

1 **Physician Burnout and Associated Factors: Orthopaedics vs Anesthesia**
2 **Original Research article**

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5
6 **Abstract:**

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8 **BACKGROUND:** Physician burnout has garnered increased attention in recent studies. It is attributed to the intrinsic stresses of
9 medical practice and affects the quality of patient care. Previous studies have reported roughly half of orthopedic surgery and
10 anesthesiology faculty and residents suffer symptoms of burnout.

11 **OBJECTIVE:** The purpose of this study is to determine if there is a significant difference in burnout rates among orthopedic surgeons
12 and anesthesiologists, between faculty and residents in both specialties, and possible associated factors that may predispose
13 participants to experience burnout.

14 **METHODS:** Data was gathered using the Maslach Burnout inventory survey (42 questions), which was distributed during the
15 spring/summer of 2017 to orthopaedic surgery and anesthesiology residents and attending physicians, anesthesiology residents,
16 orthopedic surgery faculty, and orthopedic surgery residents from various programs in the northeastern United States.

17 **RESULTS:** Survey Response rate was 238/666 = 38% response. As compared to attendings, residents scored: worse on Emotional
18 Exhaustion; worse on Depersonalization and worse on Personal Accomplishment. When comparing specialties; for Emotional
19 Exhaustion, Orthopaedic surgery scored better as compared with Anesthesiology. On Personal Accomplishment, Orthopaedic
20 surgery scored better as compared with Anesthesiology. Residents had higher levels of burnout compared to attendings. Regarding
21 specialty, Orthopaedic surgery scored significantly lower with regard to Emotional Exhaustion and Personal Accomplishment. It was
22 also discovered that Orthopaedic surgeons overall have more social events, and more residents have mentors.

23 **CONCLUSION:** Residents consistently demonstrated higher levels of burnout than attendings in both anesthesiology and orthopaedic
24 surgery. Having a mentor and more interdepartmental social events may protect against burnout.

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28 **Introduction**

29 Physician burnout has become a significant concern in recent years. In 2012, a national study found that 46% of United States
30 physicians reported at least one symptom of burnout¹. A meta-analysis found that the aggregate rates of suicide were 1.41-2.27 higher
31 in physicians than that of the general population and found that workplace dissatisfaction and burnout were almost three times higher
32 in practicing physicians compared to non-physicians². The same meta-analysis demonstrated mental illness, likely linked to physician
33 burnout, demonstrated a strong correlation to physician suicide². The most commonly accepted definition of occupational burnout
34 syndrome consists of three equally important domains: 1) emotional exhaustion 2) depersonalization, and 3) a perceived lack of
35 personal accomplishment, which are components of the Maslach Burnout Inventory: Human Services Survey (MBI-HSS)³.
36 Absenteeism, personnel turnover, cynicism, emotional depletion, and decreased job satisfaction have all resulted from physician
37 burnout and may have a negative impact on co-workers and patients⁴.

38 In 2004, Sargent et al, found that orthopaedic surgery residents reported higher rates of burnout compared to faculty, demonstrating
39 higher rates of emotional exhaustion and depersonalization. In 2009, Sargent et al, surveyed 384 residents and 264 faculty at
40 orthopaedic surgery residency programs using the MBI-HSS⁵. It was found that roughly 30% of residents and faculty showed high
41 levels of emotional exhaustion and more than half of residents and a quarter of faculty showed high levels of depersonalization.

42 Burnout affects anesthesiologists as well. In the same 2012 national study, nearly half of the 309 anesthesiologists who responded to
43 the survey also experienced burnout, only slightly lower than the fraction of orthopaedic surgeons¹. In a 2013 national study of 1508
44 United States anesthesiology residents, high burnout risk was found in 41%. Residents who were at high risk of burnout and

45 depression also reported more medical errors, more mistakes resulting in negative consequences for patients, and less vigilance in
46 patient monitoring⁶.

47 Lifestyle differences are evident between orthopaedic surgeons and anesthesiologists. Based on the 2017 Medscape Physician
48 Compensation Report, the average annual salary for orthopaedic surgeons and anesthesiologists are \$489,000 and \$364,000⁷.
49 Anesthesiologists work on average 43-55 hours per week and take call 1.5 nights per week⁷. In 2011, Balch et al, studied 155 private
50 practice and academic orthopaedic surgeons and found that they averaged 51.1 work hours per week and 1.8 nights on call per week,
51 with a career satisfaction rate of 80%⁸.

52 The purpose of this study is to determine if there is a significant difference in burnout rates among orthopaedic surgery and
53 anesthesiology residents and faculty overall, and between residents and faculty in each specialty. Based on previous studies, it is
54 expected for burnout rates between specialties to be similar, and expect residents to have higher rates of burnout. While burnout at
55 one point in time among these groups has been studied and published in the past using the MBI-HSS survey, no study to date has
56 directly compared these groups.

