of citations indicating acceptance of the theory led to a loss of critique from the psychological academic community (Humphrey et al., 2007). Although the theory has

contributed to work design theory, Oldham and Hackman (2010) have since discovered that the job characteristic model (JCM) neglects to explain the significance of social characteristics of work.

In the healthcare setting, the concept of what motivates workers presents measurement challenges. One of the difficulties scholars found when measuring motivation at the individual level (Oldham & Hackman, 2010) involved the complexity when caring for other humans in a healthcare setting. More specifically, multiple motivators may be in place at one time representing entangled and complex situations. For instance, in patient care, not all outcomes are positive. Patients admitted to hospice, where the sole purpose of work is to provide comfort care to the terminally ill, may present different questions related to why a worker would be motivated in what appears to be a sad situation. Thus, it is plausible other motivations for workers in a healthcare context exist (Humphrey et al., 2007). Due to the recognition and need for new theorizing in work design, scholars suggest new conceptual models of social context that include the “fluid relationships among people” (Oldham & Hackman, 2010, p. 27) while also being flexible in scope for systemwide changes at the individual task level (Torraco, 2005). Expanding on these concepts, as is suggested in this study, could be a multidimensional design that could recognize knowledge as product and additional considerations outside of Herzberg’s (1977) intrinsic and extrinsic motivators.

Medical workplaces can vary from an office setting to a hospital setting; however, some studies, as noted in the previous literature review, either distinguished these two workplaces related to research design or groups all participants and workplaces together. Therefore, to maintain the scope of environment and context research for this study, work design research

related to medical residents and interns were also included (Montgomery, 2014; Panagioti et al., 2017).

Burnout and Social Contexts

The social contexts of work are not fully defined in the literature but can be a factor that can contribute to burnout or engagement. Literature reviewed here is in context to burnout and engagement to further understand what has been researched.

Workers may experience a combination of burnout dimensions at different times under different conditions in the workplace. Meta-analysis of burnout research (Aronsson et al., 2015) found that if research designs' current distillation of three burnout dimensions were considered instead of (i.e., emotional exhaustion, cynicism, inefficacy) one or two, researchers might better understand the relationships among the dimensions to the individual. Aronsson et al., (2015) made the case that burnout is comprised of interwoven dimensions, thus focusing on one or two of the three burnout dimensions denies the scholarly community a whole picture of related research impact and connections in burnout research. As the theoretical framework for this study expands to include social support as an equally important concept, Table 2.1 provides research related to dependent social support factors and the relationship to burnout dimensions. The table highlights a unifying thread throughout the literature of the factor and role people have in relationship to the person experiencing burnout.

Table 2.1

Chronological Research on Social Support Factors Related to Burnout Dimensions and Work Design

Social Support Factors	Relationship	Author(s) Work design Burnout
Holistic patient care Patient/Family recognition Workgroup integration Occupational solidarity	Inverse relationship to burnout	Burnout (Hoff et al., 2011)
Supervisor support Coworker support	Sense of community related to all dimensions of burnout	Burnout (M.P. Leiter & Maslach, 2004)
Interaction outside organization Initiated interdependence Received interdependence Social support (i.e., advice and assistance from others)	Contributes to employee motivation and well-being	Work design (Morgeson & Humphrey, 2006)
Dealing with others Feedback from others	Acts as job motivator	Work design (Oldham & Hackman, 2010)
Support from supervisors Support from family and friends	Higher level support needed in rural hospitals	Burnout (Saijo et al., 2013)
Negative gossip Informal social support	Contributes to emotional exhaustion and depersonalization	Burnout (Georganta et al., 2014)
Social support + emotional resilience personality traits	Predicted lower levels of psychological stress	Burnout (Bore, Kelly, & Nair 2016)
Job support Job demands Possibility to exert control	Predictive of emotional exhaustion	Burnout (Aronsson et al., 2017)

Scholars have differing definitions of social support in the workplace. For example, research conducted with hospital medicine physicians in rural and urban areas found that social support, conceptualized as relationships with supervisors, co-workers, and friends, was a stronger contributing factor leading to job stress and emotional fatigue compared to urban physicians (Saijo et al., 2013). Social support in this context appeared to be represented as a relationship one has with his or her supervisor that could predict the degree of commitment one feels with the organization. These findings bring up the question, does social support need to be

different between urban and metropolitan based hospital medicine physicians? Are there other considerations in urban versus rural settings that require more, or less social support related to tendency for burnout? Likewise, Leiter and Maslach (2003) found that presence of supervisor and coworker support mediated the tendency for burnout across all occupations.

Social support is an important concept though ill-defined related to burnout. Other factors such as work life have contributed to burnout as a means of engagement, thus, scholars started to consider complimentary concepts to social support such as work life. The following discussion will integrate social support to work life, communication, and control.

Social Support and Relationships

Leiter and Maslach (2003) created the areas of work life survey (AWS) that measured the following factors of workload, autonomy, compensation, relationships, and organizational fairness. Positioned within this framework, Leiter and Maslach (2003) posited that community in the workplace was a central factor in mediating burnout. In essence, the model suggests that positive workplace relationships will provide access to resources, such as knowledge, skills, and materials of the workplace versus negative relationships that will hinder access (Leiter et al., 2014). The concept of community within Leiter and Maslach's (2003) areas of work life framework appears to place an emphasis on community as a resource where knowledge and skills from others in the workplace are indicative of a work community. The same authors suggest community should include strength of coworker and supervisor support and acknowledge a workplace where happy employees work together or individually; but still feel supported as indicative of strong community.

Social support can be identified in different places within and outside of the workplace. Morgeson and Humphrey (2006) suggested that interaction outside of the organization can buffer

negative effects of employee well-being and motivation. However, in some occupations, such as law or medicine, interactions outside of the organization are prohibited by confidentiality rules. All healthcare workers who have access to patient records are required to keep patient confidentiality; they cannot share any aspect of a patient's medical condition with any individual other than people who are authorized (i.e., designated family, spouses). Preventing one from verbalizing and sharing with friends, family, or others about particularly difficult or emotionally taxing patient situations based on confidentiality rules can be challenging and has been associated with increased exhaustion and disengagement (Løvseth, Fridner, Jónsdóttir, Marini, & Linaker, 2013). Based on this context of authorized confidentiality, it is plausible that the requirement to keep challenging work situations internal without a peer outlet to talk with could contribute to rural hospital medicine physicians' experiencing a need for more social support (Saijo et al., 2013). One unanswered question remains of how do hospital medicine physicians receive social support outside of their work life when confronted with confidentiality requirements? For example, it is not uncommon for hospitalists to treat end-of-life issues for patients. Treating patients who are facing incurable diseases place an emotional load on the hospital physician who is responsible for this phase of care.

In addition to relationships with peers and coworkers, relationships with one's supervisors are predictive of the capacity for organizational change and an employee's commitment to the job (Leiter et al., 2014), thus it is plausible that the strength of supervisor support with employees contributes to social support. Supervisor support can be considered a component of community that represents leadership and guidance in a group. It was also noted that the most destructive aspect of community is unresolved conflict in the workplace (Leiter & Maslach, 2003). Expanding on the existing burnout and social support concepts connected to

supervisor and employee relationships, unresolved conflict appears to be an additional source of stress.

The role of unresolved conflict among peers over time can be contribute to stress and be an obstacle for creating healthy relationships for individuals. Related to conflict is how employees, coworkers, communicate and resolve conflict. There may be a sub-context of conflict expressed through different communicative contexts (i.e., perceived negative or positive). The effect of negative gossip, or “negative evaluative talk” (Georganta et al., 2014, p. 76) was confirmed as a contributing factor to emotional exhaustion and depersonalization. These results align with the presumption that communication exchanges are predominantly positive. Based on Georganta et al.’s (2014) findings, communication acts as a gateway for inclusion or exclusion in the workplace through different communication channels. Centered on this concept, it is plausible social support can also include different types of support that includes the absence or presence of negative talk and undermining suggesting differing levels of connectedness and perceived control in the workplace.

Work Design

Interactions and communication within groups are considered variables of social behavior that can contribute to a sense of cohesiveness or community depending on how the exchange is perceived (Homans, 1958). Social behavior is expressed through norms established through socialization of members in organizations. For example, socialization includes the “thought and action(s)” subsequently observed by workers (Van Maanen & Schein, 1977, p. 1) such as appropriate greetings, or actions involved when solving problems. Continuing with this thread of social exchange among workers, Grant’s (2007) model of relational work design expanded on Hackman and Oldham’s (1976) five-factor motivational design that posited workers

are motivated to the degree the worker has contact and a perceived impact on the beneficiaries. Thus, workers are motivated through the act of prosocial behavior seen through the psychological state of relationships and with the worker outcome of knowledge in how the beneficiary was affected (Grant, 2007).

The stance taken in this study is physicians have been shown to be satisfied with patient care provided; thus, it is possible that relationships could serve as a motivator for their work. What appears to be missing from our knowledge is when a hospital medicine physician experiences burnout, does patient care continue to be a prosocial motivator or are there other relationship factors that provide hospital medicine physician satisfaction? Based on Grant's (2007) relational worldview, it is possible that a physician's commitment to patient care serves as the prosocial motivator. The context and setting of a hospital are an important variable for consideration because hospital medicine physicians see patients without connecting for follow-up care, which is a mediating factor for the relational model.

Burnout and Socialization

Socialization refers to how newcomers learn about their new organizational role (Van Maanen & Schein, 1977). Socialization research is included in this review based on burnout research that has stated the phenomenon is socially situated (Freudenberger, 1974; Leiter & Maslach, 2003).

Research on job satisfaction for hospital physicians suggests a positive relationship exists between quality of work and career choices. Specifically, hospital medicine physicians have reported satisfaction with their career choice (Glasheen et al., 2001; Hoff et al., 2002), quality of patient care they deliver (Hinami et al., 2012) and relationships they have with colleagues (Glasheen et al., 2001; Hinami et al., 2011). Thus, within the context of work, relationships with

work-related individuals and the organization in a broad sense are the social characteristics. Based on the positive relationship of career choice, quality of patient care (e.g., work), and work relationships formed at work, what could represent the process of integration into their career?

Socialization research is typically focused at the new hire level as the newcomer learns the norms of the organization necessary to do the job (Van Maanen & Schein, 1977) and can be focused at the individual or organizational level. At its core, however, the socialization model suggests organizations offer more than “just merely a job”(Van Maanen & Schein, 1977, p. 961), but an individual commitment to a “distinct way of life complete with its own rhythms, rewards, relationships, demands, and potentials” (p. 961). The same authors related how work contributes to our professional identity complete with negative or positive experiences during our lifetime. For example, many of us remember our first job with implicit stories about what we did and how it may have formed our worldview on work through what we may have learned, but also who we worked with and the impact on our work story.

Scholars suggested organizational socialization starts at the beginning when the newcomer learns the ropes of the organization and how patterns of thought get passed on from one generation to another (Van Maanen & Schein, 1977, p. 964). Socialization at work has also been treated as a learning process that includes the “collective social dimensions” such as quality of relationships in the workplace (Korte, 2010, p. 41). Van Maanen and Schein (1977), during their conceptualization of socialization, questioned how norms, behaviors, and attitudes pass on from one generation to another generation of workers.

Expanding on current and historical research on socialization (Irby & Hamstra, 2016; Korte, 2010; Van Maanen & Schein, 1977), it appears physician socialization might take place during medical school observed by modeling from their teaching physician (i.e., attending

physician). Socialization of physicians is conceptualized as underlying assumptions that are acquired during medical training with different implications. Bandini et al. (2015) found in a qualitative study of physicians caring for critically ill patients that there was a “hidden curriculum” (p. 57) for medical residents, defined as “the commonly held ‘understandings’, customs, rituals, and taken-for-granted aspects of what goes on in the life-space we call medical education” (p. 57). Specifically, Bandini et al. (2015) revealed the process of physician socialization was represented through learning and by what medical students presented through an implicit hierarchy in medicine represented by value of research versus clinical practice. There were also two different aspects of a medical student’s education. The first related to competencies such as maximizing efficiencies, providing excellent patient care, and working in medical teams (Bandini et al., 2015). The hidden curriculum referred to the values and behaviors modeled by their attendings throughout medical school. Medical students observed their attendings retreat physically and emotionally after providing comfort to patients in particularly difficult situations, with the expectation of the medical student to adopt the same behaviors (Bandini et al., 2015; Phillips & Dalgarno, 2017). The authors suggest that medical students are held accountable for their detachment perhaps as much or equal to the amount of empathy that is required for patient care. Lack of empathy and compassion is also present in physicians who experience burnout which leads to one of the most impactful dimensions of burnout represented by cynicism.

Although Bandini et al.’s (2015) research found subversive socialization components leading to detachment from practicing medicine, other research identified socialization related to medical students reveal a shift from medical resident to physician. Related to Van Maanen and Schein’s (1977) inquiry how professional norms transfer from generation to generation, Phillips

and Dalgarno (2017) found the passage of student to physician was presented through shifting emotion and compassion away from themselves or for patients. Indeed, participants claimed in the study that compassion was considered a liability instead of an asset, but also a necessary characteristic to adopt to be viewed as a credible clinician (Phillips & Dalgarno, 2017). As the medical student passes from the social identity of student to licensed physician, adoption of behaviors is an expected part of socialization in medicine. Phillips and Dalgarno found participants lamenting the passage into the medical professional represented by neglecting balance in self-care and commitment to working long, emotionally exhausting hours.

Competency and measurement of medical professionals who earn a medical degree was adopted by the medical community using Miller's (1990) pyramid, a concept consisting of four performance constructs. Figure 2.3 illustrates Miller's professionalism conceptual design.

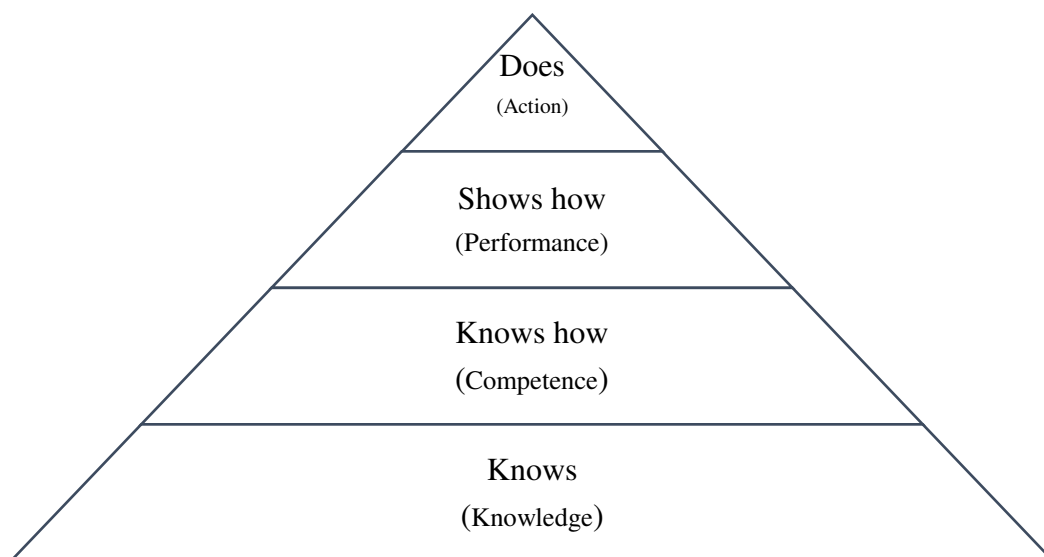


Figure 2.3. A conceptual model of medical student assessment. Adapted from “The Assessment of Clinical Skills/Competence/Performance,” by G. Miller, 1990, *Academic Medicine*, 65, p. s65.

Medical education scholars suggest an additional performance construct be added above the top of the pyramid called “Is” (Cruess et al., 2016). The suggested construct is defined by

the “physician (who) demonstrates the attitudes, values, and behaviors expected of one who has come to “think, act, and feel like a physician” (Cruess et al., 2016, p. 2). Competency of becoming a physician can be considered as more than the ability to synthesize clinical data. Cruess et al. (2016) regarded this additional performance criteria to include appropriate behaviors expressed by the student through their education leading to licensed physician; however, there is no direction for the individual who models the values and behaviors to support the additional construct of “Is.”

Social support in the workplace. Social support was briefly referenced earlier as a mediating component of burnout and engagement. Burnout scholars (Leiter & Maslach, 2004) and hospital medicine authors (Hinami et al., 2011) have acknowledged that social support provides a protection against burnout for hospitalists, however lack of social support can contribute to stress. Scholars conceptualized the social aspect of work in different ways that included social support (Maslach, 2003), community (Shanafelt & Noseworthy, 2017), and interpersonal transactions (Leiter & Maslach, 2003). For Maslach (2003), social support included the quality of interpersonal relationships and related transactions (p. 191) such as high work demands, low resources to complete the work, chronically demanding work and the presence of social conflict (Kahn, 1990). It was within social conflict, that social support was embedded, and the absence or presence of unresolved conflict was a predictor of burnout in the workplace (Maslach, 2003). In concurrent research that addressed areas of work life connected to burnout, Leiter and Maslach, (2003) defined community as “the overall quality of social interaction at work, including issues of conflict, mutual support, closeness, and the capacity to work as a team” (p. 98). Maslach (2003) furthers the importance of social relationships at work as a dimension associated with work demands and resources.

Additional conceptualizations of social support consider the impact that people and relationships have in the workplace. Theoretically, social support has been considered as a mediating factor to help individuals cope with stress (Bliese & Britt, 2001; Cohen & Wills, 1985). Bliese and Britt (2001) suggest that a positive social environment confirms one's social identity, provides instrumental aid when needed and emotional aid. Hence Bliese and Britt's conceptualization of social support intersects and intertwines with Kahn's (1990) theory of engagement and disengagement in the workplace. For example, Kahn (1990) posited that psychological safety, meaningfulness and availability need to be present for the individual to fulfill one's role at work. Thus, it is plausible that in a socially supportive environment, one's social identity is confirmed through interactions that support aid to the individual, and those acts of aid are met to circumvent or diminish the effect of stress.

Burnout has been identified as a reaction to chronic stress in the workplace, however a distinction will be made here between chronic prolonged stress and stressful events. An entirely stress-free workplace is not completely achievable, and it is assumed here that there will be times of stress for workers. An example of a stressful event are firefighters who fight fires and may have to save victims from fire, however firefighters experience stretches of interspersed time when they are not fighting fires but are still working. Whereas burnout (i.e., exhaustion, cynicism and inefficacy), is considered the result of continued stress where the worker does not have the internal (i.e., cognitive, psychological, physical) resources to work through prolonged chronic stress, stress has been the most commonly studied factor of the three factors. This distinction is made for consideration of work contexts of stress and whether stress is a continual event, or temporal (e.g., stressful event->time to recover) event.

A positive, socially supportive workplace can be considered an asset for workers who have stressful work. A positive workplace is where availability of resources exist such as instrumental or emotional support (Bliese & Britt, 2001), and a presence of social networks (Brass, Galaskiewicz, Greve, & Tsai, 2004). Instrumental support can be conceptualized as tangible support such as 24/7 informational technology support (e.g., IT or internet support) in a hospital setting. Emotional support can be conceptualized as expression of concern (Kossek, Pichler, Bodner, & Hammer, 2011) toward the effected worker. Social network theory assumes networks consist of relationships with varying closeness and separation (Brass et al., 2004); but existence of a social network does not necessary imply support. Conversely, although some form of a social network must exist from which to draw on for social support, it is posited here that the individual is embedded and uses his or her social support network dependent on the quality of the network and needs of the individual.

Additionally, social support can provide a buffering effect against stress at work in (Cohen & Wills, 1985; Meyerson, 2017). Cohen and Wills (1985) theorized social support is constructed of structure (existence of relationships), function (extent of interpersonal relationship availability). However, the availability of support was not shown to be as important as the quality of available support. In other words, a hospital system could provide structural and functional support, but the quality of the relationships one has at work is more important in buffering stress (Cohen & Wills, 1985). Thus, it is possible a main effect against stress can be experienced from both forms of social support (e.g., instrumental and functional) and a better understanding of how workers consider the quality of relationships and with whom can provide insight into how and who is included in a worker's social support network.

Other professions that require service to the community like hospital physicians are firefighters. Firefighters work closely as a team and share common physical space comparable to hospital medicine physicians, if the facility where the physicians work provide it. Shanafelt and Noseworthy's (2017) conceptual design for physician engagement included the concept of commensality or sharing a meal together, borrowed from firefighters who work extended hours together (i.e., >24 hour stretches). The intentional reserved space for physicians can contribute to a culture and atmosphere of community that was found in firefighter communities (Shanafelt & Noseworthy, 2017). The authors did not discern whether the framework is intended for office or hospital environments; however, the framework provides opportunity for practice and work design to further define and support community in hospital medicine workspaces.

Hoff et al., (2002) found social support was a predictor to longevity in the hospital medicine field. The authors defined and measured social relations for hospital medicine physicians as patient/family recognition, workgroup integration, and occupational solidarity. The authors further defined "favorable social relations" (Hoff et al., 2002, p. 76) as camaraderie, acceptance of one's peers, and recognition that may otherwise mitigate the effects of negative work conditions such as the effects of economic impacts related to work. Strength of social relations for hospitalists was theorized as a means of protection against burnout for hospitalists (Roberts et al., 2013); however, research on how social relationships can protect against engagement or disengagement is not known. Of note, economic rewards were found to be less important and impactful related to burnout compared to social support for hospital medicine physicians.

In a study using the MBI to measure the relationship of work demand and social support for hospital medicine physicians in rural versus urban areas, Saijo et al. (2013) found rural

hospital physicians experienced greater job stress than their urban peers connected to lower social support. The authors found urban physicians had higher work demands and lower control over their work; but significantly lower stress associated with social support, defined as relationships with supervisors, family, and friends. The authors posited that expectations from urban patients were possibly higher than those of urban physicians due to the demographic of patients and the availability of more specialty physicians on staff. Saijo et al.'s research suggested rural hospital medicine physicians acquire "empowerment" (p. 230) over social support, however this concept was not defined.

Social networks at work can provide tangible and hidden support. For example, individuals can access their networks information and knowledge that may not be tangibly available by other means other than through interpersonal communication. Inherent in this concept of individual social network utilization, is the question of the strength of one's network to collect information or support, consistent with Cohen and Wills' (1985) theory that social support is structural (e.g., informational) or functional (e.g., degree of interpersonal availability). Indeed, the degree and strength of a singular functional relationship provides stronger support than multiple superficial relationships. Thus, it is suggested here that the individual possibly determines who is in her or his network and places a value of one's network based on the strength of the relationships in and is affected when there are changes in one's social support network either within or outside individual control. The interdependence of employees on each other to cope with difficult or joyful times at work would be variable depending on the strength and type of existing relationships. For example, some may be more affected by the departure of a worker with whom he had a close, supportive relationship compared to a coworker with whom he had a superficial relationship.

Changes in an employee social support network that are beyond the employee's control due to factors such as downsizing, employees leaving the organization, or relocation of employees can have a positive or negative effect on how employees perceive the strength of their social support network. Social networks represent an interconnection of existing relationships in organizations (Brass et al., 2004) that can function as resource or stress for individuals. For instance, Brass et al.'s (2004) research revealed individuals choose people to add to their network based on capability and resource needs. However, of importance to this study, what occurs for individuals if they do not have control over individuals to add to their network? Does lack of individual control over the possibility of losing needed resources contribute to a stressful environment or is it predicated on the kind of resource needed? To further this concept, organizational leaders would find value in being aware of presence, absence and strength of a worker's social supportive networks as further evidenced by strong social support to increased job satisfaction and retention (Hinami et al., 2012; Humphrey et al., 2007; Koy et al., 2015). In order to gather a better understanding of a social support network, the next section will focus on the conceptual framework for the study.

Theoretical and Conceptual Framework

The following discussion will provide the theoretical and conceptual framework for the proposed study. Discussion begins with the (a) the individual hospitalist situated in the study, then (b) description of the social context construct, and (c) discussion of relationship of work, burnout, engagement and disengagement.

Going forward from a perspective of what is known about burnout, engagement and work design this study will contribute to the question of how individuals use their social support network. Thus, the overarching question that guides this study is what is the role of social

support networks related to burnout and engagement for hospitalists? The following conceptual framework (Figure 2.4) provides a further visual guide for the study. Figure 2.4 suggests a possible relationship of burnout, engagement to social support. Discussion and integration of the framework follows Figure 2.4 and 2.5.

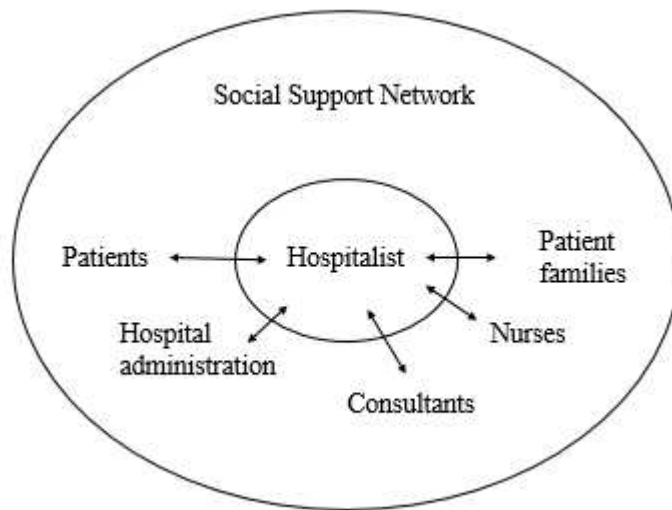


Figure 2.4. Conceptual model of the hospitalist social support network.

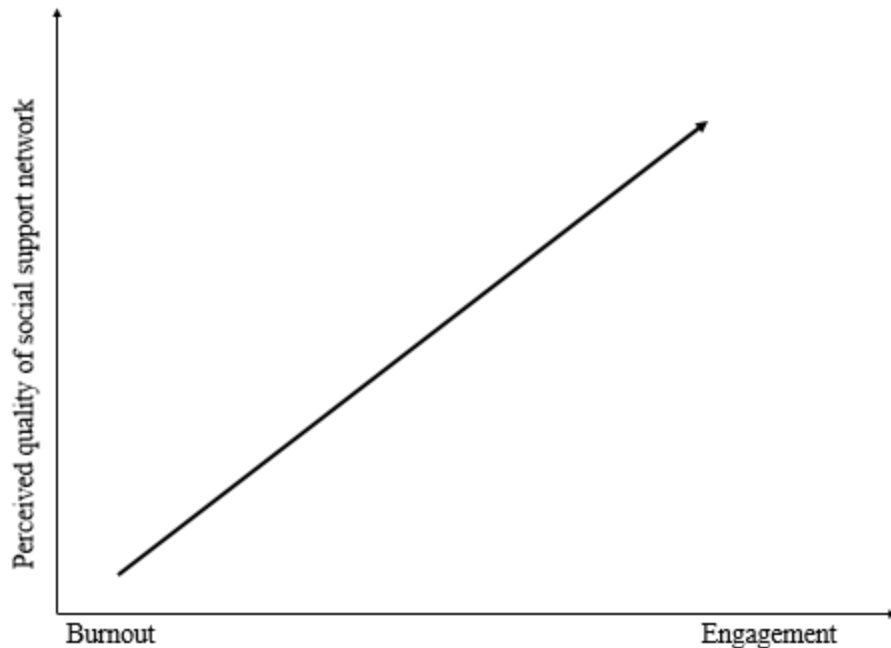


Figure 2.5. Suggested effect of individual social support network interactions related to burnout and engagement.

The individual. Research has revealed that there appears to be a cognitive shift an individual undergoes moving from student to becoming a professional. In the context of this study, medical students begin their way into a profession identified by early traits inherent to the profession like being virtuous, compassionate, and ethical (Phillips & Dalgarno, 2017). By the time a medical student transitions into a professional physician (i.e., licensed medical doctor or M.D.), different attitudes and behaviors appear and are expected, like detachment behavior with devotion to the craft of medicine and outward competence but privately feeling uncertain in making medical decisions (Eitel, 2000).

The process of the individual moving from student to becoming professionalized aligns with Van Maanen & Schein's (1977) theory of socialization which suggested as individuals become socialized into a group, information and values are transferred in a social context. Thus, it is posited that the experiences professional physicians share during professional training

contributes to a social identity connected with different physician groups within a hospital setting. The theory of social identity (Hogg, Abrams, Otten, & Hinkle, 2004) supports the idea that physicians want to be part of a social group at work. Because of the various social groups within a hospital with variable professional identities, hospitalists represent multiple groups that constitute complex socially supported structures.

Building resilience and strength for the individual to draw upon requires a supportive work community from which to draw. Wilson and Ferch (2005) suggested that caring relationships promote and support individual resilience, providing hope in hopeless situations or during times of chaos and change. Of note, Wilson and Ferch found that building a community of caring relationships requires strength and openness among members so that when disagreement occurs, there is freedom to engage in discussion of difficult personal or organizational challenges and issues. Physicians learn that dual behaviors associated with socialization, like care and empathy, are successful traits to possess for professional doctors. However, physicians also learn disengagement behaviors and are expected to exhibit different behaviors especially during difficult emotional situations with patients and families as they near medical licensure (Phillips & Dalgarno, 2017). For instance, when faced with difficult patient care issues, doctors learn behaviors modeled by their attending physicians to retreat emotionally and physically, ultimately disengaging from being a compassionate practitioner (Bandini et al., 2015). Furthermore, the unspoken cultural expectation of normative behavior learned during training has been suggested to be a stronger factor contributing to one's social identity formation and possible cause of burnout (Bandini et al., 2015; Frederic, 1998; Hafferty & Franks, 1994; Montgomery, 2014; Suchman et al., 2004) Thus, it is theoretically plausible that a resilient physician may not be able to overcome difficult situations due to learned, normative behavior.

Social context. A strong shared social environment can moderate the effect of a stressful workplace for individuals and work groups (Bliese & Britt, 2001). Bliese and Britt (2001) defined a positive social environment as one that includes confirmation of social identity in a group, instrumental aid, and emotional support (p. 426). The attention given to measuring individual burnout and individual social support, has been studied more than the contextual effects related to a social environment. In burnout and social support context research, multi-level analysis of contexts has been difficult to capture empirically. However, collective quantitative burnout research suggested a mitigating effect embedded in social support (Bore, Kelly, & Nair, 2016; Meyerson, 2017; Shanafelt & Noseworthy, 2017).

Burnout has been referred to as a social problem for many years (Freudenberger, 1974; Leiter & Maslach, 2017; Maslach & Jackson, 1981), leaving opportunity for further scholarly attention to understanding the relationship of burnout and social constructs at work. The concept of social problems has not been formally defined, however it is suggested here that social problems logically involve perceived conflict people have at work among individuals or groups of people. It is recognized that not all problems can be solved in the workplace, thus it is plausible that individuals adopt coping strategies to achieve work expectations. Social support theory posits that positive social environments provide confirmation of social identity that includes instrumental and emotional aid (Bliese & Britt, 2001). Understanding an environment where supportive relationships can exist and grow for hospital physicians, has not been explored from a qualitative perspective. Hospitalists forego an outpatient clinic practice (Wachter & Goldman, 1996), where there would conceivably be communication about staff changes or physician input into personnel choices. Hospitalists are physically scattered throughout a

complex physical and hierarchical organization; an environment that represents a complex environment (Starrin et al., 1990) nested inside a larger organization and/or institution.

Social identity for individuals can serve as vital connections in social contexts. Haslam (2004) defined social identity as the individual sense of oneself within a group who “shares goals, values and interests with others” (p. xxi). Based on the theory of social identity, hospitalists will have a stronger sense of themselves if they interact with others in their group; however, little is known about the process and circumstances of this phenomenon.

The following theoretical discussion discusses the three concepts from job satisfaction and hospital environment research that indicate a positive social supportive hospital environment could mitigate stress and burnout: (a) relationships with supervisors (Saijo et al., 2013), informal social support from peers (Georganta et al., 2014); (b) support from patient/clients (Glasheen et al., 2011; Hoff et al., 2002); (c) absence or presence of conflict (Rizzo et al., 1970); and (d) opportunity to elicit advice from peers (Morgeson & Humphrey, 2006).

