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Multi-specialty Physician Online Survey Reveals Burnout Related to Adverse Event Involvement May be Mitigated by Peer Support

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Abstract

Objectives: Involvement in adverse events can negatively impact physician well-being. Because burnout is increasingly recognized as a threat to patient safety, we examined the relationship between physician adverse event involvement and burnout as well as facilitators and barriers to support among physicians experiencing burnout.

Methods: We surveyed physicians in the U.S. who are members of the networking platform, Doximity. We conducted quantitative and qualitative analyses investigating experiences with adverse events, the impact of adverse events, the type of support the physician sought and received after the event, and burnout.

Results: Across specialties, involvement in an adverse event and burnout was common. Most respondents involved in an adverse event experienced emotional impact, but only a minority received support. Those reporting that the error resulted in emotional impact were more likely to experience burnout (AOR: 1.90, 95% CI: 1.18–3.07); this association was mitigated by the most common form of support sought, peer support (AOR for burnout among those who received peer support vs. those who did not: 0.65, 95% CI: 0.52–0.82). Barriers to support after an adverse event include punitive culture and systems factors such as administrative bureaucracy. Facilitators that emerged include peer, professional, and spiritual support, mentorship, helping others, the learning environment, and improved/flexible working hours.

Conclusions: Physicians who experienced emotional repercussions from adverse events were more likely to report burnout compared to those who did not. Respondents proposed barriers and

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facilitators to support that have not been widely implemented. Peer support may help mitigate physician burnout related to adverse events.

INTRODUCTION

Physicians involved in adverse events and medical errors experience negative emotional consequences well described in existing literature as the “second victim” effect.[1,2] Psychological impacts of adverse events on physicians are well-documented,[3] and shame and secrecy about mistakes remains prevalent in physician work culture. Experts have developed peer support programs for physicians involved in adverse events,[4] but their implementation remains incomplete.

Our prior research suggests a link between the physicians’ adverse event involvement and physician burnout.[5] Burnout is known to be a critical patient safety concern; organizations including the Institute of Medicine are calling call for action to reduce burnout and improve support for those experiencing it.[6,7] Given that burnout among U.S. physicians is increasing and burnout may lead physicians to cut down clinical time or leave the practice of medicine altogether,[8] further study of interventions that may mitigate the potential impact of error involvement on burnout is warranted.

Few studies have jointly investigated the impact of adverse events, burnout, and support. Therefore, we conducted the largest multispecialty physician survey to date to characterize the relationship between involvement in adverse events and burnout, our primary outcome. We hypothesized that physician involvement in adverse events would be common and burnout would be more prevalent among those who had experienced an adverse event related to patient care. We examined whether support might mitigate the negative emotional impact of adverse events on physicians.

METHODS

Design

We conducted a cross-sectional online survey study. On July 31, 2019, we posted a brief article on the second victim effect (Figure 1) on Doximity, an online physician networking platform founded in 2011 (San Francisco, CA). The article also invited readers to anonymously participate in a short survey to capture frontline physician perspectives about involvement in adverse events, burnout, and support. The article included a link to the survey hosted by Zoho (Chennai, India). The survey link remained open for two weeks.

Participants

The Doximity professional medical network is wide-reaching, with approximately 70% of the physicians in the United States as members.[9] In 2018, Doximity membership exceeded one million medical professionals spanning roles, training stages, and specialties.[10] Doximity verifies the identities of its members upon joining.

Main Measures/Approach

The survey included questions about respondent demographics, experiences with adverse events, the impact of the adverse events on the respondent, the type of support the respondent sought and received after the event, and burnout (Appendix 1).

In addition to the characteristics included in Table 1, we also asked respondents for zip code. We intentionally did not collect participant gender or race/ethnicity to minimize risk of re-identification. Additionally, we asked respondents the approximate number of hours worked per week.

To identify participant involvement in a medical error, we used a dichotomous question, "Have you ever made a medical error or experienced an adverse event when caring for a patient?" We chose not to explicitly define these terms for respondents to capture a wide range of experiences. Additionally, we did not ask for a time frame of the mistake, as previous research demonstrates that involvement in a medical mistake across a career can have lasting effects and the temporality of a mistake and its association on burnout was not an outcome of interest.[5]

Participants who responded "Yes" to involvement in an error or adverse event were then asked, "Did this experience have an emotional impact on you?" They were given the option to respond Yes/No and to report when in their career the event occurred (in medical school, in residency/ fellowship, in practice as an attending). Following this, we asked if respondents received any support after experiencing the mistake, Yes/No. Those who responded "Yes" were asked to indicate types of support received or sought out from a structured list (informal support from peer colleagues; discussion with supervising colleague; formal support from healthcare organization/ place of work; professional counseling; discussion with a chaplain or religious figure; discussion with a spouse or partner, or personal friend; legal counseling; other).

We assessed burnout using the single item burnout question (validated against the Maslach Burnout Inventory) from the widely used Mini Z Burnout Survey.[11,12] The question is worded: Using your own definition of "burnout," please select one of the answers below. Survey respondents were given the following options to select from: 1) I enjoy my work. I have no symptoms of burnout. 2) I am under stress, and don't always have as much energy as I did, but I don't feel burned out. 3) I am definitely burning out and have one or more symptoms of burnout, emotional exhaustion, etc. 4) The symptoms of burnout that I'm experiencing won't go away. I think about work frustrations a lot 5) I think about work frustrations a lot. I feel completely burned out. I am at the point where I may need to seek help.

