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Factors Contributing to Physician Assistant Burnout

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FACTORS CONTRIBUTING TO PHYSICIAN ASSISTANT BURNOUT

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Abstract

Workplace burnout is known to be extremely prevalent among employees in the medical professions. For other health care professions such as physicians or nurses there is a plethora of existing literature on workplace burnout, but there is a lack of research on workplace burnout as it relates to Physician Assistants (PAs). This research study sought to discover what potential factors are specifically contributing to workplace burnout among PAs, symptoms of burnout experienced, and the personal strategies that PAs have found useful in coping with burnout. Interviews with ten currently practicing PAs in the Minnesota and Wisconsin region were conducted to investigate and look for causes, symptoms and strategies PAs used to deal with burnout.

Of the 10 interviews, nine participants stated they felt emotionally exhausted, four felt a sense of depersonalization, and 6 felt a decreased sense of personal accomplishment. Major causes of burnout identified include increased patient load, increased patient difficulty, longer work hours, increased patient load, a decreased scope of practice, and improper recognition by colleagues and patients. Coping mechanisms used by participants include having a well-defined work-life balance, and re-investing in the profession. Compared to other more well studied health professions, PAs are experiencing less depersonalization but a lower sense of personal achievement. Scope of practice and improper recognition are also causes not see in other health professions.

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Chapter One: Introduction

Introduction

The following chapter serves to introduce the idea of workplace burnout in the medical community. This chapter provides background to the issue, as well as illustrates the lack of research and need for research on the subject as it relates to physician assistants (PAs). Current research about medical workplace burnout does not give attention to PAs but instead focuses mostly on physicians (Bell, Davidson & Sefcik, 2002). This chapter also introduces the research questions the study will be looking to answer in further chapters and provides reasons why this research is significant to the physician assistant (PA) profession and the healthcare system. In addition, this chapter includes limitations and delimitations of this qualitative study.

Background

Workplace burnout can be broadly defined as a type of stress. The Mayo Clinic defines it as "a state of physical, emotional, or mental exhaustion combined with doubts about competence and the value of your work" (Mayo Clinic Staff, 2015, para. 1). Burnout in regards to medical professions is an issue mainly studied with respect to physicians. One study states that 45.8% of physicians reported at least one symptom of burnout (Shanafelt et al., 2012). Shanafelt showed that compared to the national baseline level of occupational burnout of between 20-30% (Shanafelt et al., 2012) for professionals without a medical degree, the percentage of physicians experiencing burnout symptoms is much greater than the average person experiences, including those with multiple higher education degrees (Shanafelt et al., 2012). Burnout has also been categorized into three categories, being emotional exhaustion, depersonalization, and a lack of personal achievement (Leiter & Maslach, 2009).

Burnout among people employed in human service industries, including healthcare

providers, such as physicians, registered nurses, and PAs, is an ongoing issue that needs attention because of the severe consequences that can follow (McCormack & Cotter, 2013). The emotional and mental exhaustion from work has been shown to put strain on a healthcare provider's personal life and family relationships at home (Rheaume, 2016). According to the Journal of Healthcare Management, evidence from previous studies has also suggested that burnout is linked to an increased occurrence of anxiety, depression, and substance abuse among physicians (Gregory & Menser, 2015). Healthcare providers should not be expected to pour from an empty cup; they need support and resources to first prioritize their own well-being so that they can be healthy and better able to care for their patients (Aiken, Clarke, Sloane, Sochalski & Silber, 2002).

Burnout not only hurts providers alone, but can have overarching effects on the rest of the healthcare system. Increased burnout tendencies among professionals has been linked to increased patient dissatisfaction, errors in documentation, and overall increase in incidences of malpractice (Gregory & Menser, 2015). Increases in health care provider burnout has also been shown to increase turnover in caregiving professions, with an increase in burnout being a marked predictor for turnover (Leiter & Maslach, 2009). An increase in turnover not only places stress on the surrounding medical staff, but can lead to increased mortality among patients and cause increased burnout in other professionals working around the burned out provider due to their increased workload (Aiken et al., 2002).

Several notable factors contribute to physician burnout. Common factors of physician burnout according to the Medscape 2016 Physician Lifestyle Report include things such as increasing bureaucracy, increasing overall workload, and increasing automation and scripting of practice (Peckham, 2016). With current increasing trends in health care provider burnout

(Peckham, 2016), addressing and attempting to fix this phenomenon is crucial.

Despite the numerous studies on physician burnout that have occurred, little data exists on burnout for PAs**.** One study has looked at rates of burnout within PA populations that work in the emergency department (Bell, et al., 2002), but overall little data has been collected about physician assistant burnout levels, the underlying causes of PA burnout, or the prevalence of PA burnout in the profession. In order to maintain the longevity of the profession, further research on burnout specifically addressing PAs is necessary.

Problem Statement

With increasing stress on America's healthcare system and the rapid changes resulting from such stressors, maintaining and expanding the pool of available practitioners is vital. Because PAs provide cost effective healthcare, preventing this demographic from burnout is important. A study by The Medicus Firm, a physician recruiting agency who surveyed over 200 healthcare employers and hospital systems, found that 82.9% of these surveyed executives expected to recruit a larger number of nurse practitioners (NPs) and PAs (Punke, 2012). Hiring PAs in lieu of physicians reduces healthcare employers' financial costs for services of an equal quality because they will pay less than a physician salary (Punke, 2012). Little research on PA burnout has been done, while a plethora of information on causes and levels of burnout for other healthcare professions is evident. As the PA profession is expanding, and the use of PAs within the healthcare system increases, keeping PAs from experiencing burnout is paramount. Key causes and themes of burnout need to be identified among the PA profession to preserve the health and well-being of current and future practitioners.

Purpose of the Study

The purpose of this study was to examine and identify key themes that contribute to workplace burnout, symptoms of burnout, and coping strategies among PAs in Minnesota and Wisconsin. Most burnout research has focused on identifying the presence of burnout, cataloging its effects, and creating a case for attending to its impact (Gregory & Menser, 2015). Few studies have investigated qualitative factors that influence workplace burnout. This study may be used to identify if there are unique contributing factors of burnout that is specific to PAs.

Significance of the Study

Identifying the common contributing factors of burnout among PAs is an important issue, since identifying the issues will allow for a better idea of how healthcare systems can solve or decrease the problem of burnout. A 2002 survey of emergency room PAs states that 66% of the participants reported symptoms of depersonalization, one of three categorizations of burnout (Bell, et al., 2002). By identifying key factors unique to PAs, solutions can be created to successfully prevent burnout.

One of the purposes of the PA profession in the healthcare system is to produce more healthcare providers to offset the nationwide physician shortage and share the workload ("What is a PA," 2012). Looking farther into the future though, an alarming prediction exists that PAs may eventually experience the same shortage that physicians have faced, as hospitals continue to hire increasing numbers of PAs (Punke, 2012). Punke states, "In 2011, the Journal of the American College of Surgeons predicted that the supply of physician assistants will be 20 percent less than demand by 2025" (2012, para 4). Thus, efforts to support the energy and well-being of PAs will be crucial in preventing them from experiencing the same burnout as the

physicians with whom they work.

The knowledge discovered from this study will be useful to many people and groups. Clinics, hospitals, and essentially any medical establishments who employ physician assistants will be able to use this knowledge. Physician assistants themselves, and educators of PAs will also find the study useful because they can arm themselves with self-care strategies to prevent burnout. Policy making bodies such as the American Academy of Physician Assistants or the Minnesota Academy of Physician Assistants could utilize information on this topic, as they have the ability to influence policy. Research into burnout factors could help decrease and prevent burnout among PAs in the workplace.

Research Questions

To gain insight concerning the factors of burnout among PAs in Minnesota and Wisconsin, the research was designed to answer the following questions:

1. What patient care, scope of practice, and business factors are contributing to burnout among PAs?
2. What symptoms of burnout are PAs experiencing?
3. If PAs are experiencing burnout, what coping mechanisms are they using?

Definitions

For consistency and understanding, terms relevant to this study must be defined.

1) A *healthcare provider* encompasses three types of medical practitioners: physicians, both medical doctors (MD) and doctors of osteopathy (DO), PAs, and NPs.

2) A *PA* is a nationally certified medical professional who is licensed to practice medicine and prescribe medications, as part of a healthcare team with physicians ("What is a PA?", 2016).

3) *Burnout* is defined as a state of mental, physical, or emotional exhaustion (Mayo Clinic staff,

2015) in response to chronic stress in the workplace (Rheaume, 2016). Burnout has been previously measured in terms of depersonalization, emotional exhaustion, and personal accomplishment (Leiter & Maslach, 2009).

Conclusion:

Burnout in the workplace is a problem many professionals face. However, burnout for medical professionals is an issue that can be detrimental to both providers and patients. Contributing factors to burnout should be assessed in efforts to minimize its negative effects. Despite the overwhelming amount of research for levels and contributing factors of burnout for physicians, very little information can be found about burnout for PAs. Both PAs and employers need to focus on contributing factors of burnout to preserve the longevity of the profession.

The amount of existing literature on physician burnout and its speculated cause and effects provide an important design and methodology for this study, and will be reviewed in the following chapter.

Chapter 2 : Literature Review

Introduction

This chapter reviews the existing literature concerning the levels, factors, and causes of burnout in the medical community with specific regard to PAs. This literature review will include the following related topics: factors contributing to burnout, effects of burnout, the definition and measurement of burnout, current levels of burnout in the medical community, barriers preventing support for burnout, recommended solutions for burnout, and potential burnout factors for PAs.

Factors Contributing to Burnout

Employees do not generally burnout in response to one stressful factor in the workplace but rather to several factors working in concert (McCormack & Cotter, 2013). Current research has revealed identifiable factors that contribute to employees' burnout levels; workload, lack of rest and rejuvenation in the workplace, age and years of experience, personality types, physical environment, and lack of autonomy all contribute.

McCormack and Cotter (2013) suggest that age or years of experience has been proved to have some contribution to employee burnout. "One theory is that it is common for young people to enter certain professions or lines of work for which they are not suited" (McCormack & Cotter, 2013, p. 28). McCormack and Cotter (2013) argue that professionals who enter the field at young age, may suffer from burnout later in their careers because they lack adequate professional preparation and analyzation of their chosen field. In contrast, workers who enter the field at an older age have been linked to experiencing less burnout. Older employees "have had more time to understand the pros and cons of their chosen profession, and have the maturity to better handle certain stressors" (McCormack & Cotter, 2013, p. 28). Years or employment in a

field has also been linked to increased burnout. Workers who are new to their job are at an increased risk to experience burnout, rather than employees who have many years of experience (Burke & Richardson, 1996). But, these results are not universally shared. Roberts' (1997) found no direct correlation between new or experienced employees and burnout.

Theories have developed that certain personality types in the workplace are simply more prone to burnout. Roberts' study (1997) suggested that these personality types prone to burnout include type-A workaholics and high achievers, and people inherently drawn to stressful situations. Yet, Burke and Richardson (1996) argued that sensitive, anxious and empathetic employees experienced burnout more frequently. Employees who derive a great part of their identity through their work and career and strive for workplace recognition, are more apt to burn out (McCormack & Cotter, 2013). The Casserly and Megginson (2009) study suggests that employees who fail to set boundaries between the job and the home are prone to burnout. These employees see personal, physical, and emotional sacrifices as part of their job, and struggle to separate their personal and professional identity (Casserly & Megginson, 2009). Casserly and Megginson (2009) also called these employees "high fliers" and categorized them as being inflexible. These personality types are thought to have less control in choices because they react quickly to outside stimuli, rather than discuss, evaluate, and interpret the situation (Casserly & Megginson, 2009). Casserly and Megginson (2009) suggest these employees focus too intently on the immediate problems of their job, making them too exhausted or burned out to perform another workplace task.