Relationships and social support. Burnout scholars (Maslach et al., 2001) and researchers who focus on the hospitalist profession (Glasheen et al., 2011; Hoff et al., 2002; Roberts et al., 2013) agree that close relationships and social support from supervisors and coworkers can mitigate the effect of burnout. What is not known about relationships in this context is the quality of the relationships and support. For instance, academic hospitalists have been found to value personal relationships with their hospital division leaders more than their overall relationship with the organization (i.e., hospital) where they work (Glasheen et al., 2011); however, there is no known investigation of how one has a relationship with an organization and in this context. If close relationships mitigate burnout in this context, knowledge of a close relationship for a hospitalist is needed.

Patient confidentiality rules require employees to keep conversations regarding patient care situations to stay within a hospital. This brings up the question if outside social support is possible for healthcare workers due to confidentiality constraints. Hospitalist scholars (Hoff et al., 2002) and work design theorists (Morgeson & Humphrey, 2006) agree that relationships with peers, patient/clients, and co-workers contribute to a strong work community. In a meta-analysis that compared inpatient to outpatient physicians, the role of social relationships contributed in mitigating burnout (Roberts et al., 2013); however, how hospitalists operationalized social relationships in a workplace where it is common to be physically scattered throughout the day was not revealed. Nevertheless, the interplay of the individual and relationships formed in the workplace appear to be an important element related to the possible strength of a work environment.

The theory of communities of practice further illustrates how a sense of community and cohesiveness among members contributes to a resilient hospitalist culture. Wenger's (1998) theory of communities of practice is based on the premise that within organizations people will form groups based on three concepts: (a) a common goal or mission; (b) the way the group functions and engages with each other in a social context; and (c) resources (i.e., routines, sensibilities, artifacts, vocabulary, artifacts, etc.) that are shared develop over time (p. 2).

Although physicians have a shared identity as professionals, according to Wenger (1998), this might not constitute a community of practice without further knowledge of the context. Using Wenger's (1998) theory, hospitalists reflect communities of practice because they are bound by what is important in their setting and self-organize in response to needs of patients and use of resources, such as various technologies and expertise in the hospital.

To summarize relationships and social support, theoretically, members in a hospitalist community of practice negotiate commonalities through the strength of their relationships, as they temporally and physically come together throughout the day. Thus, a hospitalist community of practice would provide regular opportunities to share experiences and knowledge and can provide support in times of personal and group stresses. Logically, individual hospitalists are comfortable with their peers and would enjoy connecting with those who are like them. This dynamic represents a socially supportive environment that includes positive, supportive and caring relationships. What is not known about hospitalist relationships, is what relationships and with whom provide a supportive network that is strong enough to mitigate burnout.

When workers disagree with their peers at work, this can result in unresolved conflict. Unresolved conflict with inter-specialty physician teams was found to be a contributing factor to increased burnout for physicians (Kavalieratos et al., 2017). Additionally, it was revealed in hospital settings that gossip, defined as negative talk about an absent third party, contributed to increased stress and burnout, decreased levels of engagement at work and suboptimal patient care (Georganta et al., 2014). Continuing with this idea of conflict, it was also found in burnout literature that the most significant contributing factor to destruction of workplace community is unresolved conflict (Leiter et al., 2014). Conversely, from a communication perspective, gossip can also be considered an alternative positive pathway for information, or another way of talking about what is happening that is not necessarily stated through formal channels such as meetings.

Attention is given to gossip here because of the reported effect negative gossip has on individuals particularly in hospitals and healthcare settings (Georganta et al., 2014) as a stressor. Thus, conceptually, it can be assumed that some form of gossip is taking place, but what form and function it has within the social contexts of work is unknown. Furthermore, little is known

about the perception and role that conflict can serve as informal communication pathways to obtain information in a highly structured, hierarchical system like a hospital. Because of the detrimental effects of negative gossip, the concept is considered worthy of studying alternative pathways for communication and socialization.

What can be taken from this theoretical discussion regarding conflict is that it appears the process and method of how individuals use social relationships contributes to strong workplace communities. Leiter and Maslach (2003) go on to state that “people thrive in community and function best when they share praise, comfort, happiness, and humor with people they like and respect” (p. 98) which confirms the perspective of social support theory that suggested a positive social environment helps individuals cope with stress on the job (Bliese & Britt, 2001). From the theoretical lenses of socialization and community of practice, it is plausible that norms are established and reinforced with respect to how conflict is or is not resolved and subsequently treated through individual negotiation of community.

In summary, it is assumed conflict in the workplace will be present and unavoidable at varying times. Conflict in the context of the study consists of negative talk about others behind their backs (e.g., gossip), however gossip is also shown to be an alternative channel for positive communication (Georganta et al., 2014). Consideration of conflict in the context of constructing a socially support network is needed because of the detrimental effect conflict has on the individual and group.

Based on the results of the social support network research suggested in this study, it is suggested that the individual will self-report burnout or engagement based on the perception of the quality of the hospitalist social support network. However, investigation into what constitutes a hospitalist social support network and the relationship to individual burnout or

engagement is the focus of this study. Based on the social support network research results it is expected further knowledge will be found to understand the relationship, if any, of the perception social support networks have on hospitalist burnout or engagement.

Summary

In summary, burnout in workers has been conceptualized as emotional exhaustion, cynicism, and a lowered sense of personal accomplishment (Schaufeli et al., 2009). Burnout and hospital physician research suggested social support is a factor contributing to burnout, but the definition and how social support is situated within work contexts in the literature is limited as to the form and function of support. Burnout stressors include lack of control over one's workload, lack of resources to accomplish tasks, and lack of social support. Initial observations of a 'burned' out worker was first experienced as a reaction to lowered trust of leaders and phenomena embedded in social contexts of the workplace (Freudenberger, 1974; Maslach, 2003; Starrin et al., 1990), suggesting a possible lack of a feeling of support or let down from one's leader. Despite early observations of burnout linked to one's perception and relationship with leaders (Freudenberger, 1974), research has focused on changes at the individual level to cope with stressful environments instead of including organizational situations related to the individual. This study will go beyond tangible changes that have been researched such as reduced workload or variable work schedules toward a deeper understanding of how hospitalists experience burnout, engagement, and social support networks in their workplace.

CHAPTER THREE: METHODS

The purpose of this study was to increase our understanding of burnout, engagement, and social support as experienced by hospitalists using the following research questions: (a) What is the nature of burnout experiences for hospitalists, (b) what is the nature of engagement experiences for hospitalists, and (c) what is the nature of social support networks for hospitalists? This chapter includes the philosophical approach, research methodology, research questions, sampling and participants, data collection, data analysis, coding, and trustworthiness approach for research.

Philosophical Approach

A constructivist philosophical approach was used for this study. Positivist and post-positivist paradigms are based on the premise that a reality exists in context-free situations; whereas, the constructivist philosophical assumption is that reality is socially constructed (Merriam, 1998; Guba, 1990). Going with this assumption, lived experiences of burnout, engagement and social support networks represented socially constructed realities for the participants in this study. Additionally, burnout survey research revealed that exhaustion can result from too much work without appropriate resources (Hinami et al., 2012; Leiter & Maslach, 2003; Sutinen et al., 2002); however, inherent in this implication is what constitutes an appropriate resource in a hospital environment for a hospitalist.

A constructivist worldview provided a way to understand the social nature of the phenomenon and posits reality and values are socially constructed and are, thus, contextually situated (Guba, 1990) with multiple interpretations of reality (Merriam, 1998). As such, contextually situated research considers differences but also similarities in different locations

adding to internal validity. For instance, contextual considerations of the intensity of exhaustion and quality of work environment can be explained further through a qualitative method(s). In other words, a constructivist stance considers a value laden context that includes “uncertainty, flux and transformation” (Guba, 1990, p. 71) in relation to the phenomenon and participant. Therefore, to study a socially constructed, complex environment required the choice of qualitative methods that provided a descriptive and interpretive lens into the phenomenon in this study.

Literature on the topic of burnout and engagement suggests that to further define and understand the existing empirical quantitative research, a different approach to the phenomenon is needed by and for the individual physician (Lemaire & Wallace, 2017). Thus, the positivist/post-positivist research is informative at one level as a means of awareness of the phenomenon; but also limited in ways that can understand a phenomenon at a deeper level where meaning is constructed at multiple levels (Merriam, 1998). From a broad constructivist viewpoint, results of this study can be used for further defining knowledge of the socially constructed hospital environment that could lead to future burnout or engagement interventions for hospitalists.

The limited qualitative research on burnout suggests narrative inquiry is needed to better understand the context and structure of a hospitalist workplace (Kavalieratos et al., 2017). Current research on physicians’ process of social identity during medical training (Irby & Hamstra, 2016; Phillips & Dalgarno, 2017) suggests that physicians may be learning avoidant behavior as a coping strategy to stressful, unpleasant, or poor (e.g., chronic illness or death) patient outcomes experienced at work. As such, this study sought to further explore social support theory constructs (Bliese & Britt, 2001; Kossek et al., 2011) by understanding how

hospitalists experience certain aspects of their workplace that included burnout, engagement and their social support networks.

In summary, this study took a constructivist stance that allowed participants to construct who is included in their social support network and how these networks affected the individuals' relationship to work. More specifically, participants were allowed to participate within a narrative inquiry framework where participants shared their lived experiences of burnout and engagement with the opportunity to construct singular or multiple meanings. Furthermore, these meanings related to what individuals engaged in, whom they engaged with, and how they engaged in relation to individual social support networks.

Researcher's Perspective

My positionality in this study has personal significance. Being a non-clinical medical administrator for the past 30 years has provided me countless opportunities to observe social situations connected to burnout, engagement and social contexts. Because of the expansive time spent with physicians who work in hospitals and after participating in active collaboration with physician leaders over many years, the cumulative experience is not intended to impose personal meanings in this study, but instead, provide perspective on alternative meanings. Researcher experiences related to specific studies provides other possibilities of meaning (Corbin & Strauss, 2008) that can enhance and enrich research. Caution will be taken to stay empathic and allow participant experiences to come forth.

Research Methodology

This study was designed to understand how participants experienced burnout, engagement and social support networks. Understanding lived experience is situated in qualitative methods; and basic qualitative research design employs analysis through interviews,

document analysis and observations (Merriam & Tisdell, 2016). Merriam (2002) stated there are three hallmarks to qualitative research: (a) how people attach meaning to their experiences; (b) the researcher is the instrument (compared to the survey for quantitative methods); and (c) analysis of findings are rich and descriptive. Qualitative research methods contributed to understanding the social nature of work because little was known about how hospitalists interacted with their work environment. Since their environment is considered a socially constructed phenomenon (Merriam, 1998), an epistemological stance using basic qualitative research in this study was used to understand how hospitalists experienced the “phenomena as social” (Vagle, 2014).

Some scholars consider participant viewpoints unique in their own right and necessary for inclusion because of the lens workers have in making sense of their reality (Shuck, Rocco, Albornoz, & Carlos, 2011). Use of qualitative and quantitative methods have limitations depending on what knowledge is sought. In this case, qualitative methods have been scrutinized due to the subjectivity of the researcher as the instrument. Merriam (2002) suggested identifying researcher bias in order to increase transparency in qualitative research. To this end, identification of bias and reflective memos aids the researcher to keep perspective during data collection, analysis and findings.

Research Questions

This study sought to answer the questions: (a) What is the nature of burnout experiences for hospitalists?, (b) What is the nature of engagement experiences for hospitalists?, and (c) What is the nature of social support networks for hospitalists?

An interview protocol was created (Appendix B) to guide the interview portion of the study. During the time when participants filled out the exploratory social support network

survey, a guiding question was provided for participants and is listed below. Overall, there were main questions connected to the research questions and study protocol. For example:

- Explain a time when you experienced burnout at work. What was the specific situation that led up to your experience?
- Explain a time when you experienced engagement at work, or when you were having a really good day. What was the specific situation(s) that provide an example of engagement?
- Explain how important your social support is for you at work. What role or department is most important in your network? What role or department do you receive the most/least support from? What department or role would you like to receive more support from but currently do not?

These three questions aligned with early analysis categories and provided a foundation to final conceptual analysis for the study.

Basic Qualitative Method

Data collection for basic qualitative research is accomplished through interviews, observations and/or document analysis (Merriam & Tisdell, 2016). The process of comparison and contrast (Guba, 1990) through individual perceptions of burnout, engagement, and social support networks provided an empirical lens of deeper inquiry to further understand the phenomena. Staying true to a constructivist philosophical stance alluded to earlier (i.e., Guba, 1990) meant that the most beneficial choice of method was the use of semi-structured interviews. Subsequently, the process of analysis that leads to subsequent findings in basic qualitative methods is accomplished by uncovering reoccurring patterns and themes within transcribed data (Merriam & Tisdell, 2016).

A constructivist paradigm and narrative inquiry guided the study. With qualitative instrumentation, the researcher is considered the instrument to achieve co-construction of meanings for participant's lived experiences related to the phenomena under study (Guba, 1990). For instance, a constructivist lens applied to narrative interviews would be considered a co-constructed interview that invites dialogue between the researcher and participant using everyday talk that included turn-taking, relevance, and exit talk (Reissman, 2008). When conducting interviews in qualitative research, researchers are cautioned against adhering to rigid techniques and stay open to stories and experiences told by participants (Reissman, 2008).

Qualitative research methods provided insights into social phenomena when extensive quantitative research exists (Bazeley, 2013; Reissman, 2008). Although a considerable amount of quantitative survey research on burnout and engagement existed (McCray, Cronholm, Bogner, Gallo, & Neill, 2008; Montgomery, 2014; Panagioti et al., 2017; West et al., 2016), questions remained about how hospitalists experienced burnout and engagement; and how they constructed their social support networks a hospital context. As Krathwohl (2009) suggested, qualitative research is appropriate when there is a "concern with local knowledge and with perceived and constructed reality" (p. 236). Dauber, Fink, & Yolles (2012) echoed a similar thought process claiming answers to complex phenomena require complex answers (p. 13). Thus, semi-structured interviews provided further inquiry into how hospitalists socially constructed and made meaning of these phenomena.

Sampling and Participants

Purposive sampling is a method of focusing on particular populations with shared or different characteristics that can answer or contribute the most insight to the research question and pre-defined criteria (Merriam, 1998). Thus, in this study purposive sampling supported the

research as it provided depth to the interviews with hospitalists that included self-reported feelings of burnout or engagement. Temporary hospital medicine physicians (e.g., locum tenens) and physicians who work in specialties other than internal medicine were excluded from the study.

The chosen population sample for this study was hospitalists, or hospital medicine physicians, defined as physicians who provide the majority of clinical care in a hospital setting (Wachter & Goldman, 1996). Wachter and Goldman (1996) predicted that hospitalists would dominate hospital care in hospital settings but also sacrifice an office practice to concentrate on care delivered in a hospital. It is recognized that it is a common practice for some physicians to practice both in a hospital and in an office setting, so for this study participants were required to meet two following criteria for inclusion in this study: (a) currently practicing hospitalists who deliver >75% clinical patient care in a hospital setting, and (b) be practicing for a period of a year or more in a community, non-academic hospital. Participants were asked to fill out two validated surveys prior to individual interviews provided by the researcher: (a) the Abbreviated Maslach burnout inventory (Appendix A), and (b) Gallup's work engagement survey (Appendix B). Both surveys are abbreviated validated studies that will provide a deeper understanding when compared to interview data.

Recruitment of participants was made initially through email or phone contact to the hospital physician leaders responsible for staffing the hospital medicine service (i.e., chair of department of medicine) at local hospitals. After recruitment, volunteers contacted the researcher directly and separately from the recruiter (supervisor) contact to preserve anonymity of their participation from their supervisors. Respondents were assured their participation was voluntary. Participants scheduled interview time and location directly with the researcher.

Staffing of hospitalists is usually dependent on the size of the hospital (i.e., number of beds, average number of admissions to the hospital, etc.), the demographic area, and the consideration of hospitalist staffing needs. Hospitalists typically provide coverage 24 hours a day, 7 days a week (Wachter & Goldman, 1996), so it was a reasonable assumption that availability of participants would vary and require researcher flexibility.

Hospitalists, although not formally named until 1996 (see Wachter and Goldman) have been in existence in a hospital setting for many years. Based on this knowledge, recruitment of hospitalists for this study began in the Western U.S. region and would be geographically broadened if necessary.

In this study, the intent was to understand the nature of experienced burnout and engagement for hospitalists, and how they constructed their social support networks. To provide saturation for data analysis, an appropriate sample size was needed to represent an adequate number of hospitalists. Saturation occurs when minimal or no new data are added to coded categories or theory during data analysis (Bazeley, 2013). In the study, adoption of basic qualitative research design was used based on Merriam and Tisdell (2016) that attempts to describe “the facts and characteristics of a given phenomenon” (p. 5). The design in this study was applied using Merriam and Tisdell’s basic qualitative research framework of: (a) understanding how hospitalists experienced burnout, engagement, and constructed their social support networks, (b) how hospitalists interpreted these three phenomena, and (c) how hospitalists attributed meaning to their experiences. So, the sample size for this study was driven by the question and subsequent design to answer the research question. Thus, sample size for this study was driven by reaching saturation (i.e., found repetition of themes or patterns in the data).

Gibson and Brown (2009) further explained that the concept of saturation achievement in qualitative analysis occurs when theoretical work is exhausted (i.e., application of a category); and continued coding of data consists of reaffirming the data set results. Furthermore, sample size methods espoused by Bazeley (2013) can be achieved when no new categories come forth and suggests that the goal is fully developed categories relative to the number of participants. Qualitative research conducted on quantifying optimal participants revealed that 12 participants within a homogenous group were sufficient for developing descriptive categories (Bazeley, 2013).

In summary, sample and sample size in qualitative research are distinguishing hallmarks of how the researcher will answer the research question. In experimental design quantity is important to support reliability; whereas qualitative research relies on repetitive themes, and patterns to support the conceptual design. The final sample size in this study was 15 hospitalists that provided sufficient saturation to answer the three research questions of what is the nature of burnout, engagement, and the structure of social support networks.

Data Collection

Qualitative research is concerned with how participants construct meaning of their reality in different situations (Merriam & Tisdell, 2016). In basic qualitative research, interviews are a common method of collecting data for interpretation. This study will utilize semi-structured interviews as the primary source of data, using surveys as additional information to add additional perspective to answer the research questions.

All data collection elements will be discussed in detail in this section starting with an illustration of data collection that occurred with each participant. Further clarity of the data

collection process is provided in Figure 3.1, and includes all data collection elements to be analyzed:

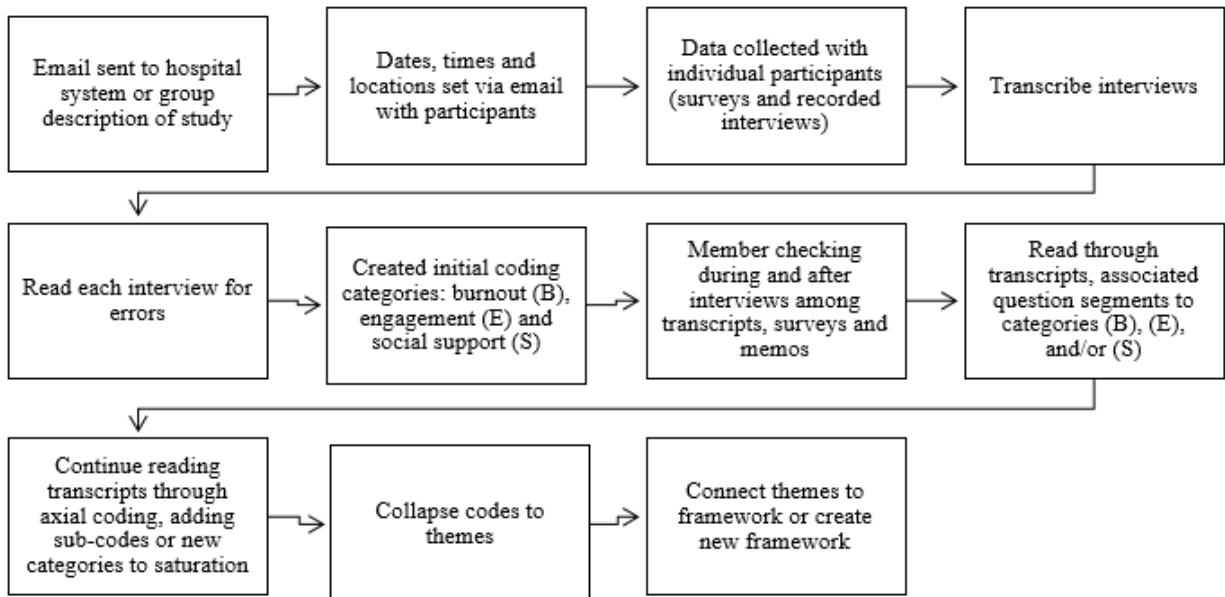


Figure 3.1. Data collection flowchart for study. This figure describes the order of recruitment, data collection and data analysis for the study.

The following discussion will begin with the recruitment process.

Recruitment of participants. Hospitalists who were recruited for the study came from community hospitals (i.e., non-academic centers) and health systems, and private practices. The 15 participants came from four different hospitals in the Western U.S. The recruitment letter and subsequent IRB letter was provided in each email with instructions for hospitalists to contact the researcher directly (through email, or cell phone) to set a time and place for the interview.

Informed consent was included in all responses so that participants could review the study prior to meeting and also to provide time to opt out of the study prior to meeting in person

Results of pilot test of the study. Prior to data collection from participants, a pilot test was conducted with a hospitalist who was well known to the researcher. Results of the pilot provided information on timing and structure of the data collection elements. The initial order of

data collection was administration of the Maslach and Gallup surveys and social support network survey, ending with the semi-structured interviews. However, it was revealed during pilot testing that the social support network survey (Appendix D) administration needed to be moved toward the end of the interview; giving participants an opportunity to talk about burnout and engagement first. This reorganization of data collection also allowed more time for participants to fill in and discuss the social support choices. Thus, the social support network surveys were provided at the end of the data collection time. The order of data collection changes based on the pilot test provided invaluable feedback during the formal data collection. No other changes to the protocol were needed throughout the study.

Semi-structured interviews with participants. Interviewing as a method of data collection is based on a curiosity about what people experience and how they make meaning of those experiences that are difficult to code through numbers (Seidman, 2013). Narrative interview methods allow the researcher to ask questions so participants can share their experiences in their own way (Reissman, 2008). Additionally, narrative methods require the researcher to decide whether questions will be asked in a structured or semi-structured format. Corbin and Strauss (2008) distinguished between these two methods of questioning in the following way: semi-structured interviews allow for participants to tell their stories in their way and structured interviews require participants to respond to a set of formalized questions based on the interviewer's previously collected data.

In this study, there were two overarching interview methods that were followed. The first method was Reissman's (2008) narrative inquiry stance that allows for the participant to take the lead during the "narrative occasion" (Reissman, 2008, p. 23), to let go and allow participants to "go down their path" (Reissman, 2008, p. 24). The second was Merton, Fiske and Kendall's

(1990) focused interview method. Merton et al. (1990) recognized that participants in a study have experienced a situation that has been previously theoretically considered by the researcher who subsequently develops an interview guide for the study. Critical incident questions, in this study, provided participants the opportunity to explain their meaning of situations connected to the aim of hospitalist social support networks. (Butterfield, Borgen, Amundson, & Maglio, 2005).

Reissman (2008), and Merton et al's. (1990) guidelines provided structure to gathering data in the study. The interviews guide (Appendix C) was constructed following a general format: (a) opening the interview, (b) engage critical incident questions to elicit participant experiences of burnout and engagement and construction of social support networks, (d) engage in probing questions for completeness, and (e) close the interview. More specifically, this study elicited participant's experiences in constructing social support networks situated in the context of self-reported burnout or engagement which will be recorded at the time of the interviews. Structure of semi-structured interviews borrows from Merriam (1998) to provide thick description for analysis. An initial approach to composing the interview was:

- Ask how participants chose medicine as a profession and if there was a relationship that aided this choice.
- Ask what relationships were in existence that could be considered a social support network.
- Connect the individual social support network to burnout or engagement at work.
- How did the addition or deletion of individual participants in social support networks affect hospitalists in relationship to burnout, engagement or other dimensions of support at work?

The entry into the medical profession has been shown to be guided by socialization into the profession that influences how individuals react to stressful patient, peer and professional situations (Dyrbye & Shanafelt, 2016; Phillips & Dalgarno, 2017). Socialization includes others in the workplace and could assist workers in making meaning of their workplace, so a plausible interview strategy would be to better understand how physicians construct their social support networks and what relationship the networks have to burnout or engagement. Hospitalists may be protected from stress at work known as a ‘buffering’ effect attributed to the strength of social support (Cohen & Wills, 1985; Meyerson, 2017). The presence of social support is reported to play a role in satisfaction at work, but there is no known definition of a social support network for hospitalists (Glasheen et al., 2011; Hinami et al., 2012; Kahn, 1990). There is low control over whom hospitalists work with, choice of patient population patients, colleague and medical staff collaboration connected to ambiguity and uncertainty that can cause stressful situations. Thus, it is possible that stressful situations are felt at the individual level but created at an organizational level. Continued stress on the job (Freudenberger, 1974; Leiter et al., 2014), lack of control (Sutinen et al., 2002) and uncertainty (Meyerson, 2017) in the workplace appear to be socially constructed. Social support networks can be a resource (Brass et al., 2004; Higgins, 2001) and strength for burnout and engagement.

Initial questions were used to help participants feel comfortable in the interview setting. For example, these questions consisted of how participants became interested in choosing medicine as a career, and more specifically, hospital medicine. This question allowed participants to talk freely about their experience in choosing their career, which led easily into sharing sensitive stories about moments of burnout in their lives. Location of the interviews were dependent on participant schedule and location. Time and location of interviews varied

depending on the participant, flexibility was provided for participants who needed to conduct interviews while they are onsite and working.

Interviews took place between June and August of 2018, and lasted approximately 60 – 75 minutes. Participants were asked the following question about burnout:

- Have you experienced burnout at work?
- All participants had experienced burnout which led to this follow-up question: Can you describe the situation where you were burned out?
- Participants shared situations of burnout where they could not finish their work or continue any longer in their particular situation.

Probing and follow-up questions provided more information to the study by asking participants to share the situations or context during the time of burnout.

The conceptual framework of hospitalist social support networks was used as a guide for data collection. The conceptualized social support network (Figure 2.3) consisted of interrelationships between and among hospitalists and patients, hospital administrators, consultants, nurses and patient families. This framework was conceptual and served to form initial concepts connected to the questions based on theoretical assumptions of social support networks for hospitalists who have experienced burnout or engagement. The nature of this study and the nature of qualitative research are intended to open and explore concepts associated with individual social support networks related to burnout and engagement. During exploration of the social support network construction, participants contributed interview data as they talked aloud during the time they were filling out and constructing their social support network surveys and conversation between the researcher and participant. The role of the researcher during this segment of data collection served as a facilitator and listener. This segment was also recorded

and transcribed; with portions of relevant participant excerpts included in Chapter 4 (Findings). To gather additional information, two known surveys and an exploratory survey was used that supported the qualitative data. Further clarity of the interview process is included in Figure 3.2.

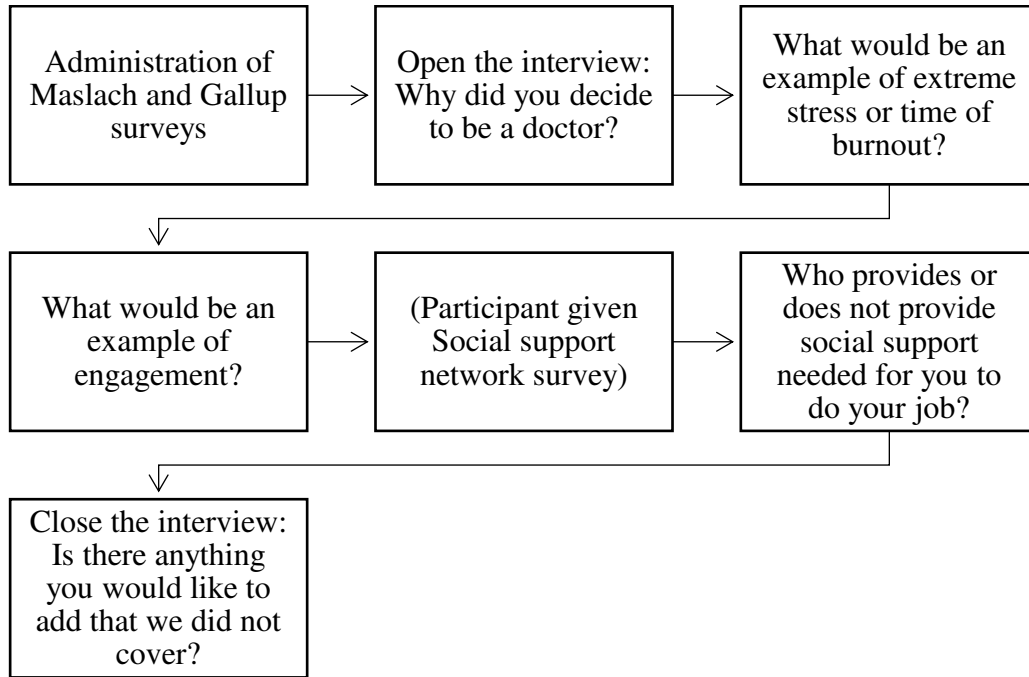


Figure 3.2. Interview data collection process. This figure illustrates and describes the order of data collection for the study.

Some participants had specific requests to ensure further confidentiality during data collection. Some of these requests came in the form of using personal emails to avoid business emails that could be possibly read or traced, as well as interviews that took place in personal homes of participants and off-site office spaces. After collection of all data elements, coding and analysis ensued and is discussed in the next section. The next section starts with the exploratory social support survey, followed by the abbreviated Maslach burnout survey and Gallup 13-item worker engagement survey.

Scrutiny of qualitative methods have historically been challenged. Trustworthiness refers to the scholarly rigor and truth of the data collected (Lincoln & Guba, 1985). Triangulation of

data sources added to the rigor of data analysis for qualitative inquiry, and in this study was represented by a triangulation of data sources. In addition to interview data collection, participants were asked to complete two commonly used burnout and engagement surveys and to construct a social support network survey. Although the focus of this study was not a collection and analysis of quantitative measures of burnout and engagement through surveys, the surveys provided an additional element of trustworthiness and triangulation of data and added additional information to the study.

Social support network survey. Following the course of data collection events illustrated in Figure 3.2 the participants filled out an exploratory social support network sheet (Appendix D). Creation of the social support network sheet was based on the conceptual framework for hospitalist social support in Figure 2.4 that included patients, patient families, hospital administration, consultants and nurses. Participants were asked to list in their own terms, three to five individuals they would consider their social support network as a starting point on the topic (Appendix D). Theories of social support in the workplace have most notably focused on explanations related to family conflict (French, Dumani, Allen, & Schockley, 2018), however the earliest known conceptualization of social support was in relation to individual well-being (Cobb, 1976) that was realized in the workplace. Perceptions of positive social support included feeling loved, cared for and part of a social network that is supportive and available (Cobb, 1976) at work. The social support network survey used in this study is based off of two concepts from social support literature. The first concept is from the belief that a worker views social support based on the perception of feeling valued and cared for (Cobb, 1976). The second concept is based on the degree of direct or indirect access workers have to specific sources (Kossek et al., 2011) of support within a hospitalist workplace context. To pull

the two social support concepts together, the conceptual framework (Figure 2.4) of hospitalist social support was theorized as being dependent on sources or roles that support hospitalists. For example, the concept of feeling loved and appreciated would theoretically come from patients and patient families. Indirect support would be experienced through hospital administrators and consultants. Thus, the social support network survey was intended to help answer the research question of what and whom represents hospitalist social support, the value and need of named social support sources and what social support roles or individual are missing from one's social support network that is needed, but not available.

Maslach's abbreviated burnout survey. When Freudenberger (1974) initially observed the behavioral phenomenon known now as burnout, there was no quantitative measurement instrument available. Since that time, the Maslach burnout inventory (MBI) has become the gold standard to measure three scales of the phenomenon: (a) emotional exhaustion, (b) cynicism and (c) depersonalization (Maslach & Jackson, 1981; Schaufeli et al., 2009). The concept behind the 22-item survey was to capture the individual experience of burnout expressed through the three factors. The full scale 22-item MBI continues to be the most reliable and valid survey (Wiederhold, Cipresso, Pizzioli, Wiederhold, & Riva, 2018) for use in the human services industry which is why the instrument continues to be used for healthcare workers. Over time, an abbreviated version (aMBI) has been used as a reliable proxy to the full scale MBI (Riley, Mohr, & Waddimba, 2018), and is commonly used for researchers who either do not need all 22 items for analysis, or to save time for participants.