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58 **Methods and Statistical analysis**

59 Rights to use the validated Maslach Burnout Inventory: Human Services Survey (MBI-HSS) were purchased and permission to
60 perform this study was obtained from the Institutional Review Board. A cross-sectional online survey was distributed during the
61 spring and summer of 2017 to orthopaedic surgery and anesthesiology residents and attending physicians from various urban

62 academic programs in the northeastern United States. The survey, consisting of forty-two questions, included the MBI-HSS survey
63 plus additional questions examining potential indicators of burnout such as socio-demographic and work stressors. A total of 228
64 surveys were collected from orthopaedic surgery attending's (29), orthopaedic surgery residents (61), anesthesia residents (63), and
65 anesthesia attending's (75). Responses were collected via an online survey tool and responses were completely anonymous.

66 Statistical analysis was performed by the Temple Clinical Research Institute Department of Clinical Sciences. The dependent variable
67 was professional burnout, measured by three subscales of the Maslach Burnout Inventory survey. Degrees of burnout (low, average,
68 and high) have been used frequently in the literature to compare and contrast burnout among different groups. The cut off values in
69 Table 1 [from the Third Edition of the Maslach Burnout Inventory Manual, Maslach et al. (1996)] are typically cited in the literature
70 as representative of low, average, and high degrees of burnout.

71 High levels of depersonalization and emotional exhaustion or low scores on personal accomplishment indicated professional burnout.
72 Statistical analyses as categorical variables of the individual question data was performed as well as a statistical analysis of continuous
73 variables of the three core scales relating to the burnout syndrome - Emotional Exhaustion, Depersonalization, and Personal
74 Accomplishment. A statistical analysis of categorical variables regarding the degree of burnout associated with the three core aspects
75 of burnout syndrome was also performed. Lastly, a univariable analyses of Emotional Exhaustion, Depersonalization, and Personal
76 Accomplishment scores based on the partitions created by the responses to Question 25 through Question 41 was performed.

77 Scores for each of the three core scales were partitioned into low, average, or high categories based on the criteria for each scale
78 (Table 1). The resulting categorical data was assessed using the Chi-Square test (or the Fisher's exact test as appropriate) for each

79 score for each of the three respondent partitioning's. Question 39 in the survey identified respondents as either orthopaedic surgery
80 attending's (29), orthopaedic surgery residents (61), anesthesiology residents (63), or anesthesiology attending's (75).

81 Derived scores for the three core scales of burnout syndrome (Emotional Exhaustion, Depersonalization, and Personal
82 Accomplishment) were assessed using non-parametric methods. For this study, the Wilcoxon test was used if two groups were
83 compared and the Kruskal-Wallis test was used if three or more groups were compared. Based on statistical analysis, the results of
84 the study were found to have a non-normal distribution based on three tests of normality.

85 A univariable analysis of the three core scales of burnout was created using responses to questions 25 through 41 using the Kruskal-
86 Wallis and Wilcoxon tests as described above. The data was cleaned as respondent 135 responded 6 (i.e. 'every day') to all 23 burnout
87 questions and identified him or herself as both an anesthesia resident and attending in separate responses. In addition, two respondents
88 seemed to have made "fat finger errors" on Q41 of the survey, in which they identified themselves as residents but responded that they
89 had been practicing for 1-5 years as attending's. These respondents answered all other questions in the survey as residents
90 consistently.

91 For selected questions, alternative data sets creating a derived response were created excluding responses of "prefer not to answer"
92 and for those who "did not take any call" in questions 31 – 33. These alternative data sets were created such that only informative
93 answers were analyzed.

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95 **Results**

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97 The Survey Response rate was $238/666 = 38\%$ response rate. As compared to attending's, residents scored worse on
98 Emotional Exhaustion (M 21.50 vs. 24.00, SE 1.25 vs. 1.06, $p=0.1075$); worse on Depersonalization (M 6.0 vs 10.5, SE .64 vs.63,
99 $p<.0001$); and worse on Personal Accomplishment (M 41.0 vs 38.0, SE .59 vs .63 $p=0.0051$) (Table 2). For Emotional Exhaustion,
100 orthopaedic surgery scored better compared to anesthesiology (M 20.0 vs 24.5p, SE 1.19 vs 1.07, $p=0.0181$). On Depersonalization,
101 anesthesiology scored better than orthopaedic surgery (M 9.5 vs 7.5, WE .73 vs .60 $p=0.0867$). On Personal Accomplishment,
102 orthopaedic surgery scored better as compared with anesthesiology (M 42.0 vs 38.5, SE .67 vs .58 $p=0.0117$) (Table 3). It was also
103 discovered that orthopaedic surgeons overall have more social events (table 4), residents take more overnight call (higher rates of
104 burnout), more anesthesiologists are married (81.5 vs. 69.5 $p=0.0365$, higher rates of burnout), more anesthesiologists take in-house
105 call (higher rates of burnout), and more residents have mentors (higher rates of burnout).