Research does not agree if it is the personality characteristics or the workplace environment that intensify burnout levels. Maslach and Leiter (1997) provide clear and consistent evidence that the roots of burnout stretch far beyond the individual and into the work

environment. Burke and Richardson (1996) argued that burnout is specific to the workload and time constraints placed on employees. "Overwork, of course, is a major contributing factor to burnout" (McCormack & Cotter, 2013, p. 2). An excessive workload and an unremitting pace are now noted as the norm in the workplace for modern America, and with this pace, employees may find it difficult to find relief from burning out (Shanafelt et al., 2012). McCormack and Cotter (2013) suggests that an excessive workload is positively linked with burnout as well as excessive job demands. Restful moments for employees to simply catch their breath at work are lacking (Maslach & Leiter, 1997). Workload continues to increase as resources and supplies appear to remain in a stagnant growth. "Additional demands might be manageable if employees were given more resources; extra support or equipment can turn increased demand into an opportunity. But instead, the current scramble for survival often results in a shortage of resources" (Maslach & Leiter, 1997, p. 39). Employees appear to be most susceptible to workplace burnout when the demands of said job are high (McCormack & Cotter, 2013). A 2015 study, modeled after Maslach and Leiter's research, also concluded from data collected that workload is a significant contributor to burnout. Increased levels of burnout were specifically noted when the workload exceeds the employee's capacity and there was not enough time given to the employee to meet the demands (Gregory & Menser, 2015).

The type and quality of work an employee performs has been linked to workplace burnout as well. Employees exposed to potentially harmful situations, or even situations perceived to have high risks, stimulate a state of stress for employees (Maslach & Leiter, 1997). McCormack & Cotter (2013) explain that medical personnel who are exposed to unwell patients and diagnoses are at an increased risk of suffering from emotional exhaustion, which is a key element to burnout. Occupations which involve human service, especially those in which

employees require empathy such as interacting with patients, are vulnerable to burnout. Physicians have been noted as having some of the highest levels of depersonalization, another attribute of burnout (McCormack & Cotter, 2013). A study involving primary care physicians noted that frequent contact with demanding patients not only leads to imminent burnout levels, but exacerbates their burnout over time (Schaufeli, Maassen, Bakker, & Sixma, 2011).

An employee has control when he or she feels like an influential, engaged participant and has the ability to be autonomous in the workplace (McCormack & Cotter, 2013). Leiter (2005) suggested that workplace control is less about how and when the workplace is performed, but rather is a state of leeway that employees experience. Employees who feel in control at their job, are more likely to "influence their workload, rewards, social interactions, and institutional justice" (Leiter, 2005, p. 132). Autonomy has been directly linked to an employee's sense of control, and subsequently, an employee's sense of burnout. Workers who feel that they lack autonomy are at a greater risk for experiencing burnout (McCormack & Cotter, 2013). Lack of control can take on a variety of forms: micromanaging managers, lack of collaborative decision making or reciprocity and sense of inability to address organizational problems (Maslach & Leiter, 1997). A diminished sense of control was supported again to be a key contributor to burnout by data in Gregory and Menser's 2015 study of primary care physicians. Gregory and Menser state, "The data collected in this study fit the model first presented by Leiter and Maslach" (Gregory & Menser, 2015, p. 143), meaning the three criteria for burnout were further being established.

When applying Maslach and Leiter's research models to physicians in primary care, Gregory and Menser's study (2015) found that congruence in values also contributes to burnout. Congruence in values can be defined as how well the physician's own values align with the

values expressed by the organization or employer (Gregory & Menser, 2015). "Workload, control, and values congruence are the largest drivers of burnout for practicing primary care physicians" (Gregory & Menser, 2015, p. 133).

Effects of Burnout

Workplace burnout can be detrimental to the employee's health and ability to perform at peak best. The overarching objectives of the business and the collective American population can suffer as well due to changes in a person's behavior, feelings, thinking, and health status (McCormack & Cotter, 2013).

Burnout and stress are terms that are often used interchangeably. Stress is known to have negative effects on a person's overall health (McCormack & Cotter, 2013). The American Institute of Stress (AIS) explains that "chronic workplace stress often leads to significant health problems such as high blood pressure, cardiovascular disease, heart attacks and strokes and can aggravate many already existing conditions" (McCormack & Cotter, 2013, p. 3). Most notably, burnout is noted to cause a constant sense of overwhelming fatigue for the employee. A correlation between job stress and burnout has been shown, including various self-reported indices of personal distress including fatigue, insomnia, increased use of alcohol and drugs, and family issues (Maslach & Jackson, 1981), ultimately, declining the individual's overall health.

Once an employee experiences burnout, their energy and effectiveness at work declines so much that the quality and quantity of their work suffers (Burke & Richardson, 1996). Work capabilities decline, comradery drops, and morale suffers when employees are burned out. Emotional exhaustion, an attribute of burnout, has been linked to employees being hostile and irritable towards fellow co-workers, and ultimately causing frustration and anger towards the organization collectively (McCormack & Cotter, 2013). Ultimately, a burned out employee has

lost their initial idealism they once had for their work (Schaufeli et al., 2011).

When burned out employees do not perform at prime performance, businesses often reap the financial burden. A price tag of about $300 billion per year is what the AIS has estimated that stress and burnout on the job costs US businesses (Walter, 2012). "Costs are incurred because of reduced productivity and revenue, decreased job satisfaction, increased absenteeism and sick leaves, job turnover, low morale, and the necessity for replacement workers, along with compensation, litigation and disability claims" (McCormack & Cotter, 2013, p. 4). Workplace burnout has also been linked to increased workplace accidents, which incurs costs for businesses (Shanafelt et al., 2012). A group of burned out employees can lead to low workplace morale, which in turn, can directly influence the quality and quantity of work produced (Maslach, 2003).

Defining, Quantifying, and Measuring Burnout

The definition of burnout is "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity" (McCormack & Cotter, 2013, p. 7). Perhaps the most influential and widely used burnout measurement instrument, The Maslach Burnout Inventory, was developed by Maslach and Jackson (1981), who quantified burnout as having three identifiable characteristics: emotional exhaustion, depersonalization, and a reduction in personal accomplishment. By defining and segmenting burnout into three distinct dimensions, an employee's level of burnout can be calculated. The Maslach Burnout Inventory includes twenty-two survey style statements, such as, "I feel frustrated at my job" that require the employee to answer on a scale of "never" (a score of zero) to "every day" (a score of six) (McCormack & Cotter, 2013). The Maslach Burnout Inventory is intended to sift employees experiencing true job burnout from those experiencing a "bad day" (Maslach & Jackson, 1981). Burnout is not a product of intermittent

workplace crisis, but rather, is the response to a chronic onslaught of continuous tension (Maslach, 2013). Interestingly, an employee does not need to experience burnout in all three dimensions to feel burned out (Maslach & Jackson, 1981). The design of The Maslach Burnout Inventory is to determine the manifestation and possible source of an employee's burnout level (Maslach & Jackson, 1981), by quantifying their emotional exhaustion, depersonalization and decreased sense of personal accomplishment. The three dimensions of burnout, as determined by Maslach and Jackson (1981) are highlighted here.

Emotional exhaustion leaves employees feeling that their emotional resources are depleted and can no longer contribute to their work on a psychological level (Maslach & Jackson, 1981). Often the primary manifestation of burnout is emotional exhaustion and is often accompanied by "a general weariness, the inability to sleep properly at night, physical lethargy, and a host of physiological symptoms including stomach problems, muscle fatigue, and headaches" (McCormack & Cotter, 2013, p. 7). This dimension of burnout results in the employee wearing down secondary to chronic workplace stressors. Maslach and Jackson (1981) state that emotional exhaustion occurs frequently among individuals who work in the human service industry.

Exhaustion is generally accompanied by feelings of depersonalization or cynicism, the second major dimension of burnout (Maslach & Jackson, 1981). Employees develop adverse attitudes towards the recipients of their services in the workplace. "They also become disenchanted with their work. Communication becomes a strain, and burned out employees respond by seeking to avoid contact with people around them" (McCormack & Cotter, 2013, p. 7). Job eagerness requires energy, and when that energy is depleted, it is easily replaced by cynicism (McCormack & Cotter, 2013. The cynicism that develops creates a pessimistic attitude

not only towards the group of people the employee is intended to help, but often towards colleagues and supervisors as well (McCormack & Cotter, 2013). The new attitude causes a pivotal change in personality and attitude in the employee and often causes them to abandon the commitment they initially had towards their job (McCormack & Cotter, 2013). Depersonalization produces a change in personality or attitude that can be observed (Burke & Richardson, 1996).

The third dimension of burnout is the reduction of personal accomplishment, also referred to as self-efficacy, or the feeling of inability to be effective (Maslach & Jackson, 1981). A decreased sense of personal accomplishment results in the "tendency to evaluate oneself negatively, particularly about one's work with clients" (McCormack & Cotter, 2013, p. 8). This in turn, causes a sense of unhappiness with workers as they reflect upon and feel dissatisfied about their personal job accomplishments. Feelings of inadequacy can make employees vulnerable to cynicism about the "value of one's occupation and doubtful of one's capacity to perform" (McCormack & Cotter, 2013). Gregory and Menser (2015) suggest that a decreased sense of accomplishment has been linked to the type of work and status of the employee.

Levels of Burnout for Medical Professionals

Levels of medical workplace burnout have been steadily increasing over time (Shanafelt et al., 2014). In 2012 a survey of the physicians who were member of the American Medical Association found that 45.8% of physicians were symptomatic of at least one symptom of burnout using the Maslach Burnout Inventory (Shanafelt et al., 2012). Shanafelt et al. sent the survey out again in 2014, and the results showed that 55.4% of physicians who responded showed at least one symptom of burnout (Shanafelt et al., 2014). Physician work-life satisfaction also decreased in the measured period of time, with 48.5% of physicians being

satisfied in 2012, and 40.5% being satisfied in 2014 (Shanafelt et al., 2014). The decrease in physician work-life satisfaction is is in contrast with the national level of burnout, which had decreased (Shanafelt et al., 2014). These above studies have been further corroborated by a study of Israeli physicians comparing burnout from 1990 to 2001. The Israeli study showed statistically significant increase in burnout levels between the two-time periods (Kushnir, Levhar & Cohen, 2004).

Physician burnout has been categorized by the Maslach Burnout Inventory, and broken down into the three criteria of depersonalization, emotional exhaustion, and personal achievement (Leiter & Maslach, 2009). A 1994 study of physician burnout cited that a large percentage of physicians scored higher on the emotional exhaustion and depersonalization components of the inventory, but lower on the personal achievement category, with 44% of physicians experiencing emotional exhaustion, 40% experiencing depersonalization, and 8% experiencing low personal achievement (Deckard, Meterko & Field, 1994). This has been recently corroborated in a 2008 study among UK physicians, with 40% of physicians reporting symptoms of emotional exhaustion, 35% reporting depersonalization, and 32% reporting low personal achievement (Soler et al., 2008). Physician assistants may also experience burnout. A survey of emergency medicine PAs in 2002 looked at levels and categories of burnout (Bell, et al., 2002). Physician assistants measured had a similar categorization of burnout compared to physicians, with 66% of participants reporting depersonalization, 59% reporting emotional exhaustion, and 34% reporting low personal accomplishment (Bell et al., 2002).