At the end of the survey, respondents were also given the options to respond with free text to the question "Is there anything else you would like to share?"

Analysis

For the analysis, we dichotomized the responses to the burnout questions, comparing respondents with at least one symptom of burnout, symptoms of burnout that do not go

away, or complete burnout to those who responded with no symptoms of burnout out or stress and reduced energy without burnout. We used logistic regression models to examine the relationship between experiencing emotional impact of an adverse event and burnout, adjusted for years in practice, practice setting (suburban vs. urban vs. rural), training versus non-training practice site, and specialty. For the subset of respondents who reported an adverse event with emotional impact, we further examined whether there was an association between type of support received and burnout, adjusted for the same factors listed above.

Two of the authors (KC and NG) collected data from Doximity and exported data from Zoho to Excel. One author (NR) conducted statistical analysis using SAS software, version 9.4 (Cary, NC).

We qualitatively analyzed free text responses to a question, “Is there anything else you’d like to share?” (n=388). The study team developed an inductive coding scheme to categorize responses. Inductive coding entails approaching the data without a prespecified coding schema (such as used in deductive coding), allowing researchers to identify themes that emerge directly from the data.[13] Using this approach, two of the authors (KG and SL) jointly coded 38 of the 388 free text responses using Excel. They then independently coded an additional 48 until they reached high inter-rater reliability (agreeing on 91% of categories). A third author (US) helped resolve disagreements. KG then coded the remaining 302 responses independently.

In qualitative responses, respondents commented on contributors to and factors protective of burnout, facilitators and barriers to receiving support after an adverse event, as well as mention of adverse events, second victim experiences, and malpractice more generally. The study team decided to exclude responses in which the respondent provided a text response but did not provide any detail relevant to the question (e.g., “No”) as well as comments providing feedback on the survey itself, rather than describing their own experiences.

The Committee on Human Research at the University of California, San Francisco, reviewed and certified this study (18–2463).

RESULTS

There were 3,436 unique views of the article with 2,728 clicks on the survey link. From the 2,728 who clicked on the survey, 1,808 completed it for a participation rate of 66% (52% of users who saw the article completed the survey). Physicians across a wide range of specialties participated in the survey (Table 1). Most respondents reported at least some burnout (1006/1808, 56%) and reports of burnout were prevalent across all specialties (Figure 2). Reports of involvement in an adverse event (overall, 1372/1808, 76%) were widespread across all specialties, and the majority of respondents involved in an adverse event experienced negative emotional impact (1292/1372, 94%, Figure 3).

Of those who experienced emotional impact related to an adverse event, a minority (350/1292, 27%) reported receiving any type of support (Figure 4). The most common type of support respondents sought out was informal support from a colleague, or peer support, as this form of support is commonly called (272/350, 78%). In adjusted analyses,

those reporting that an error had emotional impact on them were more likely to experience burnout (AOR: 1.90, 95% CI: 1.18–3.07). The adjusted association between emotional impact and burnout was mitigated by peer support (AOR for burnout among those who received informal peer support vs. those who did not: 0.65, 95% CI: 0.52–0.82). None of the other types of support was significantly associated with differences in burnout (data not shown).

Twenty-one percent of respondents provided free text responses to the final survey question, “Is there anything else you’d like to share” (388/1,808). We excluded 29% of responses (111/388), including a total of 277 in our qualitative analysis (277/388, 71%) for the reasons described in the Analysis section above. Twenty-eight percent of respondents described a medical mistake/ adverse event in this section (78/277), 78% wrote about their experiences with burnout (216/277), and 15% included in their response the support they sought out, received, or wished they had received (41/277). Thirteen percent of respondents to this question said they had retired or quit as a result of the mistake, adverse event, and/ or associated experience following it (36/277).

Experiences with burnout described in more depth by this subset of respondents pertained to core themes of involvement in an adverse event or mistake, fear of making a mistake, involvement in a malpractice lawsuit, negative work culture, training, and lack of support (Table 2). Additionally, while some respondents described burnout stemming from involvement in a mistake, many experienced burnout because they anticipate making a mistake. For example, one respondent said, “…Also, while I feel that adverse events are certainly a contributing factor to burnout, the FEAR of an adverse event and the responsibility of preventing those takes as great of an emotional toll.” Concern about malpractice lawsuits was common among other respondents. Another said, “There are 2 separate issues that have affected me: an adverse event I was responsible for and an adverse event that I had no responsibility for but was sued for. The lawsuit has a much greater negative affect lasting many years.”

Respondents cited lack of support generally and on a systems level (Table 2). Broad statements about lack of support - such as “Have been entirely unsupported after traumatic events in the clinic. Glad I quit” – indicate a broad need for meaningful support after adverse events across respondents. Some described lack of support specific to health care systems. For example, one respondent said, “I feel like my employer and most health networks don’t care. I feel like a replaceable employee just like anyone else. I do not feel valued, supported, or listened to by administration and this includes physician leaders.”

We also categorized responses that described barriers and facilitators of support (Table 3). Facilitators that emerged include peer, professional, and spiritual support, mentorship, helping others, the learning environment, improved working hours, and work-life balance. Barriers include punitive culture and systems factors such as administrative bureaucracy, technology, and certain aspects of organizational culture.