106 Inspecting levels of burnout partitioned by role, researchers found a similar trend, particularly with regard to Depersonalization
107 and Personal Accomplishment, with residents showing increased rates of "high" burnout (Depersonalization 54.8% vs 34.6 %, $p=$
108 0.0012 , Personal Accomplishment 24.2% vs. 13.5% $p=.0317$). Regarding specialty, orthopaedic surgery scored significantly better in
109 Emotional Exhaustion and better in Personal Accomplishment (Emotional Exhaustion 30.0% vs 44.2%, $p=0.0371$, Personal
110 Accomplishment 14.4% vs 22.5%, $p=.0068$) (Table 4).

111 Univariable analysis results demonstrated many statistically significant findings with results reported for those that the authors
112 felt were most revealing. Regarding gender, (Q25alt, excluding those who "prefer not to respond") male respondents had higher

113 median Personal Accomplishment scores (suggesting lower burnout) as compared with female respondents ($p=0.0446$) (Table 5).
114 Regarding partnerships, respondents in a partnership had lower median Depersonalization scores (suggesting lower burnout) as
115 compared with respondents in that are not in a partnership ($p=0.0400$) (Table 6). For the revised response data (Q29 alt), having fewer
116 social events were associated with higher Emotional Exhaustion scores ($p=0.0364$, suggesting higher burnout) and was associated with
117 lower Personal Accomplishment ($p=0.0066$), suggesting higher burnout). (Table 7)

118 When only considering respondents that take call (Q31 alt), respondents for whom a majority (greater than 50%) of their call
119 was home call (defined as not required to physically remain in the hospital at all times) had a higher median Personal Accomplishment
120 scores (suggesting lower burnout) as compared with respondents for whom a majority of their call was in-house call ($p=0.0163$)
121 (Table 8). A derived response data set was imputed from Q31, Q32, and Q33 identifying whether the respondent takes or does not take
122 any call. Based on this derived data set, respondents that did not take call had lower median Emotional Exhaustion and
123 Depersonalization scores (suggesting lower burnout) as compared with respondents that do take call ($p=0.0188$ and 0.0148 ,
124 respectively).

125 In regards to having a mentor, respondents who had a mentor (Q35) had higher Depersonalization scores (suggesting higher
126 burnout) and lower Personal Accomplishment scores (suggesting higher burnout) as compared with those who had no mentor
127 ($p<0.0001$ and 0.0185 , respectively). However, regarding the reported agreement relative to the benefits of having a mentor (Q35 alt),
128 statistically significant associations between agreement and scores were observed. Those respondents who strongly agreed or agreed
129 that having a mentor benefitted them had lower median Emotional Exhaustion scores, lower median Depersonalization scores, and

130 higher median Personal Accomplishment scores ($p=0.0487$, $p=0.0195$, and $p=0.0002$, respectively for each score, based on an overall
131 comparison of all five levels) (Table 9).

132 There was a statistically significant association between Emotional Exhaustion and exercise (Q37) ($p=0.0389$), in which those
133 exercising the least had the highest burnout and those exercising the most had the lowest burnout (Table 10). Regarding sleep (Q38),
134 there was a statistically significant association between Emotional Exhaustion and sleep ($p=0.0040$) where those sleeping the least had
135 the highest burnout and those sleeping the most had the lowest burnout. For Depersonalization and sleep, the association approached
136 statistical significance ($p=0.0600$), in which those sleeping the least had the highest burnout and those sleeping the most had the
137 lowest burnout. Those sleeping less than five hours had the highest burnout (Table 11).

138 Looking at years of practice for attending's only (Q41 alt), there is a statistically significant association between years of practice
139 and Depersonalization scores ($p=0.0414$). Based on these data, attending's with more than thirty years of practice have lower
140 Depersonalization scores, suggesting lower burnout rates.

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142 **Discussion**

143 Results of the study demonstrated that overall, residents experience higher rates of burnout than attending's in both
144 orthopaedic surgery and anesthesiology, which is consistent with previous findings. However, our results suggest that anesthesiology
145 residents and attending's experience higher levels of burnout when directly compared to their orthopaedic surgery counterparts, which
146 is inconsistent with previous studies and surprising¹. This challenges the common belief that surgical specialties carry a higher

147 prevalence of burnout due to increased hours and a more stringent call schedule. A 2011 study of 384 orthopaedic surgery residents
148 and 264 full-time orthopaedic surgery faculty reported residents work an average of 74.2 +/- 20.2 hours per week and faculty 62.8 +/-
149 18.2 hours per week⁹. This is compared to a 2013 study which found that 76% of anesthesiology residents work less than 70 hours a
150 week and 24% work more than 70 hours per week. The same study found that 56% of anesthesiology residents have less than 5 days
151 between calls while 44% have more than 5 days between calls¹⁰. An important difference between specialties that was found to
152 directly correlate with physician burnout is number of social events per year. Orthopaedic surgery was found to have significantly
153 more social events and overall lower rates of physician burnout.