Many factors have been proposed burnout for physicians specifically. In 2016, Carol Peckham did a survey of physicians through the website Medscape looking at burnout and its causes. Over 15,000 physicians responded to the survey. The top answers in the survey were too

many bureaucratic tasks and spending too many hours at work. Other answers included increased computerization, low salary, and “just feeling like a cog in a machine” (Peckham, 2016).

Barriers Preventing Support for Burnout

Despite high levels of workplace stress and burnout, very few physicians actually get the help and support that they want in times of stress (Rheaume, 2016). A wide problem across healthcare is the set of barriers which prevent healthcare providers from seeking support. In a survey performed at a Boston hospital, 89% of physician respondents indicated lack of time as a barrier which prevented them from seeking support (Hu et al., 2012). Providers feel busy and short on time as it is, so naturally it is a burden to find the extra free time to seek help (Hu et al., 2012). Out of the 108 physicians who were surveyed in this same study, 74% indicated the stigma surrounding mental health as another barrier prevented them from seeking support for their distress (Hu et al., 2012). Vulnerability is an understandable concern of providers, who likely fear that employers and patients would doubt their abilities if any "weakness" in their mental status became known (Rheaume, 2016). "Among doctors, stigma surrounding mental illness is particularly apparent. The culture of medicine reinforces the myth that doctors are invincible, high-achieving martyrs who should never show signs of weakness or sickness" (Rheaume, 2016, p. 48). This stigma presents a need for a more comfortable setting in which doctors can feel safe to discuss their exhaustion and burnout. Despite these barriers, 94% of responders in this study answered that they desire support for work-related stress (Hu et al., 2012). Since healthcare providers who want the help are not seeking it, these barriers which deter them from seeking help are problems that the healthcare community at large needs to address.

Recommended Solutions for Burnout

Peer support from colleagues can be the most effective coping strategy for severe stress at work (Hu et al., 2012). Maslach's (2003) expert advice and a 2012 study about intervention at Brigham and Women's Hospital in Boston both advocate peer support as a way to combat burnout (Hu et al., 2012). Maslach, a pioneer of burnout research, states, "The power of your peers to help you handle burnout should not be underestimated. Indeed, they can be your most valuable resource… Whatever the format, the social and emotional support provided by peers can be critical for survival on the job" (2003, p. 183). Maslach (2003) promotes both formal methods such as professional support groups with colleagues and informal get-togethers during lunch break or outside of work. Co-workers understand better than anyone about the overwhelming demands at work and can offer their perspectives as well.

Knowing that one is not alone in the struggle of burnout at work can help break down the stigma barrier. Admitting to a struggle or weakness is easier when among others who share the same feelings (McCormick & Cotter, 2013). The evidence-based intervention at Brigham & Women's Hospital in Boston discovered significant results in favor of peer support (Hu et al., 2012). When the physicians were surveyed about the people or services from whom they would be most likely to seek support, they collectively expressed 88% likelihood of utilizing their physician colleagues. In comparison, these same surveyed physicians expressed 29% likelihood of utilizing their Employee Assistance Program and 48% likelihood to see a mental health professional for their stress (Hu et al., 2012). In response to this data collected, the hospital now advocates for peer support, offering a "one-on-one peer physician support program" (Hu et al., 2012, p. 6). The peer support program has been accepted with a very positive response overall,

and the regular meetings are even incorporated during work hours, so the "lack of time" barrier discussed above is addressed as well (Hu et al., 2012).

Potential Burnout Factors for PAs

Despite a plethora of information about causes, effects, and factors of burnout for physicians, little research has been done on issues that impact PA burnout. The factors listed below have not been studied in relation to burnout, including public perception of the PA profession, perception of PAs' clinical skills, and scope of practice issues for PAs.

Public perception of the PA profession may be a factor of burnout that needs investigation. A survey performed by the American Academy of Physician Assistants measured college undergraduates' knowledge of a PA, and the PA's scope of practice (Volpe, Bulmer & Kelsey, 2015). Volpe et al's (2015) study surveyed a randomized cross section of undergraduate students at an undergraduate institution in Connecticut, and polled the students about what procedures they believed a PA would be able to do. A large percentage of participants did not know the scope of practice for PAs, and many assumed the roles were limited to very minor parts of medicine (Volpe et al., 2015). The survey showed that 49.3% of participants at first believed that PAs could not diagnose problems, 59.6% of participants believed that PAs could not prescribe medications, and 59.2% of patients believed that PAs could not be the primary care provider for patients (Volpe et al., 2015). A majority of participants believed that PAs could order labs, counsel patients, refer, and take vitals (Volpe et al., 2015).

Many people fail to see PAs differently from other practitioners, or are not aware of the position at all. In the study done by Volpe et al., 43.1% of participants were not aware that they were treated by PAs, with 28.2% of the participants not sure what a PA was (Volpe et al., 2015).

Despite growing awareness of the profession, a large percentage of the population does not know what the PA profession truly does (Volpe et al., 2015).

Another issue for PAs is the public perception of their clinical skills. Patients largely prefer seeing doctors for their medical care ("Patient perceptions regarding," 2012.) A recent survey by the American Academy of Family Physicians show that 72% of people prefer physicians providing their care ("Patient perceptions regarding," 2012). The number of people preferring mid-level practitioners, including PAs and NPs, for care varied based on the type of injury, with 4% preferring midlevel practitioners for general illnesses, 5% for long term management, 6% for acute illnesses, and 11% for chronic disease management ("Patient perceptions regarding," 2012). However, despite this preference, 90% of respondents feel as if the additional years of schooling for physicians makes physicians more optimal in terms of care ("Patient perceptions regarding," 2012).

Furthermore, many patients prefer the care of NPs to PAs (Yen & Mounts, 2013). Yen and Mounts showed that 8% more patients would rather see a nurse practitioner (NP) over a PA in a routine care setting, and 8.7% in urgent care setting (Yen & Mounts, 2013). Of these patients, 70% stated that they would see a PA or an NP (Yen & Mounts, 2013).

Despite the lower preference for PAs in comparison to NPs, a study performed by the Kaiser Permanente Research Department found that, "Patient satisfaction with practitioner interaction, care access, and overall experience attended by PAs/NPs was equivalent to, or slightly better than, that on visits attended by MDs in primary care practices" (Roblin, Becker, Adams, Howard & Roberts, 2004, pg. 608). Despite positive favorability rates compared to physicians, PAs are still underused and misunderstood in comparison to other healthcare providers.

Physician assistants also face issues regarding scope of practice. In 17 states PAs still have limited prescriptive authority over controlled substances, with no prescriptive control over controlled substances at all in Kentucky ("PA prescribing authority by state," 2016). Physician assistants also are often not utilized to their full capability within their practice. The American Academy of Certified Urologists states " … urologists remain hesitant to use PAs to their full capacity. One reason, PAs say, is that urologists often don't understand PAs' capabilities and roles in urology" (Hilton, 2014, para 7) despite PA growth being rapid in this specialty, with an increase from 33 members in 2007 to 248 members in 2014 within the Urological Association of Physician Assistants (Hilton, 2014). Physician assistants are also hitting road blocks in terms of what roles they are given within their scope of practice. Physician assistants in emergency medicine situations are often given minor acute cases, rather than assisting in critical care situations within the emergency room despite critical care situations being within their scope of practice (Ballweg, Sullivan, Brown & Vetrovsky, 2013).

These factors are prevalent within the PA profession, and need further investigation to determine if they are contributing factors of burnout. The lack of research on factors contributing to PA burnout makes these areas of high interest for future research on the issue of PA burnout.

Conclusion

Based on the review of the existing literature, burnout is a definite problem within human service industries, particularly the medical community. Levels of burnout have been quantified specifically with nurses and physicians, but there is a lack of research about the direct application of burnout in the work of PAs (Bell et al., 2002). Furthermore, reasons for burnout among medical professionals has been attributed to poor work environment, years of experience, lack of

autonomy, and various other external work factors and internal personality factors (McCormack & Cotter, 2013).

Many studies by psychologists such as Maslach and Leiter have crafted and rationalized the causes and effects of burnout among physicians and nurses (Leiter & Maslach, 2009). However only one study was found that quantifies the levels of burnout in one specialty of the PA profession (Bell et al., 2002). The focus of this research will not to try to quantify levels of burnout, but will look at potential issues and concerns in the PA community that may contribute to feelings of burnout as well as potential solutions to these problems. Instead of a survey tool such as the Maslach Burnout Inventory, a qualitative interview format will be used to focus on potential causes.

The next chapter will include discussions about how to measure and record factors that contribute to burnout. A discussion on the structure and analysis of qualitative studies, and the methodology of the study will also be included.

Chapter 3: Methodology

Introduction

The purpose of this study was to examine and evaluate burnout among practicing PAs within Minnesota and Wisconsin. By interviewing practicing PAs in Minnesota and Wisconsin, this research served to discover causes and effects of burnout within the PA profession. The research addressed the following questions:

- What symptoms of burnout are PAs experiencing?
- What patient care, scope of practice, and business factors are contributing to burnout among PAs?
- If PAs are experiencing burnout, what coping mechanisms are they using?

The study was designed to interview and collectively analyze practicing PAs experiences about burnout to answer the above research questions. The purpose of this chapter was to examine the methodology of the study, including the study design, the study population, the study procedure, the analysis of the data, the reliability limitations and delimitations of this study. For the purpose of this chapter, the PAs interviewed will be referred to as participants.

Study Design

The study's design was crafted to be observational, qualitative, and cross-sectional. Therefore, this research was observational in nature, not experimental; no variables were manipulated. The research was retrospective, as participants were asked to reflect on past experiences. The research gathered from participants was obtained at a single point in time, only once from each participant, making the research cross sectional.

The design of the study was qualitative in nature because the research tool used open ended questions for the interview process as a means to collect data. This study's intent was to

answer exploratory style questions, instead of quantitative figures. The interview responses were analyzed, to understand the feelings, personal opinions, and attitudes of the participants, hence making this subjective analytical style part of a qualitative research design.

Study Population

The population chosen for this study was practicing PAs within Minnesota and Wisconsin. A representative sample was obtained using a list of PA preceptors and professional contacts from the Bethel University Physician Assistant Program (see Appendix A). This list of PAs obtained was thought to be a representative sample of PAs at large, due to the wide variety of specialties, ages, and geographic distribution. This sample was selected due to connections with the Bethel University Physician Assistant Program, and fits the selection criteria below. The only inclusion criteria was that the participants be currently practicing PAs within the study site. Any personal identifying information of the PAs was collected only for initial contact and establishing a set interview time, with no personal identifying information published in the final report, and no personal identifying information used to contact the individual for any other reason other than establishing an interview time or answering questions about the study.

The size of the study population was determined using saturation theory. Saturation theory is used in qualitative research to determine an appropriate sample size (Fusch & Lawrence, 2015). The theory states that if further interviews are not contributing new information to the study, then the sample size is sufficient for the study (Fusch & Lawrence, 2015). A minimum of 10 interviews were completed, as intended, with the 10^{th} interview assessed for whether or not it added new information to the study. At 10 interviews, the researchers determined that the 10^{th} interview did not add new information to the collected data,

but rather, agreed with the existing data in non-new or novel ways. At this point, data collection was stopped as saturation criteria had been successfully met.