When speaking about facilitators of support, informal support from peer colleagues came up in many responses. One respondent wrote, “I found solace in settling a malpractice suit from

the expert witness depositions given by [colleagues] I knew who recognized my [dilemma], had experienced it themselves but empathetically noted, that at the 'fork in the road' of my decision-making, I took the wrong road. I felt that I had been fairly judged by my true peers and that gave me great comfort." Respondents also pointed towards other factors creating a more supportive working environment including reduced or flexible working hours and vacation time, with one writing, "Need more doctors and better working hours. And good ancillary staff. But who am I kidding it will never happen in my life time so might as well move to a different country. I feel the only way to practice a balanced life and medicine is impossible in my field in this country. When you compare Europe or Scandinavia they are way ahead of the US in terms of more balanced life style."

With regard to barriers, themes of punitive culture as well as systems issues emerged frequently. Some described a lack of institutional support due to the punitive culture of medicine, such as this respondent: "'Discussion with a supervising colleague wasn't, in my case, a form of support for me. It was presented by my supervising colleague as [solicited] by risk management, and I perceived it as a quality review and not support." Another commented on how this punitive culture may inhibit seeking support: "It never occurred to me to try to seek help for my feelings due to the stigma of having made an error." Systems issues cited frequently included administration and bureaucracy, including the role of technology, as well as the organizational culture. One respondent remarked, "EMR [electronic medical record] systems need to be designed by doctors, not payers. The extra hours and huge volumes of mindless, repetitive documentation hides important information, perpetuates errors and adds a lot to burnout. Burnout doesn't go away after retirement, it affects all aspects of life, causes a type of PTSD: 'Post chronic stress disorder.'"

DISCUSSION

This study represents one of the largest surveys of U.S. physicians across specialties about involvement in adverse events, the associated emotional impact, and the nature of support received. Although emotional impact from an adverse event was common and receiving support seemed to mitigate burnout, most physicians did not receive any support, consistent with previous studies from the U.K. and Canada.[14,15] It is disheartening that most physicians involved in adverse events still do not receive support despite the every-growing body of evidence demonstrating the detrimental and lasting psychological impact of these events.

The negative personal and professional consequences for physicians experiencing adverse events has been well-described in the literature for many years.[6,16]. Despite this, the vast majority of healthcare institutions have not developed and implemented meaningful mechanisms for supporting impacted clinicians. The findings from this study underscore the urgent need for health systems to destigmatize the seeking of emotional support by physicians and to invest in developing formal structures and processes to provide meaningful support to physicians involved in adverse events, particularly peer support. In addition, healthcare systems would do well to measure the impact of such programs on physician outcomes, including the potential for reducing burnout and turnover.

To be meaningful, support programs at the institutional level must be proactive, incorporate a variety of mechanisms for support and be integrated into existing workflows related to adverse event review and risk management. Mechanisms for support should include peer support. Physician peers can be trained throughout the organization in various clinical areas to understand the second victim effect, what to say to impacted colleagues and how to provide support. They can also identify when to refer colleagues to more formal sources of support such as counseling, therapy, and existing employee assistance programs. Support programs must be accompanied by meaningful efforts to prompt culture change in healthcare.

Our qualitative results suggest that stigma, shame, and blame remain pervasive in health care culture. It will not be possible to support physicians through adverse events without normalizing the emotional reaction to adverse events, destigmatizing the seeking of support, and training leaders to better understand what physicians experience after an adverse event, error, or involvement in litigation. Several respondents reflected on events that occurred in training; these results underscore the importance of creating a positive safety culture in medical education as the foundation of a resilient professional identity.

Limitations

Although the respondents in this survey study represent a large total sample size, the number of responses for each question does vary. In addition, knowledge about the true denominator (how many Doximity users received an email about the article) and the likelihood that those who read the article represent a specific subpopulation (perhaps those more interested in burnout and errors) of a much larger group of physicians represent additional limitations of this study. Furthermore, responses to the questions could have been impacted by the opinions in the article. Despite these limitations, it is important to note that the percentage of respondents meeting criteria for burnout approximates national averages from other surveys.[7,8]