Despite the validity and reliability of the MBI and aMBI, subsequent development of interventions based on results of the quantitative results of the MBI and aMBI, with the intention to make positive changes for workers suffering from burnout has not been as successful to reduce

burnout rates (Eckleberry-Hunt et al., 2018). Thus, the rationale in choosing the aMBI in this study was to provide further support and triangulation to the qualitative data in identifying and confirming experienced burnout quantitatively using a common instrument in the field. To further qualify the rationale of choice for the aMBI, the study was not a quantitative study and comparison of hospitalist scores on the aMBI to the national scores could be used in future studies.

Gallup worker engagement survey. The phenomenon of engagement at work was initially studied and researched by Kahn (1990) utilizing qualitative methods. Since Kahn's seminal work on worker engagement, subsequent definitions and measurements have appeared to measure what workers experience when they are engaged. For Kahn (1990), engagement occurred at the psychological, cognitive, and emotional level for the individual. Kahn's definition of worker engagement was based on the concept that worker engagement occurred within an environment of psychological presence or absence in work roles. Many frameworks have included some or all components from Kahn's (1990) original research that included worker satisfaction and involvement (Harter, Schmidt, & Hayes, 2002, 1998), engagement as an antithesis to burnout (Schaufeli, Salanova, González-Romá, & Bakker, 2002), and the inclusion of an organizational engagement component to individual involvement (Saks, 2006). There continue to be iterations of measuring what exactly worker engagement consists of, but to aid in answering the research question as to what the relationship of burnout and engagement is to social support, the Gallup engagement survey was chosen.

Since Kahn's (1990) seminal work on worker engagement, it has been more difficult for scholars to agree on a common definition (Shuck & Wollard, 2010) of the construct. After Kahn's (1990) conceptualization of worker engagement appeared, organizations were logically

interested in how to measure if their workers were engaged because engaged workers were theoretically more productive and happier. In addition, theoretically engaged productive workers were more likely to contribute to overall financial success for organizations. However, measuring and defining what engagement means for workers has been challenging. Over the years, two measurement instruments have been shown to measure the concept of engagement at the individual level; with aggregation possible to the organizational level.

As worker engagement was conceptualized as the antithesis to burnout, burnout scholars created the UWES to measure opposite concepts of burnout: vigor, dedication and absorption in one's work (Schaufeli et al., 2002). The constructs used by the UWES measures are aligned with Kahn's (1990) early conceptualization of worker engagement (i.e., psychological, cognitive and emotional levels). Differing national consultancies subsequently created their own specific engagement surveys; however, Gallup continued to gather quantitative worker engagement data with the use of a 12-item validated instrument (Attridge, 2009) utilizing a participant database of over 10 million workers worldwide. Gallup's survey was different from the UWES in that it included questions pertaining to whether or not the individual had social relationships at work from a positive psychology perspective. If workers were happy and positive, then workers would plausibly be more engaged in their work and possibly be more productive than those workers who were unhappy. The inclusion of social relationships at work was important to the goals of this study and is the rationale behind the choice of using the Gallup survey over the UWES. In addition, the study design and goal of this particular research was not meant to validate worker engagement using a single survey.

A distinguishing finding regarding the conceptualization of engagement as an antithesis to burnout was instrumental in the research design for this study and gives additional rationale

for using the Gallup engagement survey. In an effort to understand and answer the research question of the relationship of social support to burnout and engagement, the Gallup survey provided a validated engagement instrument that was used in this study. However, some scholars have found that engagement may not be the antithesis to burnout (Leiter & Maslach, 2017), and suggest that engagement is separate from burnout altogether. This finding supports Kahn's (1990) observation where he observed healthcare workers who appeared to be engrossed in work, yet clearly exhausted and drained (e.g. burned out) at the same time. The results of the study provided further clarity to the complexity of engagement that has been expressed in the literature.

Trustworthiness

The nature of trustworthiness in qualitative research asks the question of whether one study represents the truth of the research results (Gibson & Brown, 2009). What qualifies as truth from a constructivist standpoint, however, is rendered by and through the narrative process which includes data analysis. Trustworthiness in this study was adopted and confirmed through the data analysis process and by the theoretically grounded framework for study. Additional methods for trustworthiness were provided through member checking.

Member checking is a strategy used for confirming findings in the moment (of an interview) or at the conclusion of the data analysis process (Bazeley, 2013). Member checking provides an additional way of verifying meanings using probing, follow-up questions with participants before final conclusions are made and was used in this study to further the trustworthiness of the study. Reissman (2008) pointed out that researchers engage with data from the past. Positionality of participants in surveys or interviews provides a way to recall and respond to the research questions; recalling experiences that connect to the study question(s).

Because truth is constructed through lived experiences, the strength of trustworthiness is found in the ability to defend the method of interpretation versus the stories themselves (Reissman, 2008). In other words, what is said is not under scrutiny because these are experiences of recall by the participant. The trustworthiness of the text in relation to the context of the research design is important because this answers why one method was chosen over another. Triangulation of data strengthened the trustworthiness and validity of findings.

Data Analysis

Analyzing data using narrative analysis is a method used to identify themes and patterns within narrative data (Merriam & Tisdell, 2016; Braun & Clarke, 2006; Reissman, 2008). Following the order of analytic structure just mentioned, data analysis for this study started with reading the first transcript followed by continued comparison with each subsequent transcript leading to categories and emergent themes. An overall approach of narrative analysis consists of realizing patterns that are coded and clustered to help lead the researcher in connecting abstract concepts to the theoretical framework. Analyzing the narrative data requires researchers to stay open and focused and attend to interrelationships between the phenomenon and its context(s) (Stake, 2007). Data analyses from this study came primarily from survey and interview analysis, and secondarily from researcher notes written during transcription of interviews.

One of the reasons researchers use the narrative analysis method is grounded in the search for meaning about human experiences that can be revealed through narrative analysis (Reissman, 2008). From a constructivist theoretical lens, participants construct meanings in specific situations (Charmaz, 2006, p. 130). Therefore, according to Charmaz (2006), any analysis is contextually situated and will conceptually serve to support the overarching questions

in this study regarding how hospitalists experience burnout, engagement and social support network construction in their workplace.

Additionally, Guba and Lincoln (2007) suggested social phenomena is situational and influenced by many happenings. Qualitative research scholars (Gibson & Brown, 2009; Merriam, 1998) have suggested researchers use methods that further distill the components of qualitative scholarship into data collection, data reduction, conclusions, and data display. Therefore, this study followed the order assigned to analyzing data that is suggested among narrative scholars (Bazeley, 2013; Gibson & Brown, 2009; Reissman, 2008) that started with data collection, transcribed interviews, initial coding of the transcripts into categories, cross-comparison of categories from other transcripts and survey results in the data set, and conclusions.

Coding

Coding is the process of “opening up the data” (Bazeley, 2013, p. 161) and naming phenomena based on data themes and categories. In the data collection section, broad topic areas were listed as a starting point and data collection and coding processes came from an open perspective to adhere with the exploratory nature of the study and constructivist approach.

Coding qualitative data in this study required the researcher to break down data into manageable pieces, reflect on the data through researcher memos and reconceptualize the data toward reaching conclusions (Corbin & Strauss, 2008). The aim of interview data analysis was to take raw interview data and code through a process of extracting concepts. Words used to explain situations and experiences connected to the people who constitute hospitalist social support networks contributed to the construction of a model that comprised higher level concepts and lower level concepts (Corbin & Strauss, 2008), and that pointed to an overall category that

was used for comparative analysis. Comparative analysis provides ways of discerning similarities and differences within the data while axial coding applies to crosscutting of concepts within the data set (Corbin & Strauss, 2008). Thus, in this study, coding of individual experiences connected to hospitalist social support networks explored through a participant lens of meaning will bring new knowledge to the topic.

To move the analysis into conceptual and abstract levels of analysis (Bazeley, 2013), three cognitive questions were used during analysis for context: (a) what is interesting about a passage; (b) why is it interesting, noting in the margins or memo; and (c) why is the researcher interested in this passage, line, etc. of text? The interview guide for this study is the beginning of future concepts and abstractions. Topic questions connected to the theoretically grounded interview questions provided the foundation and basis from which data collection and analysis started. Theoretical and a priori codes versus codes taken directly from the data can provide a starting point when there are previous studies from which a study is building. In this exploratory study, however, theory informed the questions to achieve core concepts that were derived from final analysis and absence of concepts did not represent an absence of theory. This format requires the researcher to bring a level of analytic rigor that constantly tests the integrity of the data to the topical questions and conceptual and theoretical framework in the study.

Following the initial coding, transcripts were open-coded through a process of reading each paragraph to look for connections to the three categories of burnout, engagement and social support for hospitalists. The first round of open coding resulted in 203 codes. Open-coding allowed for the data to be opened up for any possibilities of new themes (Corbin & Strauss, 2008) not otherwise considered during construction of conceptual frameworks. The open-coding process occurred through reading each paragraph to look for connections to the three categories

of burnout, engagement and social support for hospitalists. Attention was paid to burnout coding where a separate set of codes was needed for hospitalist leaders. This separate category emerged during the burnout analysis phase only and did not appear in the data in any other category

Initial categories. Data analysis began with transcription of participants responses from interviews. Transcription was performed by the researcher and provided an added level of immersion with the data. The process of writing memos during data analysis is best conceptualized as an internal conversation the researcher has that is written (Corbin & Strauss, 2008). Memos are considered written records of data analysis that propel the researcher to reflect and engage with concepts (Corbin & Strauss, 2008). Summary memos provide researchers with an audit trail of thought or thoughts (Bazeley, 2013; Corbin & Strauss, 2008) leading to future conceptual connections.

The method followed for this study started with coding related to burnout. During this time, it was revealed that burnout was experienced differently for participants who had or currently have hospitalist leader roles. This finding accounted for hospitalist leaders for seven of the 15 participants, so it was decided to create two data collection categories under burnout: (a) hospitalist leaders and (b) hospitalists. As data continued to be analyzed through engagement and social support, the need for dual categories did not emerge. The memo structure that was most useful was constructed on large format paper with the following headings:

Participant #	Burnout score	Engagement score	Source(s) of stress (B)	Source(s) of engagement (E)	Source(s) of social support (S)	Researcher notes
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Figure 3.3. Researcher memo headings for study.

The researcher memo headings provided a visual for all collected data points at the individual level and was useful in early stages of coding and analysis. Initial coding also provided early evidence of repeated patterns of relationships between and in some cases among participants

who worked in the same organization. To further illustrate the path of relationship inquiry, the following steps were taken:

1. Collect and reflect on journals and/or memos taken before, during, and/or after interviews.
2. Transcribe data one interview at a time and make margin notes during transcription
3. Read and re-read transcripts, noting any researcher response to the data in the margin.
4. Coding and categorizing ended when all interviews were coded.
5. Connect coded concepts to theoretical framework or revised the framework to answer research questions.

After categories were established from the data set, relating the data to the conceptual model took place to test if the model was supported or if other new knowledge was created during data analysis.

Final codes and themes. Qualitative research is an iterative process that requires the researcher to be immersed in the data at different levels. In qualitative research, Gibson and Brown (2009) referred to the analysis stage as forms of work that inform each other. In other words, the data analysis work included researcher immersion in the data (e.g., through transcription and listening of the participants' voices), and the researcher consulting the theoretical and conceptual framework for guidance, reflection, and reading of memos.

Comparative analysis provides ways of discerning similarities and differences within the data while axial coding applies to crosscutting of concepts within the data set (Corbin & Strauss, 2008). Comparative analysis in its simplest form involves early patterns or commonalities constructed from incident to incident data. Comparisons of incidents across and among participants provided saturation of concepts that led to categories. Thus, in this study,

comparative analysis assisted in answering research questions through common or dissimilar experiences and perceptions of participants. These results enabled construction of categories of meaning connected to the research questions in the study. After comparative analysis, a list of categories was critiqued for further distillation or removal of codes.

Comparative analysis assisted in answering research questions through common or dissimilar experiences and perceptions of participants. Axial coding, the process where initial codes are reintegrated through an explanatory framework (Strauss & Corbin, 2008), has been criticized as being too rigid for qualitative analysis (Charmaz, 2006); however, scholars agree there is no one correct way to approach qualitative analysis and the axial coding process cannot be separated because as one opens codes (e.g., deconstructs), one also re-constructs (e.g., axially) (Corbin & Strauss, 2008). The aim of coding is to develop concepts developed from the words that contain ideas that will come forth from the following coding process:

1. Transcribe the interview.
2. Read through transcription noting in the margin or memo early emerging themes or concepts (Figure 3.3).
3. Re-read for any missed conceptual connections;
4. Create categories from codes.
5. Use axial code to reconstruct and connect categories or sub-categories (Charmaz, 2006).
6. Identify core concepts connecting to existing or modified theoretical framework (Corbin & Strauss, 2008).

Early in the analysis, categories were created to guide initial analysis using burnout, engagement and social support (e.g., B, E and S respectively) that also correlated to the semi-structured interview questions (Appendix C) and conceptual framework (Figure 2.4).

In summary, qualitative, constructivist research is an iterative process that requires the researcher to co-construct with participants. Inherent in the process of coding is the overall aim to move from raw data collection to abstraction leading to core concepts that can answer the research question of what role social support has related to burnout and engagement for hospitalists. The nature of qualitative data analysis is iterative, meaning the researcher will come in and out of the data with comparisons to other cases, noting similarities, patterns and repetition and contrasts to exemplify meaning of text(s) (Bazeley, 2013). Administration of the surveys in this study (i.e., Maslach survey–Appendix A, Gallup survey–Appendix B, and social support survey–appendix D) was not sufficient alone to answer the research question.

Connecting the concepts and themes that were found in initial categories in the study moved the results into an abstracted level indicative of qualitative research (Suddaby, 2010). To assess if the initial conceptual frameworks were also reflected in the data analysis for the initial frameworks (Figures 2.3 and 2.4) of hospitalist social support networks, burnout and engagement for hospitalists, final themes and associated sub-themes were connected through axial coding, looking for repeated patterns and saturation of the thematic codes

Gibson and Brown (2009) refer to the analysis stage in qualitative research as forms of work that inform each other. In other words, the data analysis work included immersion in the data (e.g., through transcription and listening of the participant’s voices), consulting the theoretical and conceptual framework for guidance, reflecting and reading of memos associated using the researcher’s visual tool (Figure 3.3) that allowed for initial categories to move from general to abstract concepts. After categorical data was established from the transcription data set, triangulation for each participant took place using results of the Maslach survey (Appendix A), Gallup survey (Appendix B) and social support survey (Appendix D). An iterative process

was used, moving from categories to themes and new concepts that were used in a final analysis. In this case, the survey data was used as supportive and complimentary data in the process of constructing and critiquing the concepts of burnout, engagement and social support. In particular, the Maslach and Gallup surveys were used as a backdrop to individual experiences. The social support network survey was an exploratory tool to move participants into constructing a conceptual network. The survey results, treated as complimentary data, will be displayed in Chapter 4.

The process of categorical transcription data related to survey data allowed for themes and sub-themes to emerge and was displayed in Table 3.1. With the final themes and sub-themes confirmed through triangulation of data, the proposed conceptual models from Chapter 2 (i.e., Figures 2.3 and 2.4) were used to test if the conceptual framework was supported or if other new knowledge was created during data analysis. During this final phase of analysis, new knowledge was discovered in relation to the proposed concept of social support network and burnout and engagement concepts.

Summary and Conclusion

The purpose of this study was to understand the nature of burnout, engagement and social support networks for hospitalists. Prior to collecting data, one pilot study was conducted for purpose of testing the data collection method. Minor changes were made to the order of interview questions and reordering of the social support survey to occur after the semi-structured interview and is reflected in Figure 3.2. Shortly after the pilot interview was conducted and changes were made to the data collection protocol, recruitment of 15 hospitalists occurred. All participants practiced in community hospital settings in the Western U.S.

Analysis of raw data started with three categories: burnout (B), engagement (E), and social support (S). Analysis continued with axial coding of categories that led to concepts and final themes (Table 3.1). Additional information was provided through administration of the Maslach abbreviated burnout survey (Appendix A), Gallup's worker engagement survey (Appendix B), and use of an exploratory social support survey (Appendix D).

Socially constructed phenomena are complex and messy, calling for qualitative research methods to explain a phenomenon that has been difficult to capture quantitatively. It was suggested in this study that the perceived strength of a hospitalist's social support network helps determine whether a hospitalist will have a tendency toward burnout. Sources of social support and the strength of those sources are important to hospitalists and assist hospitalists in navigating difficult situations at work that include potential precursors to burnout. Participants shared specific precursors that contributed to their burnout such as negotiating employment contracts, staffing, and finding enough time in the day to finish documents in an EMR. Further analysis will be provided in Chapter 4: Findings. Chapter 4 will include excerpts from interview data and survey results from the study to answer the question of what role does social support networks have related to burnout and engagement for hospitalists.

CHAPTER FOUR: FINDINGS

The research questions for this study are: (a) What is the nature of burnout experiences for hospitalists? (b) What is the nature of engagement experiences for hospitalists? and (c) What is the nature of social support networks for hospitalists? These findings will be presented in three main sections addressing each of the research questions, followed by additional insights provided by the results of the two surveys commonly used to measure burnout and worker engagement: the abbreviated Maslach survey on burnout and the Gallup 13-item worker engagement survey.

Findings of the Study

The results of this study are intended to further explore the experiences of burnout, engagement and social support networks for hospitalists. The first section reports on the nature of hospitalists' experiences of burnout in a hospital setting. The second section reports on the nature of hospitalists' experiences of engagement in their work. The third section reports on the nature of hospitalist's social support networks provided by an exploratory social support network survey (Appendix D). Finally, supporting information collected from the abbreviated Maslach survey (Appendix A), the Gallup 13-item worker engagement survey (Appendix B) is presented.

Approach to Coding

Based on the interview protocol (Appendix C) used during collection of interview data, three categories were used to direct questions to participants. These categories included burnout (B), engagement (E), and social support (S) and the initial coding of the transcripts identified these major categories in the participants' interviews. Next, further coding was performed to identify subthemes within these three categories. Burnout was experienced by hospitalists in two

different ways, depending on the current role of the hospitalist: hospitalist leaders and hospitalists. Engagement was experienced overall through the ability to nurture deep connections with patients especially during difficult or terminal diagnosis events. Social support networks for hospitalists were individually structured, drawing from three areas: (a) clinical support, (b) non-clinical support, and (c) leader support.

This is followed by the results of two commonly used surveys (Maslach survey measuring burnout, Appendix A; Gallup survey measuring engagement, Appendix B). The structure related to the findings of the surveys includes individual and aggregate scores provided later in this chapter (Tables 4.1–4.14).

Additional definitions of terms used by participants are provided here as a guide for readers to clarify definitions used within participant excerpts. In order to provide clarity and differentiate among corporate leaders, hospital leaders and boss, the following additional definitions will be used throughout Chapter 4 and Chapter 5:

Corporate relationships refer to the relationships between those individuals who work at the top of an organization, but are located in a city other than where the hospitalist works.

Hospital leadership refers to local hospital leaders (e.g., CEO, COO, or what is commonly referred to as “the C-Suite”) or administrators from a physician medical group administrator. In situations where a vertical merger had occurred, this change in organizational structure affected the reporting and decision-making process that affected hospitalists and hospitalist leaders.

Corporate individuals represented a set of individuals at the top of a healthcare system or corporate hospitalist company hierarchy.

Hospital administrator in this context referred to a local onsite leader (i.e., CEO, COO) or physician services group administrator.

Boss referred to the direct relationship the physician leader (participant) had with his or her immediate boss.

Table 4.1 provides final codes, themes and sub-themes revealed from data analysis in this study:

Table 4.1

Final Analysis of Codes, Themes and Sub-themes for Hospitalists

Codes	Themes	Sub-themes
Burnout: Hospitalist Leaders	Lack of hiring authority	N/A
	Lack of business support	N/A
	Disruptive peer behavior	N/A
Burnout: Hospitalists	Unrealistic expectations	Poor relationship with a boss
	Employment contracting process	N/A
	Having enough time in the day	Enough time to see patients Time to document in the EMR Time to recover from work
Engagement	Time to spend with patients discussing difficult diagnoses	N/A
	Appreciation received from patients	N/A
	Meaningful connections with patients	N/A

Social support	Clinical support	Positive relationships with case managers, nurse staff and consultants
	Non-clinical support	Positive relationships with spouses, scribes and IT staff
	Leader support	Needed support from hospital administration and/or hospitalist program directors

Overall, the data and data analysis suggested that hospitalist networks included three sources of social support that includes clinical, non-clinical and leader support (Table 4.1). Concerning the research question regarding what relationship burnout and engagement has for hospitalists, the data suggests burnout and engagement are separate concepts. Hospitalists who shared during the interviews they were completely burned out, did not always have a score reflective of burnout. Adding further depth in explaining the relationship that engagement and burnout have at the individual level, all 15 participants expressed experiencing engagement similarly with similar stories and examples adding to rich saturation of engagement data. Engagement findings supported Kahn's (1990) observation that workers who experience behaviors consistent with burnout (e.g., emotional exhaustion, cynicism, and depersonalization) appear to also simultaneously experience deep absorption and meaningfulness in their work suggestive of full engagement. Because hospitalists appeared to have experienced engagement separately from burnout, this also suggests that burnout and engagement is not always experienced on a continuum. In particular, burnout and engagement data analysis from this study suggested

hospitalists experienced engagement independently of burnout. For instance, some participants who revealed they experienced burnout, and scored higher on the Maslach burnout survey (Appendix A) also shared they were engaged in their work. This analysis is important because it adds new knowledge to the burnout and engagement phenomenon that suggested a continuum experience for workers (Leiter et al., 2017; Leiter, Bakker, & Maslach, 2014; Schaufeli et al., 2009); and also supports engagement scholars who suggested engagement is an independent phenomena from burnout (Kahn, 1990; Shuck et al., 2011; Shuck & Wollard, 2010).

Findings on the Nature of Burnout for Hospitalists

Burnout has been viewed as a condition where one feels emotionally exhausted, cynical towards others, and lacking self-efficacy (Leiter et al., 2014; Maslach & Jackson, 1981; Maslach et al., 2001). Participants were asked to talk about when they experienced moments of burnout in their workplace. Hospitalist leaders in this study ($n = 7$), reported to have experienced burnout in two environments: (a) related to being a clinical hospitalist and (b) related to being a hospitalist leader. Hospitalist leaders were also clinicians—the difference being how much clinical time was spent with patients compared to how much time devoted to management and leadership responsibilities. Burnout findings are the only category where the role of leadership held by some hospitalists affected the analysis and findings in the study.

The Nature of Burnout Experiences for Hospitalist Leaders

When hospitalist leaders reported stress that contributed to burnout, three distinct roles emerged: (a) corporate (located away from the hospital where they worked), (b) hospital leader (located at the hospital where they work), and (c) boss (located at the hospital or in their work group). The final theme related to hospitalist leadership is in relation to hospitalist leaders

managing peers they work with and also supervise. Excerpts in this section are specifically related to the hospitalist leader.

Hospitalist leaders provided stories in response to the question about experiencing burnout as a physician-leader and as a hospitalist. Hospitalist leaders shared the following sources of burnout related to leadership responsibilities: (a) lack of hiring authority, (b) lack of business support, and (c) disruptive peer behavior.

Hospitalist leader burnout: Lack of hiring authority. Based on the responses of hospitalist leaders, the responsibility for staffing appeared to rest with hospitalist leaders; however, if the hospitalist leader did not have authority to hire, the responsibility to fill in for departed personnel fell upon the individual hospitalist leader. Hospitalist leaders Participant 3 (P3) and Participant 11 (P11) shared the impact of this responsibility. P3 recalled a time that he had hit the most severe state of burnout due to the loss of hospitalists in the group:

We were recruiting but there were some delays with getting people on board and had some administrative hangover, and they did not get our staffing into the budget correctly because they didn't really ask what they needed to be or understanding it. And trying to be like, "No, we don't have enough docs to do what we are doing, and we are actually needing to expand in order to do what you are wanting us to do." And despite going back and forth with administration, no progress.

When staffing was impacted by personnel loss(es), hospitalist leaders felt personally responsible to pick up additional shifts to cover for the personnel losses, which contributed to their exhaustion and stress. When hospitalist leaders took personal responsibility for picking up extra work due to lack of staffing, this created an unachievable workload that led to the hospitalists' resentment of leadership (corporate or hospital), and further, possible resignation. P3 recalled the final moment of burnout by sharing,

...I worked almost 30 extra days in 6 months. In January and June of last year, I probably spent less than 10 days outside of the hospital. By the end of June, I was ready

to quit my job. So, from an administrative standpoint, it came to me giving notice to senior leadership and said, “If you do not fix this now, I am done and walking.”

P11 shared the same frustration of being caught in the middle during a previous leadership role. Corporate leadership was located hundreds of miles away which caused an apparent disconnection from the needs of the hospitalist leader, ultimately leaving the responsibility of care for patients at the individual level. P11 was left without resources or solutions by the local hospital leadership. P11 recalled his final moment of burnout when he realized how the extra work took a physical toll on his body and caused him to lose time with his family:

I just, at that point, I wasn't sleeping well and I'm sure I was depressed during that time. My family felt neglected. And so finally I reached sort of a breaking point to the point of tears sometimes at home, you know, because I was just so stressed out. And I said I just can't be the group leader anymore. I have to do one or the other.

Hospitalist leaders have additional stress when their group is understaffed. Participants shared that the inability to hire temporary workers was hindered by the lack of authority to hire and the amount of time to bring on a new full-time equivalent (FTE) which takes months. Because of this, hospital leaders appeared to take personal responsibility for filling the gaps in staffing and working to the extent of placing themselves at risk of mental and physical exhaustion.

Part of the stress attributed to staffing was a disconnection related to the local needs of the hospitalist group and decisions made by corporate leaders. Participants expressed the stress of being caught in the middle between corporate and the local hospital with the hospitalist leaders having little to no authority to make changes. The feeling of being in the middle appeared to be in response to decision making made by corporate leaders. P3, P11, and P14 shared frustrations related to decision making by corporate leaders and a lack of agreement with

local hospital leaders, leaving the hospitalist leader caught in the middle and having to ask more from their hospitalist group. P3 explained,

Just having the people above you making the decisions and not being on the same page and try and keep the group functioning and operational is just like, my hands are tied. I can't do anything but work everyone into the ground. The entire group got to the point where like, if this continues, this is not sustainable or survivable. That was a hard spot to be stuck between in a big group of docs that are essential to the hospital, hospital administration, and physician group administration.

P3 further shared the repercussion of such a situation, stating, “Yeah . . . I still haven't recovered and decided whether I want to continue (*laughs*).” P3 is referring to whether or not he wanted to continue as a hospitalist leader in his group. Although he was laughing about the situation, it was clear he was not laughing seriously about what he wanted to do. Approximately four months later, P3 resigned as a hospitalist leader.

P11 shared the same frustration of being caught in the middle during a previous leadership role. The corporate leadership was located hundreds of miles away which caused an apparent disconnection of the needs of the hospitalist leader, ultimately leaving the responsibility of care for patients at the individual level. P11 was left without resources or solutions by the local hospital leadership. P11 shared,

I was the guy who was responsible for making sure the staffing was complete each time for the hospital, that the patients get good care. That was a heavy burden that I felt was filling by myself for four or five years. . . . And then I think the thing that was difficult was the hospital's response to that wasn't satisfactory to me. In other words, “Well, you guys will all just have to work a bunch of extra shifts.”

P11 shared that even if he had corporate approval of obtaining locum tenens (e.g., temporary) hospitalists, the timeline to actualizing help in the hospital would not have helped the situation which added to the isolation of his leadership responsibility without available resources. P11 elaborated by saying,

They say it's gonna take 3 months, but it takes 6 months, so there was sort of no hope that we were gonna be able to get locums in during that time and trying to face— That was it for me. I can't do this anymore and I don't know how I'm gonna do this.

Loss of personnel due to resignation or a rise in patient census left hospitalist leaders advocating for the hiring of more hospitalists; however, a gap for corporate leadership existed in understanding what hospitalist leaders faced if staffing was not authorized by corporate leaders.

Hospitalist leader burnout: Lack of business support. The activities associated with business support appeared to be linked with issues that hospitalist leaders were left to analyze on their own that led to stress and burnout. It is reasonable to assume that business support is needed to run a business. Medical clinics that operate for the purpose of seeing patients on an outpatient basis typically have a manager or administrator onsite to support the business activities pertaining to running the clinic. Similarly, hospitalist leaders stated, compared to their outpatient peers and counterparts, that they did not receive the same resources of professional business support to assist them in business activities like analyzing comparative production data to establish appropriate staffing to addressing physician behavior. The realm of business support needed appeared to fall outside of the skill set of a hospitalist leader, but the hospitalist leader was still responsible for finding solutions to problems without having business support at a local level.

When hospitalist leaders experienced understaffing in their respective groups, comparative data to benchmark data against other groups was difficult to obtain because of little to no skilled business support available to assist in obtaining and analyzing business data. P3 and P11 were consistently told at different times and in different roles by the same local physician group administrator and local hospital leadership that their hospitalist group was not productive enough to justify hiring more hospitalists. Further evidence in this study supported

the concept that local administrators were not the same as having a dedicated business administrator or executive working as a dyad partner to the hospitalist leader. For instance, in situations where data would have been helpful in making a case for more hospitalist staffing, information on productivity or other barriers to meeting production minimums were not provided by their physician group administrator or local hospital leader, leaving a stalemate in discussions among leaders. P3 shared, “It was someone [corporate leadership] willing to say you are underproductive, but no one was willing to sit down and look at it.”

At this point in the interview, P3 was asked: What business support would help you as a hospitalist leader? P3 shared the importance of data, and stated:

One thing we have been really lacking with our group is the ability to get data and analyze that data, see where we compared, and we are constantly told we are not seeing enough patients. Well, show me that data. Where does it come from, how do we compare to other groups, and what does this really mean?

For hospitalist leaders who were part of physician medical groups (PMG’s), the group structure contributed to the complexity of the decision making due to another layer of leadership. The intent of PMG’s is typically to provide business support for all medical practices in the physician group, including hospitalist practices. However, it was suggested from the findings in this study that there was a lack of support from the PMG leaders. Examples of lack of support included providing data analysis support to strengthen the reason for increased staffing or provision of temporary staffing due to turnover and increased patient loads. Overall, hospitalist leader responses revealed frustration where they had a title and responsibility of a leader; but experienced a lack of authority to staff their groups when needed. Additionally, when hospitalist leaders saw an unequal patient census to hospitalist staffing ratio place more burden on the hospitalists, hospitalist leaders stepped in and worked more hours to the point of exhaustion in an effort to make up for the staffing shortages.

Hospitalist leader burnout: Disruptive peer behavior. Hospitalist leaders mentioned stress and burnout related to responsibilities that included addressing disruptive hospitalists in their respective groups. In some cases, hospitalist leaders worked side-by-side with disruptive peers from the same hospitalist group, but they were also the leader responsible to address negative behaviors creating tension and stress. In an attempt to communicate the depth of difficulty of patient behavior issues to hospitalists' behavior issues, P14 shared, "If you're asking what's more painful? The physician issues. . . ." P14 went further by stating, "The behavioral ones just linger, [and] wake you up at night. They take a toll on you in a different way," attributing an emotional pain to addressing issues with regard to peer behavior from a hospitalist leader perspective.

When a hospitalist addressed peer behaviors that might inevitably mean that that hospitalist could leave and create a gap in staffing, hospitalist leaders also experienced tension due to addressing peers' behavioral issues. P11 shared a time filled with emotional stress that consisted of "physician behavior issues and meeting with them, meeting with administration and having some really tense meetings over those kinds of things. And some of these people I consider friends, you know? It's pretty challenging dealing with those issues." P11's recount showed another aspect of the emotional toll that occurred when hospitalist leaders had to address disruptive physician behaviors with a hospitalist who was also a personal friend.

P11 faced additional behavioral issues that surfaced from hiring a new physician after losing a physician to relocation. P11 shared that this new hire

...was a physician who probably had some mental health issues that we were unaware of and that wasn't made clear to us when we hired him. And issues started surfacing a little bit and we actually had to let that physician go as a result because it was unsafe for patient care.