154 Socialization outside of work settings helps promote teamwork and comradery. This strategy of teambuilding and morale-
155 boosting events outside of the work setting has been utilized and found to be effective in the financial and corporate world. Results of
156 the study indicated an inverse correlation between number of social events and burnout, based on the three core values. One
157 possibility for the observed difference in number of social events between orthopaedic surgeons is that more anesthesiologists were
158 found to be married, which limits time outside of work to be spend with fellow colleagues due to the responsibilities inherent to
159 partnership and family. Married orthopaedic surgery residents who had higher Revised Dyadic Adjustment Scale scores had a greater
160 sense of personal achievement, while married faculty with higher scores was strongly associated with lower emotional exhaustion,
161 lower depersonalization, and higher personal achievement⁷. A 2012 study comparing burnout and satisfaction with work-life balance
162 of 7,288 US physicians and 3,442 working United States adults found that being married was associated with a lower overall risk of
163 burnout¹.

164 Another possibility is that orthopaedic surgeons tend to come from background of competitive sport where teamwork and the
165 understanding of the importance of supporting one's associate are imperative to success. Social events, focused around team-building
166 activities should be a regular occurrence among residency departments and must involve both residents and attending's, so that the
167 whole department feels engaged in efforts to build relationships and bonds that can be carried over into the workplace. These building
168 blocks, forged away from the familiar hospital setting, can develop relationships that can act as pillars of support and strength should a
169 physician experience the symptoms of burnout. Closer relationships with colleagues may help an attending or resident physician seek
170 help before symptoms severely impact patient care and one's mental health.

171 Findings of this study highlight that mere involvement in a mentor-mentee relationship does not protect against symptoms of
172 burnout. More residents have a mentor, but experience higher levels of burnout than attending's in both orthopaedic surgery and
173 anesthesiology. However, regarding the reported agreement relative to the benefits of having a mentor, statistically significant
174 associations between agreement and scores were observed. Those respondents who strongly agreed or agreed that having a mentor
175 benefitted them had lower overall rates of burnout than those who disagreed and strongly disagreed. In a study of three hundred and
176 eighty-four orthopaedic surgery residents, Sargent, et al, found that 60% reported having at least one mentor. Levels of emotional
177 exhaustion decreased and personal achievement increased as the frequency of contact between mentor and mentee increased.⁹ Higher
178 personal achievement, lower emotional exhaustion, and lower depersonalization scores were also found in those who reported it
179 helpful to speak with their mentors.⁷

180 Often time's mentors are assigned to a resident when they begin residency randomly with no prior relationship between the
181 two. In order to create more valuable mentor-mentee relationships, care must be taken to provide mentees with mentors that are an
182 optimal "fit." If attending's and residents can socialize and familiarize themselves with one another to establish relationships ahead of
183 time, this can be achieved. Random pairing of mentors to mentees can lead to this relationship being suboptimal due to differences in
184 personalities, professional and personal interests, and the parties' overall interest in a mentor-mentee relationship.

185 One suggestion to help foster this important relationship is to have residents seek out attending's who they would like to have
186 as a mentor based on an already established relationship. This way, residents can choose whether or not they would like a mentor at
187 all. If so, they can select a relationship which they feel will help them grow personally and professionally. Those who may feel this
188 relationship has no benefit, can save themselves the time and strain associated with a mentor that they did not choose, or has little
189 interest in truly being a mentor. One study of a radiology residency program found that residents having self-selected their mentors
190 were significantly more likely to consider their faculty mentor as their primary mentor than those with assigned mentors. They also
191 reported significantly higher satisfaction with the mentoring program than those with an assigned mentor.¹⁰ Another study of an
192 emergency medicine residency program concluded that an individual's active participation in mentor selection can yield better
193 outcomes, as 44% of residents thought shared academic interest and 44% thought a comfortable personal dynamic were most
194 important to a successful mentor-mentee match. In this program, at the end of intern year, residents provided a list of three possible
195 mentors for the remainder of training and were assigned one of those mentors.¹¹

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197 **Conclusion**

198 Anesthesiologists consistently demonstrate high levels of professional burnout compared to orthopedic surgeons. There are
199 several weaknesses inherent in our study. One weakness is that the surveys were collected during a single time point during the spring
200 and summer months in the northeastern United States. Temporal and seasonal difference may impact survey results, as rates of
201 seasonal depression peak in the winter. We only polled physicians in large urban medical centers. Opportunity for future studies
202 include redistributing surveys over the course of a year (winter vs. summer) to find if seasonal changes may affect the outcomes.
203 Studies could compare burnout rates with non-perioperative specialties with mostly daytime hours and thus no overnight calls and
204 patients without critical illnesses. Comparing rural and urban centers and different areas of the country can give insight to the potential
205 effects of demographic factors. Given our findings about the impact of social events, studies could explore the details about the types
206 of social events, frequency, quality, etc. that could potentially impact burnout rates.

