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Physician Burnout, Resilience, and Patient Experience in a Community Practice: Correlations and the Central Role of Activation

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Abstract

Clinician burnout and patient experience are important issues that are often considered separately. New measures of resilience may influence both. We explored relationships among clinician resilience, burnout, and patient experience. Analysis included 490 physicians who completed surveys measuring burnout and resilience (decompression and activation) and had at least 30 patient experience surveys available for analysis. Burnout was measured with 2 items from the Maslach Burnout Inventory (MBI) which were part of the organization's ongoing measurement of clinician experience. Resilience was measured with 8 items from 2 Press Ganey validated subscales related to clinicians' ability to decompress from work and their experience of feeling of activation and connection to purpose while at work. Clinicians reporting more frequent symptoms of burnout based on the MBI items reported less ability to decompress (r for individual measures ranged from $-.183$ to $-.475$, $P < .01$) and less feeling of activation (r for individual measures ranged from $-.116$ to $-.401$, $P < .01$). Individual elements of decompression and activation were significantly associated with patient experience. In terms of activation, feeling that one's work makes a difference (r ranged from .121 to .159, $P < .05$) and believing one's work to be meaningful (r ranged from .102 to .135, $P < .05$) were positively associated with patient experience with their care provider. However, elements of decompression such as being able to free one's mind from work (r ranged from $-.092$ to $-.119$, $P < .05$) and being able to disconnect from work communications such as e-mails (r ranged from $-.094$ to $-.130$, $P < .05$) were negatively associated with patient experience with their care providers. Patient and provider experience are intertwined in that clinician resilience is associated with both burnout and patient experience, but individual mechanisms of resilience may be beneficial for the clinician but not for the patient.

Keywords

burnout, decompression, activation, patient experience, community practice, medical practice

Clinician burnout and patient experience are challenges that are increasingly important to health-care organizations but often considered separately. More than half of US physicians have at least one symptom of burnout (1, 2), and studies of nurses also find high rates of burnout (3, 4). Multiple studies demonstrate that higher burnout rates among clinicians correlate with worse quality and safety, loss of productivity, and higher employee turnover (5–8).

Some studies have demonstrated relationships between clinician burnout and patient experience (9–11), though other work suggests that clinicians experiencing burnout may continue to provide high-quality care (12). Data on these relationships have been insufficient to dissect how clinicians' morale relate to patients' experiences.

In this report, we combine data on patient experience, physician burnout, and measures from subscales of a new tool for measuring "resiliency" in terms of the concepts of activation and decompression. "Activation" represents the

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notion of being able to be engaged with work, even when it is challenging, and to interpret one's work as effective and meaningful. Measures from the activation subscale address the extent to which providers are excited by and find motivation in their jobs. "Decompression" represents the extent to which clinicians can appropriately distance themselves from their work and experience a healthy mind-set when they are not at work. Measures of decompression assess the extent to which providers are able to "let go" and detach themselves mentally from their jobs when they are not actually working.

Our findings demonstrate relationships among individual components of decompression, activation, and burnout and reveal surprising interactions of how activation and decompression correlate with patients' experience.

Methods

Data from 2 quality improvement projects were combined for these analyses. All billing providers (physicians, physician assistants, and nurse practitioners) working within the Mayo Clinic Health System were eligible for the study. This included providers working at community practices across locations in Minnesota, Wisconsin, and Iowa and excludes Mayo Clinic destination practices in Rochester, Arizona, and Florida. Using the Mayo institutional review board (IRB) Human Subjects Wizard, the study was deemed to be exempt and did not require formal IRB review. Specifically, the IRB exemption was granted because the study was based on "Research involving study of existing data, documents, records, or pathological or diagnostic specimens."

Provider Experience Measures

Providers were surveyed via e-mail between September 12, 2016, and October 4, 2016. Providers were invited to participate after receiving communication from Mayo Chief Medical Officers, which alerted them that they would be e-mailed a short survey related to burnout and provider experiences. Providers were informed that their responses to the survey would be administered by Press Ganey, meaning no person from the Mayo Clinic would be able to link responses to a provider. A file containing provider e-mail addresses, unique identification numbers, and clinician specialty was submitted to Press Ganey for administration of the survey.