Although P11 and P14 said behavioral issues were “intermittent” (P11), the depth of stress connected with these situations was categorized as a significant emotional stress that led to burnout and, for P11, a potential reason to resign from his position. He stated, “There are a lot of other things and I would say the second thing that drove me to I don’t want to do this was dealing with disruptive physician behavior issues. That is really tough.”

Summary of Hospitalist Leader Burnout

Hospitalist leaders faced an additional layer of burnout related to their leadership role that was separate from the role of being a hospitalist. Overall, hospitalist leader perspectives of burnout were expressed through the themes of hospitalist leader responsibility in the following areas: lack of hiring authority, the need for business support, and addressing disruptive peer behavior. Specifically, hospitalist leaders experienced burnout related to the personal responsibility taken on from being understaffed. The hospitalist leader worked additional shifts to the point of emotional and physical exhaustion. Hospitalist leaders also faced burnout related to a lack of business support that afforded other medical practices within physician medical groups, but they were not given to hospitalist practices. A third burnout factor for hospitalist leaders related to disruptive physician behavior within their respective group. These situations were difficult for physicians to cope with because, at times, the disruptive physician was also a personal friend.

Issues related to hospitalist leader were related to conflicts that hospitalist leaders had with corporate or hospital leaders. The data from hospitalist leaders were treated as additional findings and provide a greater understanding of hospitalist leaders sources of stress. Further conclusions will be addressed for this sub-population in the next chapter. Overall, hospitalist leader perspectives of burnout were expressed through the themes of hospitalist leader

responsibility in the following areas: lack of hiring authority, the need for business support, and address

The next section addresses burnout findings specific to hospitalists that did not have leadership roles. Although seven of the 15 participants had a dual role as a leader and hospitalists, these experiences that were attributed with their peers and will be discussed in the following section.

The Nature of Burnout Experiences for Hospitalists

This section reveals findings related to times at work when hospitalists experienced burnout. The well-known accepted concept of burnout that consists of emotional exhaustion, depersonalization, and cynicism was not provided to participants to draw from when they described a time of burnout which provided for open-ended answers. Participants had the opportunity explore what burnout meant to them and provided stories and situations that they attributed to the concept of burnout. After analyzing the data attributed to burnout collected from hospitalists, three overall themes emerged: (a) unrealistic expectations and a poor relationship with a boss, (b) from the employment contracting process, and (c) having enough time in the day to finish work.

Hospitalist Burnout: Unrealistic Expectations and a Poor Relationship with a Boss

The second theme to emerge concerned the relationship hospitalists had with their boss. The definition of 'boss' in this study refers to a direct reporting relationship between the hospitalist (participant) and his or her supervisor who was also a hospitalist. Participants in the study shared that negative or poor relationships with their boss contributed to stress and burnout. Relationship themes contributing to burnout for participants in the study related to one's boss included a lack of trust and not taking interest at a personal level. Participants shared that conflict

with their boss contributed to emotional and physical stress. The following interview responses in this section supported the theme of participants experiencing unrealistic expectations of their boss.

P9's best friend, whom she attended medical school with, had recently experienced a brain injury. Because the close friend lived in another state, P9 could not be there to help her friend. During the time of P9's grief over her friend's severe life-threatening injury, P9's boss was also rolling out an organizational development initiative to help coach physicians. P9's boss had expressed disappointment in her lack of enthusiasm. P9 shared that her boss' expectation of her was to leave her grief about the sickness of her friend and be supportive of an initiative she was against. At the time, P9 was regarded as leader in her group with more responsibility than other hospitalists, but the leader of her group was also her boss. Because P9 was a leader, she also had a closer relationship with her co-leader/boss, but the expectations of her co-leader/boss during this time came across as unsympathetic. An indication of her co-leader/boss expecting her to act and feel like her, was expressed by her boss' expectation for P9 to be "black and white" and forget about the impact P9's friend's injury had on her at work. P9 appeared to have an expectation of her boss to be one of collegial understanding during a difficult time because P9's friend was also a highly regarded physician residing in another state. P9's moment of burnout occurred when she realized her boss/co-leader had no empathy for her during this difficult time and simultaneously dealt with the impact of her close friend's medical situation. Even after sharing her situation with her co-leader/boss, P9 further described her moment of exhaustion by saying,

You realize I could barely get myself out of bed to work in the morning, so I was doing the best I could. And I would psych myself up and work really hard to walk in with a

good attitude and it would just fall apart because I was so depleted because I couldn't do it anymore. I was done. I mean I was just empty. And she really took offense to that.

Despite P9's openness of the emotional difficulty her friend's medical situation had on her, P9's boss was dismissive of her situation and took offense to her inability to be herself. P9 also had an internal leadership role and was responsible for human resource oversight and general business and administration. In a follow-up question during the interview, P9 was asked what her boss could have done to reverse the outcome of P9 stepping away from her internal position within the group. P9 shared that her boss was not interested in her as a person. She further explained,

She never once asked, "What's going on with you? This isn't what I expect." . . . She never once said, "Wow, you're not acting in a way that I would, you know, expect. What's going on with you?" Not once. Instead it was, "Well, you're not doing a good job," and [she] just kept pounding on me and pounding on me. . . . She never ever took an interest in what was going on with me.

Even though P9 resigned from her internal position, she reflected on the loss from stepping down due to her boss' unrealistic expectations of her. She said,

I would have never left because I loved what I was doing. I was doing the HR stuff, so a lot of coaching, mentoring, a lot of employee engagement and stuff that I was just starting to pick up and planning on doing more of this year.

Analysis of the results showed a shift of responses from failing one's boss to the next sub-theme of receiving passive punishment from one's boss. P13 shared his reason for leaving a previous hospital system when he was asked to absorb responsibility that would potentially threaten his liability and defense against future medical errors. Of note, the employee structure for P13 is illustrated in this way: employee (hospitalist) reports to a local physician leader employed by an outside/separate corporation from hospital system. Thus, the hospitalist was an employee of an outside corporation that has contractual staffing obligation to the hospital; however, the hospitalist, as a member of the hospital medical staff, was subject to rules and

policies made by local hospital leadership. P13's boss encouraged him to voice concern about the potential threat to his medical licensure with local hospital leadership, which he thoughtfully prepared and sent by email. After the communication was sent, P13 shared,

I was put on probation for inappropriate communications and for not going through appropriate channels even when it was my direct supervisor who encouraged me to write the letter I wrote. And she wouldn't acknowledge her own part in it and wouldn't go to bat for me.

P13 was misled by his boss for what appeared to be her support; however, P13 was later penalized by the same person for the very action she purportedly endorsed. This sequence of events suggested what some participants referred to as "having one's back" during difficult situations which can strengthen, weaken, or break the relationship between the boss and direct report. P13 subsequently resigned from his job and accepted a position with a competing hospitalist group in the community. P13 described the unachievable expectation of being a "good doctor":

Our boss over there was all about toeing the line and a good doctor is a doctor who does not complain and who does not try to push back against corporate and does not do anything other than a yes sir, yes sir approach to hierarchical management.

When asked about how his resignation was accepted by his boss, P13 said, "I think he was perfectly fine to lose me. . . ." Within the context of burnout between the hospitalist and a boss, there appeared to be a distinctive difference regarding the sources of stress. In an attempt to clarify which source of stress between clinical and corporate related stress was greater, probing questions were used to gain deeper understanding as to the quality and difference of the two sources. When asked about the extent of the clinical stress P13 experienced, P13 explained that the clinical stress "is nowhere near as frustrating as the junk that rolls down from the C-suite."

In a similarly related hospitalist or more commonly referred to as physician-owned (i.e., private practice versus hospital or corporate owned) employment relationship, P15 was sent to peer review for what he understood as performing appropriate procedures in the intensive care unit. P15 was professionally credentialed (i.e., approved) and hired to perform procedures in the ICU. Furthermore, he was endorsed by his boss, who was the CEO of the hospitalist group. On his first day of work, “within the first 18 minutes”, P15 stated, he was subsequently reprimanded for performing said procedures. P15 shared that his stress was related to a “lack of support” from his boss when he was sent to peer review in the hospital. P15 asked his boss for her support and to intercede on the particulars of the situation; however, “She did not. She would not. So, I feel very unsupported by leadership,” P15 shared. The peer review result from the hospital was inclusive. When P15 was asked during our interview if he spoke with his boss afterward about the incident, he shared, “The CEO is very vindictive. If you ever cross her you will pay. We have a dictatorship.”

Ironically, P15 came from a previous position from another state where his trust was eroded and broken by hospital administration. P15 was partner and leader in his practice that was offered contracts of hospital employment; otherwise, their contract would be severed, and they would not be able to practice medicine at that hospital. P15 had sent a strategic, private email to his group through a hospital email address, and in doing so, his hospital email was internally stolen by the hospital. P15 shared this stressful exchange: “This is a private email conversation with members of my group that, unfortunately, I was using a [redacted hospital] email. Therefore, I will never go back there because I will never trust that administration again.” Other participants expressed similar mistrust: P2, P9, P13, and P15 insisted on using private email for correspondence. In three cases, we met offsite due to the participants’ experiences of

“being burned” or even found to be participating in something they feared their boss, hospital, or corporate leaders would deem inappropriate.

Implicit trust during performance reviews appeared to be used vindictively. For instance, P15 shared that during a performance review to address specific “attitude” issues with his boss, he took that opportunity to confide in and connect with his boss. P15 explained however, that this led to less open communication:

Things I said in previous reviews which were open and honest reviews were used against me. You know you have yearly reviews mostly done in August/September have been used against me. I can't in my yearly review, *I don't feel like I can tell the truth*. I have a tremendous amount of trust issues with my group and I have actually said that. I have screwed myself by telling my boss that I can't trust you. I told her face to face that I can't trust you.

Hospitalists who were led to believe their actions were supported by their boss appeared to struggle trusting that person again. The depth of the relationship a hospitalist has with his or her boss, possibly dependent upon the strength of how open a direct report can be in a safe environment, appeared to have a role in contributing to hospitalists' burnout.

Hospitalist Burnout: From Employment Contracting Processes

Depending on the structure of their hospital or employer, participants shared experiencing burnout related to corporate and/or hospital leadership decisions that are made either directly or indirectly regarding employment and/or contracting for services with the hospital. Hospitalists are either employed by: (a) a vertically integrated health system with corporate leaders (e.g. VIC) located in another city, (b) directly with a hospital, (c) employed by a private practice who then provides inpatient services with a hospital (or hospitals) in a health system, or (d) employed by an outside corporation who contracts with the hospital or health system. Therefore, the employment relationship and process of contracting with one's employer or contracting of one's employer with the hospital system provides a context of complexity. It appeared from this

research that decisions made by health systems were made that effect hospitalists without any known input from the hospitalists.

This section of data was different than previous sections because of the effect of decisions made offsite where the hospitalist had no input in health system, hospital or corporate strategy but in the aftermath, were deeply affected at the individual level. Although the notion of having hospitalists weigh in on every decision made would be unreasonable, resentment seemed to build in the absence of conversations with those leaders who have hiring and contracting authority. Participants often referred to local hospital leaders as “C-suite” (i.e., chief executive officer, chief of medicine, chief of nursing, etc.).

Income or pay was not mentioned in any other area of the study except for physicians who were or had worked through difficult contracting seasons with their hospital or corporate leaders. Two concepts are connected with contracting for hospitalists: contracted work per contract and actual work. One full-time equivalent (i.e., one FTE) means one full-time hospitalist. Hospitalists are contracted up to one FTE. However, P2, P7, and P15 shared that their contract for work with the hospital or health system and their *actual* work was not always equal, which led to frustration surrounding employment contracting negotiations with health system leaders. Two of these hospitalists had willingly moved to lesser populated areas of the state where alternative work options would be limited in the event that their employment contracts did not get signed. For P2 and P7, their initial contracts were drawn and signed between the hospital and hospitalist. In this next iteration for P2, P7, and P15 contract negotiations were conducted through vertically integrated leadership (VIC) because of a vertical merger. P7, a 15-year practicing hospitalist, shared his frustration related to his treatment due to

the misconception that hospitalists will just accept implicit work environment expectations given to them without any direct input or communication:

I'm not in their shoes, obviously, but seeing their behavior (*pause*), they seem to think that they can just piss all over their physicians in terms of contractual realities that they want to impose on us without someone saying, "Well, screw you. I will just go and get another job somewhere else."

P7 is referring to the implicit work expectations or "contractual realities" as a "computer system to deal with" and "a non-compete in your contract." P7 referred to the concept of negotiating with people he did not see face-to-face, and that these people "running medicine now" are not local to the hospital: "There is all of this game-playing, that the suits and the accountants are running medicine now—let's face it. . . ." The process some hospitalists go through to be employed appears to leave them in vulnerable situations without a clear advocate for their well-being dependent on the employment situation. In addition, participants also appear to be insulted by a somewhat mechanical employment process without human interaction.

P7 also shared a situation where there has been incongruity between what is in an employment contract and how much he works on a regular basis. P7 stated that he had been contracted as a .6 FTE since he started at that location but works as a 1.0 FTE. P7 stated part of the reason he would only accept a .6 FTE contract was that he did not see his job as making him complete nor did he need the accompanying salary. Based on P7's comment about being a .6 FTE, further probing on this topic continued: "Do you think that part of the frustration and burnout you see is due to the workload or schedule? If you had the group working at .6, do you think that would solve a lot of the problem?" P7 responded:

Yes. Definitely. Because there would be less (*pause*). Well, let me back up a little bit. One of the things that has made it hard here is that we have been understaffed for such a long time and people are asked to work more than their contractually allotted shifts. So, I am .6 FTE, and I am supposed to work 9.3 shifts per month. What have I been doing the last couple of years? Ten to 14 [shifts].

P7, despite his belief that a .6 schedule was sustainable, has sustained a work output closer to a 1 FTE; however, there was a difference for him between working beyond his contractual obligations and being *told* he has to work more than his contractual obligations. In response to what would be a tipping point for P7 to leave, he shared:

What would make me say I'm done? If administration came around and said even though you're a .6 FTE, we are not going to have a work cap on you and have you work as many shifts as we think you need to work and work a lot of night shifts. I might say thank you and go fuck yourself. But that wouldn't be because of burnout, but because I don't want to do that at my stage in life. I don't need to or want to and just be a locums doc which I don't want to do. I want to be here and finish my career. I like working here. It's a good job. I like the people, the place, and it fits my lifestyle. But it's not burnout, though.

Thus, it appears that the ability for P7 to control if he wanted to do more than his contractual amount of work or not was more important than actually doing the work. It is possible that the relationship to how much hospitalists work, how much hospitalists are contracted to work, and hospitalists' willingness to do the work without administrative intervention is an overlooked phenomenon.

P2 was also facing a contract renewal period and questioned what he would do because he said the employment contracting process was the most stressful event aside from worrying about if he had missed clinical symptoms with patients. P2 shared:

It's stressful going through these contract negotiations because when I moved here 3 years ago, I thought I would retire here, and now I'm dealing with [employment] contract issues that maybe I can't swallow. Maybe I can't sign the (*pause*). Maybe I don't know. We will wait and see what happens. Then I have to deal with what am I gonna do.... Do I want to go somewhere else now?

P15 faced a similar situation when the hospital he worked for announced they would no longer contract with his private group and was given six months to either be a direct employee of the hospital or leave the hospital. He shared:

We were hoping there would be a negotiation of some sort. But they wanted something else and we had subsequent meetings of what can we do administratively, and it was just not negotiable. “We are just not renewing your contract.”

P15 eventually saw the reality that the hospital was planning on finding a temporary outside hospitalist group while the hospital regrouped:

At six months, the hospital started to shop for a hospitalist service because they felt that they couldn't hire and form a group of five to eight. So, the plan was to use a national company at least initially, and then not renew their contract after three years and build their own group.

P15's loyalty to the hospital and the possibility that a last-minute negotiation remained; however, he discovered that he and his group's commitment to the hospital and the community he served was not perceived mutually as valuable with the hospital leadership. I asked, “What did they say when you brought that argument to them? Face to face?” P15 responded, “It was not perceived as value. It was perceived as hospitalist a, b, and c can be replaced by hospitalist d, e, and f.” P15 left the hospital and moved after the hospital implemented and hired an outside group to replace his group. During this time, the hospital formed another group and ended up employing hospitalists from his old group after three years had passed and the outside hospitalist group that replaced P15's group, was terminated.

Hospitalist Burnout: Having Enough Time in the Day to Finish Work

The next burnout theme is related to having enough time in the day to see patients, document in the EMR, and recover from work. Overall, findings suggested that when participants were afforded the ability to use and allocate their time to accomplish their work in an unpredictable environment, they were more satisfied with their work. However, participants perceived responsibilities and activities that took away from providing patient care as competition for their time. Participants also found satisfaction when they finished their work and were able to get home at a reasonable hour, an occurrence that did not happen often enough.

Although the majority of participants mentioned the importance of time allocation at work and “getting through the volume” of patients, four participants (P6, P8, P14, and P15) did not cite time as a contributor to stress at work. P6 and P8 worked in a small community hospital that experienced a lower census. P14 and P15 had access to personal scribes to assist the hospitalist in documentation in real time, alleviating the hospitalist of this clerical responsibility, which allows the hospitalist to have higher quality face-to-face conversations with patients without the distraction of making notes during the visit. The continuing theme of high patient volumes related to stress contrasted P6 and P8 who continued to be vulnerable to exhaustion because they were the only hospitalist working for an entire week. P14’s and P15’s support from a scribe helped them get through patient volumes that other participants seemed to face but with less stress. Three sub-themes will be described in this section: (a) enough time to see patients, (b) time to document in the EMR, and (c) time to recover from work.

Burnout: Enough time to see patients. When P2, a 15-year practicing hospitalist, was asked what his most stressful times consisted of, he said, “I’m worried about getting everyone seen, so that’s where the bad days are now.” Of note, P2 did not mention anything other than having time to see patients, and not that he did not want to see patients. This theme continued with P3 as he recalled the overwhelming sense of responsibility as the admitting hospitalist:

You get called to admit 18 patients and you are trying to admit seven of those while you are taking 18 admission phone calls, it’s just—. So most of it is just too much to do in too short of a time, and I feel like it’s really what cramps and makes the days miserable.

P5 explained the push and pull of too many patients to see and deliver the kind of care patients need, yet still retaining the urge to see every patient thoroughly. P5 said,

So, there is a worst-case scenario admitting day where the admissions just keep coming and you’re backed up hours behind getting people admitted. And they keep calling and you’re on the phone talking to the ER docs and talking to the transfer center. And people are calling with consults, and you’re like, I would love to go see all of these

people. [You] can't get off the phone and those just get stressful because you get so far behind, and you hear about so many people that by the end of the day, it's difficult to keep everybody straight.

P5 shared that competing issues for time and attention added to a stressful environment that prevented her from performing her first responsibility: seeing patients. P12 echoed the same situation related to time and the need to 'sit and reflect' on either difficult patient situations or working through a difficult diagnosis. P12 shared the following story after being asked if there were any situations causing significant stress:

The type of days when I really can't finish one thing before you're being asked to do something else. So that's probably the biggest stressor for me at work. Because I am someone who needs to sit and think and organize my thoughts. So that is really disruptive and distracting and makes me think I can't actually get to see my patients in a timely manner.

P8 saw the shortage of time to see patients as more of an altruistic contribution to patient-centered care. Participants referred to the shortage of time to see patients as a provision of appropriate care based on time need for each patient. For P8, patient-centered care and physical healing were connected to hospitalists time with patients:

I think we need to be more cognizant of the fact that patients will get better care and be happier and be better physically if we are able to spend appropriate amounts of time with them. The trend I had seen over the past few years, it seemed like we were moving in the wrong direction.

Competition for hospitalists' time at work appeared to contribute to higher amounts of stress and burnout at work. The next theme that contributed to burnout associated with time constraints for hospitalists connected to time spent with hospital electronic medical records (EMR) and documentation.

Burnout: Time to document in the EMR. The evolution from paper charting and documentation to electronic documents (e.g., EMR) in hospital systems has changed how hospitalists document patient care. For P2, the enormity of the EMR burden related to all of the

other ancillary work hospitalists are responsible for: “computer stuff, billing, like ward clerk stuff....We’re doing all of that stuff now. They have gotten rid of typists, ward clerks, medical records, pretty much we do all of that.”

Consistent with the prevailing findings that burnout is the result and reaction to chronic persistent stressors, P2 shared, “I must spend at least twice as much time on the computers as I do on patients. That’s what’s gonna get me to quit.” For participants, the overall resentment appeared to come from the need to document and see patients simultaneously. Hospitalists did not excuse the legitimacy of documentation but rather the method and increased burden that using an EMR to document has created. P2 stated that work “has just become everything about sitting in front of the computer and documentation that most of us don’t want to read the stuff that we’re generating.”

P7 noted his frustration with EMR documentation was partially because of the lack of value it added to patient care:

The third most stressful thing is the f----- computer. And, I am very efficient with it, but I know it’s a lot less so for others. But still I spend so much time in front of that radiating thing, which is really not about patient care at all. It’s about documentation and about proving.

P5 shared that it was difficult to be a doctor in America and find satisfaction in one’s work due to hospitalists being in the middle of patients who they cannot treat on a regular basis like their peers in an outpatient setting. I asked her to expand on what this meant for her, and she related many things, including EMR:

You can’t jot down a note in five minutes any more. You can’t sit down and just dictate a note and have it be done. It has to be something where you push pause and come back to it three hours later and then you know, there are all of these spots to fill in and putting in your own orders? It’s just so time consuming it’s ridiculous.

P5 brought up how EMRs were an inefficient use of her time, not just with documentation but also corroborating P2's earlier reference with the clerical burden shifting from support staff (i.e., ward clerks) to the hospitalist. P5 explained,

And now, if you're like I don't know how to put this order in the computer, like I physically don't know what word to search to get this order to show up, you just sit there for 20 minutes guessing and randomly chasing people down asking, "Hey do you know what I put in?" You know, it's ridiculous. This isn't why I went to school. It's just a total waste of time.

For P5, using the EMR for order entry was a demeaning task that was not a good use of her time.

P11 connected the inefficiency of restricted time seeing patients yet fulfilling the requirements of documentation. P11 explained,

We want to improve all of these things and spend more time with our patients, but the EMR has taken up 70% of our time during the day trying to cross all of our T's and dot our I's. But we are also trying improve patient satisfaction scores which takes more time with the patient, so you're in multiple different directions, and I think that's honestly, that's driven at root by volume.

P11 and P5 articulated the difficulty they face in fulfilling requirements of documentation and EMR input and spending more time with patients in a thoughtful manner in an effort to raise patient satisfaction scores for the hospital. P11 also shared that documentation responsibility was not an unreasonable ask for hospitalists; however, the difficulty resided in the combined task of multiple "opposing objectives" and not knowing how or where the personal reserve or resource will come from to accomplish all of it. P11 related that if the census was capped at a realistic number, or if they had a fully staffed hospitalist group, this would provide time for him to accomplish more. P11 elaborated by saying,

If we could keep our census at a reasonable number, or have enough doctors to staff us every day, and keep it at a reasonable number of 15 every day and then you could accomplish a lot of those things. I think that's the root, honestly, of the problem. I don't think the things that doctors are asked to do are completely unreasonable. I think a lot of them have opposing objectives. Like, we want your documentation to be perfect so we can charge the most for this patient's stay. Well . . . you're not going to get that, *and* you

spend 30 minutes with each patient in the room every day or 15 or 20 minutes. You're not going to get both and get home on time.

The contrasting objectives appeared to represent hospitalists torn between opposing purposes, all of which needed to be addressed and accomplished with EMR responsibilities representing a barrier to patient care.

P14 and P15 were clear exceptions to attributing EMR responsibilities and burnout. P14 and P15 used scribes in their daily practice of medicine. P14, a leader in her private group, tried to address the problem of spending too much time on the computer, which took time away from patient care and was an inefficient use of physician time, with the EMR source company and local hospital IT. Their answer to her was to understand how to use the software more efficiently. Her employer was a private practice contracted with the hospital, and as a group decision, they decided to try using scribes to alleviate physicians' clerical burden. The IT department of the hospital was not "happy" with the hospitalist group because it appeared as a threat to the people in the IT support system. The reality of a high patient census was the same for P14 and P15 compared to other participants. P14 shared a time where she arrived at the hospital and was the admitting physician for the day in her group. Being the admitter has been shown in this study to be one of the more stressful situations if there are no real controls or caps to how many patients need to be seen in a given day or shift by the admitting hospitalist. The stress however, appeared to significantly decrease for P14 and P15 who had scribes. P14 shared how the work of a scribe and work of the admitting hospitalist can alleviate stress for the hospitalist and allow the hospitalist to devote focused face to face time with patients:

I got here in the morning, saw a couple of people and started getting more people then started getting admissions but we did between myself and the scribe who is new, that means she hasn't been here that long. But we did 5 admissions in 3 hours....

The ability to rely on a capable partner provided a clear support for patient care efficiency without adding to any distraction in the room. This kind of efficiency support allowed P14 and P15 to connect with patients and provide a start to the documentation process; thereby eliminating note taking in front of the patient, which was necessary, but distracting for the hospitalist who was intent on connecting with the patient. P15 provided an example of how having a scribe worked in the workflow during the admission process with a patient:

...you can go in and sit down and talk to the patient and I introduce them, and they are typing. They can't touch the patient, can't do anything, but it's kind of nice because I can sit and just talk and I'm not having to take notes and stuff and I know all of that is done.

P14 shared that the value of having a scribe allowed her to stay calm because she knew the added efficiency a scribe adds to her workflow would aid her in seeing patients without being rushed.

P14 shared the importance of "being able to get people in efficiently" which allowed her to "get a good plan in place." She elaborated that getting patients in efficiently and establishing a plan of care with the help of a scribe was "a function of staying calm" even though there were four more people that need to be admitted. Her stress was alleviated however when she took in the fact that she had a scribe saying, "it will be fine. I'm on to the next."

Although the use of scribes has been suggested to increase efficiency for physicians in an effort to alleviate stress (Kroth et al., 2018; Linzer et al., 2016; Williams, 2018), relatively few hospitalist groups and hospitals employ scribes as a method to increase physician efficiency and mitigate sources of stress attributed to the additional time documentation required for physicians, especially where the patient volume is high or days when hospitalists are the admitting physician. P15 cited two ways scribes had helped him in his daily work life. The first was in efficiency because of his poor typing skills, and the second was an "unpredicted" benefit of personal emotional support, a source that will be further explored in the social support section of

this chapter. P15 estimated the addition of a scribe to his workday when he was admitting patients resulted in a saving of 2-3 hours a day. P15 also said he tried using voice-activated software, but that process failed.

Hospitalist burnout: Time to recover from work. Time to recover from work represented the final sub-theme of burnout and the concept of time. Hospitalists are typically known to have different types of work schedules due to the 24/7 type of coverage provided in the hospital. Although many iterations of a work schedule are possible, P2 said, “We work 15.2 days a month here. You would think having 15 days off a month would be a lot. Well, not really.” P11 described the career allure of working half of every month before experiencing how the type of work and schedule can affect the time to recover physically:

Oh gosh, I only work 15 or 16 days a month and I have 15 days off! How could that be bad?” You don’t realize that after working seven days and maybe five-day shifts and two-night shifts, I mean literally, there are 2 or 3 days where you are just done. You get those days off. Well, the first day off you didn’t sleep the night before so you’re sleeping all day. Then it’s 2 or 3 days of recovery after that because you are trying to switch your sleep schedule over.

P2 and P11 shared similar stories that suggested the cognitive demands of the job left them depleted over the next 2-3 days and in need to recover from the previous week of work. P2 further expanded on his inability to engage in any decision-making:

You just finished making thousands of decisions and all of this stuff here you are involved in. I am not very good at getting much done on that first day off. . . . Then I’m kind of toast all day.

In relation to caring for acutely ill patients, time for P6 to recover included time to reflect clinically on what could have been done better, however, this was not a regular occurrence, as P6 shared:

You reflect back on it and it was horrible, but if you have some time to recover and have some cases that do well, and don’t have those back-to-back days, you can get through it and find the joy in medicine.

Despite a poor patient clinical outcome, P6 shared that the joy he found was not just in working with patients when things went well, but also working on patient cases that did not go well. This is possibly a testament to the training hospitalists receive that contributes to a unique resiliency for emotionally draining work that is rewarding if given time to absorb certain clinical situations.

The final sub-theme for burnout with hospitalists in this study is related to physical exhaustion. Physical exhaustion appeared to be a factor of burnout for participants because it seemed to affect their cognitive acuity. The combination of physical and mental fatigue appeared to threaten participants' ability to care for patients in the way they had been trained. P3 described a day where a patient's stomach was explored or "scoped" in search of an internal bleed. After stabilizing the patient, it was revealed that most of the patient's bowel was dead and needed to be removed. The following section provides a glimpse of how physical and emotional hospitalist exhaustion appeared to be intertwined at times. P3 described the situation during and after a patient died under his care:

GI [gastroenterologists] scoped him and we put in over 40L of products and got the bleeding stopped, got him stabilized, and [the patient] still died because we had to embolize [remove] so much of his bowel and it was ischemic throughout. That was one of those that you put in so much time and effort in something and you're like in the end, there's nothing really to show for it. Those situations are the ones that really hit you the hardest.

The brevity of trying to save a patient, and then losing the patient with "nothing really to show for it" suggested that despite experiencing fatigue, P3's dedication to patient care continued to be the priority.

P8 recently left a large urban hospital and accepted a position as a full-time hospitalist in a small community hospital. As she reflected on how exhaustion had contributed to her decision

to leave, she thought of the final moment that caused her to consider that moving to another town and starting over would be better than what she was experiencing at her job. P8 shared,

This is too much. I am exhausted all of the time. I don't feel like I am able to provide the kind of care that I want or should be doing. So, there were plenty of days where, you know, how do I make this better? Do I want to look for a job? Not really.

P8 shared her decision to leave was a good one because in the last year there had not been a day that she did not want to come in to work, unlike her previous job. The patient volumes were lower (i.e., half as much), and as such allowed P8 more time to connect with patients and “be the kind of doctor” she envisioned.

As shared earlier, P7 stated that keeping his work schedule at .6 FTE would enable him to work longer because his overall time at work was lower than a full-time equivalent hospitalist. Even though P7 had not been working at the .6 FTE level, he identified with P8's experience that time was more important than financial gain, and time to recover from the demands of being a hospitalist (i.e., lack of sleep, sick patients) provided a dual personal gain: perceived sustainability in the profession and ability to engage in self-care.

Summary of Hospitalist Burnout Findings

Burnout findings from this study provided further depth about commonly accepted constructs of exhaustion, depersonalization and cynicism (Leiter & Maslach, 2017; Halbesleben & Buckley, 2004; Heinemann & Heinemann, 2017; Maslach et al., 2001; Maslach & Jackson, 1981). At times, it appeared that these three constructs overlapped, and other times, exhaustion seemed to be more prominent stated by participants in one way or another. It also appeared that the source of stress for participants predicted the type of stress they experienced. Hospitalist leaders reported two different sources of stress as one source was in relation to the role of being a leader and the other source was in relation to providing patient care. Overall, after careful

analysis of the burnout data, the concept of burnout from the findings suggest burnout as a relationship between the individual hospitalist leader and/or hospitalist through the following four themes that emerged: (a) burnout for hospitalist leader as a result of stressful demands from corporate, hospital, or local leadership; (b) hospitalist burnout related to conflict with one's direct supervisor or boss; (c) hospitalist burnout related to the employment contracting process; and (d) burnout related to a lack of enough time to get through work efficiently.

Further analysis of the four burnout themes might suggest that a relationship existed between a hospitalist and leadership, responsibilities of working in various hospital systems and the consistent strain to work through large patient volumes, document efficiently and personally recover from the stress of the work. Conflict for hospitalist leaders and hospitalists without leadership responsibility appeared to be a factor that contributed to burnout and stress and was related in specific issues (i.e., employment contracting for hospitalists or staffing resources for hospitalist leaders). Depending on what issue participants were currently addressing at an individual or leader level, the level and quality of stress also dictated how participants were individually affected based on the strength of those corporate, hospital, or local leadership relations.