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234 The follow 4 tables are our primary tables and figures to be included in the article.

235 ~~1.~~ **Table 1.**

236 ~~2.1.~~ **Maslach Core Scale values and their interpretations**

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Core Scale	Low	Average	High	Directional Interpretation
Emotional Exhaustion	≤18	19–26	≥27	Higher score suggests higher burnout
Depersonalization	≤5	6–9	≥10	Higher score suggests higher burnout
Personal Accomplishment	≥40	39–34	≤33	Lower score suggests higher burnout

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245 **2. Table 2: Summary Statistics and Testing of Three Core Scales Partitioning by Role**

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion										0.1074	Wilcoxon
Attending	104	22.69	12.72	1.25	0.00	12.50	21.50	31.00	54.00		
Resident	124	25.06	11.79	1.06	0.00	17.00	24.00	33.00	52.00		
Depersonalization										<.0001	Wilcoxon
Attending	104	8.08	6.57	0.64	0.00	3.00	6.00	12.00	30.00		
Resident	124	11.68	7.00	0.63	0.00	6.00	10.50	16.50	29.00		
Personal Accomplishment										0.0051	Wilcoxon
Attending	104	40.22	6.04	0.59	18.00	36.50	41.00	45.00	48.00		
Resident	124	37.73	6.98	0.63	11.00	34.00	38.00	43.00	48.00		

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255 **3. Table 3: Summary statistics and testing of three core scales partitioning by speciality**

<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion										0.0181	Wilcoxon
Orthopaedic surgery	90	21.52	11.34	1.19	0.00	14.00	20.00	30.00	50.00		
Anesthesiology	138	25.58	12.60	1.07	0.00	16.00	24.50	34.00	54.00		
Depersonalization										0.0867	Wilcoxon
Orthopaedic surgery	90	10.92	6.93	0.73	0.00	6.00	9.50	16.00	25.00		
Anesthesiology	138	9.46	7.05	0.60	0.00	4.00	7.50	14.00	30.00		
Personal Accomplishment										0.0117	Wilcoxon
Orthopaedic surgery	90	40.08	6.40	0.67	17.00	36.00	42.00	45.00	48.00		
Anesthesiology	138	38.08	6.76	0.58	11.00	34.00	38.50	43.00	48.00		

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265 **Table 4: Degree of burnout, four-way partitioning, summary statistics**

<i>Scale</i>	<i>Low</i>	<i>Average</i>	<i>High</i>	<i>Total</i>	<i>p-Value</i>	<i>Test Method</i>
Degree of Burnout - Emotional Exhaustion					0.0325	Chi Square
Orthopaedic surgery attending	15 (51.7%)	8 (27.6%)	6 (20.7%)	29 (100.0%)		
Orthopaedic surgery resident	25 (41.0%)	15 (24.6%)	21 (34.4%)	61 (100.0%)		
Anesthesiology attending	28 (37.3%)	16 (21.3%)	31 (41.3%)	75 (100.0%)		
Anesthesiology resident	12 (19.0%)	21 (33.3%)	30 (47.6%)	63 (100.0%)		
Total	80 (35.1%)	60 (26.3%)	88 (38.6%)	228 (100.0%)		
Degree of Burnout - Depersonalization					0.0252	Chi Square
Orthopaedic surgery attending	11 (37.9%)	7 (24.1%)	11 (37.9%)	29 (100.0%)		
Orthopaedic surgery resident	11 (18.0%)	16 (26.2%)	34 (55.7%)	61 (100.0%)		
Anesthesiology attending	33 (44.0%)	17 (22.7%)	25 (33.3%)	75 (100.0%)		
Anesthesiology resident	15 (23.8%)	14 (22.2%)	34 (54.0%)	63 (100.0%)		
Total	70 (30.7%)	54 (23.7%)	104 (45.6%)	228 (100.0%)		
Degree of Burnout - Personal Accomplishment					0.0008	Chi Square
Orthopaedic surgery attending	21 (72.4%)	5 (17.2%)	3 (10.3%)	29 (100.0%)		
Orthopaedic surgery resident	38 (62.3%)	13 (21.3%)	10 (16.4%)	61 (100.0%)		
Anesthesiology attending	43 (57.3%)	21 (28.0%)	11 (14.7%)	75 (100.0%)		
Anesthesiology resident	18 (28.6%)	25 (39.7%)	20 (31.7%)	63 (100.0%)		
Total	120 (52.6%)	64 (28.1%)	44 (19.3%)	228 (100.0%)		