Burnout was assessed using 2 items from the Maslach Burnout Inventory (MBI). The full-scale MBI has been validated for multiple professions (13). Single-item measures from the full MBI have also been shown to be useful predictors of elements of burnout (14). The 2 questions chosen had previously been validated (15,16) and were also part of the annual employee survey used at Mayo Clinic—"I feel burned out from my work" and "I have become more callous toward people since I took this job" (1,2). Both burnout items utilized the same 7-point scale, where higher scores indicate less favorable experiences (ie, more burnout) using the following anchors: 0 = never, 1 = a few times per year, 2 = once a month, 3 = a few times per month, 4 = once a week, 5 = a few times per week, and 6 = every day.

Provider resilience was measured using an 8-item instrument developed and validated by Press Ganey to measure resilience, which included subsections to measure decompression (Four items including *I rarely lose sleep over work issues*, *I am able to free my mind from work when I am away from it*, *I can enjoy my personal time without focusing on work matters*, and *I am able to disconnect from work communications during my free time*) and activation (Four items including *The work I do makes a real difference*, *My work is meaningful*, *I care for all patients/clients equally even when it is difficult*, and *I see every patient as an individual person with specific needs*). Items from the decompression and activation scales all utilize a 5-point agree/disagree scale, where: 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree. Items are worded such that higher scores indicate a more favorable experience.

In addition to items related to burnout, decompression, and activation, providers reported their gender, years in practice, and the proportion of their professional effort devoted to formal administrative responsibilities.

Patient Experience Measures

The Press Ganey Medical Practice survey was used to gather patient evaluations of their ambulatory care experiences as part of an ongoing quality improvement effort. This instrument includes subscales related to access (4 items), moving through your visit (2 items), nurse/assistant (2 items), care provider (10 items), personal issues (4 items), and overall assessment (2 items). The care provider measures, those asking the patient to evaluate interactions with their specific clinician, were used for this study. All survey items ask patients to evaluate an aspect of the care experience using a 5-point Likert-type scale, where higher scores indicate more favorable experiences using the following anchors: 1 = very poor, 2 = poor, 3 = fair, 4 = good, and 5 = very good. Raw scores were linearly converted to a 0 to 100 scale using the following transformation: Transformed score = (Raw score − 1) × 25. Subscale composites are calculated at the patient level as the average of items (using the transformed score) within that subscale.

The instrument was previously validated (17), with a revision and psychometric update in 2010. Principal component factor analysis with Varimax rotation was used to affirm the structure of the scales. Cronbach's alpha for the entire instrument was .97.

Patient evaluations of their experiences with Mayo Clinic Health System providers in the clinic setting are gathered continuously. Following an encounter with a provider, patient contact information is used to initiate the survey process. An initial random sample is selected to receive a mailed survey that is printed on demand and mailed within

24 hours of sampling. Any patient record not sampled for a mail survey immediately triggers the initiation of an e-mailed version of the instrument.

For this study, survey responses from patients who received care from a provider in the Mayo Clinic Health System between January 1, 2016, and December 31, 2016, were retrieved. Surveys were received from 84 411 patients across 1571 individual providers of 47 specialties. Patient-level responses were aggregated to the physician/provider level, with providers being retained for analysis if at least 30 patient responses were returned during the year.

Provider-level scores for each patient experience measure were summarized as the average transformed score for responses from patients who had been cared for by that provider. Provider-specific scores were then ranked against the Press Ganey national database to yield a national percentile rank for each measure based on the clinician's specialty. Patient experience results expressed as national ranks for the full year were linked to physician evaluations of elements of decompression, activation, and burnout collected during the September 12 to October 4 period based on the unique provider identifier, with the linking variable subsequently being removed from the data set. Of the 640 providers who completed the survey about their own experiences of burnout and resilience, 469 had at least 30 patient experience surveys returned and were retained for analysis.

Statistical Analysis

Burnout measures were summarized as categorical variables through frequency distributions for descriptive purposes. Clinicians' evaluation of their professional experiences (ie, elements of decompression, activation, and burnout) and patients' experience of their care (ie, evaluations of interactions with their care provider with their care providers) were treated as continuous variables and summarized using mean and standard deviation for the purposes of linking data and analyzing relationships. Two-tailed bivariate Pearson correlations were used to assess relationships among measures. All analyses were completed utilizing IBM SPSS Statistics version 22.