Time for participants to be used as they appeared to be a factor that impacted perceived quality of care delivered to patients. For example, participants were not dismissive of the responsibility they had with documenting patient visits; however, those hospitalists who had clinical scribes or a reasonable patient census did not attribute EMR or documentation as contributors to burnout.

Although burnout scholars have suggested that the antithesis of burnout is engagement (Schaufeli et al., 2009; Leiter & Maslach, 2017) at work, there is also a scholarly imperative to

move past the measurement of burnout into dimensions for physicians that include factors other than a status of absence of burnout or presence of engagement (Eckleberry-Hunt et al., 2018). To this end, the next section will reveal findings based on what participants reported was the nature of their engagement in their work.

The Nature of Hospitalist Engagement Findings

The following section presents findings for how hospitalists experienced engagement at work. Initially, the interview protocol (Appendix D) treated the concept of engagement as how hospitalists celebrate at work. Upon further reflection, because participants were taking a worker engagement survey (Appendix B), the concept of celebration was reframed as engagement to align with the survey and previous work in the field of engagement (Kahn, 1990; Shuck et al., 2011). The questioning about hospitalists' experiences of engagement came after the questioning about their experiences of burnout.

Participants were asked to describe a time or situation where they felt engaged at work and to provide specific times or events that they attributed to engagement. Participants included explicit times when they felt very engaged at work and did not need time to reflect on this concept. Three categories of engagement emerged and will be discussed: (a) time to spend with patients during difficult diagnosis, (b) appreciation received from patients, and (c) meaningful connections with patients. These three themes will be discussed next.

Hospitalist Engagement: Time to Spend With Patients During Difficult Diagnosis

Findings showed that participants found engagement or equated such engagement as a "good day" when they spent time with patients and/or patient's families currently experiencing terminal diagnosis or medical issues connected with these types of diagnoses. P1 shared that there was a night where the admissions were spread out sufficiently, so he felt he had enough

time to devote to patients, but he also said patients were “sick enough” to justify being admitted; meaning, his clinical expertise could be used. In particular, P1 shared an engaged or really good day for him was experienced when he helped patients embrace a terminal diagnosis:

The two times that I feel that I am doing something worthwhile are like when I help convince a patient or a family that yes, hospice is really what you need to do. Rather than like going through all of the pain and suffering that we are going to put you through or like the patients that are really, really sick like the ICU patients. That’s when I feel like I am doing something worthwhile.

P1 found satisfaction in the act of communicating with a patient what he or she could experience in relation to suffering. Engaging with patients intimately as they were faced with a terminal disease reinforced his identity as a physician by helping patients choose how they wanted to live out the end of their life. P4 experienced a similar satisfaction connected with having time to communicate with patients. He shared that this satisfaction came when “you have appropriate amount of time to actually devote to or communicate complex stuff.” The dual act of combining clinical expertise and communicating clinically complex diagnoses in a way that patients understand their clinical situations provided a path and place of engagement for P1 and P4.

For P6 and P8, who practiced at a facility where the patient census was half as much as all of the other participants, having time to communicate and connect with patients was a regular and deeply satisfying occurrence. P8 shared,

One of the things that I really appreciate about this job is that I can take as much time as I feel I want to with each patient, and truly, you know, spend the time at bedside . . . and have more meaningful interactions. And build more relationships with my patients and feel like I am able to be everything I want to be as a doctor.

Seemingly unlimited time to spend with patients in order to build a connection with patients connected P8 to her identity and goal of being ‘everything’ she wants to be as a physician. P8 continued that a “really good day” was not where she had more than six hours of sleep over the course of a few days, but when she had “invested” clinical time and concern for a local patient.

In the particular situation P8 shared, she had also made connections with the patient's family who did not reside in the area, but she kept them apprised of their loved one's situation due to the severity of the patient being in the intensive care unit most of the week. P8 shared,

I went off of service that Friday morning. I extubated him and he was doing great, and he literally pulled the tube out, looks up, and he says, "Hey doc, how ya doing?" (*laughs*) I said, "I'm good, how are you?" And he said, "I'm *wonderful*." ... And he got all tearful and said thank you for saving his life, and it was just a heartwarming moment. You know, three nights earlier I had to call his family and tell them I am intubating him. I'm concerned he is not going to make it through all of this. So, it was nice to call them this morning and say, "I just wanted to let you know I am calling with good news for a change. We just took the tube out and he is doing great." That was just so rewarding for me.

Although not all patients survive as in P8's situation, engaged, meaningful days were also experienced during the death of patients. P9 and P12 experienced highly engaged and rewarding days when they were able to commit time during pivotal moments for patients and families who faced terminal illnesses. P9 shared that it was through the act of giving empathy to her patients that she found satisfying:

I had a 50-year-old guy who was dying, and he had 2 kids in the 18-20'ish range and his wife. And I spent about half an hour with her every morning because it was just hard for them. He had been diagnosed with cancer a couple of months ago.

Providing emotional support for this family, and especially the patient's spouse who was shouldering the burden of honoring her dying husband's wishes, brought an internal, emotional satisfaction for P9. She said, "And he died that day. And it was good. See that one was good, like I made a difference because I spent time with his spouse each day and really supported her."

Discernment during death and dying with patients brought an additional dimension of engagement for P12 who explained:

Just when somebody is dying, what you do or don't do kind of makes a big difference, and just being able to provide comfort for a family member or for the patient. I think those are the interactions I find most meaningful and rewarding. I think those would be,

even though they are challenging on an emotional level, I tend to come away from those feeling I made a difference and feels worth it.

P12 shared the dual nature of providing comfort and empathy, or clinical expertise that may go unnoticed by patients but also bring similar feelings of engagement. P12 elaborated on this concept by stating that it is these moments when you are “taking care of someone who is critically ill because you feel like this is the medicine and what you trained for.” P7 went further in illustrating how important this dimension of caring for patients was by stating that it is “the heart thing and connecting with people” that matters most. Consequently, P7 also described the barrier to connecting with patients was when the patient census was too high. He said, “Obviously, if I have 20 patients, it’s really hard to do that and [I] can’t spend 45 minutes at the bedside with everybody...”.

Finally, P11 described how there is a general misconception that physicians do *not* want to spend time with patients, or otherwise appear annoyed or rushed from a patient perspective. When P11 was asked what a good day would be for him, he described the misconception and seemingly unattainable wish to have more time with patients:

I am going to have a good day because, I know this sounds pie in the sky, and I think a lot of physicians feel this way, but a lot of physicians get a bad rap about having this inclination. But I thoroughly enjoy walking into a room and feeling like I don’t have to rush out, pulling the stool out, sitting down, looking at the patient, and talking to them and saying what is going on and what can I do to help you? How can I figure this out? That’s the part of the day I enjoy.

Participants acknowledged that having time with patients, connecting with them at eye level, and giving the patient their focused time was a workplace goal that was not experienced enough.

Hospitalist Engagement: Appreciation Received From Patients

Participants expressed engagement in their work by receiving explicit gratitude from patients and families. Appreciation for spending time with them or for explaining diagnoses was

shown to participants verbally from patients and their families. The concept of engagement through appreciation was distinct because appreciation appeared to be related to explicit situations where participants provided care to patients where the patients and/or families remembered the care they received and wanted to thank them for their care. P3 recalled an additional form of appreciation expressed from a family where there was nothing more to be done clinically:

There was a very difficult, to an extent, very difficult family dynamic. And the patient was dying and there was nothing that could be done about it. Despite great efforts to make them comfortable, I had to spend time with them and even though the family was obviously not very happy that their loved one was dying; at the end of it, some of the family members came up and thanked me for everything that was done.

Even though P3 could not clinically treat the patient, his presence was felt and appreciated by the family. Participants experienced a dimension of meaning to their work when they gave all that they could to help a patient, but nothing further clinically could be done to save them, yet P3 was received appreciation from the family. P3 shared that the meaningful days are days that may appear as though things did not go well.

P3 continued to share a situation where he was working an overnight shift and he was not busy that evening. A friend of a physician peer of his was diagnosed with incurable cancer and instead of going back to the call room (a room where hospitalists can sleep or rest between admissions), he decided to visit the family on the unit, or floor, where the patient was located. P3 recalled how appreciative the family was of his time,

And they were all like, you know very appreciative that, middle of the night instead of being asleep, I just sat down in the unit and talked with them. Again, I think some of it is around those connections with those patients and families.

It seemed that the appreciation from the patient's family centered on the sacrifice of P3's sleep and his concern expressed through physical presence and genuine concern and empathy for the

patient and family. Similar to P6's experience where time spent with patients and their families will not clinically save a patient who is facing eminent death, P3 shared the feeling he had when he extubated a patient he had been concerned about. He stated that he "didn't claim to save somebody's life very often, but those cases that are very clear cut where you made the difference in making it or not are so rewarding and ride you through the tougher times."

P13 expressed that appreciation from patients and staff provided an engaged and overall good day even during hard diagnoses. On one occasion, P13 had to drive back to the hospital after just ending his shift because of receiving a call from the hospital nurse. A poor, terminal neurological diagnosis had just been received and she did not want to leave the discussion for the next physician. P13 willingly turned around and drove back to provide explanation of a poor diagnosis to the family after having left work for the day. P13 related that providing deep, connected care to the patient and their family was part of a "ying and yang" by sharing,

I remember the room it was in, like the corner of the old ICU pod (*laughs*). I can't remember what the diagnosis was, but sitting down there, there were about a dozen people in the room. All family. Patient was intubated, sedated, non-participatory, just [the] centerpiece in the middle of the room, and I still remember walking them through whatever it was—(*laughs*). So, clearly the emotional part of that memory was the important one, not the scientific part of it! And the getting sort of—, getting them up to speed and getting a plan in place and having them feel—. It wasn't a, oh, this is exciting, but thank you for caring. Thank you for going through everything ... That definitely made me feel good about the process.

Although this was a "crappy" situation for P13, and the fact that the biology of the situation was not memorable, the deep human connection resonated with him and provided a really good day.

The impact hospitalists can have for families who lose their loved ones cannot be understated, and families who lost loved ones carry these memories with them for long periods of time. P3 referred to these situations as "those deep connections" with patients that were personally confirming and engaging. P9 was caring for a patient whose wife recognized her

from many years ago when the wife had lost her brother due to illness. P9 shared the moment when the wife realized that she was the same doctor who cared for her ailing brother years ago.

The wife told P9,

You took care of my brother. He came in and he died somewhat unexpectedly, and you were so amazing. And after he died, I looked all over for you that day in the hospital and couldn't find you and wanted to thank you, and I've carried you with me for 10 years. I was so excited to see you today, and I am so thankful you are taking care of my husband.

Appreciation from this patient's wife created a good day for P9. Appreciation from a patient from years ago also provided a humbling experience for P9. She stated, "This is why I do what I do. So, that's success when somebody 10 years later can remember my name." The patient's wife not only remembered P9's name, but also what P9 provided for her brother during a difficult time.

P7 shared a somewhat sarcastic response when asked during the interview what a really good day looks like for him,

A really good day . . . (*laughs*) . . . where every patient interaction is wonderful, all of my tests come in on time...I don't have to stop my day in the middle of the day to do an admission in the ER because that usually breaks my stride, but if I do it's not a problem.

He later related that engagement at work for him was helping people that makes for a memorable day. He said,

...umm, where I get all of my work done and if it's a 7am shift I am out by 2:30pm. That's a good day and I have had fun and had good patient interactions and felt fulfilled that I helped somebody. Even one person.

Participants stated that engagement for them consisted of appreciation from patients, which made for a really good day. As P7 said, even if he helped "one person." The back and forth of giving to patients and receiving appreciation from patient families during difficult times or recovery, as P6 shared, brought deep meaning and confirmation for participants that they had

also made the right career choice. The next section will provide findings related to individual engagement for hospitalists related to time used to connect with patients.

Hospitalist Engagement: Meaningful Connections With Patients

Participants provided examples of a highly engaged day when they were able to connect with patients. At times, developing connections took time that wasn't always achievable. In situations where there is a new terminal or difficult diagnosis conveyed to patients and their families, it is logical to expect a relationship to follow in order for the family to trust the hospitalist in receiving difficult news. Contrary to delivering difficult news to patients, participants also shared meaning and fulfillment in connecting with their patients and knowing them better in a short amount of time, according to the patient and situation at hand. In addition, this theme represents the meaning of deep connections with patients that provided professional confirmation and joy. For P3, time to sit and talk with patients in order to get to know them a bit better as a person was the main reason he chose to be a physician:

Largely it's the patient interactions. . . . So, especially if you have a good amount of time to sit and talk to them, explain things to them, answer all of their questions, they are very appreciative. And that's really what's the most rewarding thing.

P3 was asked whether he had time to spend with patients, and he shared that it depended on seasonal variations to the patient census as well as the staffing situation. P3 shared that it is not always all the time he wants, like when he was an intern,

where you sit for hours with patients and you gather the entire background and you probably don't know just their medical issues, but all of their social history and spending hours talking to a veteran about all of the different stuff that happened to him.

It was the social background of patients that provided context to the whole patient, as P3 stated that "the social connection is helpful and when I can work that into the schedule—it's nice." P13 equated that getting to "deeper connections" provided a pathway to reaching people on a deeper

“conversational” level that allowed him to treat the person instead of “going through the motions” of only treating a disease. In other words, spending time with patients allowed hospitalists to get to know patients as people with disease(s) instead of a disease attached to a person, and this time also appeared to possibly mitigate feelings that led to depersonalization. Depersonalization has been shown to be part of burnout symptoms for physicians (Linzer et al., 2014) and has been shown to decrease quality of care (Salyers et al., 2017).

P7 explained the bridge he crosses between getting to know a patient better, and the quality of care he delivers with short visits because of his undistracted time he gives at the bedside. He further clarified the difference between having the time to spend and *choosing* to spend time with patients to gain satisfaction and engagement. P7 shared during our interview that when he knows he may not have the amount of time he needs to spend with a patient, he makes that time count as he explained when he enters a room,

...looks them in the eye, like I am looking at you, I am looking at you. I am seeing you. Even if I am only there for 2 minutes. If I see you, you are going to feel like you had me for an hour. And it ain't a game. It's true. So, that's what I do to people!

In contrast to the times P7 does not have time to give to patients, he explains the intuitive nature of how he attributes the time he has to patients he senses is needed. P7 explained that,

...sometimes I spend 45 minutes if I really want to. I have to feel something for somebody to do that to take time out of my life. Sounds selfish, but to take time out of my life to give that to a person, like with this alcoholic upstairs, I felt it was necessary, like it might matter, and it might help her and that's not a process I think through—it's just a feeling.

P7 went further to say this feeling is innate and cannot be learned in his opinion. Knowing when to give more of his time or less is an art, but for him, when he chose to give time, he was intentional about the act.

P11 shared a similar story of deep satisfaction when combining the science of medicine to solve problems and the social interaction of getting to know his patients. At this intersection, P11 found “joy” in practicing medicine:

The problem-solving side of medicine, I still thoroughly enjoy. I find that fascinating every day and talking to the patient. That’s where the joy of medicine still is. Patient contact, good patient contact, even if it’s a patient that’s not happy, you know? I don’t even mind that as long as I can spend the time with them to help figure that out and help make it right for them. And then I think the art of medicine, the problem-solving side is still, those are where the enjoyment of medicine and the kernel is, I think.

P11 did not refer to making patients happy as meaningful, but rather, the importance of connecting science to patient care, quality patient contact through meaningful conversations and making their experience “right” regardless of the clinical outcome.

Some hospitalists shared meaning through levity associated with direct patient encounters. P8 shared earlier that after she extubated a formerly seriously ill patient, the patient subsequently looked up into her face and said, “Hiya doc!” lifting P8’s spirits and creating a memorable moment between her and her patient. Similarly, P13 shared a patient encounter with an elderly “super sweet” female patient and wanted to make sure he had gone over everything clinically with her and her son before he moved on to another patient. P13 asked if there were any other questions from the patient to which she replied, “I’ve been wondering this whole time and all I’ve been paying attention to is your hair. How did you get your hair into such a great point? (*laughs*) I said, well, it’s a widow’s peak. It wasn’t on purpose.” Humor from patients that were led by patients provided light, but deeply meaningful moments for some of these participants.

Summary of Hospitalist Engagement Findings

Scholars have suggested that engagement is shown through an employee’s cognitive, emotional, and psychological state toward organizational outcomes (Shuck et al., 2011), and a

deep emotional absorption in their work (Kahn, 1990; Saks, 2006). The examples of engagement from participants in this study appeared to support the construct of deep emotional absorption through deep connections with patients. When participants were given control over how to allocate time to patients, this provided really good days where engagement gave participants confirmation about their career choice and reasons for why they do what they do. Engagement for participants appeared to be resistant to physical exhaustion, but when participants did not have time to spend as they chose, time became a barrier to engagement. In summary, engagement findings for physicians were expressed and categorized into two themes:

- Engagement expressed as finding “joy” by practicing medicine through time spent during terminal or difficult illnesses.
- Engagement experienced from patient appreciation.
- Engagement experienced coming from discretionary use of time spent with patients.

Overall, findings from engagement were intertwined with enough time to make meaningful connections and relationships in a limited amount of time. Some patient situations had the heaviness of a new terminal diagnosis that participants had to share, however these times also brought deep meaning, work satisfaction and high engagement. These meaningful interactions also provided opportunity for patients and patient families to express their heartfelt appreciation to their hospitalist.

Summary of Findings on Hospitalist Burnout and Engagement

In Chapter 2, Figure 2.1 proposed a conceptual model of the relationship burnout and engagement would have on participants suggested that as one feels more engaged, he or she also will experience less burnout on the job. The concept was based on prevailing knowledge about

burnout and engagement where burnout was experienced as emotional exhaustion, lack of self-efficacy, and cynicism (Maslach et al., 2001); engagement was generally accepted as the opposite to burnout. Thus, engagement was conceptualized where one exhibits energy, involvement, and effectiveness (Leiter & Maslach, 2017). However, findings revealed that participants who were burned out also experienced moments of engagement expressed as a really good day. Participants revealed situations where they experienced physical and emotional exhaustion, the most commonly researched construct associated with burnout, but they also experienced profound involvement with their patients, thus, confirming that the state and rate of burnout and engagement alone did not appear to contribute to answering the initial question of why physicians' burnout rates continue to rise relative to other occupations. For these reasons, the next section provides results on the role of social support, the last concept suggested, to add more depth in understanding the relationship to burnout and engagement.

The Nature of Social Support Networks for Hospitalists

The following section will describe the results of the analysis related to how hospitalists experienced social support networks at work. Social support for hospitalists was conceptualized in Figure 2.4 as support coming from varying sources for hospitalists which included (a) patients, (b) hospital administration, (c) consultants, (d) nurses, and (e) patient families. These five sources of support theoretically would form a social support network for hospitalists that could mitigate stress and burnout, and if the quality of the relationships in the framework was high. If theorized sources of support provided support for participants, then it could be logical to assume that hospitalists would have a source of support during difficult days.

Participants were asked to construct a social support network survey (Appendix D) to explore the role and degree of social support had for them. In contrast to when participants filled

out the burnout and engagement surveys before the interview, when participants filled in the social support form, they talked through their choices and answers as they simultaneously filled out the form. Results from the social support data suggested a range of support from low to high coming from varying sources of support. Themes emerged into three categories: (a) clinical support, (b) non-clinical support, and (c) leadership support from a corporate, hospital, or administrator from a physician medical group. Participants did not name patients or patient families as a form of support verbally, nor did they list them on the social support network sheet; thus, this finding changed the conceptual framework. Results of the social support network are described in the next section.

Participants were asked to write down people, departments, and/or roles that existed in their respective hospitals that provided or did not provide support they needed to do their job. Sources of social support could also include people outside of work. Additionally, this process provided a safe place for participants to talk about sources of support they *wish* they had, and in some instances, did not. Participants thoughtfully reflected upon their choices, and as a result, construction of participant social support networks was co-constructed by the researcher and participant. This portion of the study was considered exploratory in order to gain an understanding of the form, function, and quality of hospitalist social support at work. In addition, the conversations that took place between participants and the researcher during co-construction of the social support networks provided additional depth and support of the concept of social support.

Results of Hospitalist Social Support Network: Clinical Support

The following examples represented clinical social support for participants. Initially, the conceptual framework put forth included nurse staff and consultants (e.g., physicians who

represent specific specialties such as cardiologists, gastroenterologists, etc.). More specifically, 13 participants named nurses, six named case managers/social workers, and four named consultants (i.e., specialty care physicians) who provided very high support. The following section considers the level and quality of support perceived by participants. For participants who named nurses as providing high support, the reasons were profound and directly related to the depth of support nursing staff provided. P7 described the role nursing staff played for him, but also empathized with what nurses do every day for patients:

Nursing. I couldn't do my job without them. . . . [It's] astounding to me that I come along, see the patient for 5 minutes or 10 minutes, or 45 in the case of [one] woman, and I chat, and I think and cogitate about this or that, look at data, write some orders and I walk away and go to the next patient. But they're there at the bedside all day long dealing with their whining, dealing with their praise or wiping their butts, dealing with an irate family member, changing this or that out, repositioning the patient, getting the MA [medical assistant] to help you reposition the patient and get them on the toilet and off the toilet, put the hot compress on and you make \$27/hour. You should be making \$50 dollars an hour. I said that to her.

P6 also shared how important nursing staff was in the hospital where he worked, but he also believed it was because local hospital administration supported and “empowered” the nurses. When asked who P6 thought was most important in his social support network, he said, “I think nursing staff first and foremost because I have more encounters with nurses on any given day and they're, you know, first line.” P9 shared the same value of her nursing staff when she was asked who among her list of support would be difficult to lose: “The nurses. By far. One-hundred percent.”

P12 and P13 described the relationship they had with their nurses as that of a clinical partner. P13 shared that in order have a relationship with a nurse he can rely on when he cannot be everywhere, he needs to first put the time into the relationship:

Maintaining a relationship such that trying to keep it open that they are willing and able to call me on stuff which on the one hand can be maddening. Are you kidding me, you're

paging me again? (*laughs*) Would you have paged a surgeon about this? Come on!
(*laughs*) But, knowing that is the time investment I put in to be able to get the calls. . . .

The reward from putting in time into his relationships with the hospital or floor nurses came in the form of trust. P13 described that when floor nurses paged him, and if he knew the nurse, he trusted that they were paging him for a reason even if she could not articulate exactly what the reason was, as was the case of one nurse who paged him and said, “So I don’t know what’s going on and I don’t have anything specific, but my spidey-sense is tingling. . . . You know, there’s just *somehthin’ up* with this patient.” P13 considered this kind of communication valuable and an “early warning” to potential worsening with a patient. The depth of communication P13 had with his nursing staff was due to his personal investment in getting to know nurses, and also talking to nurses about “how and why” he does the things he does in medical practice. P13 articulated a common theme for the majority of participants about the importance of clinical support: “You can’t have a hospital without a nursing staff.”

Results of Hospitalist Social Support Network: Non-Clinical Support

When some participants were going through difficult times at work, there was a reliance on non-clinical support, which was identified as spouses, inner-circles of friends, and scribes. Non-clinical in this sense refers to those individuals who provided personal and/or emotional support with some connection for participants to do their job. The perception of this category of support was viewed through the participants’ lenses, such that they could not do their job without their spouses and/or inner circle of friends outside of work.

Though it could be assumed that spouses provided support for each other, P12 and P13 said they could not do their job without their outside support. As P12 said, “I think my husband is number one.” P9 said her husband provided domestic support that she could not do without: “He cooks, cleans, and does the laundry. I’m a princess. You have no idea.” P9 also shared she

had an inner circle of friends with whom she got together with on a monthly basis that was also important to share things about work that she did not share with her husband in order “to keep it separate.”

The sources of social support varied for participants. P2 shared that patient advocates provided a confirmatory type of support when he encountered difficult patient family situations, and P15 shared that scribes provided high support. Related to the social support source of scribes, P15 stated he received emotional social support from his scribe. P15 wished he had more time with his peers to obtain social support like he did in his previous job, but the environment did not support things such as time for conversations with his peers. Further questions during the interview with P15 revealed that his scribe provided intimate emotional support pertaining to difficult patients. The generally accepted rule for medical scribes is that they do not interact with patients and are silent notetakers in the clinical setting that allows the physician to interact with patients. For P15, his scribe provided a confirmatory emotional support similar to P2’s patient advocate especially when there are challenging patient interactions in the exam room. P15 said:

people are difficult, and you know they [scribes] hear, “God, that patient is a real f***-up.” I have to say that and voice it in my head and they hear it and I’m pretty confident they don’t repeat it, but they are actually emotional support that I would not have predicted. . . . But I will actually talk with them and they will talk back with me. We will actually have a– not a global discussion, but I will ask them what are you planning to do, not that I ask them what I should plan to do, but they are a surprising social support I get that I would not have predicted.

In a similar way, for P2, patient advocates provided emotional support with difficult patients. Although patient advocates typically represent and advocate for the patient (hence, the title), patient advocates for P2 also appeared to serve as a relational bridge between the patient physician. When P2 was asked what patient advocates do to provide this type of support, he

responded, “They just come and see the patient with me and they are very supportive. Emotionally supportive. “Yeah, you’re doing the right thing. Yeah, that’s the way to deal with it. . . .” Participants who named non-clinical social support as an important part of their network, spouses, scribes, and patient advocates provided a unique type of social support experienced as a highly personal, individual element of their work.

Participants named case managers, social workers, and/or discharge planners as another strong source of social support, referred hereafter as “discharge planners.” Discharge planners are typically used in hospitals to assist the physician with planning and provision of support services after patients are discharged. The needs of patients vary, but until services are secured, patients cannot be discharged from the hospital; thus, the role of case managers are vital to hospitalists and distinctive in their roles from hospital floor nurses.

Six of the 15 participants named discharge planners as providing strong support connection to patient care. The skillsets discharge planners have were described as crucial to discharging patients from the hospital. When P2 was asked during the interview, after filling out his social support sheet, which social support would be most disruptive to lose, he answered:

Oh, if you don’t have discharge planners, you can’t do anything. So that’s probably the most important. I can’t do that. I can’t call facilities. And you know, like everything else, administration tries to cut back on costs and care management is one that gets cut back on.

P2 recognized that discharge planners are crucial to his moving patients out of the hospital with appropriate resources and acknowledged that budgets affect staffing of discharge planners. P5 also acknowledged the necessary skills supporting the discharge process by stating discharge planners “help you figure out how to get out of the hospital. . . . In 30 minutes, they will do some amazing miraculous discharge plan that would have taken you hours to put together.”

For P5, discharge planner offices also provided a “safe space” to vent about things. In particular, when patients or patient families are challenging and difficult to work with. P5 shared,

Care managers can be a really nice sounding board because sometimes you will be like, I think this person is a little inappropriate and demanding and has really unrealistic expectations of what we should be doing for them here, and what their discharge plan is going to be. And the nurse is all on board with what the patient wants, and then you talk to the discharge planner and they are, like, that other reasonable human who says *what are we doing here?...*

The “additional reasonable human” for P5 included the skillset of a discharge planner and a non-judgmental space for her to vent frustrating patient situations. In follow-up to P5’s thought on discharge planners dealing with behaviors and not necessarily technical or medical situations, additional questions during the interview revealed:

Yeah, so they have to talk to the family and they get to understand a little bit more of the social dynamic. And they have a keen sense of who is going to make it at home and who is not, and just by talking to the family a few minutes and collecting some information they can get an idea of who has a reasonable home situation and who doesn’t. And they of course know about the insurance stuff and who you can try to place and who you can’t.

Discharge planners provided two sources of support for hospitalists. The first role of support they provided is to help patients get discharged from the hospital appropriately according to what the hospitalist has recommended. The second source of support discharge planners provided is emotional support for hospitalists during difficult interactions with patient families. This type of support was important to hospitalists when they encountered difficult family discussions and discharge planners provided another “reasonable” person in the room for hospitalists to rely upon.

In summary of who provided the highest forms of clinical social support for hospitalist participants in this study, 13 of 15 participants named nurse staff, followed by six participants who named discharge planners in the clinical support category. Overall, nurses were mentioned

as vital to the critical depth of support needed to assist patients when participant hospitalists were unable to be at patients' bedsides. Discharge planners provided high support for six participants to the extent participants communicated that they would not be able to do their job without them. In the next section, the role of leadership had for hospitalists is the last theme in social support discussed.

Results of Hospitalist Social Support Network: Leader Support

The following texts are examples the impact leadership had on hospitalists, regardless of the role the hospitalist had in their group (leader or non-leader). Participants viewed leadership in two ways: (a) currently received source of social support, or (b) as needed but received very low support.

P3 served in a hospitalist leadership role and explained that he needed more business support to administer the group. P3 discussed the layers of management and hierarchy within the health system he worked in and said though the hospital administration was supportive, the decision to provide more support was made by corporate leaders located in another city. P3 explained how corporate leaders "just don't provide business support for a group this size and don't really have clear guidance on the scope. And I think they are getting there, but at this point, they are not there." Although P3 was a leader in his hospitalist group, he had very little to no authority to approve more hospitalist staffing or business support staffing, leaving him in a vague gray area with respect to being a leader, with no one person to turn to and nowhere to go for business support.

P3, a hospitalist leader, also shared that he received low to no hospital administrative support within his vertically integrated health system and would like to have their support in order to manage and run his group. P3 stated that the apparent disconnect for corporate (non-

clinical leaders located in another city) decision makers stemmed from a misunderstanding about what his group provided for his hospital. P3 stated that corporate needed to have,

people understand what that front line of care really is, and how it really needs to operate, and able to make decisions to lead docs who are like herding cats going like this (*gesture of hands moving in opposite direction*) and uniting them in a uniform direction toward something that is hopefully better.

As P7 related, hospital administrators and physicians had a history of friction, stating, “It has always been a tenuous relationship between admin and docs. They aren’t clinical. They don’t know how we think or why we want what we want.”

P7 and P3 were close friends in the same group where P3 was the hospitalist leader in a recent vertically integrated health system. Although P7 was personally affected from a lack in staffing and his employment contract was negotiated at a .6 level, he had been working as a full-time hospitalist. P7 tried to support his friend and colleague through working more shifts, but P7 also witnessed the impact that lowered business and staffing support was having on his friend. P7 shared,

He confided in me, so I knew what was going on at that time. He was getting *unbelievable* bullshit from Administration and no support and was working a lot of shifts and night shifts, and it just caught up to him and he just lost it. Came close. Not scream and yell, but actually he did.

As P3 had no tangible leadership support, he took additional responsibilities on himself by working more until he could not any longer. As the chronic stress and responsibility of leading without authority wore on P3, he reached burnout. P3’s stress was not attributed to caring for patients because he also shared in the same interview that patient care was where he experienced meaning. In this instance, it appeared there was a duality to burnout; one attributed to the role of being a hospitalist leader of a group and the other to being a hospitalist.

P12 was a locum tenens hospitalist for 3 years before settling in with her current

hospitalist group. As P12 filled in her social support sheet, she started to talk about how her two hospitalist leader/bosses were very supportive. She also sensed a shift in local hospital administration from one of concern about her and her group as people versus the “business” side of what her group produced:

I don't know if we as a group feel supported by the administration to be able to do our job or empowered to do our jobs in the best way possible. . . . It seems like it's turned much more into an emphasis on numbers and productivity that I'm sure a lot of groups around the country face.

When P12 was probed further during the interview to explain what administrative support would look like, she said that lately, “it feels like we don't have a voice,” but that it was not always the case. P12 operationalized support as administration supporting the group's need for staffing but felt like “that's where the support ends.” As a non-leader in her group, the lack of administrative support was tangible where staffing needs and patient census thresholds intersected. She noted, “This is the third administration” since she started, and the group was “smaller, closer knit, our volumes were a lot less” at 12-14 patients a day being the “norm.” Now, she said the group was “lucky” if hospitalists had less than 18 patients a day. P12 noticed her hospitalist leader was unable to convince the corporate leadership that they needed more hospitalists and had to work more than her .8 contract specified. P12 observed the increase to their patient census load without more staffing in order to allow time to see patients and this led her to surmise that her group was not important to corporate leaders who made staffing decisions located in another city.

It appeared that in situations where there was a need for staffing and low to no strength of a relationship between the hospitalist group and hospital or corporate leadership, resentment could build. P5 shared her anger due to a misalignment of corporate leader vision and local needs of her group that included staffing shortages. P5 shared a time when she received a

corporate email explaining the recent vertical integration where she worked. The email explained the reason behind the vertical integration was to expand market share in the area:

And then there's this big email that went out about expanding our brand and sent out this survey about, like are you proud that we are a part of [*name redacted*] and don't you think we do a better job taking care of our patients because we are a part of [*name redacted*] health?