266 The follow tables are supplemental and tables

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268 **5. Table 5: Three core scales partitioning by gender**

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion by Q25alt (Gender)											
Male	161	22.71	12.27	0.97	0.00	14.00	21.00	32.00	54.00	0.0872	Wilcoxon
Female	56	25.84	10.88	1.45	6.00	19.00	24.00	33.00	51.00		
Depersonalization by Q25alt (Gender)											
Male	161	10.21	7.09	0.56	0.00	5.00	9.00	15.00	29.00	0.2863	Wilcoxon
Female	56	8.80	5.89	0.79	0.00	3.50	8.50	13.50	20.00		
Personal Accomplishment by Q25alt (Gender)											
Male	161	39.42	6.47	0.51	17.00	36.00	41.00	44.00	48.00	0.0446	Wilcoxon
Female	56	37.52	6.80	0.91	11.00	33.00	38.50	42.50	48.00		

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270 **6. Table 6: Three core scales partitioning by partnership**

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion by Q26alt (Partnership)											
Yes	167	23.18	11.67	0.90	0.00	15.00	22.00	31.00	54.00	0.1670	Wilcoxon

<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
No	51	25.59	12.22	1.71	0.00	18.00	25.00	36.00	50.00		
Depersonalization by Q26alt (Partnership)											
Yes	167	9.33	6.72	0.52	0.00	4.00	7.00	14.00	29.00	0.0400	Wilcoxon
No	51	11.49	6.96	0.97	0.00	6.00	10.00	18.00	24.00		
Personal Accomplishment by Q26alt (Partnership)											
Yes	167	39.26	6.47	0.50	11.00	36.00	40.00	44.00	48.00	0.2118	Wilcoxon
No	51	37.80	7.16	1.00	17.00	33.00	39.00	44.00	48.00		

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272 | 7. Table 7: **Three core scales partitioning by number of social events**

<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion by Q29alt (Social Events)											
0-2	83	26.69	12.98	1.42	0.00	19.00	26.00	35.00	54.00	0.0364	Kruskal-Wallis
3-4	100	22.74	11.42	1.14	2.00	13.50	22.00	32.00	48.00		
5 or greater	44	21.00	11.10	1.67	0.00	13.50	21.00	30.00	42.00		
Depersonalization by Q29alt (Social Events)											
0-2	83	10.07	7.33	0.80	0.00	4.00	9.00	16.00	26.00	0.6154	Kruskal-Wallis
3-4	100	9.67	7.06	0.71	0.00	4.50	7.00	14.00	29.00		
5 or greater	44	10.34	5.81	0.88	0.00	6.00	9.50	15.00	24.00		

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Personal Accomplishment by Q29alt (Social Events)										0.0066	Kruskal-Wallis
0-2	83	37.01	7.45	0.82	11.00	33.00	39.00	42.00	48.00		
3-4	100	39.40	6.14	0.61	22.00	35.00	40.50	44.00	48.00		
5 or greater	44	40.95	5.36	0.81	26.00	38.00	42.00	44.50	48.00		

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274 | 8. Table 8: **Three core scales portioning by home call (vs. in – house call)**

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion by Q31alt (Home Call)										0.5916	Wilcoxon
Yes	68	23.75	12.49	1.51	0.00	15.00	22.50	32.50	50.00		
No	136	24.71	12.05	1.03	0.00	16.00	24.00	33.00	54.00		
Depersonalization by Q31alt (Home Call)										0.7772	Wilcoxon
Yes	68	10.15	7.17	0.87	0.00	5.00	9.50	15.00	26.00		
No	136	10.33	6.75	0.58	0.00	5.50	9.00	15.50	29.00		
Personal Accomplishment by Q31alt (Home Call)										0.0163	Wilcoxon
Yes	68	40.00	6.67	0.81	17.00	35.50	42.00	45.00	48.00		
No	136	38.00	6.75	0.58	11.00	34.00	39.00	42.50	48.00		

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9. **Table 9: Three core scales in those with a mentor**