Results

Of 1371 providers invited to complete surveys, 640 completed the survey (46.7%), with respondents generally reflecting the gender and specialty distribution of the invited provider population (Table 1). Thirty-seven different subspecialties were represented among respondents, with family medicine being the most common (n = 255). The response rate for the patient experience surveys during this time frame was 22.4%, a rate comparable to the response rate reported (23.2%) for nationally implemented surveys (18). Based on an analysis of nonrespondents for visits occurring in the full year of 2016, respondents were more likely to be female, χ^2 (1) = 167.473, $P < .01$, older, χ^2 (5) = 19 811.396, $P < .01$, and white, χ^2 (3) = 1297.5909, $P < .01$ (Table 1).

Provider respondents reported a range of experiences related to burnout, decompression, and activation (see Table 2). Although the full set of providers were included in analyses, the results for family practice clinicians (the largest subspecialty represented) are included for comparison. For burnout measures, where higher scores indicated more severe symptoms, the total set of provider respondents indicated more experience of emotional exhaustion ("I feel burned out") than depersonalization ("I have become more callous"). Overall, 39% of participants reported emotional exhaustion and 18.9% of participants reported depersonalization on a weekly or more frequent basis.

For resilience measures, where higher scores indicate better experience of resilience, decompression measures had lower scores (mean score range of 2.90-3.34) than measures related to activation (mean score range 4.26-4.59) for the total provider sample. The lowest mean score among decompression measures was for being able to disconnect from work communications (2.9), whereas more higher scores were reported for being able to enjoy one's personal time (3.34). For the activation items, the highest scores were observed for seeing each patient as an individual with specific needs (4.59).

Relationships Among Provider Experience Measures

Relationships among provider experience measures were explored by correlating the Maslach burnout items with the decompression and activation measures (Table 3). The 2 dimensions of burnout, emotional exhaustion and depersonalization, were significantly correlated ($r = .639$, $P < .01$). Measures of decompression were all significantly correlated with each other. The strongest relationship was observed between the ability to free one's mind from work and not losing sleep due to work-related issues ($r = .607$, $P < .01$). Measures of activation were all significantly correlated with each other, with the strongest relationship between feeling that one's work makes a difference and that work is meaningful ($r = .844$, $P <. 01$).

Decompression measures were negatively correlated with emotional exhaustion and depersonalization, that is, providers who reported more ability to decompress also reported less frequent feelings of emotional exhaustion and depersonalization. All correlations were significant at the .01 level. Measures of decompression were more strongly associated with emotional exhaustion than depersonalization. The strongest negative relationships were seen between report of ability to enjoy personal time ($r = -.475$, $P < 01$) and being able to free one's mind from work ($r = -.455$, $P < .01$) with emotional exhaustion. Multiple regression using the enter method found that the 4 decompression measures explain a significant amount of the variance in emotional exhaustion, $F_{4,249} = 23.55$, $P < .01$, $R^2 = .27$, $R^2_{\text{Adjusted}} = .26$). However, only the items regarding rarely losing sleep,

Table 1. Demographics of Provider and Patient Respondents.

