



An exploration of the role of religion/spirituality in the promotion of physicians' wellbeing in Emergency Medicine

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ABSTRACT

Background: Burnout is highly prevalent among Emergency Medicine (EM) physicians and has significant impact on quality of care and workforce retention. The objective of this study was to determine whether higher religion/spirituality (R/S) is associated with a lower prevalence of burnout among EM physicians (primary outcome). A history of malpractice lawsuits and maladaptive behaviors were the secondary outcomes. **Methods:** This was a cross-sectional, survey-based study conducted among a random sample of physicians from the Massachusetts College of Emergency Physicians mailing list. Burnout was measured using a validated 2-item version of the Maslach Burnout Inventory. Maladaptive behaviors (smoking, drinking, and substance use) and medical malpractice were self-reported. R/S measures included organized religiosity, religious affiliation, private R/S practice, self-rated spirituality, religious rest, and religious commitment. Logistic regression was used to model study outcomes as a function of R/S predictors. **Results:** Of 422 EM physicians who received the invitation to participate, 138 completed the survey (32.7%). The prevalence of burnout was 27%. No significant associations were observed between burnout and R/S indicators. Maladaptive behaviors (adjusted OR = 0.42, CI: 0.19 to 0.96; $p = 0.039$) and history of medical malpractice (adjusted OR = 0.32; CI: 0.11 to 0.93; $p = 0.037$) were less likely among physicians reporting to be more involved in organized religious activity and to observe a day of rest for religious reasons, respectively. **Conclusion:** This study provides preliminary evidence for a possible protective association of certain dimensions of R/S on maladaptive behaviors and medical malpractice among EM physicians.

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Introduction

According to a recent survey conducted by the Physicians' Foundation, more than half of physicians in the United States are pessimistic about the future of the medical profession, about one third report feeling "overextended and overworked", and almost half plan to retire or take various steps to reduce patient load—such as cutting back on hours or reducing the number of patients they see (Anon., 2014). The proportion of physicians abandoning the medical profession is particularly high among doctors working at the very "frontline" of medical practice, i.e., Emergency Medicine (EM) (Doan-Wiggins et al., 1995; Goldberg et al., 1996; Kelley et al., 2004), where the number of physicians planning

to retire is greater than the number that will be replaced through residency training (Gallery et al., 1992; Goh et al., 1999).

Evidence indicates that burnout, a syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach et al., 1998) is an important determinant of physicians' departure and has reached epidemic levels among EM physicians' workforce (Goldberg et al., 1996; Goh et al., 1999; Curtis and Puntillo, 2007; Shanafelt et al., 2012). About a third of EM physicians present signs of psychological distress and burnout (Goh et al., 1999), with over 70% showing significant levels of emotional exhaustion and depersonalization and about half reporting low to moderate perception of personal accomplishment (Goldberg et al., 1996; Goh et al., 1999). Similar high burnout levels have been detected among EM physicians in Europe and Turkey (Embriaco et al., 2007a; Heinke et al. 2011; Lederer et al., 2008; Erdur et al., 2006).

The most important consequence of burnout is a decline in the quality of care offered to patients (Dyrbye et al., 2010; Shanafelt et al., 2010;

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West et al., 2006; Shanafelt et al., 2002; Firth-Cozens and Greenhalgh, 1997). Second, burnout takes a toll on physicians' health, as indicated by associations between burnout, substance use, and depression (Gallery et al., 1992; Erdur et al., 2006; Burbeck et al., 2002; Lloyd et al., 1994; Oreskovich et al., 2015). A third important consequence is the impact of burnout on EM staffing. Given the predicted increase in demand for critical care services due to the aging of the US population and the stable supply of physicians, it has been estimated that by 2020 the deficit of physicians working in EM and intensive care will reach approximately 20% of demand, and by 2030 it will approach 35% (Kelley et al., 2004).

Several factors have been linked with lower burnout among EM clinicians. System-level factors that have been studied include the quality of organizational leadership (Shanafelt et al., 2015), guaranteeing time away from clinical practice (Lloyd et al., 1994), a reduced workload (Embriaco et al., 2012; Embriaco et al., 2007b), the development of palliative care protocols (Treece et al., 2004), and offering clinicians the opportunity to share the experience of caring for severely ill patients (Smith and Hough, 2011; Hough et al., 2005). Individual-level factors include being in a committed relationship or cultivating a hobby (Doan-Wiggins et al., 1995). Among such factors, the study of the possible association between religion/spirituality (R/S) and burnout has received limited attention, despite evidence indicating that R/S plays an important role in the life of medical professionals (e.g., religious beliefs affect physicians' practice and attitudes toward end-of-life decisions (Curlin et al., 2005; Chan et al., 2003) and more than 50% of physicians report being involved in various forms of private spiritual practice) (Catlin et al., 2008).