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion by Q35alt (Relationship with Mentor Benefits)										0.0487	Kruskal-Wallis
Strongly agree	49	22.94	10.93	1.56	0.00	18.00	23.00	28.00	45.00		
Agree	58	21.59	8.75	1.15	2.00	16.00	21.00	29.00	40.00		
Neutral	39	27.51	12.99	2.08	4.00	16.00	26.00	37.00	54.00		
Disagree	15	28.60	14.77	3.81	7.00	15.00	27.00	41.00	50.00		
Strongly disagree	13	30.69	12.61	3.50	10.00	24.00	27.00	39.00	51.00		
Depersonalization by Q35alt (Relationship with Mentor Benefits)										0.0195	Kruskal-Wallis
Strongly agree	49	10.61	6.15	0.88	0.00	6.00	9.00	15.00	24.00		
Agree	58	9.76	6.55	0.86	0.00	4.00	8.50	14.00	24.00		
Neutral	39	11.05	7.02	1.12	0.00	5.00	10.00	17.00	25.00		
Disagree	15	12.67	7.46	1.93	2.00	7.00	12.00	19.00	26.00		
Strongly disagree	13	16.69	5.68	1.57	8.00	13.00	18.00	20.00	29.00		
Personal Accomplishment by Q35alt (Relationship with Mentor Benefits)										0.0002	Kruskal-Wallis
Strongly agree	49	39.80	5.36	0.77	25.00	36.00	40.00	44.00	48.00		
Agree	58	40.34	5.05	0.66	28.00	38.00	41.50	44.00	48.00		
Neutral	39	36.51	6.57	1.05	21.00	32.00	38.00	41.00	47.00		
Disagree	15	33.93	9.11	2.35	17.00	26.00	37.00	42.00	44.00		
Strongly disagree	13	31.92	8.46	2.35	11.00	29.00	32.00	36.00	43.00		

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278 **Table 10: Three core scales partitioning by number of days of exercise per week**

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion by Q37 (Exercise)										0.0389	Kruskal-Wallis
0	46	27.26	11.31	1.67	1.00	16.00	26.50	34.00	54.00		
1-2	108	24.36	11.75	1.13	3.00	16.00	23.00	33.00	52.00		
3-4	55	21.44	12.82	1.73	0.00	12.00	20.00	31.00	47.00		
5 or greater	18	19.39	12.18	2.87	0.00	11.00	19.50	25.00	48.00		
Depersonalization by Q37 (Exercise)										0.5418	Kruskal-Wallis
0	46	10.83	6.28	0.93	0.00	6.00	11.50	15.00	25.00		
1-2	108	9.63	6.49	0.62	0.00	5.00	8.00	15.00	26.00		
3-4	55	10.31	8.27	1.11	0.00	4.00	7.00	19.00	29.00		
5 or greater	18	8.50	6.61	1.56	0.00	2.00	8.00	12.00	21.00		
Personal Accomplishment by Q37 (Exercise)										0.0674	Kruskal-Wallis
0	46	37.30	7.36	1.09	11.00	33.00	39.00	42.00	47.00		
1-2	108	38.53	6.26	0.60	17.00	35.00	39.00	43.50	48.00		
3-4	55	40.33	6.36	0.86	20.00	36.00	42.00	45.00	48.00		
5 or greater	18	39.94	7.48	1.76	21.00	36.00	41.50	47.00	48.00		

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280 **11. Table 11: Three core scales partitioning by number of hours of sleep`**

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion by Q38 (Sleep)										0.0040	Kruskal-Wallis
Less than 5	22	33.64	13.25	2.83	7.00	23.00	36.50	41.00	54.00		
5-6	137	23.23	10.81	0.92	0.00	16.00	22.00	30.00	50.00		
7-8	60	22.18	11.61	1.50	4.00	12.50	22.00	31.00	45.00		
Greater than 8	8	20.00	21.38	7.56	0.00	0.50	13.50	40.00	52.00		
Depersonalization by Q38 (Sleep)										0.0600	Kruskal-Wallis
Less than 5	22	13.73	7.33	1.56	3.00	8.00	12.50	19.00	29.00		
5-6	137	9.82	7.04	0.60	0.00	4.00	8.00	15.00	26.00		
7-8	60	9.12	6.02	0.78	0.00	4.50	9.00	12.00	23.00		
Greater than 8	8	8.00	7.65	2.71	0.00	1.50	6.00	14.00	21.00		
Personal Accomplishment by Q38 (Sleep)										0.2456	Kruskal-Wallis
Less than 5	22	35.68	8.65	1.84	11.00	32.00	37.00	42.00	48.00		
5-6	137	39.34	6.31	0.54	17.00	36.00	41.00	44.00	48.00		
7-8	60	38.83	6.11	0.79	23.00	33.50	40.00	44.00	48.00		
Greater than 8	8	38.75	9.16	3.24	25.00	31.50	39.50	47.50	48.00		

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282 **Table 12: Three core scales partitioning by resident level of training**

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion by Q40alt (Year of Training)										0.7726	Kruskal-Wallis