The impact of the vertical integration was profound for P5 because of the impact to local decision making. Where decision-making used to occur at the local level, it was apparent this organizational move impacted P5 as she recalled vividly how she felt after she read the email when she said, "No! I think it's been a general shit show since we became a part of [*redacted name*], because leadership and decision making were moved to another city." P5 perceived this move of leadership as the hospital and her hospitalist group being neglected because decisions were no longer locally made and discussed.

As healthcare systems became more vertically integrated, so too the decision-making became less local. Despite participants who felt the effects a lack of leadership support had on their personal lives, participants also recognized that their local hospital leaders had little power to help them, even if they agreed due to the power shift to corporate leadership affecting decision-making power. P11 shared,

Now the local leadership is saying corporate leadership has control of everything. So, you know we may see eye-to-eye, but it might not help us at all because corporate doesn't see eye-to-eye. So, it may be a combination of these two because corporate didn't see eye-to-eye and allowed local leadership to help us achieve our goals and establish a sustainable hospitalist group that wasn't going to turnover.

At an individual level, P3 shared similar empathy toward local hospital leadership since a vertical integration occurred, even though their apparent lack of action led to his frustrations. P3 stated, "I think our local leadership wants to help, but their hands are tied." P11 tried to put himself in their hospital COO's place as he compared his ability to make local, impactful

decisions that affected the hospitalist group before and after the vertical integration. P11 wondered if the COO “sits there in his office, saying, ‘I really have no control. Why am I even here?’”

P6 (a hospitalist leader) and P8 (a hospitalist), had strong support from their local hospital leaders and stated that this support was integral to their feeling successful in their hospital. When P6 was asked what supportive leadership looked like, he shared the following story about the ease of accessibility to his hospital CEO and listening skills from his hospital CEO. They had recently been in a meeting together; P6 shared,

I just walked by and said, “Hey [*name redacted*], here is my perception of where we are like right now. These are the problems we are having, and these are the fixes that I think we need to do.” He was like, “Great, I think the same thing. Thanks for your help and involvement, and what do you need from me?”

The impact P6 experienced collaborating with his leaders was tangible. P6 and P8 had worked in a large urban hospital and had subsequently moved to a small community hospital. In this smaller setting, they both experienced hospital C-suite executives who listened and acted on suggestions coming from both participants.

P15 had a similar collaborative, supportive hospital leader he worked with when he was in a hospitalist leader environment where he was able to address problems and bring ideas, stating that it was one of the best times of his professional career. He explained,

We got big things done that would not have happened in a committee setting, so I really miss that person. He was my favorite administrator because he was interested in outcomes. He recognized the politics which is why we met in his office with the door closed and never kept minutes. That power to change, that ability to change, that ability for him to say, “Alright, I gotta go do these three things and let’s meet again in 2 weeks and see what happened.” ...that power to change I don’t have anymore.

Overall, findings from the social support category of leadership were supported by the conceptual model that hospital administration was a source of support. Findings also provided

the depth, breadth, and quality of what hospital leadership looks like for hospitalists and hospitalist leaders. The impact that a vertically integrated health system had on hospitalist groups however was a finding that was unanticipated. Decision making and collaboration with hospital leaders at the local level was impaired because of the decision-making power shifting to another city. In contrast it appeared when local hospital leaders are given authority to make changes in their hospital coupled with availability to discuss the local challenges, hospitalists named these leaders as very important to their work. Results of these findings illustrate the need and impact corporate, local hospital, and administrator leaders have in a hospitalist social support network.

To revisit the initial the social support framework outlined in the Literature Review (Chapter 2, labeled as Figure 2.4) it was suggested specific people would provide specific social support for hospitalists:

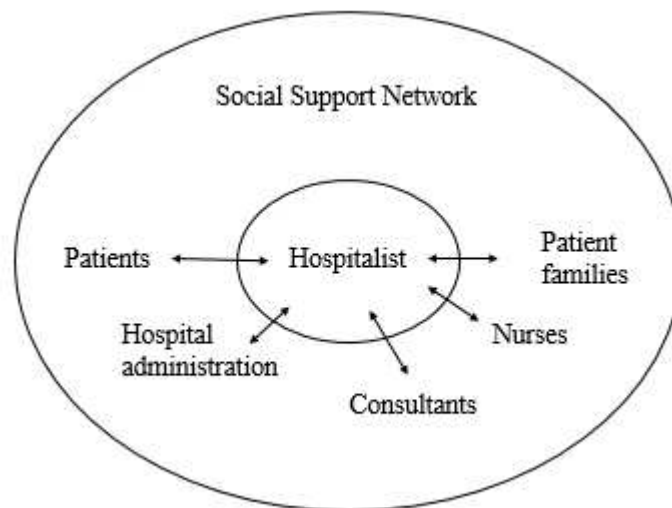


Figure 4.1. Conceptual framework of social support network for hospitalists.

Figure 4.1 showed five types of people that would provide social support for hospitalists: patients, hospital administration, consultants, nurses, and patient families. The conceptual

framework was changed to include sources of social support with varying degrees of importance and strength for the individual. These sources are: (a) clinical support, (b) non-clinical support and (c) leader support. Findings from this study resulted in the following revision to the social support network illustrated in Figure 4.2, a conceptual framework that now includes clinical, non-clinical and leader support. Of note, not all of the groups that are included in the social support network actually provide support. Of the three new sources of support, participants ranked leader support as lowest, but needed in their social support network.

Part of the social support analysis included completion of the social support worksheet (Appendix D). As participants filled in their social support network sheets, they also talked through some of their answers. Staying true to the interview protocol, construction of social support networks was meant for participants to explore freely what social support meant to them without specific questions. For an overall view of where participants placed their social support sources in a clinical, non-clinical or leader support category, Figure 4.2 provides a visual aid for results.

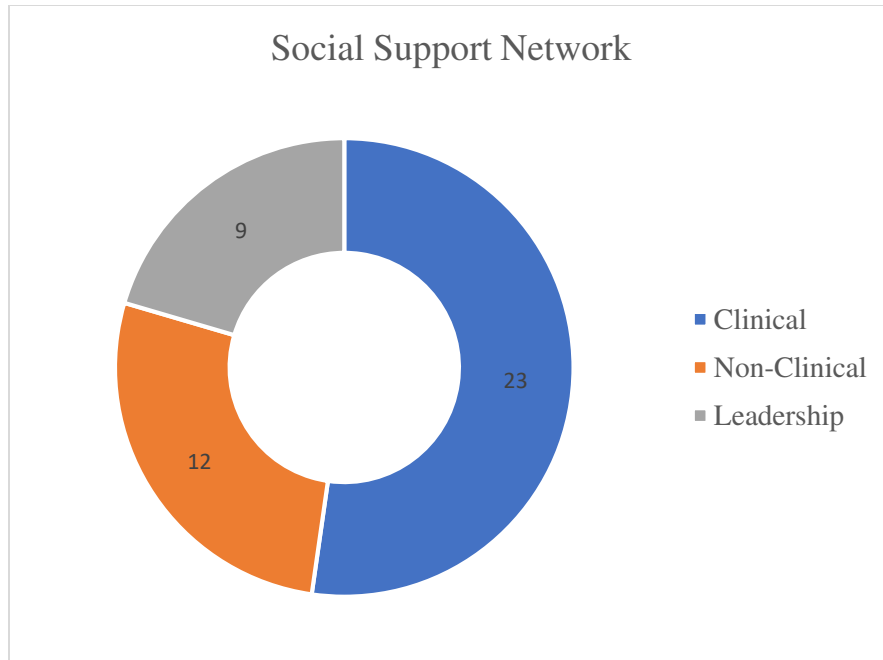


Figure 4.2. Social support network results ($n=15$).

The social support network results revealed three emerging categories. Categories of social support generally landed on whether the support source was clinical, non-clinical, or related to a leader. As Figure 4.2 suggests, the majority of social support networks were attributed to clinical people (i.e., nurses, discharge planners, and specialists in the hospital). Non-clinical social support was generally represented by outside sources (i.e., spouses), but also from sources that were included in the clinical support category (i.e., nurses, emergency room physicians) suggesting a dual nature of support depending on the quality of the relationship participants had with certain people. Lastly, leader support had interesting variability that included a need for leader support that was perceived as being absent and needed for some participants. Two participants, P6 and P8, both of whom worked together at the same hospital, had said that their local hospital leaders provided a strong source of social support for them. The remaining seven participants who named leader support as important for them received no to low leader support. Table 4.2 illustrates further details of the responses from participants.

Table 4.2

Social Support Network Results by Participants

Participant	Clinical support/specified role other than patient care or unspecific role (U)/score by participant	Non-clinical support/specified role other than emotional or personal support or unspecific (U)/score by participant	Leader support/role specific or unspecified (U)/score by participant	Sources of support needed /Role/Rank
P1	Nurses/5	Administrative assistant(U)-5	Program director/preparing schedule and working with hospital administration-5	
P2	Case management and Patient advocates/5 Specialists and peers/5	N/A	N/A	
P3	Nurses/4	Spouse/5 IT/analytics/5	Hospital administrators/U/-4 Physician group administrator/U/-2	
P4	Discharge planners/5 Social workers/5	N/A	N/A	Utilization review/contested discharges/5
P5	Case managers/5 Nurses/4	N/A	Corporate and local hospital leaders/U/-1	Emergency room physicians/collaboration/1
P6	Nurse staff/5 Consultants/5 Case managers/5	Emergency room physicians/4	N/A	
P7	Case managers/5 Nurses/5	IT/U/2-3	Hospital administration/U/-1	
P8	Charge nurse/5 Nurse manager/administrative/5 Peer/5 Emergency room physician/5	Peer/5 Nurse manager/5 Emergency room physician/5	CMO/leadership/5	
P9	Nurses/5 Discharge planners/2	Executive coach/career development/5 Spouse/"life"/5	Program directors/structure/1	
P10	Case managers/5 Consultants/5 Pharmacists/5 Primary care physicians (outside of hospital)/continuity of care/4	N/A	N/A	
P11	APPs (i.e. physician assistants)/4 Case managers/2	IT/U/4	Local hospital leadership/data, hiring and credentialing/2	

			Corporate leaders/U/-1	
P12	Program directors/5	Spouse/5 Program directors/5	Hospital administration/U/-2	
P13	House manager nurse/resource direction/5 Nurses/5	Spouse/5	Program director/U/-4	
P14	Hospitalist nurses/5 Peers/5	Scribes/efficiency/5	Local group CEO/business support/5 CMO/Mentor/5	
P15	Nurses/4	Physician leads/2 Scribes/4		Career coach

The detailed responses resulted in the decision to place categories of clinical support roles together (e.g., case workers, social workers, nurses) in order to represent those workers that provided a clinical aspect of support. To also illustrate the complexity of the supportive roles in the table, some clinical and non-clinical people served dual purposes between the clinical and non-clinical categories, but rarely in the leader support role.

There were two changes to earlier conceptual frameworks (Figures 2.4 and 2.5). First, the initial social support network put forth in Chapter 2 (Figure 2.4) was changed; recategorizing sources of social support into three categories: (a) clinical support, (b) non-clinical support, and (c) leader support. Results from this study suggested a revision to the initial conceptual framework of hospitalist social support. Changes to the initial conceptualization was based on the data analysis and findings that hospitalists appear to experience social support from three sources: (a) clinical, (b) non-clinical, and (c) leaders. The following Figure 4.3 displays the revision to the initial social support network model.

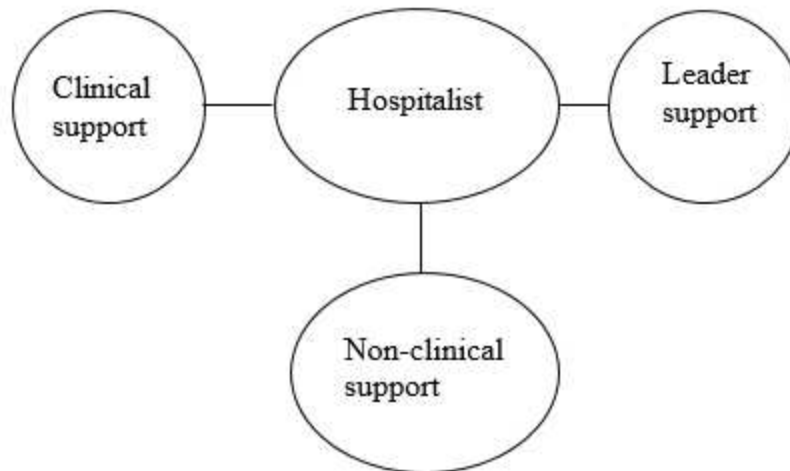


Figure 4.3. Revised conceptual framework for hospitalist social support network.

The strength of support was ranked by participants and revealed all three sources of support are needed; however, leader support was low to non-existent for participants. Additionally, patients and patient families are removed from the initial framework because there was no indication that social support came from these two sources. In relation to worker burnout, results from this study suggests that the strength and role of the sources of social support could moderate the degree of burnout. In relation to worker engagement, there is low to no evidence that social support is related to engagement because hospitalists experienced engagement independently from burnout.

The second conceptual framework revision is concerned with the idea that burnout and engagement occurred along a continuum for workers. Based on literature available and conceptualization of a continuum for hospitalists, a framework was put forth in Chapter Two (e.g., Figure 2.5) and is provided here as a reference:

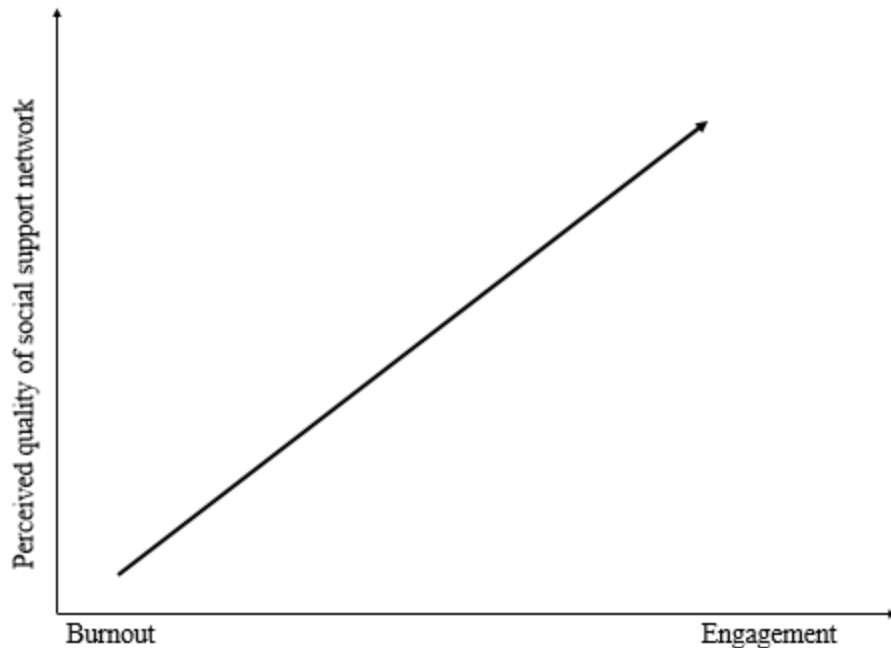


Figure 4.4. Suggested effect of individual social support network interactions related to burnout and engagement.

Results from interview data and supported by the Gallup engagement survey data suggested engagement is an independent construct from burnout. Furthermore, data analysis also suggested that hospitalists experienced engagement independent of the source and strength of hospitalist social support. Adding to the complexity of burnout, results of data analysis from this study revealed hospitalist leaders experience additional sources of burnout that was related to their current or previous roles as a leader. This knowledge will add to further depth to the burnout phenomena that can help differentiate between regular employees and employees who have leadership roles in the workplace.

Summary of Hospitalist Social Support Network Findings

Analysis of who was in, and the perceived quality of individual social support networks was an important dimension of this study. Social support networks can provide a buffering effect to stressful situations at work (Cohen & Wills, 1985) when considering the strength and quality of those networks. Critics of the buffering theory suggest that there is bias inherent in the

individual level of analysis approach that has dominated the literature on social support networks (Bliese & Britt, 2001), suggesting that social support networks and their effects need to be treated as a shared attribute. The shared attribute approach for hospitalists seems logical if teams are part of the work environment, however hospitalists move in and out of co-located teams throughout the hospital, making a shared attribute approach to measurement less useful. Analysis of the social support network data did not suggest that hospitalists named teams as supportive, but instead named important functions and roles in and outside of the hospital. In addition, hospitalist leaders face different work environment challenges that appear to be very isolated and without business support personnel that suggested an additional individual level of analysis might be appropriate for future research design. The opportunity for participants to talk through and construct their social support network simultaneously varied, so the transcription provided further support of social support networks when mentioned.

Sources of social support came from a variety of places for participants and were analyzed and collapsed into three overarching themes: (a) clinical support, (b) non-clinical support, and (c) leadership support. Results from this study partially supported the previous conceptual framework suggesting that nurses and consultants (e.g., specialists) provided social support. However, participants revealed that their highest form of clinical support came from nursing staff followed by case management/social workers and (clinical) specialists (e.g., cardiology, gastroenterology, etc.).

Non-clinical support, as conceptualized in the previous framework (e.g., in Chapter 2 and repeated earlier in this Chapter as Figure 2.1), suggested patients, patient families, and hospital administration theoretically provided hospitalists social support. Support from patients and patient families was not directly named as part of participant social support networks; a finding

that departed from the previous conceptual framework. A primary source of support was one that emanated from the relationships formed with patients/patient's families. A secondary source of support for participants appeared to come from the relationships that were formed with patients and patient's families. Indeed, the relationships and connections associated with patient and patient families appeared to have influenced the quality of hospitalists days.

Hospital administration was the last source named in the previous framework. Though there was congruence from the initial framework to current findings that suggested hospital administration could provide a source of support, this category split into four sub-categories that included (a) one's boss (direct supervisor); (b) physician group leader (e.g., hospitalist may or may not directly report to); (c) hospital administration (no direct reporting relationship); and (d) corporate leaders (typically referenced as leaders in other cities). These four sub-categories pointed to the role that the relationships hospitalists had or currently have with a leader in some capacity, so the category of leadership was used as a proxy for these four categories to represent the role and relationship the hospitalist has or wants to have with leadership in the workplace. The role of leadership in the social support network were the only category of clinical and non-clinical categories mentioned as providing low or no support to hospitalist participants. Although the rating of leaders was low, these findings were not dismissive of the need for a relationship with one's leaders regardless of the capacity or relationship to leaders. Thus, hospitalist participants supported the leadership rating with the need or desire to have better support from leaders. In other words, hospitalists listed leaders as a needed source of support, but they received low or no support from this source of support.

Findings from the Maslach Burnout Survey and Gallup 12-Element Worker Engagement Surveys for Hospitalists

The following findings are based on participants' ($n=15$) results of taking the (abbreviated) Maslach burnout survey (i.e., Maslach survey; Appendix A) and the Gallup 12-element worker engagement survey (i.e., Gallup survey; Appendix B). Participants were asked to complete these surveys immediately prior to the interview and were scored by the researcher during data analysis. Findings from these two surveys were intended to provide additional information about the participants' experiences of burnout and engagement.

In the initial conceptual framework, it was suggested that if measured burnout (i.e., with a validated burnout survey such as Maslach's survey) is lower in an individual, then engagement would theoretically be higher. The abbreviated Maslach survey measures the following constructs with associated questions for workers: (a) emotional exhaustion (e.g., "I feel emotionally drained from my work"); (b) depersonalization (e.g., "I feel I treat some patients as if they were impersonal objects"); and (c) personal accomplishment (e.g., "I deal very effectively with the problems of my patients"). The Gallup survey measures the following four factors: (a) basic needs (e.g., "I know what is expected of me at work"), (b) individual needs (e.g., "At work I have the opportunity to do what I do best every day"); (c) teamwork (e.g., "The mission or purpose of my company makes me feel my job is important"); and (d) growth (e.g., "In the last six months, someone at work has talked to me about my progress"). Results from both surveys were not intended as a benchmark against national findings for hospitalists, as it is not known if such measurements exist and it is logical that organizations ensure confidentiality of internal survey results.

Results of both surveys were used as a comparison tool against each other within the boundary and scope of this study, as well as comparisons to the texts of the interviews. The Maslach survey results are displayed through two different Figures (Figure 4.2 and 4.3). Figure 4.2 includes emotional exhaustion and depersonalization; and Figure 4.3 provides results on the personal accomplishment single construct. There is debate among scholars about where cut-off scores should occur when analyzing the Maslach survey (Eckleberry-Hunt et al., 2018). And, further debate relevant to this study is whether the three constructs (e.g., emotional exhaustion, depersonalization, and personal accomplishment) are an appropriate survey to be used with professionals where there is a lack of long-term relationships with patients; as is in the case with hospitalists. Hospitalists see patients in hospital settings over a course of a few days or weeks compared to their internal medicine peers who see patients over the course of many years. Thus, a conceptual argument can be made that when the Maslach survey is used with hospitalists, the results may not be reliable. Indeed some scholars measuring physician burnout (Shanafelt et al., 2016; West et al., 2014) have suggested single constructs are useful due to varying definitions of burnout and limited agreement of cut-off scores (Eckleberry-Hunt et al., 2018). A final complexity to reporting results of the Maslach survey resides within the third measure of burnout (i.e., personal accomplishment) because of the reverse scale used.

Maslach Survey

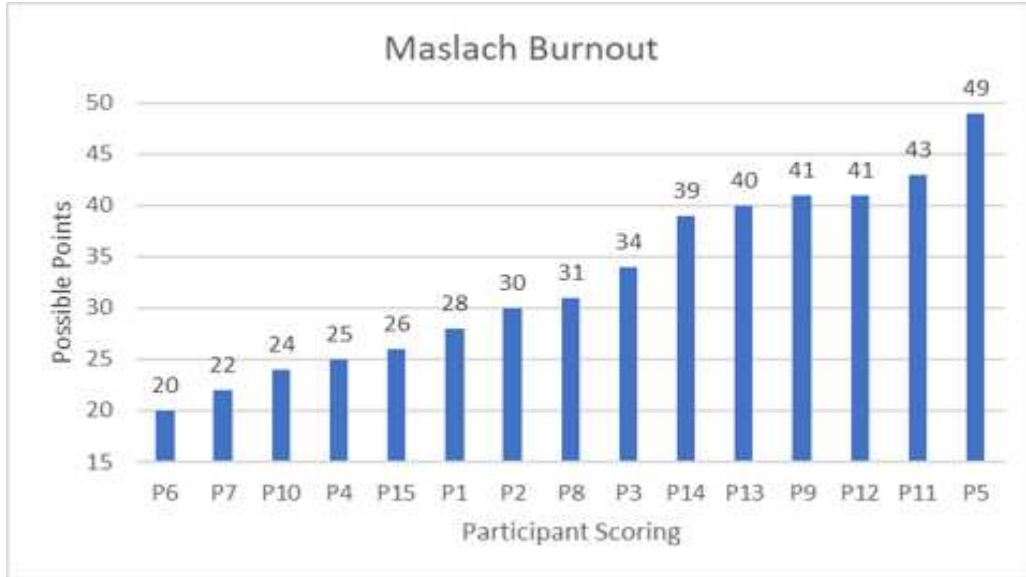


Figure 4.5. Distribution of self-reported Maslach burnout scores.

Figure 4.5 shows combined score results of the Maslach burnout scores ($n = 15$) on three constructs: (a) emotional exhaustion, (b) depersonalization, and (c) personal accomplishments based on a 5-point Likert scale for each construct. In addition, Figure 4.5 represents the distribution of scores for 15 participants in the study as noted in Figure 4.5. The range of possible scores are from zero (no self-reported burnout), to 54 (high level of self-reported burnout). In this study, participants scores ranged from 20 at the lower end of self-reported burnout to 49 with an average score of 36.

Summary of Maslach Survey Findings

Overall results suggested that participants in this study reported feeling moderate to higher levels of burnout. Participants were asked to take the survey to add depth to the study connected with the conceptual framework that suggested hospitalists will experience lower levels burnout if they experience higher levels of engagement. The next section will report findings from the engagement portion of the study. Participants were asked to take the abbreviated

Maslach survey, which is a validated and a commonly used survey used to measure burnout for physicians (Eckleberry-Hunt et al., 2018; Shanafelt et al., 2015). Overall results suggested that participants in this study reported feeling moderate to higher levels of burnout. Participants were asked to take the survey to add depth to the study connected with the conceptual framework that suggested hospital medicine physicians will experience lower levels burnout if they experience higher levels of engagement. The next section will report findings from the engagement portion of the study.

Gallup Survey

The following graphs represent ($n=15$) responses from the Gallup survey (Appendix B). Gallup's engagement survey is structured around 12 statements with available responses ranging from strongly disagree to strongly agree. The 12 statements from the survey correlate with measurements of the following constructs: (a) basic needs, (b) individual needs, (c) teamwork, and (d) growth. Examples of statements connected to each construct will be provided with each construct.

Figure 4.6 illustrates the cumulative total score for the Gallup survey for each participant. Participants ($n=15$) who scored closer to 60 (0-60) theoretically reported higher levels of engagement in the workplace based on the constructs (i.e., basic needs, individual needs, teamwork, and growth) measured within the survey.

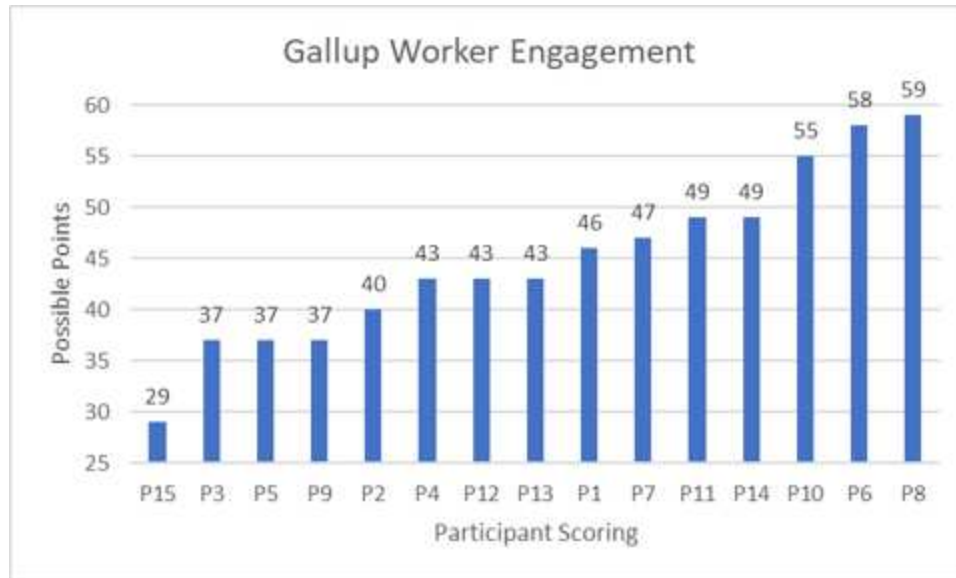


Figure 4.6. Distribution of self-reported Gallup engagement survey scores ($n=15$).

Figure 4.6 shows the distribution results of the Gallup engagement survey results that measured the following combined worker engagement constructs using a 5-point Likert scale for each element: (a) basic needs, (b) individual needs, (c) teamwork, and (d) growth. The total score possible ranged from zero (indicating a low level of worker engagement) to 60 (indicating a higher level of worker engagement). Participant scores showed a range of 29 to 59 with an average score of 44.8.

The Gallup engagement survey was not specifically targeted toward healthcare workers; however, it is a common survey used to measure general worker engagement. Measuring engagement for workers has lacked clarity and consensus (Kahn, 1990; Shuck, 2011) resulting in a need for further clarification of what engagement consists of for workers. Thus, the rationale to use any survey at all in this study was in response to the literature that posited burnout and engagement are two polar opposites that fall on the end of a continuum. For additional clarity and to better understand the tension participants reported in relationship to burnout or engagement, survey results from both measurements were compared by participant side by side.

For additional clarity and to better understand the tension participants reported in relationship to burnout or engagement, survey results from both measurements were compared by participant side by side.

Results of a Comparison of the Maslach and Gallup Surveys

Figure 4.7 shows results from the Maslach and Gallup’s survey results ($n = 15$). In order to compare both sets of data at the highest possible points (e.g., 60), the Maslach scores were reordered to compare equally between each participant’s score.

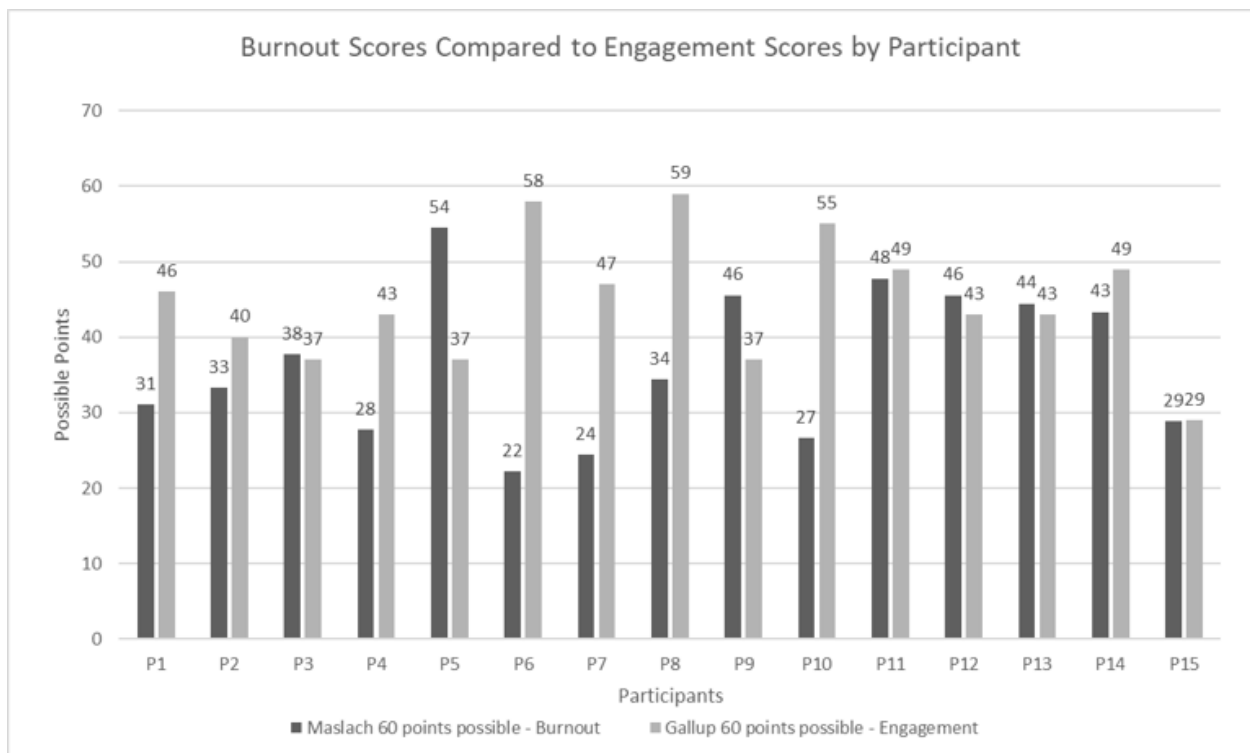


Figure 4.7. Burnout scores compared to engagement scores by participant.

The results of both surveys provided opportunity to add depth to the study, thus it was decided to compare survey reports of burnout and engagement to participant text explaining their experiences of burnout and engagement. Looking at Figure 4.7, it appeared P3, P11, P12, P13, P14 and P15 were experiencing burnout and engagement, while the remaining participants were

experiencing either burnout or engagement. The following section will discuss the results of additional quantified analysis of qualitative interview text data.

Overall, the survey findings suggested some participants were experiencing burnout and engagement separately and simultaneously. To further explore and compare the Maslach (burnout) and Gallup (engagement) survey findings to the interview texts, seven questions were identified related to the seven constructs measured by both surveys: Maslach constructs of (a) emotional exhaustion, (b) depersonalization, and (c) personal accomplishment; and the Gallup constructs of (a) basic needs, (b) individual needs, (c) teamwork, and (d) growth.