Procedures

The participants were contacted via the email on a list of PA preceptors and professional contacts obtained from the Bethel University Physician Assistant Program. The researchers obtained this list from the program from an existing faculty member. Initial contact consisted of an email letter (see Appendix B) and informed consent (Appendix C). This email (see Appendix B) was identical for all participants with the exception of the personal greeting. Participants who agreed to the study, responded via email and provided contact information to set up an interview time. The participants were informed that electing to move forward with the study meant they acknowledged, read and agreed to the letter of informed consent (see Appendix C) via email.

The contact list was randomly split alphabetically into equal thirds between the three researchers. Each researcher used a copy and paste method to send the same introduction content in a separate email to each individual PA. The individually sent emails eliminated the risk of a "reply all" email response in efforts to keep participants anonymous. Each researcher was responsible for interviewing the participants who responded via email. The participants who responded chose a time and location for the phone interview at their discretion and were informed that the interview would likely take 12-15 minutes.

The interview was twofold to include the interview script (see Appendix D) as a means for the researcher to introduce an overview and expectation of the interview and the interview tool (see Appendix E) which required participant interaction. The researcher used the interview script (see appendix D) at the start of every interview. The script included a statement by the researcher that personal identifying information would not be released, and that the participants

did not have to answer questions if they felt uncomfortable. The researchers used the survey tool (see Appendix E), to ask the participants open ended questions. The interview was conducted using the personal phone lines of the participant and researcher, as previously given by the participant.

The participants were informed that the conversation would be audio-recorded, then translated to a typed transcript. The participants were informed that the recording would be deleted after transcription, and that the transcriptions and notes would be locked in a secure place as written in the letter of informed consent.

If at any interview question, the researcher felt that clarification was needed for an answer, the researcher asked the participant to elaborate or explain the answer further. The extent of the elaboration was up to the discretion of the participant and the researcher, but did not constitute asking a completely new question that was not on the approved survey tool. When the researcher felt that the interview had gathered all needed information, the interviewer was able to end the interview at their discretion.

The phone interviews lasted approximately 12-15 minutes. Audio recording began after the interview script (see Appendix D) was completed, and before the interview tool (see Appendix E) began. The interviews were recorded on a computer recording device, using the researchers password protected computers. Th recordings excluded the names of participants or place of employment for confidentiality. These recordings were transcribed onto the researchers' password protected computers within 3 weeks' time. Once the recording was transcribed, it was deleted from the researchers' computers. The audio recordings, and transcripts of the interview, both as a hard copy and on a hard drive, were stored safely in a locked Bethel PA Program office. The interview information was promptly removed from the

researchers password protected computers. An exploratory analysis began during initial phases of data collection, and continued with new data completion. A total of 10 interviews were conducted over a three week span. As previously outlined, saturation theory was identified when the 10th interview was reviewed found not to contribute new pivotal or novel data to the existing data pool, thus appropriately ending data collection.

All transcripts, emails, and any other source of personal identifying information were kept in a locked office within the Bethel PA Program office for a minimum of five years past the point of publication. Any questions involving the handling of personal identifying information can still be directed to one of the researchers. If a participant requested earlier disposal of any information, that request was granted as soon as soon as the data was able to be disposed of in a safe manner. If participants wished to withdrawal from the study prior to completion, any item containing their personal identifying information was shredded as soon as their data was able to be disposed of in a safe manner. This data was then removed from data collection, analysis and ultimately withheld from the final research report.

Study Tools

The study tool was developed by the researches with collaboration from the Bethel PA Program faculty. The interview tool was thoroughly reviewed by practicing healthcare providers for clarity and content review prior to launch and pending IRB approval. Two active healthcare providers, one PA and one nurse practitioner reviewed the interview tools, and provided specific feedback regarding the interview tool. Collectively, it was suggested that the researchers should provide examples of patient care, scope of practice, business factors under factors contributing to burnout on the interview tool (see Appendix E) should the participant need a better understanding of the question's objective. Also, it was collectively suggested that the

researchers offer a formal definition for term burnout if the participant needed help understanding how burnout was defined. Both of these suggestions were added to the interview tool (see Appendix E) in blue font as to only be read in the interview if the participant needed further clarification.

The study was done via phone interviews, with the researchers following an interview script (see Appendix D) without extreme deviation. This interview script included the explanation of the voluntary nature of the study, the confidentiality risks and procedures done to conduct the interview. After complete reading of the interview script, the researcher read the questions on the interview tool (see Appendix E). Part one of the interview tool was demographic information including practice specialty, and number of years practiced. Part two of the interview tool addressed possible factors that could be contributing to burnout. This section was further broken down into three separate questions assessing if the participants experienced burnout from patient care, scope of practice or business factors in their workplace. Part three of the interview tool assessed if the participants experienced symptoms of burnout. This section was further broken down into three separate questions assessing if the participants experienced a sense of depersonalization, emotional exhaustion, or personal achievement. Part four of the interview tool assessed how participants coped with burnout.

The participants were contacted with the initial content email (see Appendix C), which also included an email attachment of the letter of informed consent (see Appendix B). This email was sent to participants using the contact information provided by Bethel University PA Program. If any participants wished to partake in the study, they were asked to reply to the researcher's email stating their acknowledgement and agreement to the letter of informed consent (see Appendix B). The letter of informed consent (see Appendix B) outlined the scope

of the study, confidentiality risks, protocols taken, and the voluntary nature of the study.

The interview tool (see Appendix E), was specifically created for this study, and thus has not been tested for reliability and validity in other formal research. Further repeats of this study will need to be done to assess the reliability and validity of the data. Prior to interviewing the participants, the interview tool (see Appendix E) was reviewed, and edited to ensure clarity of content by current practicing healthcare providers that were otherwise were not eligible for the study.

The study sought level one IRB approval. All appropriate materials were submitted to the Bethel University IRB committee in July, 2017. The study was given level one IRB approval in July, 2017 (see Appendix F), with data collection beginning in July 2017, with completion in August, 2017.

Data Analysis

Analysis of the data followed the plan for qualitative analysis discussed in John Cresswell's 2003 book, *Research Design: Quantitative, Qualitative, and Mixed Methods Approaches*. In the book, Cresswell offers a six step method for qualitative analysis. A summary of the six steps are as follows:

1. Organize and collect data.
2. Read through all of the data, and reflect on the overall meaning.
3. Code the material, sorting material into "chunks" based on similar themes.
4. Use the codes generated as major themes for analysis.
5. Advance the themes with several sub-themes or narrative creation
6. Interpret the data. (Cresswell, 2003).

The codes and themes discovered using this method of analysis are reported in Chapter 4 of this research, with subsequent interpretation of said data in chapter 5. Each subheading in Chapter 4

are major codes or themes identified with analysis process. Direct participant quotes are reported to further support the major codes or themes. No personal identifying information is associated with quotes, making all quotes reportedly anonymous.

Limitations, Delimitations, and Bias

The following is a list of limitations that may have affected the data collection process and therefore, have indirect implications on the data itself. These include but are not limited to:

1. The accessibility to a pool of PAs was limited, and therefore, may not collectively represent the Minnesota and Wisconsin profession accurately.
2. Each participant may have had a different definition of burnout, which was not reflected when the research questions were created, as it was impossible to account for every participant's personal definition.
3. The participants were aware that this was a research study that would analyze answers, and therefore may alter responses accordingly.
4. The participants were made aware that identifying information would remain anonymous, yet there is little control of the honesty of their answers.

The following is a list of delimitations, purposely placed on the study by the researchers, that may have affected the data collection process, and therefore have indirect implications on the data itself. These include but are not limited to:

1. The sample size was small due to the nature of the qualitative study and time constraints. The interview time slots were be variable and open ended. Therefore, it was practical that the sample size was small to best complete this study in a timely manner.

2. The collected data was exploratory, rather than confirmatory. Due to the subjective nature of the data, a cause and effect relationship was not confirmatory.
3. No PAs outside of Minnesota and Wisconsin were interviewed.
4. Only PAs who were accessible to the researchers were approached for this study.
5. The interview was designed to be short, estimated for 12-15 minutes.

The following is a list of biases that were present in the study that may have affected the data collection process and therefore, have indirect implications on the data itself. These include but are not limited to:

1. The subjectivity and inherent variance of personal experiences and emotions was not taken into account.
2. Three researchers conducted individual interviews, therefore, inter-rater bias may have happened. Although a standard interview script (see Appendix C) and interview tool (see Appendix D) were used in attempt to control inter-rater bias, each researcher inherently has a different style or tone of asking questions. Also, there was freedom for the researchers to inquire further about specific answers, saying dialogue such as "Can you explain that answer further?"
3. The participants were asked to reflect on past experiences to answer questions, which may not have resulted in perfectly accurate information. This memory bias results in natural-human-recall errors and was not able to be avoided.

Conclusion

In conclusion, this study was conducted to closely examine causes and effects of burnout in the PA profession. This was done by crafting the research into a threefold study as follows: what specific factors contribute to PA burnout, what symptoms of burnout do PAs exhibit, and how do PAs cope with burnout. The intent of the study was to compile, analyze and compare the thoughts of PAs regarding their own personal opinions of how they experience burnout in their workplace. The interviews collected represent the thoughts and impressions that PAs have individually reflected upon to highlight potential factors, symptoms and solutions of burnout. Based on the interview response answers, this collected data was organized, analyzed, and reviewed in the following chapters.

Chapter 4: Results

Introduction

This chapter serves as a review and display of the results of the data collected during the interview process. Researchers used the interview tool (see Appendix D) in attempt to understand the cause and effect of workplace burnout among the PA profession. For the purpose of this chapter, the PAs interviewed will be referred to as participants. The purpose of this chapter was to collect, analyze, and compare the individual answers from the participants to identify common and universal themes that answer the threefold research questions, with the dominant focus on the first:

1. What patient care, scope of practice, and business factors contribute to burnout among PAs?
2. What symptoms of burnout are PAs experiencing?
3. If PAs are experiencing burnout, what coping mechanisms are they using?

Participants were asked to reflect and answer honestly on their personal experiences with workplace burnout in attempts to answer the research questions as stated above. Participants were interviewed over the phone, with the interview recorded and then transcribed. The data was then reviewed by the researchers to identify common threads of dialogue between individual participants. The findings presented in this chapter are based off the participants' opinions and set up in a manner that suggest the most pivotal and prominent themes highlighted found during data review. The follow material and data is exclusive to the participants' answers.

Demographics:

All of the participants interviewed were PAs currently practicing in Minnesota or Wisconsin. The researchers assumed participants were currently licensed as that is a state requirement by law. All participants had close affiliation with the Bethel University PA Program as either a previous, current or future PA preceptor. A total of 10 participants were interviewed. The average number of years practiced among the participants was 9.15 years. No specific medical specialty was overrepresented as the participants were quite varied including: family medicine, urgent care, surgery, internal medicine, hematology and oncology, emergency medicine, psychiatric medicine, and dermatology.

Data Analysis:

Ten participants volunteered to be interviewed. After the tenth interview, the data was assessed by the researchers to identify if saturation theory criteria had been fulfilled. The tenth interview did not add any new or novel data to the already collected set, therefore saturation theory criteria had been successfully fulfilled and data collection could be stopped. Further details on the methodology used for data collection can be found in greater detail in Chapter 3.

