

Feasibility of Nonanonymous Burnout Surveys in a Large Academic Department

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BACKGROUND AND OBJECTIVES: Burnout is prevalent among clinicians and entails negative personal, professional, and organizational consequences. Assessments of burnout are typically anonymous to facilitate psychological safety. This limits the capacity of leadership to help struggling providers and reduces the level of demographic detail. Nonanonymous, confidential assessments may facilitate outreach to individuals or targeted interventions for at-risk populations.

METHODS: We administered the Maslach Burnout Inventory to physician faculty and advanced practice providers in an academic department of family medicine. We identified a wellness officer within the department who served as an honest broker to keep nonanonymous survey responses confidential. Respondents had the option of taking the survey anonymously or confidentially. Anonymous respondents were allowed to withhold demographic information to ensure anonymity.

RESULTS: Sixty-seven of 109 providers responded (61% response rate), with 46 (69%) doing so confidentially. Burnout rates were similar between groups: 48% among confidential respondents, and 43% among anonymous respondents ($P=.71$). Subscales of the MBI also showed no significant differences. Because a large proportion of anonymous respondents withheld demographic data, no demographic trends could be identified among them. Younger confidential respondents were more likely to exhibit depersonalization ($P=.01$).

CONCLUSIONS: Most participants chose to respond confidentially. There was no significant difference in the level of burnout between confidential and anonymous respondents. Our findings refute the conventional wisdom that clinicians require anonymity to respond to burnout surveys. This finding has the potential to open a new line of inquiry regarding burnout, its drivers and potential solutions.

(Fam Med. 2020;52(4):278-81.)

doi: 10.22454/FamMed.2020.471855

Burnout is characterized by exhaustion, cynicism, and inefficacy.¹ It has significant negative personal and professional consequences.² Burnout is frequent among clinicians.³

Burnout remains stigmatized and thus hidden by providers,⁴ and so is typically measured anonymously.⁵ Anonymous assessments are used

to create systematic interventions to address burnout.⁶ This approach has two important shortcomings. First, for surveys performed within an organization, true anonymity is threatened by detailed demographics.⁵ As such, organizations must choose between incomplete anonymity or incomplete demographics. Limiting demographic detail may reduce

knowledge of at-risk groups for targeted interventions. Second, no individuals can be contacted to discuss their issues. This reduces the ability of local leadership to assess individual drivers of burnout, generate custom solutions, and reassess the impact of interventions. A nonanonymous burnout survey might meet those needs.

Nonanonymous surveys assessing burnout have been used previously.⁷⁻⁹ Research suggests survey participants prefer anonymity for sensitive information,¹⁰⁻¹¹ yet other studies have demonstrated high response rates on nonanonymous surveys and willingness to share sensitive information.¹²⁻¹⁵ To our knowledge, no nonanonymous burnout surveys have been reported within an academic department.

We assessed the feasibility of conducting a nonanonymous burnout survey in a large academic department. We hypothesized: (1) most providers would respond anonymously, and (2) burnout rates would be higher among anonymous respondents.

Methods

The wellness officer was chosen on September 17, 2017, and announced to the department on January 5, 2018. Table 1 details wellness officer responsibilities. We administered

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the survey between January 5, 2018 and February 6, 2018. Participants were 109 faculty physicians and advanced practice providers (APPs) employed by the department of family and community medicine in a tertiary care university hospital system with 14 urban, suburban, and rural ambulatory clinical sites. Physicians provide inpatient coverage in two hospitals, and prenatal care and obstetrical care in one hospital. Faculty demographics at the time of the survey were 57 (52%) women, mean of 16.7 years since residency graduation (physicians), mean work effort 0.92 full-time equivalents, 34 (31%) associate professor or professor (APPs have no rank), 15 (14%) provide daytime in-patient care, 23 (21%) provide overnight in-patient call, and six (6%) provide obstetrical care.