Malpractice litigation and maladaptive coping behaviors (i.e., smoking and substance use) are also fairly prevalent among EM physicians (Oreskovich et al., 2015; Studdert et al., 2006; Hull et al., 2008). While no study has so far attempted to evaluate the possible role of R/S in the prevention of these factors among physicians, the literature has shown robust associations between specific religious characteristics (i.e., worship attendance) and reduced alcohol intake, cigarette smoking, and substance use in a variety of populations (Gillum, 2005; Whooley et al., 2002; Salmoirago-Blotcher et al., 2011; Rasic et al., 2011; Robinson et al., 2012).

This study was a preliminary exploration of the possible role of R/S in the promotion of EM physicians' wellbeing. The purpose of this study was to determine the relationship between markers of R/S and prevalence of burnout (primary outcome), malpractice lawsuits and maladaptive coping behaviors (secondary outcomes) among EM physicians.

Methods

Design and study participants

This was a cross-sectional, survey-based study. In 2014, 683 physicians randomly selected from the Massachusetts College of Emergency Physicians mailing list received three email messages describing the scope of the study and inviting them to participate, along with a link to a confidential on-line survey. Messages were followed by one paper copy of the survey by mail. Participants who preferred to complete the paper version were instructed to complete the questionnaire without including identifiers and to return it to the study office using a pre-stamped envelope provided together with the survey. Doctors ($n = 422$) who opened at least one email message were considered to have received the invitation to participate (Shanafelt et al., 2012; The American Association for Public Opinion Research, 2015). Participants completing the online survey were asked to provide consent by checking a "yes" or "no" bullet prior to survey completion. For those completing paper surveys, survey return was considered proof of consent. Participants were offered a \$20 gift card as a compensation for their time.

The study and all study related materials received Institutional Review Board (IRB) approval at the University of Massachusetts Medical School.

Study assessments

The study survey was pilot-tested among a group of EM physicians prior to posting or mailing for verbiage, participant burden, and acceptability. Physicians' suggestions were used to generate the final version of the study questionnaire. To respect individual feelings and perceptions about R/S and based on the feedback we received from physicians during the pilot-testing of this survey, we did not explicitly mention R/S in the survey; rather, questions about R/S attitudes and practices were embedded under the heading "Thoughts and Feelings". All information was collected using the REDCap electronic data capture system hosted at the University of Massachusetts Medical School (Harris et al., 2009). For paper and pencil surveys, a research assistant blinded to the study outcomes manually entered the data into REDCap. Data were then imported into analytical datasets.

Primary outcome

To assess burnout we used a 2-item validated version (West et al., 2009, 2012) of the Maslach Burnout Inventory (Maslach et al., 1998) used in a previous large survey-based study of physician burnout (Shanafelt et al., 2012). Physicians were asked to indicate how often the following two statements applied to them: "I feel burned out from my work" and "I have become more callous toward people since I took this job" (never, a few times a year, once a month or less, a few times a month, once a week, a few times a week, every day).

Secondary outcomes

Secondary outcomes were the prevalence of maladaptive behaviors and of previous malpractice lawsuits. Maladaptive behaviors included self-reported smoking status (never, current, ex-smoker); number of alcoholic drinks consumed per week; and previous or current substance use (cocaine, painkillers, or marijuana for non-medical reasons). History of involvement in a medical malpractice lawsuit was assessed using a single question ("Have you ever been involved in a medical malpractice lawsuit?") with 3 possible answers (yes, no, prefers not to answer).

R/S predictors

We chose measures that have been included in validated R/S assessment batteries (the Fetzer Institute Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research) (The Fetzer Institute, 2003). *Organized religiosity* was measured as frequency of attendance at religious services (never, less than once a year, several times a year, about once a month, 2 to 3 times/month, nearly every week, every week, several times a week). *Religious affiliation* was measured as none, Buddhist, Hindu, Jewish, Muslim, Roman Catholic, Eastern Orthodox, Protestant, other Christian, and other. *Private religious/spiritual practice* was assessed with the questions "How often do you pray privately in places other than at church, synagogue or other place of worship?" and "How often do you meditate?" (Never, less than once a month, once a month, a few times a month, once a week, a few times a week, once a day, several times a day). To capture individuals who would not identify with any organized religious system and yet still consider themselves "spiritual" we included assessments of *self-rated spirituality* "To what extent do you consider yourself a spiritual person?" (Very spiritual, moderately spiritual, slightly spiritual, not spiritual at all, prefer not to answer).

Religious commitment (the extent to which an individual considers religion as the guiding principle of one's life) was measured using one statement derived from Hoge's Intrinsic Religious Motivation Scale: "I try hard to carry my religious beliefs over into all my other dealings in life" (Agree strongly, agree somewhat, disagree somewhat, disagree strongly) (The Fetzer Institute, 2003; Roge, 1972; Koenig et al., 1997).

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