<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
PGY1	14	25.07	7.42	1.98	12.00	19.00	24.50	31.00	40.00		
PGY2	31	26.32	12.98	2.33	4.00	16.00	23.00	39.00	47.00		
PGY3	38	25.58	11.32	1.84	2.00	19.00	23.50	33.00	52.00		
PGY4	22	25.55	13.86	2.95	0.00	16.00	28.50	35.00	52.00		
PGY5	19	21.37	11.15	2.56	1.00	10.00	21.00	32.00	38.00		
Depersonalization by Q40alt (Year of Training)										0.2613	Kruskal-Wallis
PGY1	14	13.71	6.40	1.71	3.00	9.00	14.00	20.00	22.00		
PGY2	31	10.06	6.88	1.24	0.00	5.00	10.00	14.00	29.00		
PGY3	38	13.03	6.74	1.09	0.00	8.00	14.00	19.00	24.00		
PGY4	22	10.73	7.42	1.58	0.00	5.00	9.00	17.00	25.00		
PGY5	19	11.21	7.47	1.71	0.00	5.00	9.00	16.00	25.00		
Personal Accomplishment by Q40alt (Year of Training)										0.5704	Kruskal-Wallis
PGY1	14	38.43	7.60	2.03	22.00	32.00	41.50	44.00	47.00		
PGY2	31	38.06	6.80	1.22	20.00	34.00	38.00	44.00	48.00		
PGY3	38	36.18	7.59	1.23	11.00	33.00	38.00	41.00	47.00		
PGY4	22	37.73	7.20	1.53	23.00	31.00	39.00	44.00	48.00		
PGY5	19	39.79	5.06	1.16	29.00	35.00	41.00	43.00	48.00		

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284 **Table 13: Three core scales partitioning by attending years of practice**

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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
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<i>Core Scale</i>	<i>N</i>	<i>Mean</i>	<i>StdDev</i>	<i>StdErr</i>	<i>Min</i>	<i>Q1</i>	<i>Median</i>	<i>Q3</i>	<i>Max</i>	<i>p-Value</i>	<i>Method</i>
Emotional Exhaustion by Q41 (Years of Practice)										0.5880	Kruskal-Wallis
1-5	40	21.50	9.63	1.52	4.00	15.00	21.50	28.00	43.00		
6-10	14	23.64	11.51	3.08	3.00	16.00	24.00	29.00	46.00		
11-20	17	24.47	14.01	3.40	6.00	14.00	25.00	37.00	48.00		
21-30	19	24.00	16.32	3.74	2.00	7.00	20.00	39.00	54.00		
30+	12	20.25	12.27	3.54	4.00	9.50	19.00	28.00	41.00		
Resident physician	125	24.86	11.96	1.07	0.00	17.00	24.00	33.00	52.00		
Depersonalization by Q41 (Years of Practice)										<.0001	Kruskal-Wallis
1-5	40	8.43	5.27	0.83	1.00	4.00	7.00	11.50	21.00		
6-10	14	9.36	7.76	2.07	0.00	2.00	9.00	17.00	23.00		
11-20	17	9.82	7.92	1.92	0.00	4.00	9.00	16.00	26.00		
21-30	19	6.79	6.01	1.38	0.00	1.00	6.00	10.00	21.00		
30+	12	3.33	2.31	0.67	0.00	1.00	3.50	5.00	7.00		
Resident physician	125	11.63	6.99	0.63	0.00	6.00	10.00	16.00	29.00		
Personal Accomplishment by Q41 (Years of Practice)										0.0422	Kruskal-Wallis
1-5	40	39.05	6.73	1.06	21.00	33.50	41.00	44.00	48.00		
6-10	14	41.79	4.15	1.11	35.00	38.00	41.50	45.00	48.00		
11-20	17	38.35	6.49	1.57	18.00	36.00	38.00	42.00	48.00		
21-30	19	40.95	5.37	1.23	32.00	36.00	42.00	46.00	48.00		
30+	12	42.50	4.64	1.34	31.00	40.00	43.50	46.00	47.00		
Resident physician	125	37.82	7.02	0.63	11.00	34.00	38.00	43.00	48.00		

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Question	0	1-2	3-4	5 or greater	Total	p-Value	Test Method
Q29: How many social events are hosted by your department per year						<.0001	Fisher's Exact
Orthopaedic surgery	1 (1.1%)	14 (15.6%)	39 (43.3%)	36 (40.0%)	90 (100.0%)		
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Table 14: Marriage/partnership by specialty

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Question	Yes	No	Total	p-Value	Test Method
Q26: Are you married/in a partnership				0.0365	Chi Square
Orthopaedic surgery	61 (69.3%)	27 (30.7%)	88 (100.0%)		
Anesthesiology	106 (81.5%)	24 (18.5%)	130 (100.0%)		
Total	167 (76.6%)	51 (23.4%)	218 (100.0%)		

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Anesthesiology	2 (1.4%)	67 (48.6%)	61 (44.2%)	8 (5.8%)	138 (100.0%)
Total	3 (1.3%)	81 (35.5%)	100 (43.9%)	44 (19.3%)	228 (100.0%)

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UNDER PEER REVIEW