To rate the quality of participants responses to the three Maslach survey constructs and the four Gallup survey constructs the following Tables 4.3 and 4.4 provide frameworks for ranking interviewees' statements corresponding the seven constructs. The statements were rated as a "1" for low correspondence to a construct, "2" for a medium correspondence to a construct, and "3" for a high correspondence to a construct. Specific sections of transcribed texts for each participant when they described times of burnout or engagement were analyzed. Each construct with the associated question(s) from both surveys (i.e., Maslach and Gallup; see Appendix A and B); paraphrasing of the associated questions from the survey, and example of participant text is provided here in Tables 4.3 and 4.4.

Table 4.3 provides the specific construct taken from the survey, the associated analytic question applied to the interview texts, and the corresponding question taken from the Maslach survey.

Table 4.3.

Framework of Analysis for Comparing Participants Text Excerpts Related to the Maslach Survey

Construct	Ranking question for analyzing interviews (1=low, 2=medium 3=high)	Maslach survey questions (Question number)
Emotional exhaustion	Does the participant experience fatigue, inability to get up and go work, and/or feel like patients are a strain to work with on a regular basis?	I feel emotionally drained from my work. (3) I feel fatigued in the morning and have to face another day on the job. (4) Working with people all day is really a strain on me. (7)
Depersonalization	Is the participant disconnected to what happens to patients or has negative attitudes towards others at work?	I feel I treat some patients as if they were impersonal objects. (2) I have become more callous towards people since I took this job. (5) I don't really care what happens to some patients. (8)
Personal accomplishment	Does the participant receive meaning from work and does the participant believe that patient care delivered is making a difference for patients?	I deal very effectively with the problems of my patients. (1) I feel I am positively influencing my other people's lives with my work. (6) I feel exhilarated after working closely with my patients. (9)

The following three Figures 4.8, 4.9, and 4.10 represent the input into SPSS after the three constructs were recoded to 1=low, 2=medium, and 3=high data for comparative analysis. Each

table in this section represents a visual representation of what participants in the study scored on their survey compared to a rating conducted by the researcher to what was said during their interviews. Data comparisons in this section start with burnout constructs (e.g., emotional exhaustion, depersonalization and personal accomplishment). The following bar charts can be interpreted in the following way. The darker bars represent the survey input and the lighter bars represent text excerpts.

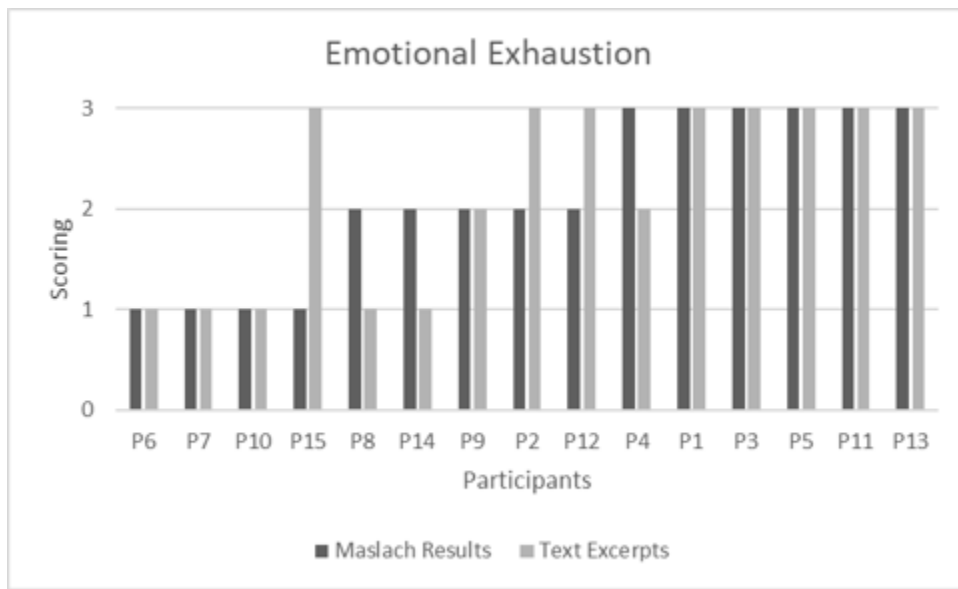


Figure 4.8.

Comparison of emotional exhaustion survey scores from Maslach’s burnout inventory and quantified text excerpts of emotional exhaustion.

The next Figure 4.9 represents the depersonalization scores compared to text excerpts.

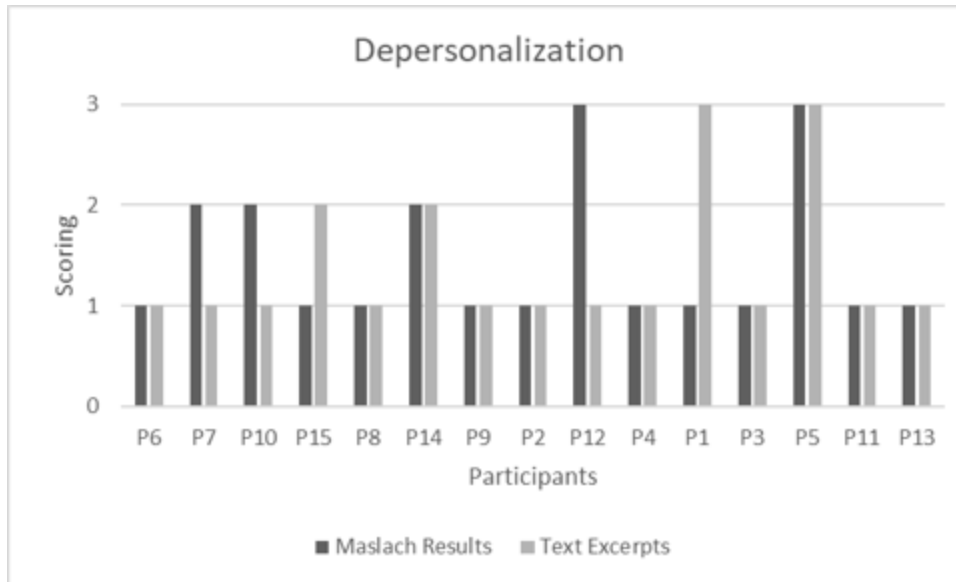


Figure 4.9. Comparison of depersonalization survey scores from Maslach’s burnout inventory and quantified text excerpts of depersonalization.

The next Figure 4.10 represents personal accomplishment scores compared to text excerpts.

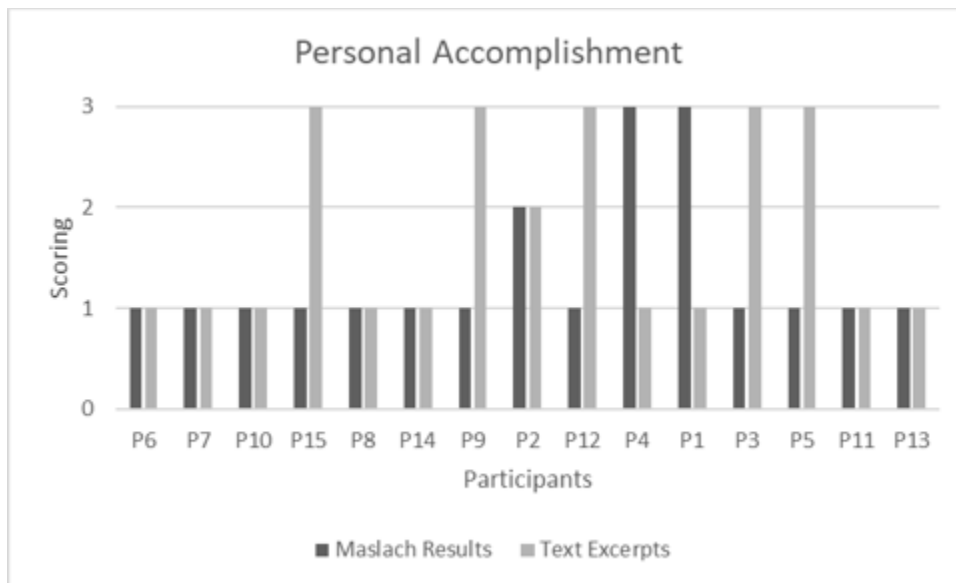


Figure 4.10. Comparison of personal accomplishment survey scores from Maslach’s burnout inventory and quantified text excerpts of depersonalization.

This section represents the framework for further comparison of data collected from surveys compared to text excerpts. As illustrated through visual figures in this section, in some instances participant responses aligned with survey responses and in other cases, there appeared to be a

discrepancy. The next section will provide similar structure to the engagement concept for comparative purposes.

Construction of Framework for Engagement Survey and Text Excerpt Analysis

The following Table 4.4 provides the constructed framework that was used to analyze participant texts in relation to engagement at work. Table 4.4 provides the specific construct taken from the survey, the associated questions, and the corresponding question applied to the corresponding analysis of the interviews.

Table 4.4

Framework of Analysis for Rated Participants' Text Excerpts Related to the Gallup Survey

Construct	Ranking question for analyzing interviews (1=low, 2=medium 3=high)	Gallup survey question (Question number)
Basic needs	Does the participant know what is expected at work and has the resources to do the work?	I know what is expected of me at work. (1) I have the materials and equipment at work to do my work right. (2)
Individual needs	Does the participant receive care, concern, or personal recognition and personal development encouragement from a boss?	At work I have the opportunity to do what I do best every day. (3) In the last seven days I have received recognition or praise for doing good work. (4) My supervisor or someone at work, seems to care about me as a person. (5) There is someone at work who encourages my development. (6)
Teamwork	Does the participant know his opinions count at work and is the	At work, my opinions seem to count. (7)

	mission of the hospital aligned with personal goals? Does the participant have a close friend at work and are peers committed to quality patient care?	The mission or purpose of my company makes me feel my job is important. (8) My associates or fellow employees are committed to doing quality work. (9) I have a best friend at work. (10)
Growth	Has the participant had a boss or supervisor provide feedback about about patient care or has been provided opportunities for growth at work?	In the last six months someone at work has talked to me about my progress. (11) This last year I have had opportunities at work to learn and grow. (12)

A scale of 1-3 (1=low, 2=medium, 3=high) was used for rating the quality of criteria in relation to the burnout and engagement constructs. Cutoff scores to assess as to whether a physician is experiencing reported burnout are typically reported (Eckleberry-Hunt et al., 2018) taking the total points possible (54) and applying participant scores to a rank of burnout (e.g., 0-18 = lower burnout, 19-36 = medium burnout, 37-54 = high burnout). The Gallup survey ascribes points to each variable in the following way: (a) 10 points for basic needs, (b) 20 points for individual needs, (c) 20 points for teamwork, and (d) 10 points for growth. In order to compare data within the same group, the Maslach and Gallup scores were converted to a scale for data analysis to examine the comparison of the scores to the interviews.

The following three Figures 4.9, 4.10, 4.11, and 4.12 represent the results after the four constructs were recoded to 1=low, 2=medium, and 3=high data for comparative analysis. Each figure in this section represents a visual representation of what participants scored on their survey to what was said during their interviews. The order of tables will follow the Gallup engagement constructs (e.g., individual needs, basic needs, teamwork and growth). The

following bar charts can be interpreted in the following way. The darker bars represent the survey input and the lighter bars represent interview excerpts.

Figure 4.11 can be interpreted as eight of the 15 participants' interview texts as similar to the survey responses; and seven of the 15 participants' interview texts as different from the survey responses in response to their basic needs being met.

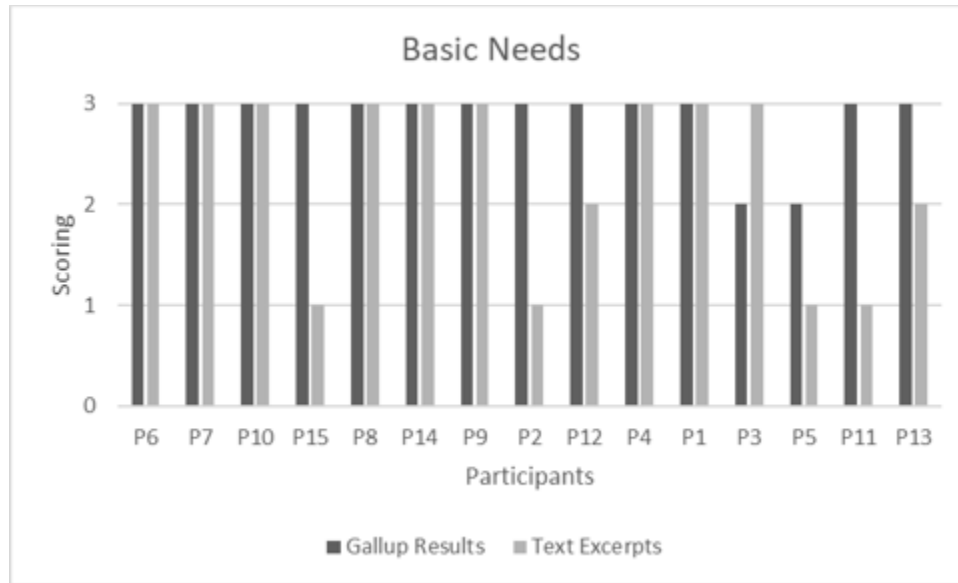


Figure 4.11. Comparison of basic needs survey scores from Gallup's burnout inventory and quantified text excerpts.

The next Figure 4.12 represents seven of the 15 interview texts as similar to the survey responses; and eight of the 15 text excerpts as different between interview texts and survey responses in relation to individual needs being met. The results show that there is some substantial discrepancy among at least half of the participants. This figure can be interpreted as some of the participant's text excerpt responses and survey responses as experiencing their individual needs are met.

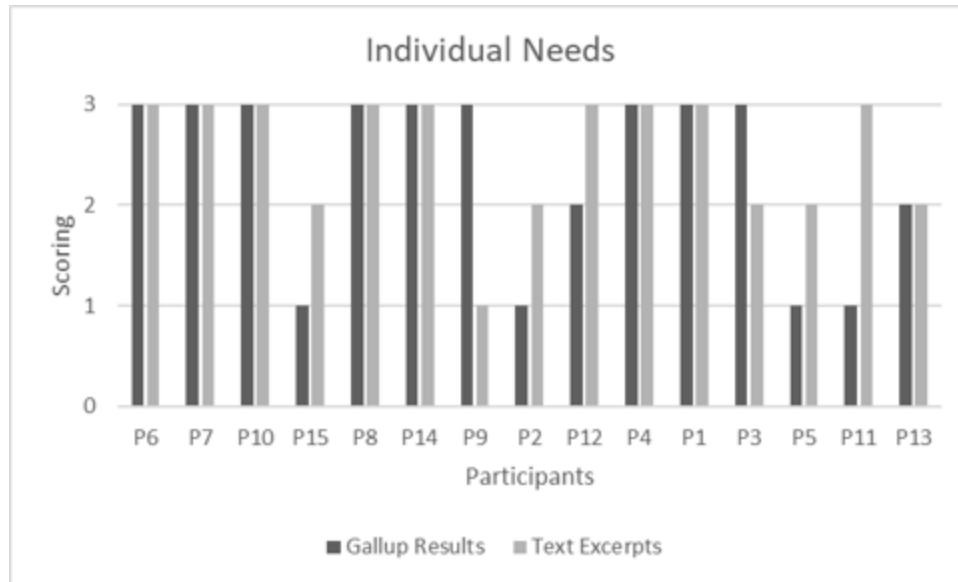


Figure 4.12. Comparison of individual needs survey scores from Gallup’s burnout inventory and quantified text excerpts.

The following Figure 4.13 represents five of the 15 interview texts as similar to the survey responses; and 10 of the 15 interviews texts as different between interview texts and survey responses in relation to teamwork in their workplace. The results show that there is some substantial discrepancy among the majority of the participant’s interview texts to survey results on teamwork.

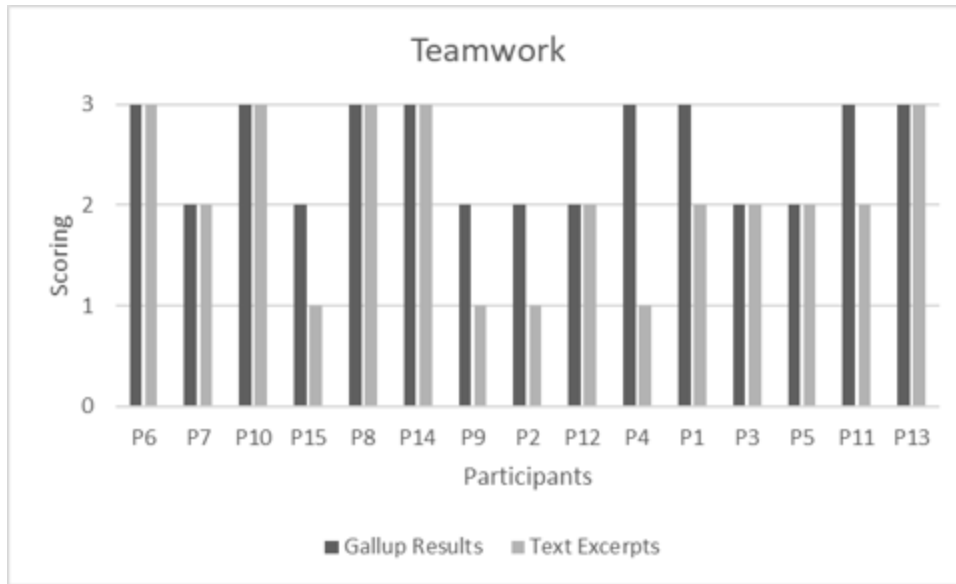


Figure 4.13. Comparison of teamwork survey scores from Gallup’s burnout inventory and quantified text excerpts of teamwork.

Figure 4.14 figure can be interpreted as one participant’s interview texts as similar to the survey responses; and 14 of 15 participant’s interview texts and survey responses being different. The results show there is substantial discrepancy among almost all of the participants in relation to questions about growth in their work place.

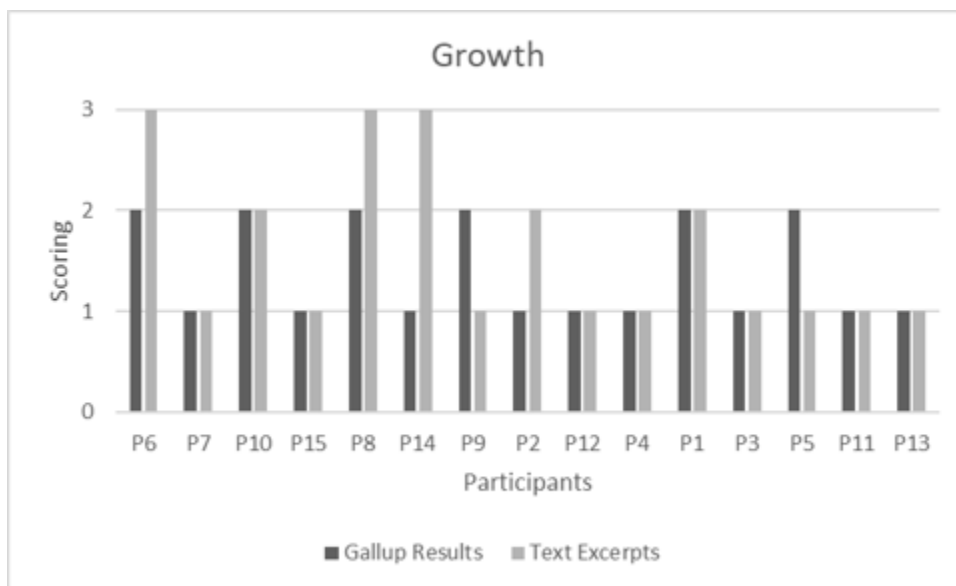


Figure 4.14. Comparison of growth survey scores from Gallup’s worker engagement survey and quantified text excerpts of growth.

The next section will provide analysis of the comparisons between survey results from both surveys and text excerpts.

Results of Wilcoxon Statistical Test to Compare Survey Data to Text Excerpts

Additional information was collected on the statistical difference between survey reports and rated texts. The Wilcoxon test is intended for not normally distributed data and to compare data within the same population (Field, 2014; Morgan, Leech, Gloeckner, & Barrett, 2013).

Wilcoxon signed ranks tests were used to compare the survey results of each participant and the quantified text data analyzed by the researcher. This resulted in the analysis of seven pairings based on categories of data relative to the survey constructs (e.g., emotional exhaustion, depersonalization, personal accomplishment, basic needs, individual needs, teamwork, and growth).

Statistical analysis was used to determine if there was a difference between the quality of participant’s text answers compared to the burnout and engagement surveys. The following Table 4.5 provides correlation and significance for the pairings.

Table 4.5

Results of Wilcoxon Signed-Ranks Non-Parametric Test Between Results of Maslach and Gallup Surveys and the Quality of Participants' Burnout and Engagement as Reported in Interviews

Variable	<i>z</i>	<i>p</i>	<i>r</i>
Quality of depersonalization- Maslach score on depersonalization	-2.76	.783	-.07
Quality of emotional exhaustion- Maslach score on emotional exhaustion	-.333	.739	-.08
Quality of growth-Gallup score on growth	-1.000	.317	-.25
Quality of personal accomplishment- Maslach score on personal accomplishment	-1.134	.257	-.29
Quality of basic needs-Gallup score on basic needs	-1.1994	.046*	-.51
Quality of teamwork-Gallup score on teamwork	-2.333	.020*	-.60
Quality of individual needs-Gallup score on individual needs	-2.496	.013*	-.64

**Note.* Significant at the $p < 0.05$ level.
Total=($n = 15$)

The first correlation analysis that will be discussed in on the burnout constructs followed by the engagement constructs. A negative inverse relationship was found on all seven pairings between the survey results and text, and in light of this finding, focus turned to the strength and statistical significance ($p < 0.05$) on each pairing.

Comparative results suggested a negative relationship existed between the quality of text analysis and survey results for the three burnout constructs as follows: (a) emotional exhaustion ($p = .739$; $r = -.07$); (b) depersonalization, ($p = .783$; $r = -.08$); and (c) personal accomplishment ($p = .257$; $r = -.25$). None of the three burnout relationships suggested a significant difference

between text excerpts and survey data results. The strength of the burnout pairings suggested a small or smaller than typical effect r (Cohen, 1988). Based on the visual Figures 4.6, 4.7 and 4.8, and comparative analysis that included lower p and r values, it appears that there is little difference between text excerpts and survey data, however due to the lower p value, the results are not significant and could be due to chance.

Results of the strength for each engagement pair and significance ($p < 0.05$) for the four engagement constructs are the following. Comparative results suggested a negative relationship existed between the quality of text analysis and survey results for the four engagement constructs. However, different from the burnout pairings, three of the four engagement constructs were found to be statistically significant ($p < 0.05$) between the text analysis and survey results. Significance and relationship strength for the engagement pairings are as follows: basic needs ($p = .046$; $r = -0.51$), individual needs ($p = .013$; $r = -.64$), teamwork ($p = .020$; $r = -.25$). Significance was found ($p < 0.50$) with a negative inverse strength of r values for basic needs, individual needs and teamwork. Based on Cohen's (1988) guide to analyze statistical strength of relationships, it is suggested a much larger than typical effect was observed and was less likely due to chance. Thus, the corresponding figures (Figures 4.8, 4.9, 4.10, and 4.11), comparative analysis, and significant p and r values for basic needs, individual needs and teamwork suggested that there was a significant relation between text excerpts and survey data. The fourth Gallup variable, growth, was not found to be statistically significant ($p = .317$; $r = -.25$) and can be interpreted as participant answers on the survey pertaining to growth were not significantly related to participant answers during the interview.

The following results of the three constructs found to be statistically significant will be discussed next. Further interpretation of the three significant findings that contributed to this study are discussed below.

- **Basic needs.** This difference indicated a correlation ($n = 15$) whereby 15 participant text analyses were significantly related compared to their survey results. Statistical significance was found ($z = 1.99$; $p = .046$). Effect size, based on Cohen's (1988) coefficient, was $r = -.051$, indicating a large or larger than typical effect size.
- **Individual needs.** This difference indicated a correlation ($n = 15$) whereby 15 participant text analyses were statistically related compared to their survey results. Statistical significance was found ($z = -2.496$; $p = .013$). Effect size, based on Cohen's (1988) coefficient, was $r = -0.64$, indicating a much larger than typical effect size.
- **Teamwork.** This difference indicated a correlation ($n = 15$) whereby 15 participant text analyses were statistically related compared to their survey results. Statistical significance was found ($z = -2.333$; $p = .020$). Effect size, based on Cohen's (1988) coefficient $r = -0.60$, indicating a much larger than typical effect size.

Although comparisons for the burnout constructs, for example, appeared to be represented in text excerpts and supported by survey data, these results do not provide the source(s) of individual burnout. It is suggested here and will be discussed in Chapter 5 the importance in understanding the source(s) of burnout to better address organizational change and interventions.

Results of this exploratory analysis suggest a lowered (non-significant) relationship between qualitative interview data for the Maslach survey constructs (i.e., emotional exhaustion, depersonalization, and personal accomplishment); and the Gallup survey question on growth (e.g., opportunities to learn and grow at work). Similarities existed between the Gallup survey constructs (i.e., basic needs, individual needs, and teamwork) existed compared to ranked text data.

Summary of the Nature of Burnout, Engagement, and Social Support Findings for Hospitalists

The purpose and aim of this study was to answer the following research questions: (a) What is the nature of burnout experiences for hospitalists? (b) What is the nature of engagement experiences for hospitalists? (c) What is the nature of social support networks for hospitalists? Based on interviews and additional information from surveys in this study, it appears that differing sources of exhaustion contributed to burnout. Engagement for participants was influenced by the amount of time they had to spend with patients. It was initially theorized that patients, patient families, hospital administrators, consultants, and nurses would provide the social support network for hospitalists; however, the final framework was reconfigured to represent clinical, non-clinical, and leader support.

Burnout data from this study answered the question of what was the nature of burnout for hospitalists? Results from the semi-structured interview findings provided five themes: (a) hospitalist leader burnout; (b) poor relationship with one's boss; (c) quality of the relationship with corporation/hospital leadership/physician leader; (d) burnout related to limited time constraints (e.g., time diverted to tasks that took time away from seeing patients); and (e) having enough time to recover from work. Participants who shared what burnout looked like in their

work life shared stories that intertwined frustrations associated with an overall lack of control of their workday as a result of an unachievable workload. Additional information from participants' results of scores from the abbreviated Maslach survey suggested 13 of 15 participants were moderately to severely burned out.

Hospitalist leaders cited burnout associated to situations connected to hospital leadership and/or leader/boss expectation. Situations where hospitalist leaders experienced burnout as a leader appeared in two categories: (a) passive/aggressive behavior toward the individual (i.e., conforming to and adapting to their leader) through deceptive acts on behalf of leaders (i.e., corporate of hospital leaders); and (b) restriction of resources that put the hospitalist leader between their group and hospital leadership (i.e., staffing needs) that was related to loss of trust from corporate/hospital leader acts (i.e., "stealing" and redistributing email).

Engagement data from semi-structured interviews answered the research question of what was the nature of engagement for hospitalists? Overall, the engagement data from participants illustrated that the nature of high engagement for hospitalists came from the quality of patient-physician conversations and relationships. Based on the results from semi-structured interviews, participants described meaningful encounters through specific acts such as time to spend with patients during difficult diagnosis (including end-of-life conversations), receiving appreciation from current and former patients, and time to get to know patients as humans. When hospitalists had time to engage in patient care, they stated they experienced higher satisfaction with their work that was related to meaningful work. Participants shared their physical state (i.e., exhaustion levels) had a low effect on how engaged they were with patients. Additional information was collected through administration of the Gallup 13-item worker engagement survey that measures four constructs: (a) basic needs, (b) individual needs, (c) teamwork, and (d)

growth, at work. Data results from participation in the Gallup survey found 13 of 15 participants were moderately to highly engaged.

The third research question in this study asked what is the nature of social support networks for hospitalists? Data analysis resulted from participants who ranked their sources of social support on a 5-point Likert-type scale. Three categories of social support emerged: (a) clinical (e.g., nurse staff); (b) non-clinical (e.g. spouse); and (c) leaders. Overall, participants shared that they could not do their job without nurse staff and discharge planners in the hospital. The second source of social support was attributed to participants' spouses, inner circle of friends, and in one instance, a hospital scribe. Leadership support was an important source of support for hospitalists; however strong relationships with leaders was not present for thirteen participants.

Comparison of results between the Maslach and Gallup surveys showed that nine of 15 participants experienced burnout and engagement simultaneously. Additional information from quantitative findings that compared interview text to both surveys (e.g., Maslach and Gallup) revealed a correlation to three engagement constructs (i.e., basic needs, teamwork, and individual).

Major findings from this study answered the three research questions. The nature of burnout for hospitalists was related to stress attributed to time limitations and negative relationships with a boss. The nature of engagement for hospitalists was experienced through the quality of patient connectedness; and the nature of social support networks was constructed of clinical, non-clinical and leader support. The discussion of and conclusions about these findings will be discussed next, in Chapter 5.

CHAPTER FIVE: DISCUSSION

This study was created to answer the following research questions: (a) What is the nature of burnout experiences for hospitalists? (b) What is the nature of engagement experiences for hospitalists? (c) What is the nature of social support networks for hospitalists?

This chapter includes a brief summary of findings, discussion and implications.

Summary of Findings

Findings from 15 semi-structured interviews include results from the three research questions that guided the study. The nature of burnout for hospitalists emanated from a variety of sources with an emphasis on availability and use of time throughout the day or shift. The nature of engagement for hospitalists was experienced through a variety of connections made during patient care delivery. The context of patient connections did not appear to be influenced whether the patient was happy or sad; sick or improving, but instead through the act of human connection to a patient at all levels. The nature of social support networks was represented through three categories of people (e.g., clinical, non-clinical, and leader support) who offered different sources of support. Finally, additional information was collected that informed the research questions through three different surveys. The first survey was the abbreviated Maslach burnout survey (Appendix A); and the second was the Gallup worker engagement survey (Appendix B). The third survey (Appendix D) was an exploratory social support network survey where hospitalists named and ranked the source support. The discussion section will provide discussion of the answers to the three research questions through integration and interpretation of the data.

Discussion

This study was designed to answer the following research questions: (a) What is the nature of burnout experiences for hospitalists? (b) What is the nature of engagement experiences for hospitalists? (c) What is the nature of social support networks for hospitalists?

This chapter begins with a brief summary of the findings, and then presents a discussion, limitations, implications, and conclusions. The following discussion points will focus on the nature of burnout, engagement, and social support for hospitalists. These three constructs were distinctive; but interconnected for hospitalists. A conceptual model (Figure 5.2) resulting from the findings is used for further exploration and future testing of concepts emanated from this study.

Nature of Burnout for Hospitalists

Overall, burnout findings from this study suggested that the measurement is dependent upon the constructs used for measurement. What this study contributes to burnout knowledge and scholarship is measuring the most commonly accepted constructs of burnout may not provide organizations or scholars insights into why workers appear disengaged from their work. For instance, further inquiry into the phenomenon of the prelude to burnout as Freudenberger (1974) suggested, appears warranted and could provide a pathway to specific sources of stress beyond the individual to include organization system or personnel changes.

The following discussion on the nature of burnout for hospitalists will be from the context of the three constructs used to measure burnout (Maslach, Jackson, & Leiter, 1996): (a) emotional exhaustion, (b) cynicism, and (c) personal accomplishment. Furthermore, hospitalist leaders experience burnout dependent on their role within their group or organization. Hospitalist leaders shared that a predominant source of stress came from leading their groups in an

unsupported environment resulting from lower quality corporate leader and hospital support. Hospitalist leader burnout analysis was distinctive and experienced in addition to burnout experiences from those of a clinician. This finding calls attention to the importance of work and organization context (e.g., leader role versus clinician role) when measuring burnout.

Measurement of burnout was based on the opposite constructs of burnout, even though early authors and subsequent critics of burnout cautioned against overuse of the survey and application of the construct (Eckleberry-Hunt et al., 2018; Maslach & Leiter, 1997). From a critical standpoint, use of surveys can be helpful as a precursor to organizational interventions; however, scholars whose intents have been to create burnout interventions focused at the individual level have brought little to no relief for physicians who suffer from burnout (Lemaire & Wallace, 2017; Linzer et al., 2015; Panagioti et al., 2017). In addition, participants from the current study stated their stress was influenced by positive or negative relationships with their leaders, and/or the result of decisions made by leaders that affected hospitalist work flows (e.g., increased time on EMR, moving multidisciplinary rounds). This finding suggests that continued interventions that target the individual as the object to ‘fix’ will not bring change to burnout without combined commitment from hospitalists and organizational leaders. Commitment from organizational leaders is important because the power to change systems in a complex hospital environment are not made unilaterally.

