Emergency care has historically been one of the health care specialties with the highest rates of clinician burnout for both physicians and nurses. Although there has been an explosion of interest in burnout and wellness initiatives within the emergency specialty, previous editorials or society statements have conceptualized burnout from the perspective of the individual clinician or specialist. Taking a page from the adage that no individual is an island, acute care clinicians work intimately together as a team, in a common environment, where they are exposed to similar occupational stressors that may adversely affect both nurses and physicians. Given the broad effects of such stressors, an interdisciplinary approach to burnout science may be ideal, drawing on the unique contributions and synergies of emergency frontline nurses and physicians, along with researchers, administrators, and informatics experts.

Prolonged exposure to stressful environments has been associated with the development of adverse psychological outcomes, including the development of burnout. Burnout is characterized by emotional exhaustion, physical fatigue, and cognitive weariness, which may lead to feelings of depersonalization and reduced accomplishment. Nearly half of the nearly 900,000 practicing physicians in the United States report symptoms of burnout, with emergency physicians reporting the highest rates of burnout. Similarly, 2 recent systematic reviews on burnout in emergency nurses also found high rates of nurse burnout (eg, 31%). Alarmingly, these elevated rates of burnout are seen even among early career clinicians and trainees, suggesting that the impact of burnout is significant even to early career individuals.

The negative impact of burnout on clinicians is broad, including increased risk for depression, anxiety, and substance abuse among nurses and physicians. Burnout has also been associated with poorer delivery of medical care, including clinician-reported patient care, less empathetic communication, job absenteeism, and increased medical errors. The combined impact on patients interacting with burned-out physicians practicing in highly stressful acute care environments represents a near perfect storm leading to dissatisfaction and risk of poorer outcomes.

Although a recent systematic review of interventions for physician burnout concluded that institutional interventions were most effective, none focused on burnout in acute care clinicians, as well as a core clinical partner in the emergency department (eg, nurses). An understanding of both the unique and common variables associated with nursing and physician burnout would shed new light on the development and management of clinician well-being. The impact of burnout at both the individual and team levels on effective team dynamics is a vital aspect of efficient and effective patient care delivery but has been understudied.

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to date. This may be explored in numerous ways integrating nursing and physician scientists. Nurses and physicians are key partners in the acute management and stabilization of patients in the emergency department, with shared environmental stressors and risk factors for the development of burnout. Furthermore, the unique dynamic of the nurse-physician relationship in the emergency department may interact with clinician burnout, while also having immediate and more sustained effects on patient care. For example, emergency nurses and physicians report high degrees of documentation burden. The impact of this documentation load on individual clinician performance and its downstream effects on nurse-physician or clinician-patient communication may have important implications for patient care. In addition, approaching the potential impact that physician and/or nursing cognitive load may have on patient care as well as the interactions with their clinical colleagues may build a more comprehensive model of acute/chronic stress in the acute care environment, leading to the identification of common themes or potential modifiable targets of intervention.

A collaborative research agenda involving key nursing and physician stakeholders should be based on a nonhierarchical approach, open to exploring the pathophysiology and associates of burnout from both clinical perspectives. The partnership between nurses and physician scientists should be fully integrated, with each team member’s perspective equally valued, starting from study conceptualization to manuscript dissemination. Diverse key personnel teams on funded projects should include core nursing and physician representation on grant budget justification to recognize the efforts of both teams. In addition, involvement from not just nursing and physician scientists but also other frontline clinical disciplines would help shed unique insight from the perspective of the practicing clinician. Support for these endeavors should foster the creation of both early career nursing/physician investigators, as well as mentors to help encourage such dynamic nursing-physician team projects. Many academic professional societies encourage the growth of these interdisciplinary approaches. For example, The Society of Academic Emergency Medicine has a basic research methods and study design, the Advanced Research Methodology Evaluation and Design “ARMED” course, that specifically targets early career nursing and physician investigators.

There could be multiple unique themes on a nursing-physician–led burnout research initiative, including efforts to enhance nursing-physician communication, assessments of the impact of environmental factors such as patient acuity, load, and complexity to occupational patterns such as shift work pattern and length. Computational approaches to understanding the cognitive and physiological stress associated with acute care work could leverage novel methods in informatics and machine learning to assess broader models of how such variables interact and influence the development of any clinician based or patient-facing outcomes. Future interventions for acute care clinicians could include work cycles/schedules that optimize staffing models to adjust for real-time changes in factors such as crowding, which may simultaneously improve clinician well-being, patient outcomes, and even health care costs. Other hospital models designed to enhance the workflow environment, such as use of scribes, seamless voice recognition, or overlapping clinical shifts, should focus not just on implications for clinical productivity but also on their implications on nurse-physician team dynamics and clinician well-being. Dynamic clinical scheduling may be informed by large data set/informatic approaches, which may provide unique information about optimized work schedules to maintain clinical vigilance and clinician well-being. A key aspect of patient care rests on nurse-physician communication. Future interdisciplinary work bridging the unique expertise of nursing and physician scientists would permit novel insight into optimizing communication strategies among clinicians to improve patient care. Ideally, the fruits of this work would guide institutions toward tailored interventions to offset risk in patients, clinicians, and staff, all of whom are daily exposed to potentially harmful conditions.

Like an engine running constantly to pull a heavy load up a steep mountain, emergency nurses and physicians working in a work environment besieged by acute stressors may feel ineffectual, overwhelmed, and “burnt out.” A multidisciplinary approach to studying this challenge is critical, and interventions will likely require investment from multiple components of the health care system. Ultimately, the adoption of such a research approach integrating nursing and physician partners may improve not only clinician well-being and career longevity but also optimize patient care and hospital outcomes.

**Author Disclosures**

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