Characteristic	Attribute	n (Proportion of Total) for Respondents	N (Proportion of Total) for Population Sampled
Physician gender	Female	308 (48%)	653 (47.6%)
	Male	331 (52%)	715 (52.2%)
How many years have you been in practice?	0-4 years	110 (17%)	
	5-9 years	137 (22%)	
	10-14 years	98 (15%)	
	15-19 years	89 (14%)	
	20 years or more	202 (32%)	
How much of your FTE is devoted to formal administrative responsibilities?	None (0%)	312 (49%)	
	<.1 (<10%)	155 (25%)	
	.1-.29 (10-29%)	103 (16%)	
	.3 or more (30% or more)	63 (10%)	
Physician specialty	Family medicine	255 (39.8%)	512 (37.3%)
	Internal medicine	49 (7.7%)	139 (10.1%)
	Pediatrics	32 (5.0%)	80 (5.8%)
	Obstetrics/ gynecology	31 (4.8%)	82 (6.0%)
	Surgery, orthopedic	31 (4.8%)	67 (4.9%)
	Surgery, general	29 (4.5%)	58 (4.2%)
	Cardiovascular disease	27 (4.2%)	63 (4.6%)
	Neurology	23 (3.6%)	28 (2.0%)
	Other specialties	163 (25.5%)	342 (24.9%)
Patient gender	Female	53 856 (63.5%)	233 209 (61.6%)
	Male	30 954 (36.5%)	145 392 (38.4%)
Patient age-group	0-17	5770 (6.8%)	45 935 (12.1%)
	18-34	7271 (8.6%)	63 889 (16.9%)
	35-49	9821 (11.6%)	64 704 (17.1%)
	50-64	24 403 (28.8%)	80 151 (21.2%)
	65-79	28 727 (33.9%)	80 151 (21.2%)
	80+	8818 (10.4%)	25 446 (6.7%)
Patient race	Asian	542 (0.6%)	3854 (1.0%)
	Black/African American	271 (0.3%)	3579 (0.9%)
	White	81 824 (96.5%)	335 726 (94.0%)
	Other	2173 (2.6%)	15 445 (4.1%)

Abbreviation: FTE, Full Time Equivalent.

$\beta = -.21$, $t(253) = -2.91$, $P < .01$, and being able to enjoy personal time, $\beta = -.29$, $t(253) = -3.47$, $P < .01$, remained as individual significant predictors of emotional exhaustion. Similarly, the 4 decompression measures explained a significant amount of the variance in depersonalization, $F_{4,247} = 9.03$, $P < .01$, $R^2 = .13$, $R^2_{\text{Adjusted}} = .11$. With all 4 measures in the model, only being able to enjoy personal time, $\beta = -.32$, $t(251) = -3.39$, $P < .01$, remained as a significant predictor of depersonalization.

Activation measures were negatively correlated with emotional exhaustion and depersonalization, indicating that those who experienced more activation in their work reported less frequent symptoms of emotional exhaustion and depersonalization. Measures of activation were more strongly associated depersonalization than with emotional exhaustion. The strongest relationships were seen between belief that work was meaningful ($r = -.401$, $P < .01$) and that one's work makes a difference ($r = -.339$, $P < .01$) and report of feelings of depersonalization. Multiple regression using the enter method found that the 4 activation measures explain a significant amount of the variance in emotional exhaustion ($F_{4,249} = 9.66$, $P < .01$, $R^2 = .13$, $R^2_{\text{Adjusted}} = .12$) and depersonalization ($F_{4,247} = 14.54$, $P < .01$, $R^2 = .19$, $R^2_{\text{Adjusted}} = .18$). With all 4 measures in the model, only reporting work as being meaningful remained as a significant predictor of emotional exhaustion, $\beta = -.50$, $t(253) = -4.6$, $P < .01$, and depersonalization, $\beta = -.32$, $t(251) = -3.39$, $P < .01$.

The proportion of time the provider spends engaging in administrative duties was negatively associated with one measure of decompression and positively associated with 2 measures of activation. Providers with a larger proportion of their Full Time Equivalent (FTE) devoted to administrative duties reported less ability to disconnect from work

Table 2. Provider Burnout, Decompression, and Activation.

	All Providers			Family Practice		
Item	N	Mean or Valid %	Standard Deviation	N	Mean or Valid %	Standard Deviation
Burnout[a]						
Emotional exhaustion—I feel burned out						
Never	28	4.4%		6	2.4%	
A few times a year	150	23.4%		55	21.6%	
Once a month or less	69	10.8%		26	10.2%	
A few times a month	143	22.3%		54	21.2%	
Once a week	68	10.6%		32	12.5%	
A few times a week	116	18.1%		51	20.0%	
Every day	66	10.3%		31	12.2%	
Missing	0			0		
Mean score on a 0-6 scale	640	4.07	1.788	255	4.29	1.768
Depersonalization—I have become more callous						
Never	176	27.6%		52	20.6%	
A few times a year	194	30.4%		80	31.6%	
Once a month or less	68	10.7%		28	11.1%	
A few times a month	80	12.5%		39	15.4%	
Once a week	33	5.2%		14	5.5%	
A few times a week	61	9.6%		29	11.5%	
Every day	26	4.1%		11	4.3%	
Missing	2			0		
Mean score on a 0-6 scale	638	2.82	1.796		3.06	1.803
Decompression						
I can enjoy personal time	638	3.34	1.138		3.35	1.166
I rarely lose sleep	639	3.11	1.223		3.17	1.223
I can free my mind from work	638	2.97	1.175		2.98	1.204
Able to disconnect from work communication	639	2.90	1.314		2.83	1.286
Activation						
I care for patients equally	639	4.26	.771		4.21	0.761
I see patients as individuals	638	4.59	.544		4.57	0.556
My work makes a difference	637	4.36	.715		4.30	0.741
My work is meaningful	638	4.37	.719		4.30	0.747