We assessed burnout using a licensed copy of the Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI) online using REDCap. Overall burnout scores represent respondents in the top tercile of either the emotional exhaustion or depersonalization scales.¹⁶

The wellness officer informed participants that (1) nonanonymous responses would remain with the

wellness officer and would only be made available to others with their consent, and were thus referred to as “confidential”; (2) confidential respondents may be contacted by the wellness officer to discuss their results; and (3) anonymous respondents would be able to withhold any demographics through a “prefer not to share” option, while confidential respondents would be expected to share all demographics except race/ethnicity and relationship status (for which they also could “prefer not to share”). Anonymous respondents needed to be able to withhold demographics due to the local nature of this survey, where a few key demographics might allow identification of an individual. Respondents had the option to respond anonymously or confidentially after completing the burnout questionnaire.

We conducted descriptive statistics using the R software version 3.5.1 (R Foundation for Statistical Computing, Vienna, Austria) to generate a reproducible statistical report. We analyzed differential assessments of burnout between the confidential and anonymous groups. The R package `compareGroups`¹⁷ (version 3.4.0) was used to calculate and display the statistical results incorporating appropriate tests including

Kruskall-Wallis test for continuous data and Fisher exact test for categorical data.

Our institution’s review board determined this project to be exempt.

Results

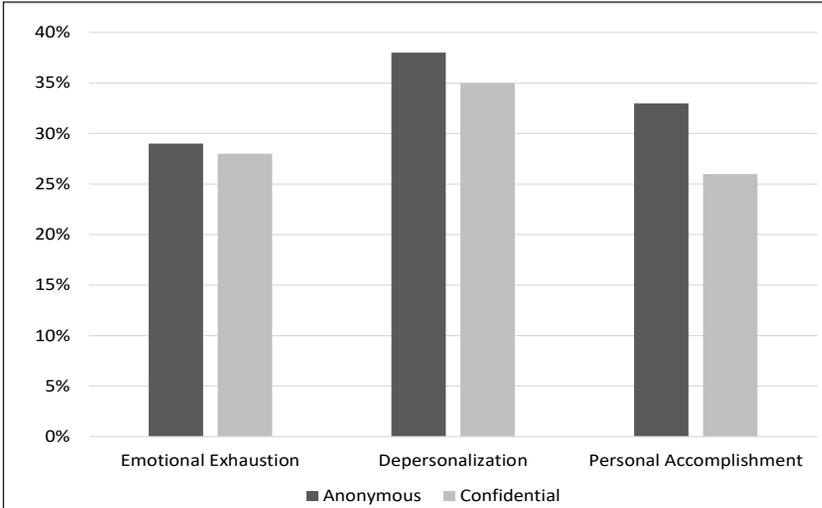
Sixty-seven of 109 (61%) participants responded. Responses were 46/67 (69%) confidential and 21/67 (31%) anonymous. The most complete demographic data among the respondents was for gender, with 26 (39%) male, 32 (48%) female, and no response 9 (13%), with no significant difference between respondents and faculty roster at time of survey ($P=.72$). No other comparisons on demographic features were possible.

Burnout rates were similar between groups: 22 of 46 (48%) among confidential respondents, and 9 of 21 (43%) among anonymous respondents ($P=.71$). Subscales of the MBI also showed no significant differences (Figure 1). No demographic trends could be discerned among anonymous respondents because many of them withheld demographic data (Figure 2). Among confidential respondents, the average age of providers with high levels of depersonalization was 39 years (SD=5.8 years) versus an average age of 47 years (SD=12.9) without it ($P=.010$).