Hospitalist leaders shared that leading their groups in an unsupported environment caused stress. For example, they described an unsupported environment where the needs of the group were ignored (e.g., support for more staffing); or individual needs were thwarted (e.g., through stolen private emails). Decisions made at the corporate level that affected local hospitalists without input from local hospitalist leaders represented what Freudemberger (1976) observed as a

precursor to burnout where workers lost trust and faith in their leaders. For hospitalist leaders, there was potential to increased burnout in two distinct roles (e.g., as a hospitalist leader and/or hospitalist) compromising patient care and the hospitalist.

A supportive relationship with a leader or boss would represent a positive relationship where leaders and subordinates support one another during agreements and disagreements. It is logical that when workers are treated with respect that workers are more productive and satisfied. At times, however, it appeared that issues related to power over decisions instilled confusion for hospitalists on what leaders were committed to or if they cared about them as people. Continued unresolved confusion and commitment led hospitalists to perceive that leaders were disconnected on the challenges that faced them on the front lines of patient care.

Critical theorists (Foucault, 1982; Jermier, 1998) would suggest that leaders displayed misuse of power, and exploitive behavior toward hospitalists through support of inappropriate emails, passive/aggressive behaviors related to risk and loss of medical licensure, and unrealistic work expectations. Staying with a critical theory framework, leaders would reap some kind of reward through use of their power, so the question remains of what the reward for leaders consisted of. Adding to the complexity is the relationship of employment for hospitalists, meaning not all of the hospitalists were direct employees where they or the leaders worked. Based on the complexity of the hospital environment and the variable employment relationships, it appears that hospitalists were used as scapegoats in situations where hospital leaders and their employers disagreed. From this perspective, future studies situated in hospitals would benefit from consideration of employment relationships and organizational structures to understand the relationships among the employer, hospital leader, and hospitalist.

Quality of care is reduced when physicians suffer from cynicism toward patients. For example, cynicism toward patients was experienced by hospitalists when time to complete clerical responsibilities (e.g., EMR documentation) exceeded the time to accomplish the task. Since 2008, the shift of the clerical burden had increasingly moved to the hospitalist in the hospital setting; a finding that was supported in the literature (Kroth et al., 2018; Linzer et al., 2016; Shanafelt et al., 2016; Williams, 2018). Under these conditions, patients are subject to becoming objects for hospitalists to move through their hospital systems that represented either a hinderance or accelerant to achieve hospital initiatives.

Even though awareness has been raised on the topic of clerical burden for outpatient physicians, research on administrative burden is inconclusive (Erickson, Rockwern, Koltov, & McLean, 2017) in a hospital environment. Research has been conducted in an outpatient setting that showed for every hour of direct patient care, two hours of EMR entry is required (Shanafelt et al., 2016). Using the context of the outpatient ratio, a hospitalist ratio (e.g., one 12-hour shift with 15 admissions) would exceed a 24-hour day. Although participants in the study did not dismiss their responsibility of documentation, hospitalists were responsible for hospital system metrics that led some participant's to become cynical toward the processes and the people who decided on those processes they could not control. Thus, the nature of burnout for hospitalists as it appears in Figure 5.2, is considered a separate construct on its own continuum with different sources and degrees of stress that contribute to the degree of burnout that hospitalists experienced.

Physicians who practice when they experience burnout have consequences that affect patients (Lemaire & Wallace, 2017; Panagioti et al., 2017; West et al., 2016). This study provided supporting evidence to previous research that suggested when hospitalists experience

emotional exhaustion not only was there more risk for lowered quality of patient care, but perceived personal accomplishment was compromised. When hospitalists had reduced time to spend with patients, participants questioned if the quality of care they provided to patients was thorough, and this concern led to self-doubt; supporting evidence for lowered personal accomplishment (Salyers et al., 2017). To this end, when participants experienced emotional exhaustion coupled with lowered personal accomplishment in this context, patient care was compromised.

Nature of Engagement for Hospitalists

The concept of an engaged worker has been challenging to define (Shuck, 2011; Shuck & Wollard, 2010) as there has not been a unifying consensus on what factors need to be included. For instance, does an engaged physician display vigor, absorption, energy, and vitality, as some researchers have suggested (Dewing & McCormack, 2015; Shanafelt, Goh, & Sinsky, 2017); or is a worker considered to be engaged when organizational goals are met (Shuck & Wollard, 2010)? Results from this study suggested that a higher quality of engagement existed when hospitalists had strong relationships with or were able to nurture relationships with patients and/or their families. Using Shuck and Wollard's (2010) definition of engagement, hospitalists in this study would have shared different experiences related to organizational goals for the hospital or their employer. However, participants shared that hospital systems and expectations were perceived as a barrier to engagement as it was defined by participants.

Kahn (1990) stated that an engaged worker is one who experiences meaningfulness, psychological safety and availability through varying degrees of psychological conditions (e.g., physical, cognitive, and emotional). Using Kahn's framework, results of what the nature of engagement meant for hospitalists was expressed in this study through physical presence with

patients, explaining difficult diagnoses with patients and emotionally connecting with patients. Thus, engagement for hospitalists emerged as a separate and exclusive experience from burnout, and despite times where participants experienced inconvenience (e.g., driving back to the hospital after leaving at the end of the day) or lack of sleep, these experiences appear to contribute meaning and career satisfaction for hospitalists in a context of engagement.

Kahn (1990) suggested engagement for workers was expressed through the psychologically-based preferred self, and human connections were expressed for hospitalists as an example of their preferred self. From Kahn's perspective, it could be argued medical students go through the process of discovering their preferred self during professional socialization. For example, during this time of inculcation, medical students learn that self-deprivation is part of a normal day in medicine (Philips & Delgarno, 2017); and asking for help to alleviate seeing patients is not viewed as a noble characteristic of a medical expert.

The accepted medical professional assessment (Miller, 1990) addresses competency through the "knows, knows how, shows how, and does" paradigm (Figure 2.3); but also tends to ignore the importance of human connections physicians have been trained to seek with patients. In addition, higher quality connections with patients contributes to open communication and trust with patients. From a medical competency context, it is possible that hospitalists are viewed by hospital leaders as workers who move patients through their hospital system without consideration of how hospital systems can prevent deep human connections for hospitalists and their patients resulting in lowered quality of patient care.

Kahn (1990) suggested when workers are unable to engage fully in their workplace, they exhibit disengagement and withdrawal. Extending Kahn's concept of disengagement for hospitalists, the question remains as to what hospitalists disengage *from*? For example, when

hospitalists are prevented from engagement with patients, do they disengage from the patient or from people in their organization? It was shown in this study that hospitalists tended to disengage from their hospital or corporate leaders through verbal cynicism. This presents opportunity to explore the nature of relationships among hospitalists and their leaders and to lessen the potential for misplaced cynical behavior toward patients.

Nature of Social Support Networks

An exploratory social support network survey (Appendix D) was used in this study so hospitalists could rank and list sources of support in their network. Based upon the responses, three categories emerged: (a) clinical support, (b) non-clinical support, and (c) leader support. Overall, participants appeared to value the quality of each category of support that was based on individual need. Clinical and non-clinical support was present for most participants, and leader support was explained as either positive or negative support; and present or absent.

Initially, the social support network for physicians was conceptualized (Figure 2.4 in Chapter Two) as a network of people that included patients, patient families, nurse staff, consultants (peer physicians from different specialties), and hospital administrators. Results from the study suggested the people in social support categories represented clinical, non-clinical, and leader support. Figure 5.2 shows the revised social support network emerged from interviews.

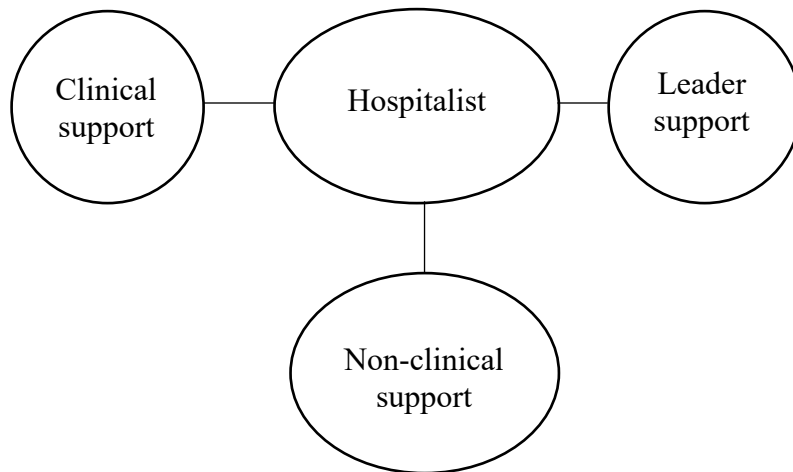


Figure 5.1. Revised conceptual framework for hospitalist social support network.

Oldham and Hackman (2010) suggested that positive social support is present in the workplace when knowledge is shared and when there is an interdependence on each other. Similarly, Grant’s theory of relational support (2007) posits that the result of stronger interpersonal work relationships will bring workers together to achieve a common goal. Taken together, these two concepts represent a positive work community of social support networks that are present during good and bad times for hospitalists.

The majority of participants stated clinical and non-clinical personnel (e.g., predominantly nurse staff and discharge planners), provided the direct and indirect professional support needed to do their job. All participants shared how important their interpersonal relationships with nurse staff were to their job in being an extension of themselves in their absence. Hospitalist’s reliance on nurse staff clinical expertise allowed them the assurance that patients were being taken care of in their absence, but also contributed to a positive social support environment (Oldham & Hackman, 2010). Some participants shared that investing time to create a professional rapport with key nurse staff contributed to a positive team or work community atmosphere that was personally satisfying and contributed to the quality of patient care.

People who filled non-clinical support (e.g., discharge planners, spouses, and/or scribes) were also important to hospitalists. For example, discharge planners provided an emotional buffer between the hospitalist and the patient. Discharge planners were also adept at finding community resources that hospitalists relied on for efficient and appropriate discharge from the hospital. Medical scribes for two hospitalists provided efficiency to see patients without sacrificing time, and an emotional support during challenging patient encounters. The function of emotional support provided what Kahn (1990) refers to as psychological safety and contributes to a positive team environment for hospitalists. Psychological safety is present when workers can react to situations without judgment thereby creating a comfortable context for physicians to express themselves openly during difficult patient situations. The final influencing factor that appeared to affect hospitalist social support networks was the role and function of leaders.

The importance of hospitalist relationships among clinical and non-clinical support cannot be understated in relationship to patient care and hospitalist satisfaction. Hospitalist positive perceptions of their networks can lead to increased patient satisfaction (Ogbonnaya, Tillman, & Bonalez, 2018). The implication for hospital leaders is that understanding who provides support for their hospitalists can result in improved patient satisfaction.

Statements about leader support relationships were explained in two ways. The first leader support theme included participants' desire to have a stronger relationship with one's boss, corporate leader, or hospital leader. Participants who shared they had weaker relationships with their boss, also said it contributed to more stress at work. Alternatively, participants who expressed that they had a relationship with their local hospital leaders felt supported in their clinical work. Additionally, Freudenberger's (1974) observation that the prelude to burnout

starts with a lack of trust in one's leader, followed by lack of enthusiasm from the leader, has received little attention. This study adds to Freudenberger's observation by showing that the quality and trust hospitalists and hospitalist leaders have with leaders affected sources of stress and quality of social support.

Positive leader support was shown through open and collaborative conversations with a few participants with their leaders that contributed to more trust and commitment during process changes in their hospitals. Social support findings from this study suggested the quality of specific relationships (i.e., boss or leader) can make a difference in whether participants had a good or bad day; or have conversations to nurture positive changes in their workplace.

Because analysis of hospitalist relationships seemed to suggest that leadership relationships for hospitalists were represented as important personal connections, it is possible that hospitalists create business/leader relationships similar to how they create connections with patients: through face-to-face conversations. Implication for leaders who have direct report relationships with hospitalists and manage decisions in a different city could strengthen their trust with their hospitalists through face-to-face meetings and conversation.

Hospitalists reflected empathy toward their local leaders who had limited decision-making authority. This perception came from the seemingly inability or lack of authority of the hospitalists' local hospital leaders to make local decisions that would improve hospitalist sources of stress such as employment contract questions and EMR workflows, but they were unwilling or unable to provide. Despite the limited authority hospitalist leader possessed, the need for relationships with these leaders continued. This means leaders have an important role for hospitalists in their social support network, and leaders in varying employment models have the ability to support hospitalists in their work and efforts that pertain to the work environment.

The need for hospitalists to have a relationship with their respective leaders suggested the need for human connection with their leaders. More specifically, despite leaders' locations (e.g., local or in a corporate office), the quality of the relationship appeared to be dependent upon the personal or business-related unresolved issues. When leaders were perceived as being unavailable or non-existent, hospitalists portrayed a negative perception of these leaders and questioned whether their leaders really cared about them as individuals.

Supportive work climates with supportive supervisors and managers can make a difference for hospitalists who work during adversity and growth at work. Stronger social networks can also serve as a buffer during stressful times (Cobb, 1976; Cohen & Wills, 1985). The nature of social support networks for hospitalists in this study suggested there are different people within different categories that provided support during times of stress. Cohen and Willis (1985) suggested that a social supportive network includes one good relationship; and Feeney and Collins (2015) stated that interpersonal relationships contribute to a supportive environment for physicians during stressful times. For instance, the physical nature of the workplace for hospitalists can place them in multiple hospitals with differing nurse personnel on different floors; however, the quality of certain nurse relationships made a difference in feeling supported. Similarly, the need for stronger relationships with a boss or leader supports Cohen and Willis' (1985) notion that a stronger relationship with one person in the right place can make a difference between feeling more or less supported. Thus, the nature of social support network relationships for hospitalists as it appears in Figure 5.2, influences how stressful situations are perceived and experienced based on the availability and quality of people in hospitalist social support network.

Conceptual Module of Burnout, Engagement, and Social Support Networks

Figure 5.2 provides a visual picture of the relationships between the three constructs (e.g. burnout, engagement and social support networks) based on the findings and analysis in this study. Figure 5.2 suggests that burnout and engagement have a relationship with an emphasis on the findings that suggest hospitalists experience these two constructs separately, on separate continuums. In other words, the results of measuring hospitalist burnout may be more useful if the results are used as indicative for system, organizational, and leadership changes to alleviate the effects of burnout as opposed to targeting changes to individuals.

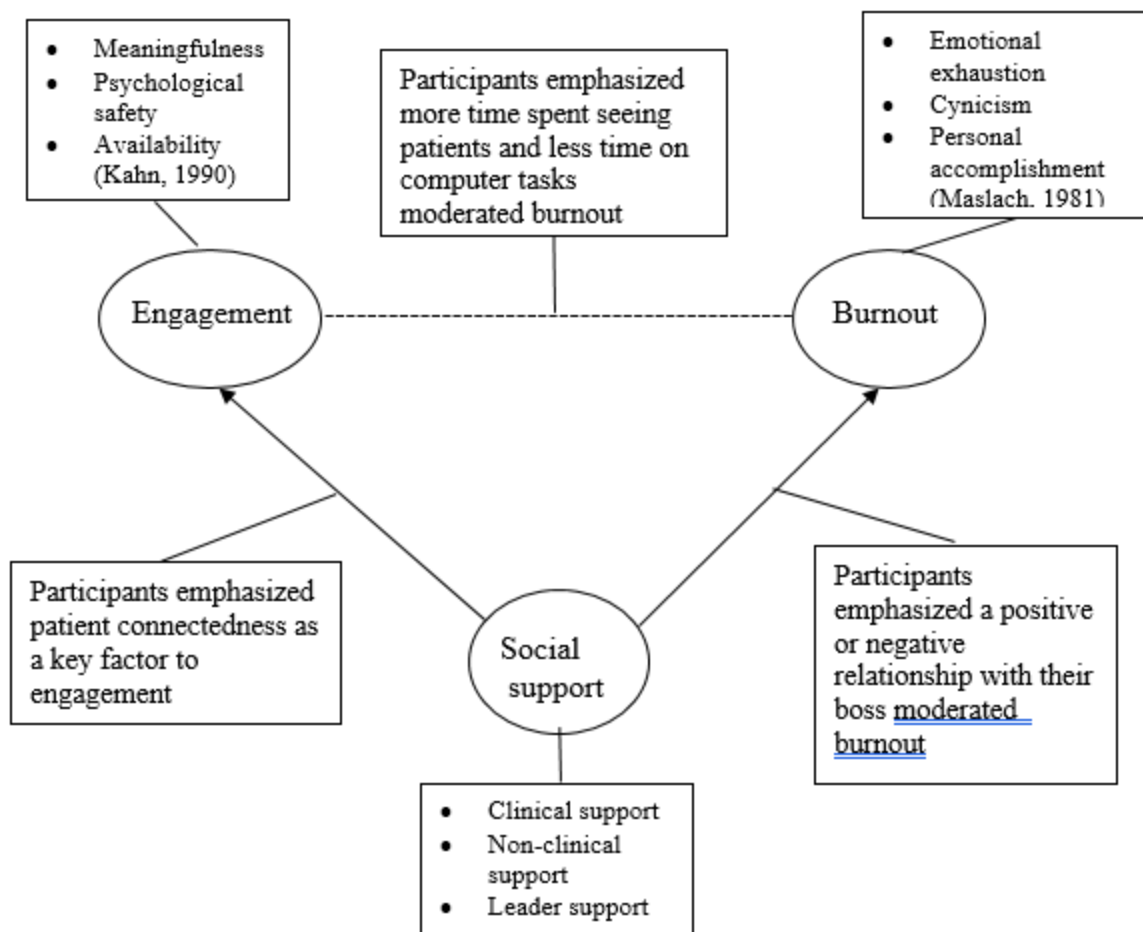


Figure 5.2. Conceptual model of the nature of burnout, engagement and social support networks for hospitalists.

As noted earlier in this study, hospitalists have been traditionally viewed as ‘guests of the house’, with house representing the hospitals where they work. If hospitalists are considered guests, then it can be assumed that if they want changes in the house, they need to go to the owner of the house. In this analogy, the owner could represent the hospital leader or leaders of the hospital system who operate the hospital. Changes to systems that hospitalists must use to see patients, (e.g., EHR, hospital system patient discharge expectations, or the flow of how a patient moves through a hospital admission and stay) are constructed by the owners of the house. For instance, participants shared conflicting allegiance between hospital system expectations and

their employer when asked to put their professional or patient safety in perceived jeopardy. Defying hospital system expectations could result in revocation of their credentials to practice in the hospital; however, refusal to obey employer rules could result in termination.

Given the complexity of the hospitalist work environment, the importance of the relationships among the natures of burnout, engagement, and social support networks is considerable. Figure 5.2 takes into consideration that hospitalists have multiple sources of people whom they rely on to provide care in their absence (e.g., nurse staff); but also rely on non-clinical sources of support (e.g., discharge planners) for essential administrative work. When hospital system expectations disrupted the workflow for hospitalists that led to burnout, loyalty to patient care was unaffected because engagement and burnout were experienced separately. Thus, taking inventory of sources of burnout, engagement and social support can provide a baseline assessment of hospitalist wellness..

Although a specific model of a hospitalist has not been conceptualized, Brady et al.'s (2018) conceptual model of physician wellness provides a framework for findings and also supports the notion that a more inclusive view of hospitalists is needed to understand where all or most sources of stress, engagement, and social support originate. In Brady et al.'s conceptualization of physician wellness they suggest a movement away from the commonly recognized opposite continuum for physicians that place them in a range of burnout or engagement at work, where physicians are considered as complex humans with varying emotional, physical and professional needs. The physician wellness framework and definition (Brady et al., 2018) integrates negative/positive frameworks (i.e., burnout and engagement) and suggests integration and inclusion of mental (emotional), social (connections), physical (sleep, exercise), and integrated (quality of life, purpose, thriving) domains into the definition of

physician wellness. Table 5.1 provides an initial conceptual crossover that starts first with the constructs—burnout (B), engagement (E), and social support (S)—and places them into negative or positive category wellness domains.

Table 5.1

Application of Burnout (B), Engagement (E), and Level of Social Support (S) Constructs and Categories to Physician Wellness Domains

Findings Constructs	Category	Wellness domain
Burnout: Hospitalist leader	(B) Negative	Mental
Burnout: Conflict with boss	(B) Negative	Mental
Burnout: Conflict with corporate/ hospital/local leaders	(B) Negative	Mental, Integrated
Burnout: Allocation of time	(B) Negative	Mental, Social, Physical, Integrated
Engagement: Time (freedom)- see patients	(E) Positive	Social, Integrated
Time (freedom): Clinical thoroughness	(E) Positive	Mental, Integrated
Time (freedom): Connect with peers	(E) Positive	Social, Integrated
Relationships with nurses, case managers (clinical)	(S) High	Mental, Social, Integrated
Relationships with friends/ Spouses (non-clinical)	(S) High	Social, Physical, Integrated
Relationships with scribes (non-clinical)	(S) High	Mental, Physical, Social
Leaders	(S) High	Mental, Social
Boss	(S) Low	Mental, Social

Specifically, social support networks, represented by interpersonal relationships, support the “integrated” wellness dimension (Brady et al., 2018, p. 95).

Data analysis results suggested that hospitalists work in a complex environment in need of a guiding framework that includes a holistic picture of a hospitalist as an employee, medical provider, or hospitalist leader. Major findings from this study support a deeper understanding of hospitalist social support sources, absorption in work operationalized through patient connectedness that represented engagement, and burnout symptoms revealed as a result of stress attributed to time limitations and negative relationships with a boss.

Limitations to the Study

Research limitations to this study included the inability to generalize across all physician studies, and in particular, to all internal medicine physicians and hospitalists. As the work environment (i.e., hospitals) for this study was specific to hospitalists and hospital system organizations, physician offices would be a related context for future studies. A second limitation to this study was in relation to the small sample size for surveys conducted (e.g., Maslach and Gallup surveys) in the sample population. It was noted that the intention to conduct and include the results of these studies related to situating the results of a generally accepted measurement of burnout and engagement with the interview texts. Therefore, the use of these surveys served their intended purpose and that was to provide depth to the participants’ overall profile and individual interviews. A repeated study that considers the context of academic hospitalists would be of value in the future. The next section will discuss implications for the field.

Implications

The following implications can be drawn from this study. The first is burnout and engagement appear to be separate constructs on separate continuums. The second implication is the perception of engagement for leaders in hospitals/hospital systems appear to be different from hospitalists. The last implication is knowing the source(s) of stress for hospitalists is needed to improve burnout and enhance hospitalist engagement.

Burnout and Engagement as Separate Constructs

For many years, there has been a scholarly debate whether burnout and engagement are separate constructs or two constructs at polar ends of the same continuum (Leiter & Maslach, 2003; Maslach & Jackson, 1981; Maslach et al., 1996) and findings from this study contributes knowledge to support the separate construct model. For example, findings from this study challenged the assumption that hospitalists were either burned out or engaged. Taking the dual and separate construct further, research is needed to explore how patient care is affected when hospitalists work in a state of higher burnout and higher engagement.

Burnout research has historically relied on quantitative methods that suggested workers are on a continuum between burnout and engagement. Although challenges remain in using burnout survey results as a sole source of measurement (Eckleberry-Hunt et al., 2018), organizations continue to use surveys to ascertain levels of burnout on single or multiple measures. Based on the literature and results of this study, it appears burnout and engagement operate on two distinct constructs: burnout and/or engagement; on two separate continuums. In essence, survey methods have been used in isolation to address burnout in humans which is a complex phenomenon. Implications for researchers and practitioners is that burnout needs to

include additional measurement methods that includes collecting data on the sources of stress and measuring the quality of hospitalist social support relationships.

Burnout and engagement measurements are useful as baseline measurements. The suggestion that hospitalists are on a continuum also suggests hospitalist instability in the workplace. The instability that the process of health system and private medical group integration creates, influenced hospitalists who work in these systems. When decision making was moved from the local hospital to a distant location, participants viewed this negatively because the decision making was no longer close, and they felt disconnected. Implications for practice include support for hospitalists who are working in a health system acquisition and integration environment, or when decision making moves from local to distant.

Understand the Perception of Engagement for Leaders and Hospitalists

The second implication is the perception of engagement for leaders in hospitals/hospital systems appear to be different from hospitalists. An environment where workers are supported by their boss or leader can be indicative of a positive work environment. More research and understanding about the relationships that hospitalists have with their leaders is important to better understand how leaders can support their hospitalists without sacrificing hospitalist patient care engagement.

Engagement can be perceived as a relationship to something. If hospitalist engagement is identified and defined at psychological levels (Kahn, 1990), then how would a leader observe strong engagement in a hospitalist? In other words, leaders may perceive hospitalist engagement for hospitalists is in relationship to participation in organizational objectives (i.e., hospital committee participation, hospital quality committee workgroups) separate from the act of patient care. Engagement for hospitalists, however, was described through the experience of

interactive patient care and nurturing relationships with patients. There is an argument for alignment of hospital and hospitalist engagement objectives to avoid future conflicts due to an absence of consensus about what is engagement.

From an organizational leader perspective, supportive acts that enhance hospitalist perceptions of engagement would provide an opportunity for trust with leaders and implied improvement to patient care. Supportive acts are dependent upon workplace context. However, discrepancies related to perceptions of engagement will continue in the absence of a common definition of engagement for hospitalists and leaders.

Identify Source(s) of Stress for Hospitalists

Sources of stress for hospitalists are integral to lessening the impact of burnout. Burnout is considered a result of chronic stressors in the workplace and it would make sense for leaders to understand where the sources of stress come from at an individual and group level. If the aggregate group sources of stress have commonalities, organizational interventions could be more effective.

Hospitalists in this study said sources of stress came from EMR responsibilities, conflict with their boss or leader and having enough time to complete their work and get home to their families. For instance, EMR entry, when considered as a source of shared group stress, could be addressed at the organization level that could positively impact individual hospitalists and their quality of life. Alternatively, hospitalists also shared in this study that conflict with their boss or leader was a significant source of stress. Furthermore, it appeared that when hospitalists experienced conflict with their boss, they did not share this type of stress with peers or colleagues and turned to their spouses or friends outside of the workplace. From an individual

perspective, hospitalist social support networks provided important sources of support when they were coping with problems at work.

This finding further enhances the importance that the quality of hospitalist social support networks is important to identify because of the supportive role networks have for hospitalists during stressful situations. Specifically, people within hospitalist networks play crucial roles that directly (e.g., nurse staff) and indirectly (e.g., discharge planners, medical scribes) support patient care outcomes. Finally, strong and healthy relationships between hospitalists and hospital leaders is essentially to ensure continued career satisfaction and patient encounter gratification continues.

Final Conclusion

Hospitalists provide an important role in the patient care delivery spectrum. They provide care to people who are in the hospital from a couple of days to a few weeks. Hospital leaders and hospitalists work in a shared environment where commitments can differ causing conflict and misperceptions that can lead to stress for both groups of people. Patients, sometimes seen as an object of measurable efficiencies from a hospital leader perspective, can sometimes clash with the objectives of hospitalists who deliver front line care. Through continuing dialogue and research, it is the hope that healthcare organizational goals, and hospitalist goals will intersect and complement each other to achieve improved patient care.

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APPENDIX A: ABBREVIATED MASLACH BURNOUT INVENTORY

For each statement, mark the box that most accurately reflects your response:

Questions	Every day	A few times a week	Once a week	A few times a month	Once a month or less	A few times a year	Never
I deal very effectively with the problems of my patients.							
I feel I treat some patients as if they were impersonal objects.							
I feel emotionally drained from my work.							
I feel fatigued when I get up in the morning and have to face another day on the job.							
I've become more callous towards people since I took this job.							
I feel I'm positively influencing other people's lives through my work.							
Working with people all day is really a strain for me.							
I don't really care what happens to some patients.							
I feel exhilarated after working closely with my patients.							

Note. From "Early Predictors of Job Burnout and Engagement," By C. Maslach and M. P. Leiter, 2008, *Journal of Applied Psychology*, 93(3), p. X. Copyright Journal of Applied Psychology.

APPENDIX B: GALLUP'S 12 ELEMENTS OF WORKER ENGAGEMENT SURVEY

For each statement please mark the most appropriate response based on a 5-point Likert scale:
 1-Strongly disagree, 2-Disagree, 3-Neutral, 4-Agree, 5-Strongly agree.

Questions	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I know what is expected of me at work.					
I have the materials and equipment I need to do my work right.					
At work I have the opportunity to do what I do best every day.					
In the last seven days, I have received recognition or praise for doing good work.					
My supervisor or someone at work, seems to care about me as a person.					
There is someone at work who encourages my development.					
At work, my opinions seem to count.					
The mission or purpose of my company makes me feel my job is important.					
My associates or fellow employees are committed to doing quality work.					
I have a best friend at work.					
In the last six months, someone at work has talked to me about my progress.					
This last year, I have had opportunities at work to learn and grow.					

APPENDIX C: INTERVIEW GUIDE

Context of Questions and Associated Activities	Question guide
<p>Question: Demographic, Opening of Interview</p>	<p>How long have you been a practicing hospitalist? Who was most influential in helping you decide to become a physician? Where did you attend medical school? When did you start your current position? How did you find out about your current employment opportunity? (i.e. through a friend, job posting)</p>
<p>Activity: Participant will be provided a piece of paper to list three to five people that comprise their social support network.</p>	<p>On the piece of paper provided, can you list in order of importance, the people in or outside of work that provide you social support?</p> <ol style="list-style-type: none"> 1. 2. 3. 4. 5.
<p>Question: Social support network focused interview questions. Intention: Seeks to uncover the hierarchy of the first and last person on the participant's social support network list. Interview Question Method: Critical Incident</p>	<p>Thinking about the people you just listed as your social support network, can you describe the situation or interaction that led you to list the first person on your list? What are situations or interactions you have experienced with the others on the list that compelled you to include them in your social support network?</p>
<p>Question: Burnout and stress. This question seeks to understand sources of workplace stress and celebration. Interview Question Method: Critical Incident</p>	<p>I would like to talk about the types of stress in your workplace that occurs daily. Can you describe a situation that occurs regularly that causes you stress? What actions do you take to cope with those situations of stress? Now I would like to talk about moments of celebration at work. Can you describe situations at work that you celebrate? With whom do you celebrate?</p>

<p>Question: Social support network addition or deletions.</p> <p>Interview Question Method: Focused, Open</p>	<p>Now I would like you to think about your social support network that you have listed earlier again. If there was one member of that group that was no longer here, which relationship would be most disruptive to you and why?</p>
<p>Question: Social support network quality.</p> <p>Intention of Questions: Addresses what qualities are most important in a social support network.</p> <p>Interview Question Method: Focused</p>	<p>Turning to the specific qualities of your social support network, how do you decide who is most important in that network?</p>
<p>Question: Quality of social support network related to burnout or engagement.</p>	<p>I would like you to think about the quality of your social support network related to burnout or engagement at work. Can you describe a situation when you have you engaged with individuals in your social support network in relation to feeling burned out or engaged at work?</p> <p>Have the people in your social support network changed over time? Why?</p>
<p>Closing the interview.</p>	<p>Is there anything you would like to add to understanding your social support network related to burnout or engagement at work?</p> <p>Is there anything you would like me to know about this topic in relation to your workplace?</p>

APPENDIX D: SOCIAL SUPPORT NETWORK SURVEY

List 3-5 individuals who you work with inside and/or outside of your workplace who provide personal or professional support associated with your work responsibilities. Examples of support could be clinical, administrative, technical, corporate, leadership, etc. Please rank each individual on a scale from one to five (1-5), with a score of five (5) representing the highest amount of support and one (1) representing very low social support.

Title/Role and Position of Individual Providing Support	Kind of support	5-very high support	4-high support	3-neither high or low support	2-low support	1-very low support
Title/Role/Position of Individual:	Type of support:					
Title/Role/Position of Individual:	Type of support:					
Title/Role/Position of Individual:	Type of support:					
Title/Role/Position of Individual:	Type of support:					
Title/Role/Position of Individual:	Type of support:					