[a] As assessed using the single-item measures for emotional exhaustion and depersonalization adapted from the full Maslach Burnout Inventory (MBI). Area under the receiver operating characteristic curve for the emotional exhaustion and depersonalization single items relative to that of their respective full MBI domain score in previous studies were 0.94 and 0.93, and the positive predictive values of the single-item thresholds for high levels of emotional exhaustion and depersonalization were 88.2% and 89.6%, respectively. Individuals indicating symptoms of emotional exhaustion symptoms weekly or more often have median EE scores on the full MBI of >30 and have a >75% probability of having a high EE score as defined by the MBI ($\geq$27).

Abbreviation: EE, Emotional Exhaustion.

communications ($r = -.164$, $P < .05$) but more feeling that their work made a difference ($r = .118$, $P < .05$) and that their work was meaningful ($r = .097$, $P < .05$).

Relationships Between Provider Experience and Patient Experience

Provider burnout and patient experience. Providers' scores for burnout, activation, and decompression were linked to patient experience metrics aggregated to the provider level to investigate potential relationships (Table 4). Unexpectedly, clinician emotional exhaustion and depersonalization were not significantly associated with patient evaluations of interactions with their care provider.

Provider decompression and patient experience. Clinicians' assessment of their ability to decompress was significantly associated with patient evaluations of many provider specific behaviors. These correlations were all negative, indicating that providers who reported greater ability to decompress had lower patient evaluations, including the global measures of confidence in the provider and likelihood of recommending the provider. Statistically significant negative relationships were found for 2 of the decompression measures—the ability to free one's mind from work and the ability to disconnect from work communications. Providers who reported greater ability to decompress from work in these domains had patient evaluation scores that indicated lower patient experience with respect to friendliness/courtesy, explanations of problem/condition, time spent with the

Table 3. Correlations Among Burnout, Decompression, and Activation.[a]

	Burnout		Decompression				Activation			
	Emotional Exhaustion	Depersonalization	I Can Enjoy Personal Time	I Rarely Lose Sleep	I Can Free My Mind From Work	Able to Disconnect From Work Communication	I Care for Patients Equally	I See Patients as Individuals	My Work Makes Difference	My Work Is Meaningful
Burnout										
Emotional exhaustion	1	0.639[b]	−0.475[b]	−0.363[b]	−0.455[b]	−0.269[b]	−0.116[b]	−0.147[b]	−0.231[b]	−0.334[b]
Depersonalization	0.639[b]	1	−0.327[b]	−0.225[b]	−0.272[b]	−0.183[b]	−0.198[b]	−0.196[b]	−0.339[b]	−0.401[b]
Decompression										
I can enjoy personal time	−0.475[b]	−0.327[b]	1	0.545[b]	0.738[b]	0.548[b]			0.132[b]	0.185[b]
I rarely lose sleep	−0.363[b]	−0.225[b]	0.545[b]	1	0.607[b]	0.395[b]			0.092[c]	0.166[b]
I can free my mind from work	−0.455[b]	−0.272[b]	0.738[b]	0.607[b]	1	0.554[b]			0.118[b]	0.180[b]
Able to disconnect from work communication	−0.269[b]	−0.183[b]	0.548[b]	0.395[b]	0.554[b]	1				0.083[c]
Activation										
I care for patients equally	−0.116[b]	−0.198[b]					1	0.467[b]	0.321[b]	0.308[b]
I see patients as individuals	−0.147[b]	−0.196[b]					0.467[b]	1	0.426[b]	0.405[b]
My work makes difference	−0.231[b]	−0.339[b]	0.132[b]	0.092[c]	0.118[b]		0.321[b]	0.426[b]	1	0.844[b]
My work is meaningful	−0.334[b]	−0.401[b]	0.185[b]	0.166[b]	0.180[b]	0.083[c]	0.308[b]	0.405[b]	0.844[b]	1
Prop of FTE admin duties						−0.164[b]			0.118[b]	0.097[c]