CONCLUSION

In our multi-specialty survey of physicians across the US, respondents who experienced emotional repercussions from adverse events were also more likely to report burnout. Among physicians who experienced emotional impact from adverse events, those reporting receipt of peer support were less likely to report burnout than those not reporting receipt of peer support. We conclude that involvement in adverse events is associated with burnout and that burnout prevention efforts should include providing meaningful emotional support to physicians experiencing adverse events. To date, discussions of how to address burnout have focused on both individual-level strategies to enhance well-being as well as changes to physician work demands including implementation of flexible work schedules[6]. Our work suggests that providing meaningful emotional support to clinicians after involvement in an error, adverse event or events causing traumatic emotional impact, may be a missing component of organizational strategies to enhance physician well-being.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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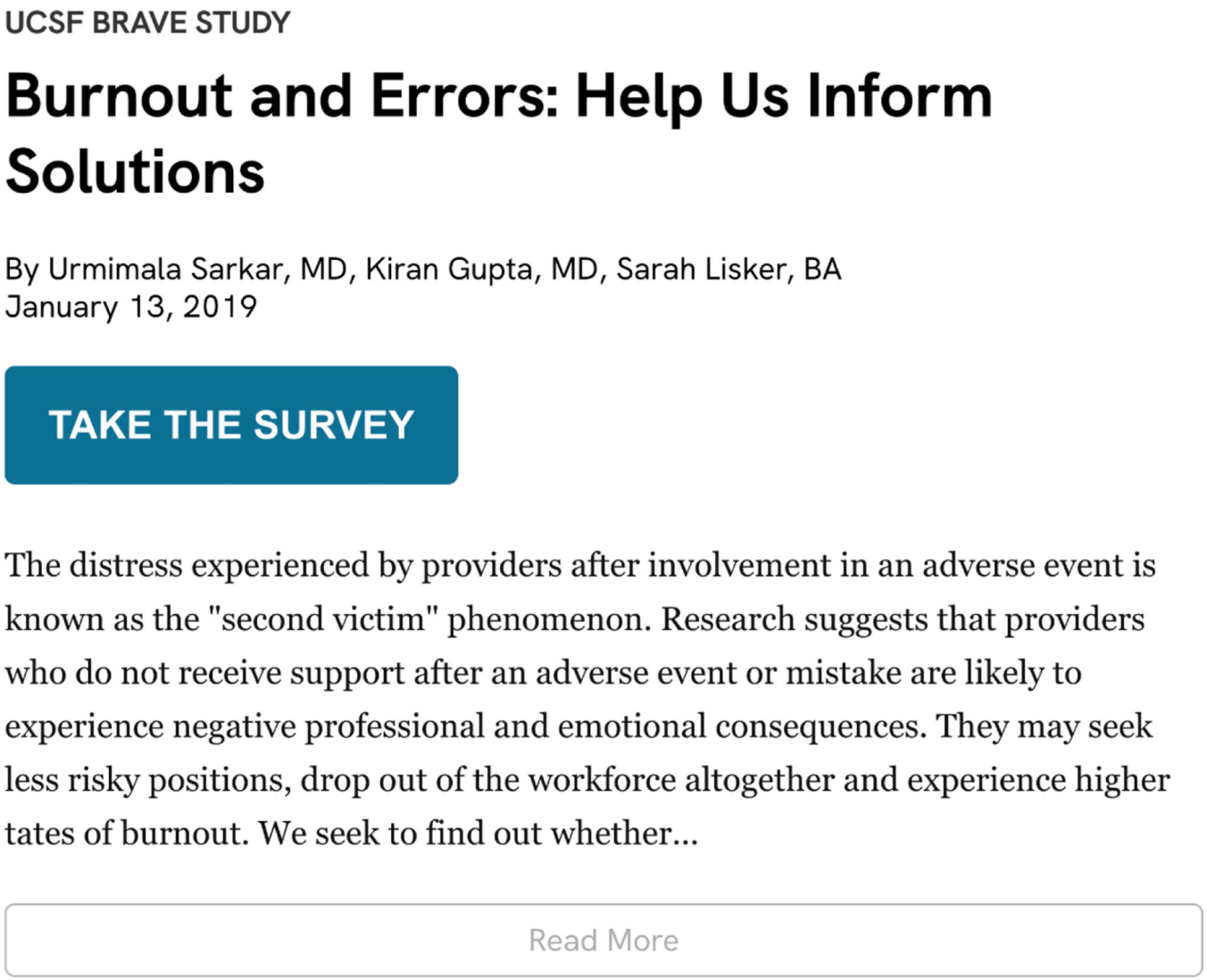