The interviews were transcribed and analyzed throughout the data collection process. Data was analyzed according to the methods found in Cresswell's 2003 book, *Research Design: Quantitative, Qualitative, and Mixed Methods Approaches.* The data was reviewed and then organized in a manner of similar dialogue amongst individual participants. Throughout this process, several prevailing ideas were identified and coded into various broad themes. These broad themes were then reduced and created into major themes which will be presented below (Cresswell, 2003).

This research served to identify PA workplace burnout in three dimensions:

potential factors contributing to burnout, symptoms of burnout, and how to cope with burnout, with the greatest focus on the first dimension. The following sections will discuss the results of the above sections in order.

Causes of Burnout

The participants were asked to reflect on potential causes of workplace burnout from personal experience. To form organized categories, the participants were questioned on three specific areas within their employment, patient care factors, business factors, and scope of practice factors, to potential identify their cause on workplace burnout. The responses were categorized with pivotal themes below.

Patient care factors contributing to burnout.

Patient overload. When questioned if there were patient care factors that may have contributed to burnout, one of the most common answers referenced the amount of workload expected. Multiple participants stated that they were seeing more patients in a day than they were comfortable with, or were working longer days than they felt they could handle. One participant stated, "I've definitely been emotionally exhausted from the volume of patients that need to be seen. We're required to see patients in 10 minute slots". This participant felt that not only patient overloaded, but also forced to keep up with higher demands of more work at a fast pace. A similar response from another participant said, "I think the biggest thing is the limited time we have to see each patient." The combination of increased workload and limited time to see patients was a frequent source of stress.

One participant stated that stress from a previous job's high demand patient load was the

primary reason for quitting. S/he stated:

> At my old job, which is the reason I no longer work there, the amount of patients we were required to see was just not very satisfying. You feel like with the increase in quantity, you have a decrease in quality and that sometimes makes you leave your job feeling unfulfilled.

The limited, hurried time with patients diminished this participant's satisfaction to the point that s/he was not able to practice medicine as comprehensively as desired.

Long hours, including on-call hours, was another area where participants felt overworked. The challenge of working long hours was illustrated by a participant who explained, "I was a full time family practice provider, and worked corrections as well. On top of work I was also on call potentially 18 hours every day. Between the two jobs I was never away from it. I was never able to put the work down". This participant went on to state that the burnout from working these long hours eventually led them to quit their job.

While many of the participants mentioned how increased patient workload was stressful, one spoke of the benefits felt of "not having to squeeze in too many patients" and therefore, did not sense burnout from patient load. This participant shared that if workplace production, such as number of patients seen, were tracked, "I would feel frustration and burnout over patient load". The participant further explained, "I think a big piece of it is that I'm salary based. If I was production based it would be a little bit more drive or feeling that I should see more patients". This participant mentions that the salary compensation package prevents them from feeling burnout.

The burnout from workload and vast number of patients felt was further exacerbated by shortage of providers on the team. "It was just a shortage of providers, and just overload

on the work," explained one participant who admits to feeling burnout. S/he described that less providers available means more patients and shorter time slots expected from the providers who are on staff.

Collectively the idea patient overload, from the amount of patients to be seen in a day, to limited time with the patients, or to "simply feeling overworked," was identified by most participants as a consistent factor for experiencing burnout.

Patient complexity. Another major theme identified from the participants' dialogue was the increased complexity of patient care. Participants stated that not only is the decision making for care management an exhausting process for complex patients, but often the participants' care goals for patient outcomes are not met, which is a source of frustration and burnout. One provider stated, "... We have a lot of struggles getting patients the appropriate care due to lack of inpatient beds, which means they have to stay in the ER department for extended periods of time". This participant felt that the lack of ability to get the complex patients' to the proper medical specialties, leaves ER PAs to inappropriately take the brunt of the patients' care.

Two participants also expressed frustration with patient care complexity and subsequent inability to care for their patients in the best manner. One participant stated, "the intricacy of patients and increasing needs for care in general make it hard to care for them in their entirety. The patients I see are very complex". Another participant added:

> Some days I feel like I don't know as much as I want to, or as much as I should. Every patient just overwhelms and confuses me. And I think, should I do this? Am I doing the right thing? Am I helping anybody?

These participants stated that provider confidence can be diminished when caring for medically

complex patients, which caused them to feel frustrated. The difficulty of some patients' care plans in combination with limited time and resources made participants experience burnout.

Other participants were frustrated that patients were not putting in the effort to meet provider goals. One participant stated, "The patients I can't solve and can't fix, I can't help. It's exhausting. They'll come back in with the same complaints and it's like 'Do what I said the first time, and the second time, and the third time". This participant admittedly felt emotionally exhausted, lacking patient understanding or patient apathy with such patient scenarios.

A different participant shared a similar experience. They stated, "Patients themselves can be kind of high maintenance, meaning they're pretty picky about outcomes… I think that's one thing that contributes, if you have to take opinions from someone who isn't a healthcare professional into account". The participant stated that the expectations of the patients themselves in respect to realistic outcomes was draining.

Another participant had a different experience, "In my current job, more so than the amount of patients, their social factors and background story can be extremely draining". For this participant, the most difficult hurdle for successful patient outcomes were social and environmental components. Rather than the complexity of medical care, this participant felt restricted in her/his medical abilities because patients' had limited environmental or social capabilities, which negatively impacted patient outcomes.

Overall, the misalignment of provider outcome goals and patients' ability to meet said goals, was a common source of feeling burnout for participants. Patients' poor effort, environmental factors, medical complexity, or unrealistic goals, all negatively affect patient outcomes. Although the reason for patients' limitations on the ability to meet the high standard of care outcomes, resulted in a sense of burnout among many of the participants.

Business factors contributing to burnout. When questioned about business and professional issues, a common theme described by participants was how the increased administrative office demands made them feel burnout. One participant stated, "It seems like there's always a form or something from an administrative standpoint that needs to be completed that gets in the way of me doing my job and seeing patients." Similarly, another participant added, "The registries and numbers that need to be completed is frustrating: the diabetic registry, the vascular registry, the depression registry". Another participant mentioned that his/her role at the clinic has shifted to incorporate medical business knowledge that was not previously needed by stating:

> There's been a decrease in office staff, so we've had to pick up on that. It has been time consuming specifically trying to fill out prior authorizations for medications, or being on the phone with the insurance companies. There's no longer anyone else to do that.

Another participant agreed that learning new business roles was frustrating as s/he moved into a managerial position, by stating, "During that time my supervising physician left and I was alone to run the practice. I suddenly became everyone's boss and that became very difficult as I was managing more internal complaints, on top of seeing patients..." These specific participants felt burnout as their PA roles expanded to incorporate increased demand of business knowledge and responsibilities and collectively echoed frustration with the amount of administration work it takes to catalogue patients' insurance, outcomes, and goals because it takes away time that can be better spent with the patients themselves.

Patient charting was another area of administrative demands that participants voiced frustration. One participant stated **"**I know my colleagues feel burnout, and one cause is the

documentation needed to support billings or some of the hospital policies. Especially when we'd rather be taking care of patients instead of doing the extraordinary amount of charting". Another participant felt similarly in regards to medical coding by stating "If a patient comes in with an elevated creatinine, then they want you to document whether it's from a mild AKI, or moderate whatever it is." These participants agree that the intricate details required with patient charting causes stress because it decreases the amount of patient care time available for them.

Another participant also felt burnout when having to pick up a role as triage nurse instead of their role as a PA. S/he stated, "We had to answer all personal patient questions and concerns and they had my personal voicemail and so that required after a long day of patient care. I got stuck doing work that could have been done by an MA or RN. Taking on additional work that could have been outsourced, was a significant source of frustration. Overall, increased office work, the complexity of charting, and increased managerial and non-PA related duties were commonly reported as sources of burnout because it collectively took away from patient care time.

Scope of practice issues contributing to burnout. When question about scope of practice factors, a common theme among participants was the underutilization of PAs collectively. Three sub-themes emerged from the participants' dialogue to suggest potential causes this limited ability to practice to their full PA licensure including: inadequate patient recognition, limited scope of practice, and a hindered voice in administration decisions.

Inadequate patient recognition. Some participants expressed that patients' misunderstanding of a PA's role negatively wore on them. One of the participants stated "Some patients will be completely done seeing me, and will have misconceptions about

what I do, so they ask me when they're going to see the doctor… Or who's going to send in their prescriptions". Participants explained that patients often misunderstand the title of a PA, and assume that PAs are simply the assistants who get them ready to see the doctor. One participant described a typical encounter with a misunderstood patient:

> A lot of patients know what a PA does, but I'd say about half of your patients don't know exactly what you do, and what you're qualified to do, and they still think that you are working to be a doctor or you're just there to assist the doctors.

Many participants echoed similar experiences of how PAs do not always receive proper patient recognition. Universally, the participants attribute this phenomenon to patients' ignorance of the PA role in its entirety. These participants stated it was frustrating and disheartening to have patients doubt their clinical abilities and see them as dependent providers. To serve a patient population that does not fully understand or appreciate the role of a PA, was an identifiable source of burnout and frustration for the participants.

Provider utilization. When questioned about limitations in the workplace, participants shared that there can be a disconnect between how a practice understands, utilizes and endorses the role of a PA. Some participants felt that they were not practicing to the fullest of their licensure, and found this to be contributing to their sense of burnout.

One participant had an experience with feeling underutilized simply because the employer "was unsure how to do so". This participant felt that PAs were thought of as assistants rather than independent providers. "We were responsible for the grunt work, including paperwork, and basic physical exams… I did not practice to the top of my licensure".

Beyond employer limitations, some participants expressed frustration with physicians, supervising or non-supervising, not trusting PAs for basic medical care. One participant felt that

physicians doubted PAs if they did not seek enough patient care or medical advice. S/he stated that "Some of the doctors are very concerned when I don't call and ask for help often enough, and I don't know if that mentality will ever go away completely". Another participant echoed similar relationship with his/her supervising physician stating, "My overseeing physician has limited my scope to very basic dermatology, which is a big source of frustration because I'm capable of a lot and know it because I've done it". This participant struggled with the conservative use of the PA role, because the supervising physician lacked comfort in redirecting large responsibilities to PAs. This participant added, that this is a new working relationship, so remained hopeful "That this will change when the physician is more comfortable with working with a PA".

Yet another participant mentioned that PAs in his/her practice were once utilized to a higher capacity than they are now. This participant stated, "The PAs are limited in seeing low acuity patients and do not perform advanced procedures as these go to the residents, which has been a dis-satisfier". The limitation in medical complexity caused this participant to struggle with burnout. They continued by stating, "Shifts in the lower acuity bays, don't make me feel as satisfied as the higher acuity cases".

Although the reasons for scope of practice limitations were largely unique for the participants, the fact that there was a limiting factor dictating the depth of these participant's roles was uniformly a source of frustration in the workplace. These participants felt limited in their capabilities, from employers, and fellow physicians alike, which ultimately caused them to feel underutilized, unrecognized and striving for trust. The lack of independence caused them to feel burnout.

Lack of administrative voice. Another common source of burnout that participants

expressed was the lack of having influence at the administration level because their opinions, or ideas were overlooked. In regards to administration, one participant shared, “They listen, and then they smile and nod, and sometimes I know I’m not going to have any solid say in the matter. Sometimes I just don’t say anything because I know it’s not going to matter.” Another participant expressed a similar frustration by saying, “I don’t feel like we have a voice when it comes to administration issues." Both of these participants felt discouraged by the sense that their PA voice seemed unimportant or not valued by administrators in the same regard of their physician counterparts. When describing professional sources of burnout, one of the participant added, “And then sometimes not having enough say in the rest of my clinic setting, because I’m not in charge of hires or fires, or any of that stuff that could potentially make things easier for everybody.” This participant felt that they could benefit the medical team collectively if a PAs’ role could take on more leadership and decision-making skills.