Table 1: Wellness Officer Responsibilities

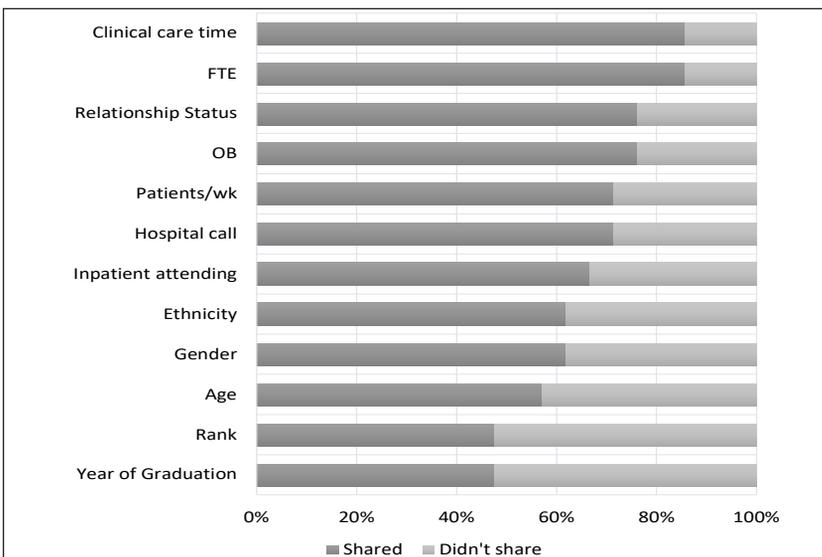
Responsibility	Description
Design, promote, and administer burnout and engagement surveys	<ul style="list-style-type: none"> Review relevant literature for evidence-based metrics. Design custom burnout and engagement survey to meet department needs and measure impact of well-being initiatives within department. Inform faculty and providers regarding the context, intent, and utility of the survey. Delineate differences between anonymous and confidential survey responses.
Aggregate, interpret, and report survey results	<ul style="list-style-type: none"> Analyze survey results and compare with existing literature as appropriate. Collate quantitative and qualitative data from both anonymous and confidential respondents to be presented to department providers and leadership in aggregate.
Identify and support at-risk individuals	<ul style="list-style-type: none"> Identify confidential respondents at elevated risk for burnout or leaving the institution. Reach out to them individually for a confidential 1:1 discussion to seek solutions for enhanced sustainability. Coordinate with office or department leadership if requested by respondent. Gather nuanced data regarding providers’ experience in the department to inform leadership policy and strategic investment.
Coordinate departmental initiatives to enhance well-being	<ul style="list-style-type: none"> Provide oversight and advocacy for strategic investment in provider and faculty well-being within the department. Create and implement programs to enhance well-being.

Figure 1: Burnout Rates: Anonymous vs Confidential



Anonymous and confidential respondents were not significantly different in any of the three elements of the Maslach Burnout Inventory. Emotional exhaustion $P=.760$, depersonalization $P=.784$, and personal accomplishment $P=.875$.

Figure 2: Anonymous Respondent Demographics



Anonymous respondents withheld a large proportion of demographic data, limiting capacity to interpret demographic trends in burnout. No significant trends could be identified among anonymous respondents.

Discussion

Given the overwhelming use of anonymous survey strategy to assess burnout, we hypothesized that most respondents would be anonymous. Instead, most respondents completed the burnout survey confidentially. The response rate was 60th percentile for nonmanagerial employees.¹⁸ Overall burnout was present in 31 of

67 respondents (46%), a level consistent with other reports in the literature.³ Therefore, the high number of confidential respondents is not likely to be due to low burnout rates or poor response rate. Our hypothesis that burnout rates would be higher among anonymous respondents was also not supported, with both

confidential and anonymous respondents having similar rates.

Younger confidential respondents were more likely to report depersonalization. Previous work has demonstrated varying results regarding the relationship between age and depersonalization.¹⁹⁻²² Potential reasons for this finding include older respondents having acclimated to the challenging environment, or depersonalization leading to attrition.²³ Anonymous respondents withheld demographic data, reinforcing the limited ability of anonymous surveys to identify at-risk groups.

Limitations of this study are its single site, small sample size, and absence of comprehensive department-wide demographic data to assess representativeness of sample. Future studies might explore providers' motivations for responding anonymously or confidentially, and the impact of one-on-one outreach to burned-out respondents.

The literature on burnout and its consequences is mostly confined to anonymous assessment. This represents a limitation on both the fidelity of the information gathered and the scope of interventions available. Our study demonstrates that confidential surveys of provider burnout are feasible in a large academic department. This may reveal new methods to assess and address the burnout epidemic by creating system-wide and individual-level interventions.

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