[a] Only statistically significant correlations are displayed. Shaded cells represent negative correlations.
[b] Correlation significant at the .01 level (2 tailed).
[c] Correlation significant at the .05 level (2 tailed).
Abbreviation: FTE, Full Time Equivalent.

Table 4. Correlations Among Provider Experience and Patient Experience—All Providers.[a]

	Burnout		Decompression				Activation			
Patient Evaluation of Provider	Emotional Exhaustion	Depersonalization	I Can Enjoy Personal Time	I Rarely Lose Sleep	I Can Free My Mind From Work	Able to Disconnect From Work Communication	I Care for Patients Equally	I See Patients as Individuals	My Work Makes Difference	My Work Is Meaningful
Friendliness/courtesy care provider					−.092[b]	−.094[b]			.137[c]	.113[b]
Care provider explained probability/condition					−.106[b]	−.113[b]			.159[c]	.135[c]
Care provider used clear language									.121[c]	
Care provider information re meds						-.118[b]			.129[c]	.103[b]
Care provider instruction for follow-up									.146[c]	.126[c]
Time care provider spent with you					−.095[b]	−.112[b]			.141[c]	.121[c]
Care provider concern for quest/worries					−.093[b]	−.100[b]			.141[c]	.113[b]
Care provider incl. you in decisions					−.119[b]	−.126[c]			.131[c]	.102[b]
Confidence in care provider					−.103[b]	−.125[c]			.153[c]	.111[b]
Likelihood of rec. care provider					−.104[b]	−.130[c]			.151[c]	.111[b]

[a] Only statistically significant correlations are displayed. Shaded cells represent negative correlations.
[b] Correlation significant at the .05 level (2 tailed).
[c] Correlation significant at the .01 level (2 tailed).
Abbreviations: incl, included; rec, recommending.

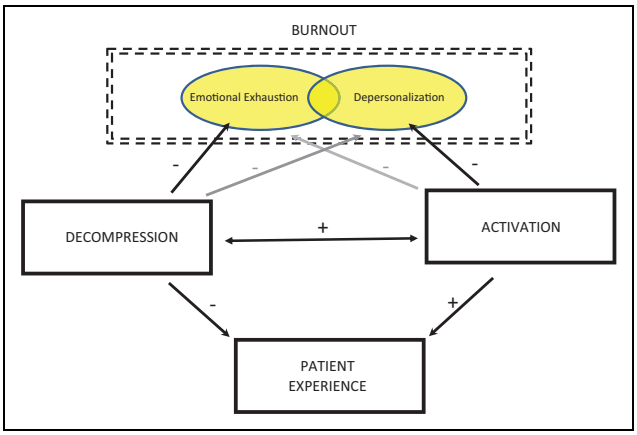

Figure 1. Relationship among constructs.

patient, provider concern for questions and worries, inclusion in decisions, confidence in the provider, and likelihood to recommend the provider (correlations ranged from $r = -.92$ to $r = -.130$, $P < .05$; Table 4). In addition, the decompression item evaluating the ability to disconnect from work communication was negatively related to patient evaluations of provider provision of information related to medication ($r = -.118$, $P < .05$).

Provider activation and patient experience. Two measures of clinician activation (My work makes a difference and My work is meaningful) were positively associated with the majority of elements of patient experience with their clinician, including the global measures of confidence in the clinician and likelihood of recommending the provider (Table 4). Clinician feelings of "making a difference" was positively related to patient evaluation of all care provider measures (all $P < .01$). Feeling that one's work is meaningful was associated with all patient experience measures (all $P < .05$) other than the item "Care provider used clear language."