Participants were disheartened with how administration interacted with PAs and other providers collectively. Specifically, participants mentioned that administration pushes PAs for fast and high volume productivity, secondary to high quality patient care. One participant commented, “I do feel like there is not a lot of engagement with the hospital leadership, and including PAs in the decision making processes. I do think that is an area of improvement.”

Minimal opportunities for career advancement and growth were also mentioned by some participants as a source of burnout. Many participants felt excluded from opportunities involving increased responsibilities and role advancement for PAs. One participant shared, “I would say one of the ‘dis-satisfiers’ is that there isn’t a leadership

pathway for PAs." This participant mentioned feeling stuck in his/her role with little advancement opportunities. Another participant echoed a similar feeling of role confinement due to parameters enforced on PAs. S/he stated "There are a few people in the business side of things....They're pretty interested in being profitable and it feels like they're pushing an agenda on to us. They're pretty streamlined in their operational aspects." These streamlined productivity requirements felt very confining for this participant, and notably held other PAs back from experiencing maximal growth and meaning in employment.

A desire to have greater input, inclusion and PA representation in administrative change and decision-making, along with opportunities for career development were consistent themes mentioned by many participants. Collectively, participants desired more potential career responsibility, but felt restricted due to administration policies in place. The participants said the lack of influence, and career growth were sources of workplace burnout.

Symptoms of Burnout

The interviews collected data on participants' symptoms of burnout. Participants were asked directly if they felt that they showed signs and symptoms of burnout in any of these three dimensions: emotional exhaustion, depersonalization, or decreased sense of personal accomplishment. All ten participants expressed that they did feel some of the burnout symptoms either through direct response or alluded to such symptoms through answers in other questions on the survey tool (see Appendix D). For purposes of analyzing the data, the participants were counted as experiencing a symptom of burnout if they directly stated it in response, or if the terms depersonalized, emotionally exhausted, or a

decreased sense of autonomy or personal achievement were used in an answer to another question. Of the ten participants, nine mentioned feeling emotionally exhausted, four stated feeling a sense of depersonalization towards patients, and eight felt a decreased sense of personal achievement.

Coping with Burnout

When asked about how the participants coped with burnout, two sub-themes emerged: professional reinvestment and managing work and life balance.

Professional reinvestment. When asked about ways that participants coped with workplace burnout, many stated that personally reinvesting in the PA career helped to cope with or diminish burnout. Multiple participants stressed that continuing medical education (CME) credits and other avenues of advanced medical education were beneficial to keeping burnout at bay. One participant stated, "Doing continuing education revitalizes your energy and interest in the specialties of a desired field, which can help add routine and structure to a practice." This participant directly used CME credits, courses and hours as a way to decrease current burnout as well as potentially prevent it, by delving deeper into the medical subspecialty area of choice. CME helped to build confident energy for this participant.

Other participants used CME to look for new experiences and refresh themselves in medical subspecialties that are less familiar to them. One participant stated, "I find it very important to look for educational experience, like CME that will give you a different kind of training, or even focus on resilience… to give us a fresh look at why they're doing what they're doing." This participant used CME as an opportunity to revitalize and expand medical knowledge in areas that are less familiar. Another participant echoed a similar response stating, "I used to go to conferences that I felt I should be attending, that would be

relevant daily practice, but lately it's been whatever I'm interested in. I'm really interested in nutrition, so I've been going to those". These participants used CME opportunities to keep their medical interests broad.

Another common burnout coping mechanism mentioned by participants was PA advocacy. One participant mentioned s/he worked with medical professional groups to further expand the knowledge base, rights and responsibilities of the PA profession. S/he stated, "I have worked very closely with Minnesota Academy of PAs and I work closely with the legislative committee in regards to changing aspects of mental health reimbursement in MN. And we have been able to pass some very important legislation". Another participant added, "Just being an advocate for the PA profession helps. You never know what more you can do until you ask". These participants expressed that working with professional groups on behalf of the PA population at large was a source of pride and reward. This sense of community accomplishment and serving the greater good of the PA profession helped these participants from feeling burnout in their day to day PA careers.

Another participant stated that working with PA education programs was important to them, and made their career more fulfilling. This participant stated, "I have felt that I needed to do something more than the day to day shift work to give myself more of an accomplishment. So starting a PA residency, and dividing my time has helped quite a bit." This participant was involved in running an educational PA program, which helped to create diversity in his/her work demands, thus diminishing the potential for burnout.

All of the participants above explained how investing time and work into the promotion of the PA profession was a significant way to be creative, diverse and involved in the collective medical field. Reinvesting energy into the betterment of PA profession

helped to prevent, and cope with workplace burnout for these participants.

Life-work balance. When questioned on balancing a home life and a work life, many of the participants noted that having a healthy separation benefited their abilities to perform as a PA. A common theme these participants mentioned from personal experience was how the lack of workplace separation was directly correlated to a PA's burnout level in the workplace. Participants mentioned that some fellow PAs are "married to their work," or "too involved with work" and miss out on family or home life events. The participants noticed how putting career gains ahead of personal enjoyment results in burnout among colleagues, and have thus have attempted to avoid the same fate.

One participant put up strict boundaries on contacting him/her outside of working hours. This participant expressed, "I make sure my staff knows unless it an absolute emergency they shouldn't reach me. I don't want emails from corporate showing up in my inbox, and when they do, I do not look at them". Without this separation, this PA felt overwhelmed with the daunting ideas of completing work outside of work hours, which inevitably would cause burnout.

Other participants stated that being a PA is only part of their identity, and that they must be well rounded outside of the work environment to excel in that role. "Being able to focus on my priorities as a parent, and a friend, and a spouse is very important. I always am very honest with myself on what my priorities are". Another participant shared that mentally or physically bringing work home is important to avoid by stating, "It's so key that people need to be able to go to work, do their job, come home, and be able to leave work at work".

Another participant was grateful for the environment instilled at his/her place of employment because it encouraged and allowed PAs to step away routinely. He/she said, "... us PAs are able to pretty much just turn it on and off; when we're there and when we're not. It's

nice to finish the shift and walk out and not really think about the job or any responsibilities until it's time for the next shift". This participant recognized how keeping a separation between work and home life reduces stress in both of these environments, thus reducing capacity for burnout.

These participants voiced in agreement that having a concrete separation between home and work life is imperative to being a successful, happy and effective PA. Many have seen firsthand how blurring this separation can result in a sense of workplace burnout, because both personal and professional aspects are competing for primary attention. Many participants have been proactive in choosing to provide barriers to help establish successful separation. Stepping away from work, both physically and mentally, allowed these participants to avoid burnout and actually feel like they were "better PAs because of that".

Conclusion

In conclusion, ten PAs were interviewed and asked about their personal experiences with burnout in workplace environments in an attempt for the researchers to understand the cause and effect of burnout among the PA profession collectively. This was done by performing analysis of burnout in three dimensions: what factors contribute to workplace burnout for PAs, what symptoms of burnout are PAs experiencing and how are PAs coping with burnout. Participants were asked to reflect and answer honestly on their personal experiences with workplace burnout in attempts to answer the three research questions. The participants' dialogue was analyzed, coded, and organized into the most prevalent and dominant themes and presented throughout this chapter in that matter. The dominant focus of this researched attempted to highlight potential factors that contributed to burnout among the PA profession, and was segmented into business, patient care and scope of practice factors to highlight specific mechanisms that make PAs feel burnout. Of the ten PAs interviewed, all admitted to experiencing at least one symptom of

burnout as defined by the researchers as emotional exhaustion, depersonalization or decreased sense of personal achievement. Nine mentioned feeling emotionally exhausted, four mentioned feeling a sense of depersonalization towards patients, and eight felt a decreased sense of personal achievement. Many participants shared positive coping and preventative measures for burnout among the workplace. The results found in this chapter are analyzed and compared to existing literature as outlined in Chapter 2.

Chapter 5: Discussion

Introduction

This chapter will discuss deeper conclusions that can be derived from the results in

Chapter 4. Findings in this research study will be compared to the existing literature for similarities and differences discovered, as well as novel ideas that this research study uniquely added. The findings to be compared and contrasted are outlined in the context of the three research questions. The questions investigated causes of workplace burnout, the symptoms of burnout being experienced by PAs, and the coping mechanisms and strategies used by PAs. The limitations of this study, as well as suggestions for future research will also be discussed.

Discussion of Findings

Research question 1. The first research question addressed in the study were the following: What symptoms of burnout are PAs experiencing? During the interview, PAs were asked if they felt any of the three symptoms of burnout, being emotional exhaustion, depersonalization, or a lack of personal achievement. If they directly said they felt a symptom in response to the question, or stated they felt a symptom in a response to another answer, that PA was said to have reported feeling that symptom of burnout. In the study, of the 10 PAs interviewed nine of them felt some degree of emotional exhaustion, four of them stated a sense depersonalization, and six of them mentioned some degree of lack of personal achievement. This study's methodology showed that many PAs express some degree of emotional exhaustion, with a little over half expressing some degree of lack of personal achievement, with the fewest experiencing depersonalization.

Although many studies exist looking at burnout for other professions, there are few studies that have looked at levels of burnout for PAs. One study specifically highlighted emergency medicine PAs, and revealed high rates of depersonalization and emotional exhaustion, with lower levels of lack of personal achievement (Bell, Davidson & Sefcik, 2002). In comparison, this study did not echo the same results because it showed a much higher

evidence of lack of personal achievement. Both illustrate a high rate of emotional exhaustion, but in Bell, Davidson and Sefcik's study, the data showed much higher levels of depersonalization, and less decreased personal achievement. Bell, Davidson and Sefcik's study however only focused on emergency medicine PAs, which is only one area of medicine, whereas this study looked at all specialties. This difference may be due to the data collection method and methodology of their study, as Bell Davidson and Sefcik's study was a quantitative survey.

Levels of burnout among doctors showed a similar trend. According to a 2008 study in the UK, about 40% of physicians felt emotional exhaustion, 35% felt depersonalization, and 32% felt a lack of personal achievement (Soler et al., 2008). Once again, this showed that doctors have higher levels of emotional exhaustion and depersonalization rather than lacking personal achievement. In comparison to the PAs interviewed for this study, the PAs had higher rates of emotional exhaustion, and a higher amount of lacking personal achievement as compared with depersonalization. Once again, the differing methodology of the other study could be contributing this effect. Due to the ability to expand on answers in an interview format, PAs interviewed may have been more likely to express symptoms of burnout when compared to a survey.

Overall, this study showed that PAs are experiencing high levels of emotional exhaustion, with significant levels of decreased personal achievement. In comparison to the doctors, PAs have a lessened rate of depersonalization in comparison to the other factors, but a much larger lack of personal achievement. Bell, Davidson and Sefcik's study also burnout also differed from this study, with depersonalization as the primary symptom of burnout and lack of personal achievement not as prevalent of a symptom. Overall, the data being compared is difficult to derive conclusions from due to the differing methodologies and populations of the studies.