Figure 1.
Screenshot of article linking to survey

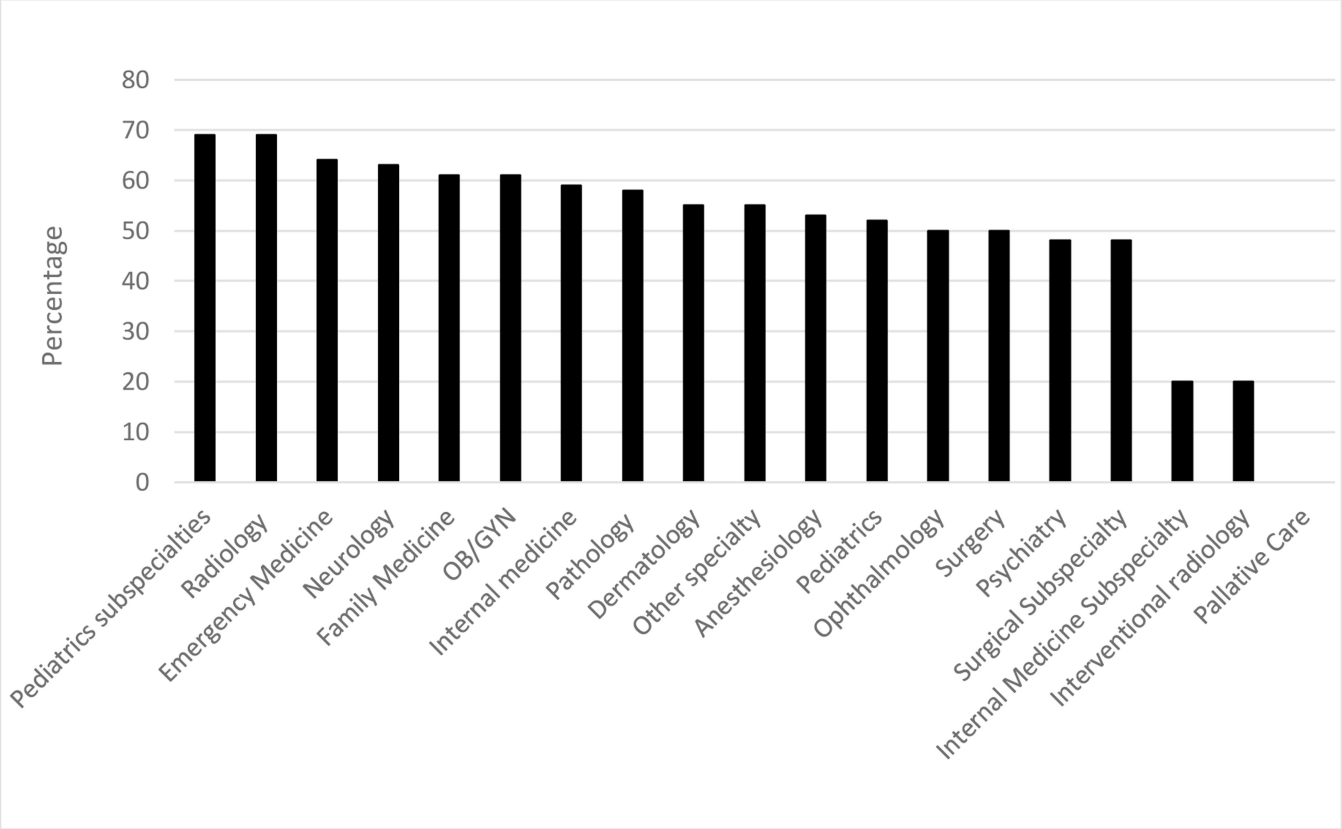

Figure 2.
Proportion of reported burnout (n=1006), by specialty

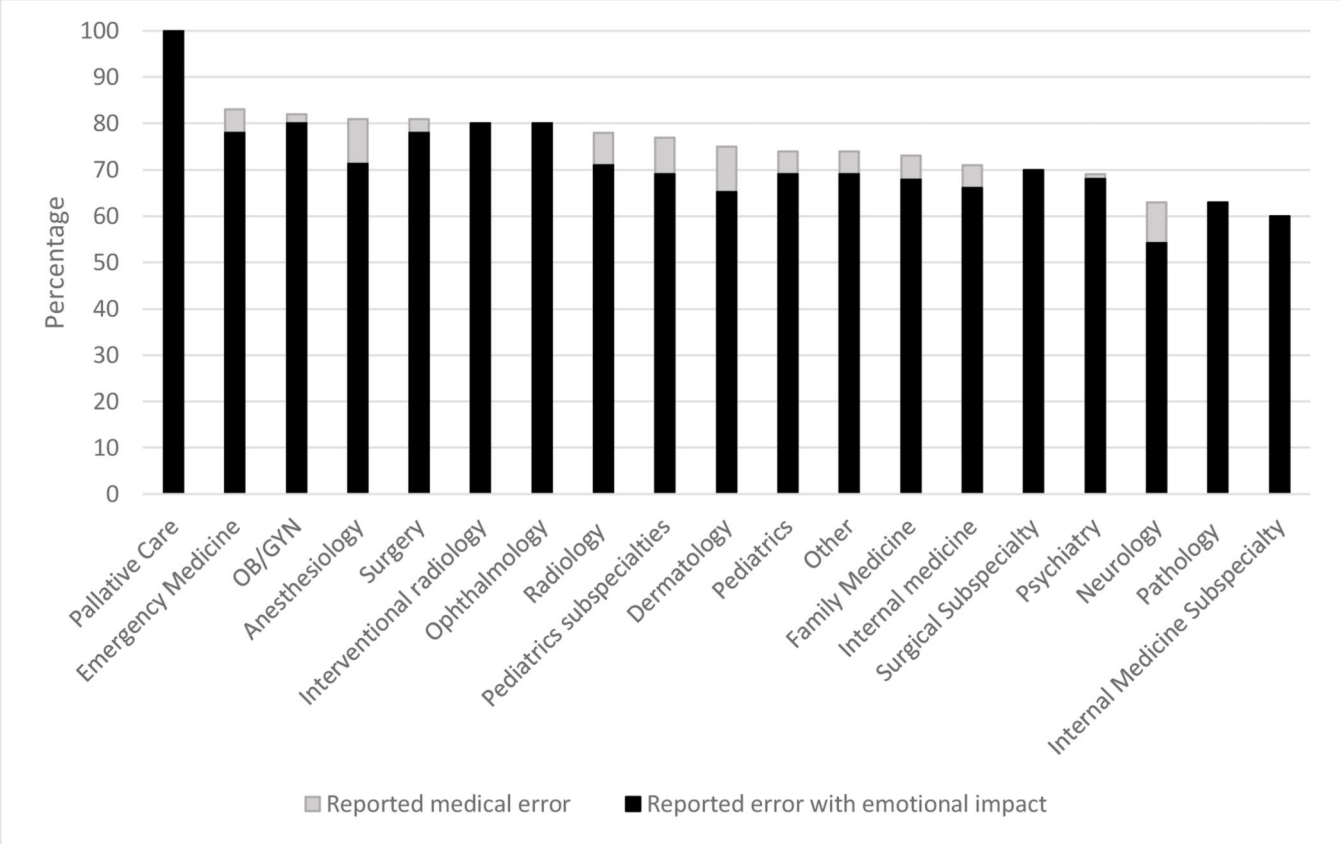

Figure 3.