Discussion

In this report, we demonstrate that providers' activation and decompression correlate with their levels of emotional exhaustion and depersonalization of burnout and that these different measures of physician experience correlate with patient experience in distinct ways (Figure 1). Providers who reported less burnout were more "activated" and had greater ability to decompress. The strongest of these relationships were between the emotional exhaustion dimension of burnout and providers report of their ability to decompress.

The interactions of these domains with patient experience were nuanced. While providers who were more activated had better patient experience scores, those who were better able to decompress from their work had lower patient experience ratings on multiple dimensions. Although enhancing both activation and decompression may be effective approaches for clinicians to reduce burnout, they appear to have differing relationships with the patient experience. The strength of the identified relationships were modest and patient evaluations of elements of physician care tend to be intercorrelated. Thus, it is the pattern of which specific measures of decompression and activation were related to patients' evaluations and the direction of those relationships that is notable.

These findings are consistent with but extend the results of previous investigations that demonstrate relationships between clinician burnout, patient experience, and quality of care (9–11). In addition to including a larger sample of patient experience data for a larger sample of physicians and providers, our study evaluates novel dimensions of clinician resilience (activation and decompression) and explores relationships not described in prior research. Indeed, the opposite ways in which activation and decompression impact patient experience suggest that not all approaches to mitigate burnout are created equal and that, in some cases, what is good for providers may have adverse effects on quality of care and patient experience. On the other hand, enhancing the sense of meaning that clinicians feel about their work might be associated with reductions in burnout *and* improvements in patient experience.

We did not find compelling evidence for a relationship between clinician burnout and patient experience in this cohort. One possible explanation is that providers who are experiencing symptoms of burnout may internalize those experiences but continue to provide sensitive care to patients, thus shielding them from the effects of those stressors. Nevertheless, provider report of decompression and activation was related to patient evaluations of clinician interaction. This supports the need for additional measures of provider experiences at work such as these scales of decompression and activation.

The findings of worse patient experience among providers who reported better ability to decompress raise questions that warrant further exploration. Findings suggest different mechanisms of relationships may be at play among the individual measures of decompression and patient experience. As previously noted, all measures of decompression were associated with provider experience of symptoms of burnout. However, only 2 of the 4 decompression measures (freeing one's mind and disconnecting from work) were negatively associated with patient experience. The other 2 decompression measures, which might reflect issues related to mental health (ie, not being able to enjoy one's free time and losing sleep), were not associated with patient experience. Thus, some elements of decompression may indicate clinicians' frustration with—and thus a level of disengagement from—their workplace that is perceived negatively by patients.

An important implication of these findings is that provider organizations should enhance the psychological rewards of patient care related to activation. This theme is consistent with a recently described framework for deconstructing burnout (17). This framework, in brief, outlines 3 critical focuses for health-care organizations seeking to reduce burnout: (1) decreasing the stresses that are external to patient care (eg, clerical burden, inefficiency created by the electronic medical record), which could lead to reduced ability to decompress; (2) enhancing the rewards that are inherent to patient care (eg, collaborative care teams that support and appreciated the efforts of other team members) to promote activation; and (3) improve the resilience of clinicians (eg, cultivating self-compassion, community, and meaning in work).

Our findings should be interpreted in the context of our study design. Survey responses from both patients and providers were voluntary. The data are derived from just one institution with one practice model and thus are of uncertain generalizability. Finally, the analyses described correlations, not the results of experiments, so cause–effect relationships are uncertain.

However, these data demonstrate that patient experience and provider experience are intertwined and that subtle yet important relationships exist between components of provider experience that are related to the overall problem of clinician burnout. A focus on innovations that enhance clinicians' activation is a particularly important focus for further research and organization efforts to improve care.

Author Contributions

DEM, TGH, and PP conceived and planned the study. DEM, TGH, THL, TS, and PP reviewed and refined the methodology. PP and DEM oversaw the gathering of data. DEM aggregated the data and conducted statistical analysis. TGH, DEM, THL, TS, and PP reviewed initial analysis, recommended further exploration, and reviewed and interpreted final findings. TGH, DEM, and THL wrote the paper with input from all authors. TGH, DEM, THL, TS, and PP reviewed and edited final paper.

Declaration of Conflicting Interests

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Supplemental Material

Supplemental material for this article is available online.

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