Research question 2. The existing literature suggested that employees do not experience burnout in response to one stressful factor in the workplace but rather to several factors working in concert (McCormack & Cotter, 2013). Therefore, the research questions were carefully crafted to best identify the potential factors that contribute to workplace burnout for PAs. The primary research question addressed in the study was the following: What patient care, scope of practice, and business factors are contributing to burnout among PAs? The research confirms the notion that burnout is not a result from one isolated factor, but rather a compilation of factors. Therefore, this section is broken down into three sections, as outlined in the research question, to highlight and compare the participants' answers outlined in Chapter 4 with the existing literature established in Chapter 2.

Existing literature had revealed identifiable factors that contribute to employees' burnout as the following: increased workload, lack of rest and rejuvenation in the workplace, age and years of experience, personality types, physical environment, and lack of autonomy. However, this literature was not strictly selective to PAs or even the medical environment in general, as there are no current studies that address potential factors of burnout to the specific field of PAs as this research study does.

Patient care. When questioned about patient care factors, common themes emerged from participants' responses: patients were becoming more demanding and medically complicated, while PAs had limited time to spend caring for these patients. Collectively, all of these factors cause an increased workload for PAs. All of the PAs interviewed mentioned an increased workload as a particular cause for feeling workplace burnout. Therefore, it can be safely implied that workload has a direct correlation to a PA's level of burnout. Specifics are highlighted below.

Existing literature argued that burnout is specific to the workload and time constraints placed on employees (Burke and Richardson, 1996). This research study strongly agreed with these as dominant causes for workplace burnout for PAs. Participants mentioned that they were seeing more patients in a day than they were comfortable with, or were working longer days than they felt they could handle. This made participants "feel overworked", and therefore drained, which McCormack & Cotter, suggest is the leading cause of burnout in today's society because the "pace is unremitting" (2013). When workplace demands are high, burnout lingers closely (Shanafelt et al., 2012). Physician assistants interviewed for this project also voiced that the job of a PA is demanding because there is a large responsibility when caring for livelihood of a patient. Add on the stipulations of a fast paced environment to the stress of caring for another person, and there is no room for mistakes. The pressure of great patient outcomes, with a large time constraint, made PAs feel stressed and directly contributed to any burnout they experience.

This research study revealed that with increasing medical complexity of patients, difficult medical decision making results, and treatment goals are less likely to be met. On top of this, add the fact that patients have unrealistic expectations from PAs. The literature reviewed revealed a study involving primary care physicians in which frequent contact with medically demanding patients not only leads to imminent burnout levels, but exacerbates their burnout over time (Schaufeli, Maassen, Bakker, & Sixma, 2011). This research study echoed this phenomenon as participants stated that the expectations of the patients in respect to realistic outcomes was draining. Patients expect high quality medical outcomes from their providers, with many of them not putting in the effort to achieve such outcomes. The misalignment between provider outcome goals and patients' ability to meet said goals, resulted in participants feeling workplace burnout. This study showed PAs truly care about their patient's care goals,

and when the patients do not meet their care goals PAs experience a sense of burnout.

Research findings from this study confirmed the literature that intense workload and heavy demands among the time constraints of the fast paced environment of American medicine have direct links to PA burnout. In fact, this research study suggested that extreme workload for PAs may be the primary source for burnout. No participant in the research was immune to the effects of workload contributing to burnout.

Business factors. The specifics of the business factors that PAs experience are relatively unique, compared to other medical professionals. These included increased office work, the complexity of charting, and increased managerial and non-PA related duties. However, there is a universal agreement that increased administrative demands take focus away from patient care hours, which is the primary role of a PA participants stated. This shift in focus was thought to be the source of burnout for the participants. Although the existing literature does not highlight these specific factors expressed by the participants, it does agree that misalignment in values between employees and employers contributes to burnout. Gregory and Menser's study on burnout in primary care physicians (2015) found that congruence in values between the physician's own value and the organization or employers' value contributes to burnout. Similarly, when the participating PAs felt that patient care was compromised secondary to their organizations' structure, this was a compromise in their values, and thus contributed to sensing workplace burnout.

Scope of practice. When questioned about scope of practice factors, a common theme among participants was the underutilization of PAs collectively. Three sub-themes emerged from the participants' dialogue: inadequate patient recognition, limited scope of practice, and a

hindered voice in administration decisions. In essence, these boil down to PAs sensing a lack of trust from the patients, providers, and communities they serve.

In the existing literature, Leiter (2005) suggested that workplace control is less about how and when the job is performed, but rather is a state of leeway that employees experience. Employees who feel in control at their job are more likely to "influence their workload, rewards, social interactions, and institutional justice" (Leiter, 2005, p. 132). Autonomy has been directly linked to an employee's sense of control, and subsequently, an employee's sense of burnout. Workers who feel that they lack autonomy are at a greater risk for experiencing burnout (McCormack & Cotter, 2013). Lack of control can take on a variety of forms: micromanaging managers, lack of collaborative decision making or reciprocity and sense of inability to address organizational problems (Maslach & Leiter, 1997). A diminished sense of control was supported again to be a key contributor to burnout by data in Gregory and Menser's 2015 study of primary care physicians. Gregory and Menser state, "The data collected in this study fit the model first presented by Leiter and Maslach" (Gregory & Menser, 2015, p. 143), meaning the three criteria for burnout were further being established.

Other factors. Literature review argued that professionals who enter the field at a young age may suffer from burnout later in their careers because they lack adequate professional preparation and analyzation of their chosen field (McCormack and Cotter, 2013). This research study included PAs with a wide range of year in practice. Since all participants expressed some degree of experience with workplace burnout, this study's methodology does not allow us to state that years of practice was a contributing factor to burnout.

The existing literature's suggestion that certain personality types are more prone to sense burnout could not be directly correlated in this research study, as no participants explicitly stated

that they were "type-A workaholics," as described by Roberts (1997). However, through careful dissection of participants' answers, it was easy to sense that many personality traits were similar among the group. Most participants described wanting more variety, responsibility, and autonomy for PAs in the medical field in order to avoid sensing burnout. This inherent draw to career advancement, or stressful situations, is a character trait described by Casserly and Megginson as employees who are "high fliers" (2009). Also, to summarize, participants mentioned that a great source of burnout was when there were barriers to providing high quality medical care for patients; if expectations were not met, the participants felt as though they had failed. Although not studied in this research, the PA profession may attract many high-achieving and driven personalities, which may also contribute to burnout. This inherent desire to expand career skills, and achieve high standards of patient care, may be personality traits that PAs have, and potentially contribute to burnout.

All ten of the participants suggested that they experienced at least one dimension of burnout throughout their PA careers. Existing literature provided information that the nature of the career has direct correlation to the burnout levels themselves. McCormack & Cotter (2013) explained that medical personnel who are exposed to unwell patients and diagnoses are at an increased risk of suffering from emotional exhaustion, which is a key element to burnout. The fact that this research study focused on PA burnout, could explain why all ten participants experienced burnout, and nine agreeing it was in the form of emotional exhaustion.

Research question 3. This research study addressed Research question 3 by asking participants what strategies they use to cope with burnout. Reinvestment in the PA profession in the forms of attending continued CME conferences and participation in legislative advocacy for

PAs was a common response from multiple participants.

Several of the PA participants expressed that CME conferences helped to revitalize energy and passion for the PA field. Existing literature stated that burned out individuals have essentially lost the idealism that they once had about their role and services when they first started out in their careers (Schaufeli et al., 2011). The responses from participants about the benefits of CME conferences as a way of preventing and coping with burnout align with that concept of protecting one's idealism for their role and sense of purpose in their career.

Similarities were also revealed in this research that correlated with patterns observed in the current literature involving professionals who "become disenchanted with their work" as a consequence of burnout (McCormack & Cotter, 2013). The PAs interviewed in this research study shared personal strategies that directly address this exact issue of becoming jaded with one's work, and how they intentionally try to prevent that from happening. One of the participants stated, "Doing continuing education revitalizes your energy and interest in the specialties of a desired field." Another interviewed participant shared, "I find it very important to look for educational experience like CME…to give us a fresh look at why we're doing what we're doing." Attending presentations on topics that are most exciting to the individual PA's personal interests helped to rekindle a sense of purpose and remind that individual of why s/he went into their chosen field in the first place. The participation in CME conferences was felt by several participants to be very beneficial, and uplifting. Participants were re-engaged and re-enchanted once again by the positive aspects of their medical calling.

Investing time in advocacy for the PA profession, especially through legislative participation, and spending time with the wider PA community were common ways that participants in this study have successfully re-established their sense of purpose in times when

they were battling burnout. These participants expressed that working with professional groups on behalf of the PA population at large was a source of pride and reward. This sense of community accomplishment and serving the greater good of the PA profession helped these participants from feeling burnout in their day to day PA careers.

In this study, none of the participating PAs directly mentioned any "peer-support programs" such as the ones discussed in the existing literature. As discussed in Chapter 2, an evidence-based study at Brigham & Women's Hospital in Boston had implemented a formal one-on-one peer support program for their employed physicians, which received very positive feedback (Hu et al., 2012). While no formal peer support meetings were mentioned by participants, it was clear many participants find strength to combat burnout through participating in the larger PA community, such as MAPA and CME conferences. This investment of time with fellow PA colleagues offered a strong source of comradery, morale, and support. Time spent with others who truly understand the same demands and stresses of the job brings an uplifting sense of comfort to people in knowing they are not alone in their struggle. Maslach's extensive existing literature stated, "Whatever the format, the social and emotional support provided by peers can be critical for survival on the job" (2003, p. 183). Peer support could very well be the reason why so many participants mentioned involvement with the PA community outside of regular work hours, as one of their top strategies for combating their feelings of burnout.

The second most common theme in participants' answers to coping with burnout was the practice of finding separation in of work and home life, to be emotionally and mentally present in both environments. Specific strategies that the participants used to accomplish work-life balance included finishing charting at work, as well as setting clear boundaries with the employer for expectations of calls and emails outside of hours. Prioritizing family, friendships,

and self-care was consistently expressed as being essential to being a happy, well-rounded, and successful PA.

Multiple participants mentioned these measures to safeguard against burnout because they have witnessed first-hand the negative toll that burnout took on colleagues. This common theme revealed in the interviews aligns with the patterns found in the existing literature that was previously reviewed. Existing literature suggested that employees who fail to establish boundaries between the career and home aspects of their lives were more prone to burnout. Existing literature revealed that employees who derived too much of their identity from their role at work in comparison to their personal and home lives faced higher rates of burnout (McCormack & Cotter, 2013). Another study described the phenomenon of many employees just accepting the belief that emotional and personal sacrifices are an expected part of the job (Casserly and Megginson, 2009). Those employees were reported to have a greater struggle in finding work-life balance, and thus higher rates of burnout symptoms were experienced among them. The existing literature was not specific to PAs; however, this research study revealed that the same boundaries between work and home-life are essential to PAs

This research study suggests that PAs need to establish healthy boundaries between work-life and home-life, just like the physicians and other employees who were observed in previous studies. This similarly emphasizes the need for increased resources in the future offered by employers to aide medical providers, including PAs, in building strategies to establish better work and home-life separation. Many participants have been proactive in choosing to provide barriers to help establish successful separation. Setting work aside both physically and mentally, when it was time to be at home or with family, allowed these participants to feel refreshed in order to perform better in the PA role and to cope with burnout.

Limitations

Several limitations were present in this study. One of the limitations was the limited sample size of the study. Due to limited access to PAs, the sample was limited to past, present or future preceptors for the Bethel PA program. Physician assistants who are or have been preceptors potentially have different levels of burnout than non-precepting PAs, which is a factor that was not accounted for in this study.