Proportion of reported medical error (n=1372) compared to the proportion of emotional impact after medical error among respondents (n=1292), by specialty

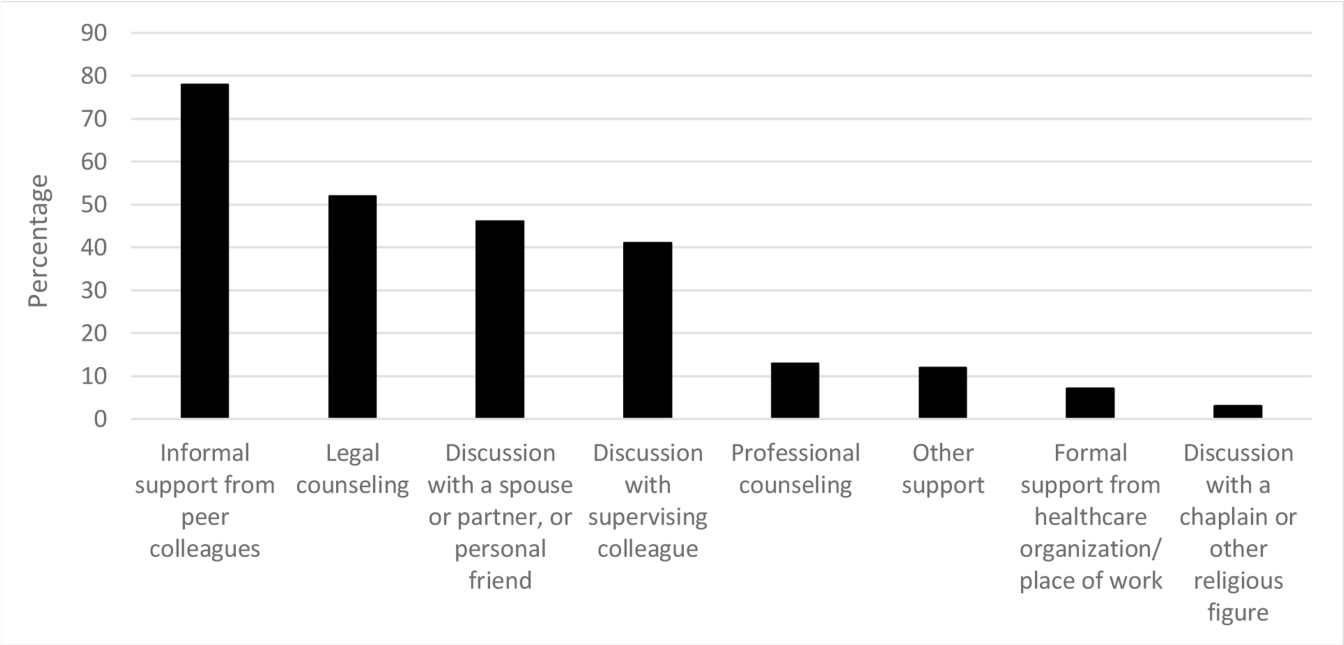

Figure 4.

Proportion of types of support received among respondents who reported emotional impact from medical error involvement, n=350

Table 1.

Clinician characteristics

	Total N=1808 (%)	Report Burnout N (%)
Practice Type		
Non Training Site	1034 (57)	579 (56)
Training Site	774 (43)	427 (55)
Practice Setting		
Suburban	712 (40)	385 (54)
Rural	242 (13)	140 (58)
Urban	854 (47)	481 (56)
Career Stage		
Trainee (student, resident, fellow)	149 (8)	81 (54)
Physician	1563 (86)	873 (56)
Retired	96 (5)	52 (54)
Years in practice		
Less than 5 years	324 (18)	170 (52)
5–14 years	380 (21)	244 (64)
15–19 years	228 (13)	140 (61)
20–29 years	477 (26)	277 (58)
30+ years	399 (22)	175 (44)
Specialty		
Anesthesiology	105 (6)	56 (53)
Dermatology	20 (1)	11 (55)
Emergency medicine	135 (7)	86 (64)
Family medicine	198 (11)	121 (61)
Internal medicine	173 (10)	102 (59)
Internal medicine subspecialty	5 (0)	1 (20)
Interventional radiology	5 (0)	1 (20)
Neurology	35 (2)	22 (63)
Obstetrics and Gynecology	101 (6)	62 (61)
Ophthalmology	46 (3)	23 (50)
Palliative care	5 (0)	0 (0)
Pathology	19 (1)	11 (58)
Pediatrics	167 (9)	87 (52)
Pediatrics subspecialties	13 (1)	9 (69)
Psychiatry	81 (4)	39 (48)
Radiology (Diagnostic)	51 (3)	35 (69)
Surgery	279 (15)	140 (50)
Surgical subspecialty	33 (2)	16 (48)
Other	337 (19)	184 (55)

Table 2.

Exemplary quotes demonstrating respondent experiences related to involvement in adverse events

Subtheme	Quote
Involvement in an adverse event/ mistake	"I believe the adverse event was a major factor in losing my job and later in getting me to switch specialties." "I've been fortunate to only make minor mistakes, yet they still trouble me greatly. I'm afraid what would happen if I were to make a serious mistake the injured or killed a patient. I have shied away from high-stakes learning opportunities as a result." "I have burned out nearly completely and stopped practicing…Bad outcomes were one part of multiple reasons I burned out several years ago. I still have lots of hatred and resentment for that time and my practice."
Fear of making a mistake	"I still practice in fear. Some days are better than others, but always waiting for the next adverse event." "I find that a lot of my burnout symptoms are not your typical. They mostly have to do with fear of hurting someone and the subsequent consequences such as law suits, etc." "Every day there are potentially hundreds of medical errors that I could make, and I find that EMR [electronic medical record] is not a reliable helper (flags the wrong contraindications but fails to flag things like antibiotics that will interact with current medications). The fear and mistrust lead to extra hours every week trying to run interaction checkers, but then still failing to account for consequences of long term use on certain medications. Very difficult for primary care to field all of this while managing a panel of over 2000 patients in 20 minute time slots. I'm surprised more errors don't occur."
Involvement in a malpractice lawsuit	"In my own personal experience my lawsuit directly led to me wanting out of a profession that I loved and worked hard at, but now the love and desire are gone. I will retire this January." "2 "malpractice" suits over [multi-decade] surgical practice career, each settled for minimal amount. There was no formal/ significant support system from my practice group—mainly spouse and legal dept. Definitely caused me to think of my patients more cautiously/guardedly from that point onward. And to prioritize myself & family higher, patients dropped in priority. It really shook my foundation and was stressful for some time, since I was caught by surprise by each lawsuit, and legal process ran its course over more than a year, as I recall."
Negative work culture	"I hate my boss. I work at a university as an employed physician. The beauracracy [*sic*] is exhausting. The physicians practice in fear of the director." "The practice I am in is very competitive. I would never ever feel comfortable talking to one of my colleagues about a medical error. I think that is one reason why I don't really enjoy my work."
Training	"I began to experience burnout when I was a resident. My husband was also a resident. We had our first child in medical school and second child during residency. My supervisors later told me they knew I was getting burnt out during residency but they did nothing to offer help or reach out during my training. They had an attitude of "just suck it up" or "we all had to get through this and so do you." I went [on] to start a [sub-specialty fellowship] and quit half way through because I was so burned out. During fellowship I continued to experience "second victim" syndrome because there were so many critically ill patients that I took care of and I made many mistakes along the way and had no way to work through hose mistakes or even learn from them. I quit my fellowship and now I practice General Pediatrics which was a hard transition because I loved [that sub-specialty]..." "As in intern I was the only doctor in the hospital that night, other than the ED docs who wouldn't go upstairs for any reason. A [patient] in the ICU was in septic shock. I had never done a rotation in an ICU before and so quickly ran out of ideas to treat [the patient]. It was a Saturday night and my supervisor was unreachable. Out of desperation I called an intensive care doctor who was not connected to the case. He graciously came in and we air lifted [the patient] to a tertiary care center. I never learned if [the patient] had survived. There was of course a meeting of the residency director et al but I was not included and only feedback I got was one resident quietly telling me I had done the right thing in calling the other doc. I developed a facial tic that night that lasted a solid week until the next Saturday, my day off."
Lack of support - general	"I really need to seek some help right now because I had [an] adverse event major surgical complication in March and have just been trying to deal with it myself." "A series of surgical complications lead to my current burnout period, even though it was not my fault. Dealing with patients who have had complications takes a huge emotional toll on physicians. Help should be available." "I wS [*sic*] shocked that no one reached out to me after the code event. I mean, we have a wellbeing committee but it seems like they must be focused on md s w drinking probs or major psych issues? I mean, why didn't I get counseling at work or space to vent that?" "Wish there were more support at the time."
Lack of support - systems	"In 11 years of private practice neonatology, I experienced too many adverse events. The "counseling" I received was to hurry up and move to the next patient because there was never enough time for anything." "What is considered a "medical error" is often just a negative outcome from 2 impossibly difficult choices with no right answer. As a doctor you accept this challenge and try to act in the best interests of your patients. Doctors are held to an impossibly high standard of being perfect. The stress of that reality and the fear of negative consequences of your actions from a financial and professional standpoint is a major driver of physician dissatisfaction and burnout. The harsh truth that a group of powerful professionals, ie lawyers, are financially incentivized to pursue so called "medical errors" is repulsive and disheartening to my colleagues and myself. As a physician you make difficult decisions and use your skill and knowledge in an attempt to help your patients. If a negative outcome occurs, you must exam your decision analysis and if you have done your best, you accept that medicine is an imperfect science and learn from your experience. Knowing that your judgement can be questioned at any time by persons with other motives than helping patients leads to a high level of stress, and physician burnout Until this system is rectified the current trends will continue."
Errors without patient harm	"I have been very lucky the patient had no adverse effects from the error. There is a wide variety of medical experiences which are extremely stressful for clinicians. Discovering one has made a mistake even with no adverse effects on the patient

Subtheme	Quote
	is 1. Patient or family decisions not to continue seeing the doctor, in the setting of failing to meet their emotional needs is another. And even inappropriate behavior by patients or patients families, when we can clearly see that it's inappropriate, still have a huge emotionally deleterious impact." "I prescribed the wrong dose of medication to a patient. No harm to patient, but worry about future errors and consequences."

Table 3.