The second limitation was with the PAs' definition of burnout. Although definitions of burnout were provided, definitions and experiences of the PAs interviewed are all subjective in nature and may have differed from the original intent. Furthermore, as this was an interview, PAs may have elaborated more on their definitions or their experiences than other PAs causing it to be difficult to collate every experience into comparable data. These differences between subjective opinions and experiences caused it to be difficult to design a study that would equalize subjective experiences and personal definitions.

A third limitation was with the honesty of each PA's answer. The PAs interviewed were made aware that each interview would be recorded and analyzed. Although each quote was made anonymous, and the PAs interviewed were aware of this fact, some PAs may not have been completely honest due to fear of being discovered. Also, as the subject of workplace burnout is a sensitive topic, many people may not have felt comfortable sharing their true feelings despite the assurance of anonymity.

Suggestions for Further Research

If this study were repeated, recommendations would be made to further enhance and narrow the focus of the study. One area of recommendation would be to focus the scope of

the study. This study dealt with all PAs of all specialties, as well as PAs of different ages and amount of years worked. Looking at one specific area of the population would allow for more targeted information and causes of workplace burnout. Areas such as specific specialties, specific age groups, or specific ranges of time spent practicing as a PA are potential areas for further research.

Another suggestion includes looking at one specific cause or symptom of burnout more specifically. This study looked at three potential realms of possibilities for causes of burnout, business factors, patient care factors, and scope of practice issues. Isolating one of the areas in more depth may give more focused results. Similarly, this study highlighted three symptoms of burnout: emotional exhaustion, depersonalization, or lack of personal achievement. Choosing only one area may also help tailor the results to a more specific cause for a specific symptom.

One further area of research could be specifically done on the coping mechanism aspect of the study. This study briefly asked about the coping mechanisms these participants used to deal with burnout, but more research could be done on the effects of the proposed coping mechanisms. Studies could look at the effectiveness of each method, popularity of each method, or accessibility to methods of burnout prevention in future studies.

Conclusion

Physician assistants are growing to become an ever important part of the medical community, therefore it was integral to investigate workplace burnout for this profession at large.

Physician assistants are necessary to offset a heavily burdened and short-staffed medical system ("What is a PA,", 2012) and demand may outweigh availability by 20 percent in the year 2025 (Punke, 2011). Although there has been a large volume of existing literature for other medical professions experience with workplace burnout, there was very little research regarding the causes and effects of workplace burnout specifically for PAs. This study aimed to look at potential factors that contribute to workplace burnout, how PAs experience symptoms of workplace burnout, and coping and prevention mechanisms for said workplace burnout. Emotionally health and satisfied PAs are essential in maintaining a functioning healthcare system.

The dominant focus of this research was intended to highlight potential factors that contributed to burnout among the PA profession, and was further segmented into business, patient care and scope of practice factors. Of the ten PAs interviewed, all admitted to experiencing at least one symptom of burnout as defined by the researchers as emotional exhaustion, depersonalization or decreased sense of personal achievement. Despite workplace burnout dominating the PA profession, many PAs engage in positive coping and preventative measures. Therefore, further research studies are needed to address more specific causes, factors and coping mechanisms in order to maintain a healthy and satisfied PA profession. Efforts to support the energy and well-being of PAs will be crucial in preventing them from experiencing the same burnout as the physicians with whom they work with.

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APPENDIX A:

Email Permission to Contact Preceptors

From: Cindy Goetz
Sent: Monday, June 26, 2017 10:47 AM
To: Connor Sacks
Subject: Permission for preceptor contact

Hi Connor,

You have been provided a listing of preceptors that can be contacted for your research. I give you permission to contact them in regards to your Master's research project.

Sincerely,

Cindy

Cynthia Goetz, MPAS, PA-C
Assistant Professor | Physician Assistant Program
Bethel University | Graduate School
3900 Bethel Drive, St. Paul, MN 55112
651.638.6747 office
612-581-3830 cell
651-287-0824 fax
http://www.bethel.edu/graduate/academics/physician-assistant

APPENDIX B:

Initial Email Contacting Participants

Appendix B:

Initial Email Contacting Participants

Hello,

We are three graduate students in the Bethel University Physician Assistant program. We are currently conducting a research project in fulfillment of our Masters thesis.

We have taken a keen interest on the subject of professional burnout. There is currently very little research on burnout as it applies to the PA profession. We are looking to interview currently practicing PAs about any experiences they've had with burnout, past or present.

We are contacting you to respectfully request your participation in our interview. The interview is estimated to be approximately 12-15 minutes in length, and conducted via phone at a time and location of your convenience in which you feel comfortable talking about the subject of burnout as it relates to the PA profession. Any personal information gathered from the interview will not be reported in the final report and will be kept confidential.

Attached you will find our letter of informed consent which explains more about the study. If you would like to participate, please read our letter of informed consent. If you would like to participate please state in an email that you have read the letter of informed consent along with any possible times you would like to be interviewed. Suggested times include the following:

- Monday -Thursday: before 9 AM, lunch hour, after 5 PM
- Friday- Sunday: Anytime

If you have any further questions about the interview or interview process, or wish to participate in the study, please respond to this email or email one of the researchers at the addresses provided below for further information. We highly appreciate your time and look forward to speaking with you soon.

Thank you,

Connor Sacks, PA-S (cws47295@bethel.edu)
Tiffany Mellang, PA-S (tim54445@bethel.edu)
Sarah Leonard, PA-S (sfl44966@bethel.edu)

APPENDIX C

Letter of Informed Consent

APPENDIX C: Letter of Informed Consent

You are invited to participate in a study of physician assistant work-life balance and physician assistant professional burnout. We hope to learn more about possible professional factors contributing to professional burnout in the physician assistant profession. You were selected due to your career as a PA and your relationship to Bethel University or the researchers. This research is for the completion the Physician Assistant program at Bethel University.

Participation is completely voluntary for the study. If you decide to participate, we will interview you about physician assistant professional issues including work-life balance and professional burnout. The interview will be conducted via phone. The purpose of the interview is to gather insight on factors contributing to professional burnout and work-life stress. The interview will take approximately 12-15 minutes. The interview will be recorded. After the interview is completed, the recording will be transcribed electronically on a password protected computer, and the audio recording will be destroyed. We ask for the interview to be completed in one sitting. Sensitive information you may be asked about may include talking about work-life balance and possible challenging aspects of your professional career. Due to this consideration we ask that the interview be done in a setting in which you feel comfortable and safe expressing the above items. Therefore, we suggest that you choose a secure location in which you feel comfortable. There is a potential risk of personal identifying information being viewed, but due to precautions outlined below it is not above negligible risk.

Any information obtained in connection with this study that can be identified with you, or could be used to contact you, will remain confidential and will be disclosed only with your permission. In any written reports or publications, no one will be identified and only aggregate or non-attributable data will be presented, such as non-attributable quotes with no identifiers or generalized themes and concepts from the interviews being reported. Transcripts, audio recordings, contact information, email correspondence and any other documents or items containing personal identifying information will be stored in a locked office within the Bethel University PA Program offices for a minimum of five years past the point of completion after which they will be discarded. Any questions involving the handling of personal identifying information may be directed to one of the researchers or the research chair, Dr. Boeve. If a person were to request earlier disposal of any personal identifying information, that request will be granted as soon as possible. If a person were to withdraw from the study prior to completion, any item containing their personal identifying information would be deleted or shredded as soon as possible, with any information from those items withheld from the final report.

Your decision of whether or not to participate will not affect your future relations with Bethel University in any way. If you decide to participate, you are free to discontinue participation at any time without affecting such relationships.

This project has been reviewed and approved in accordance with Bethel's Levels of Review for Research with Humans. If you have any questions about the research and/or research participants' rights or with to report a research-related injury, please call:

Connor Sacks, PA-S, Researcher: (952) 847-3302
Tiffany Mellang, PA-S, Researcher: (612) 710-1273
Sarah Leonard, PA-S, Researcher: (602)-762-1344

Wallace Boeve, PA-C Research Chair: (651) 635-1013

You will be provided a copy of this form to keep.

You are making a decision to participate in this study. We ask that you email the researchers at the email initially used to contact you stating that you have read and agree to the letter. The email will indicate you have read the information within this letter and have decided to participate. We will ask for oral consent again during the time of the interview should you be interested in participating. You may withdraw at any time without prejudice after agreeing to this form should you choose to discontinue participation within this study.

Signature of Investigators:

Connor Sacks, PA-S
_____

Tiffany Mellang, PA-S
_____

Sarah Leonard, PA-S
_____

APPENDIX D

Interview Script

APPENDIX D: Interview Script

Interview Script

Introduction Script:

Hello, thank you for helping us explore and research burnout in the careers of PAs. Our research team respects and greatly appreciates your personal insights that you share with us.

We have contacted you based on a list of PA Preceptors from the Bethel University PA Program with given consent to contact you, or via personal or professional relationships with the interviewers. We are conducting a recorded phone interview. The recording will be transcribed at a secure location immediately after the interview ends. The audio will be destroyed and the transcript will be kept on a password protected computer. After publication the transcripts will be held in a secure, locked file in the Bethel University PA Program until five years after publication in which they will be destroyed. No personal identifying information such as names, email addresses or dates or place of employment will be published in the final report.

We will exclude your name from documentation of this interview. In your responses, please exclude the name of your employer, clinic, or health company, for anonymity purposes. If you mention any identifiers during the recording, we will exclude that information in the final transcript. You reserve the right to skip any question if you wish not to answer it, as well as stop anytime. If you choose not to complete the interview, you will not affect your relationship with the researchers or Bethel University.

Do you have any questions? Do you still wish to participate in the interview? Are you in a location in which you feel comfortable conducting the interview? If so, we will begin the interview.

Conclusion Script:

Thank you for your time and participation in this study. If you have any further questions, concerns, or wish to withdraw from the study please let us know via the contact information provided to you on the letter of informed consent. Once again, thank you for your time and contributions to this project.

APPENDIX E

Survey Tool

APPENDIX E: Survey Tool

Demographics

How many years have you been practicing as a PA?

In what specialties/areas of medicine have you worked? Any favorites?

What does your average work week schedule look like?

Factors Contributing to Burnout

As you think about what job burnout means to you, can you identify any patient care factors that may have caused you to experience workplace burnout?

(if examples needed: patient demographics, limited appt. time, navigation in helping underinsured patients)

Can you identify any scope of practice factors that may have caused you to experience workplace burnout?

(if examples needed: co-signature requirements, privileging requirements)

Can you identify any factors within the business side of your professional environment that may have caused you to experience workplace burnout?

(if examples needed: EMR, coordination with administrators, satisfaction surveys)

Components of Burnout and Factors:

<u>Depersonalization</u>

Have you ever experienced a sense of depersonalization with your patients? What do you think caused you to feel this way?

<u>Emotional Exhaustion</u>

Have you ever experienced a sense of emotional exhaustion from your work? What do you think caused you to feel this way?

Personal Achievement

Have you ever experienced issues with being appropriately recognized as a provider with your patients? Colleagues? Community you serve?

Has there ever been a time when your job failed to provide you with a sense of fulfillment? What do you think caused you to feel this way?

Do you find satisfaction and a sense of accomplishment in your day to day role?

Coping with burnout

When you think about what workplace burnout means to you, have you found any mechanisms for coping with burnout?

Have you felt the freedom to voice your concerns or ideas in the workplace?

APPENDIX F:

IRB Approval Letter