Receiving support for adverse event involvement

Subtheme (facilitator or barrier)	Quote
Peer support (facilitator)	"The reason I do not currently experience burnout is I switched to a DPC [direct primary care] practice model. Three years ago, prior to the change, I was at the edge of suicide or disability. Disability or just walking away from the profession seemed like the only viable options until I discovered DPC. Now when I suffer because a patient suffers I get support from my DPC partner and the DPC community and my patients themselves, I'm no longer isolated by " the system"' "Seeing lack of support in my own institution, I started several initiatives including Schwartz Rounds. Others are working on peer mentoring initiatives. These do help address one problem, but burden of clinical time and lack of autonomy is harder to address."
Professional support (facilitator)	"While peers, supervisor, and spouse each have added critical support through these times, at all of the stages—student, resident and fellow, and in practice, professional therapy, with no supoenable [*sic*] records, has been invaluable." "I had a [toddler] code on the table in front of me, it wasn't my error but it was my case. My daughter was almost the exact same age. After 10 years of intense training and then almost ten years of being an attending while getting married, starting a family and having 3 kids, taking q3 call and working in an adverse environment (I had severe anxiety and PTSD from the event). After two years of counseling, I am making changes and maybe will drop to part time, I do can find it. I just need time to process being a parent, a high stakes attending, and have a moment to be human and restore the gas tank that gets sucked dry. If it was just forty hours a week and I wasn't a full time parent when I hit the door, if I wasn't dealing w a two Parent working situation, if I wasn't living in an area [with] such high cost of living, if I had some family support, if my boss didn't say things like, we've al [*sic*] been nursing mom's w[ith] babies who have croup, you don't have to wear it on your shoulder if it is happening.
Spiritual support (facilitator)	"spiritual support was very important for surmounting the negative impacts of the adverse event/ professional experience"
Mentorship (facilitator)	"Having a mentor discuss the case me would have provided encouragement."
Helping others (facilitator)	"I stopped operating in my mid 50s and moved to administration. I use my experiences to help others who are struggling or are second victims." "The road back from a patient demise is slow and painful, but in the end helping patients healed the hurt I felt from my error"
Learning environment (facilitator)	"Sentinel event meeting helped because all systems involved in leading to the event were reviewed, not just physician involvement. Also helped that patient was not harmed." "I think in the Hospitalist world sometimes you are not aware something could have been done differently after you have handed off the patient to a colleagues. I tried setting up a system where colleagues could get feedback - but either people are too busy or afraid of offending a colleague. Being able to reflect about what could have been differently would give you confidence the next time a similar situation arose. This would not be for m&m [morbidity and mortality] type adverse events but to improve regular care."
Improved working hours (facilitator)	"I work half time because I know I can't work full time without quickly becoming burned out. I'd rather make half the money and work more years than work full time and quit after just a few. I've worked full time and it's an unrealistic life for me." "Short staffing and too much clinical work with no protected time"
Work-life balance (facilitator)	"I think sometimes people need a change of scenary [*sic*] as in - trying something new. Work life balance needs to be sought." "I follow the European model - I protect my vacation time, and take at least 4 weeks a year. This allows me to re-energize, reconnect with my spouse, and is a vital component in protection from burnout." "I had the opportunity to change the focus of my work from clinical to administrative and then back to clinical over the years of my work. Also, I had 3 sabbatical leaves, one for a year and 2 for 4 months each."
Punitive culture (barrier)	"The system promotes penalizing those that ask for help. PHPs (physician health programs) have a sledge hammer approach to assistance or treatment. If you ask for help you will be stigmatized with a consent order and years of monitoring. This treatment plan is for those that self report and us no different than what a physician is subjected to for egregious offenses like prescribing for favors or inappropriate relationships with patients. The PHPs won't admit to this but survey those that have been entrapped by the system and you'll see a more realistic picture of the consequences of asking for help."
Systems – administrative bureaucracy (barrier)	"Experiencing/causing an error occurred at every step student/resident/attending. As an attending you feel far more responsible though. But those types of experiences are to be expected. We are human, medicine is often inexact. What I found frustrating (and if I had let it would probably have contributed to burnout) was the administrative burden of every. single. facet. of my workday. To the point that it seemed that as a trained professional you could not be trusted and you had no voice in the matter." "I have had 2 episodes of burn-out & am nearing my 3rd. If I can't avert the problem soon, I will be forced to retire earlier than planned. Both times before, I was able to find a position with fewer hours & what I thought would be less responsibility, but I currently have a clinic-only supposedly 40 hour work-week without hospital responsibilities & although I only see patients 36 hours/week, it takes me about 55 hours/week to finish all paperwork. This is crazy!"

Subtheme (facilitator or barrier)	Quote
Systems – technology (barrier)	"I have been a physician for 41 years, and enjoy talking with my patients, their families, and my coworkers; but all of the burdensome changes in medicine (especially EMRs) have taken their toll. I became a part time worker as soon as l became a mother, both to have a life outside of work, and to try to prolong my practice life, as full time work left me with no energy for anything else. My kids are now college age and just beyond; l had hoped to continue to work for several more years, but now dread picking up the next chart. I will be retiring in 2 months." "Feelings of frustration and burnout come more from constant time and performance pressure. Production over quality care and fighting against this. In addition to the frustration of the EMR and it's time consumption unrelated to patient care. I am considering leaving medicine and am probably at the peak of my career." "At my hospital, everything is dumped on primary care, leading to ever more administrative tasks, Computer work, and less time for patient care (although we are still demanded to give 40 hours weekly to direct patient care.)"
Systems – organizational culture (barrier)	"The academic medical system (the only one I know) is set up without regard for individual stress. It is a slight modification of the 19th & early 20th century system. It is inflexible, and does not truly acknowledge it itself is the cause. Any individual actions to really address reducing institutionalized stress, a. cost the system money and b. require acting outside the norm." "I do believe there are some cultural changes. As an attending one of my pediatric patients unexpectedly died during a [procedure], apparently due to another colleague's medical error. I burst into tears at the unexpected news. I was later chided for "unprofessional conduct". Wrapped up in this chiding was the fear of any reaction to a medical error. I think nowadays crying at a patient's death is acceptable behavior, but departmental and institutional fear is still rampant." "Looking back, years later, as a child psychiatrist, I should have been more proactive in seeking out support. At that time, the prevailing attitude was "pull yourself up by the bootstraps" and move on. The only comfort was an M and M review of the incident (child died), but nothing else. Hopefully times have changed, and there's more attention given to things that need more attention in our training and professional lives."