ORIGINALES

Burnout, communication skills and self-efficacy in emergency and critical care health professionals

Burnout, habilidades de comunicación y autoeficacia en los profesionales de urgencias y cuidados críticos

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ABSTRACT:
Aim: To analyze the level and relationship between communication skills, perceived self-efficacy and Burnout syndrome in health professionals from the hospital emergency department and the critical care unit of a regional hospital.
Method: An observational and cross-sectional study was conducted with a sample of 90 health professionals from a Regional Hospital, 19 physicians (21.1%), 47 nurses (52.2%), 24 nursing aides (26.7%). The Communication Skills Scale for Health Professionals, the Maslach Burnout Inventory Human Services Survey and the Scale of Perceived Self-Efficacy were utilized.
Results: A negative correlation was obtained between the different dimensions of the Communication Skills Scale for Health Professionals, the personal accomplishment at work of the Maslach Burnout Inventory and the perceived self-efficacy with the emotional exhaustion and depersonalization dimensions of the Maslach Burnout Inventory. On the other hand, a positive and statistically significant correlation was observed between the dimensions of communication skills with the personal accomplishment dimension in the Maslach Burnout Inventory work and the perceived self-efficacy.
Conclusions: The communication skills and the perceived self-efficacy of the health professionals in the emergency department and critical care unit are related to less emotional exhaustion and depersonalization, and greater personal accomplishment at work.

Keywords: Burnout; Communication; Self-efficacy; Healthcare professionals; emergency department; Critical Care.

RESUMEN:
Objetivo: Analizar el nivel y la relación entre habilidades de comunicación, autoeficacia percibida y síndrome de Burnout en profesionales de la salud del servicio de urgencias hospitalario y unidad de cuidados críticos de un hospital comarcal.

Método: Se plantea un estudio observacional y transversal en una muestra de 90 profesionales sanitarios de un Hospital Comarcal, 19 médicos (21,1%), 47 enfermeros (52,2%), 24 auxiliares de enfermería (26,7%). Se han usado la Escala sobre Habilidades de Comunicación en Profesionales de la Salud, el Maslach Burnout Inventory Human Services Survey y la escala de la Autoeficacia percibida.

Resultados: Se obtiene una correlación negativa entre las diferentes dimensiones de la Escala sobre Habilidades de Comunicación en Profesionales de la Salud, la realización personal en el trabajo del Maslach Burnout Inventory y la autoeficacia percibida con las dimensiones agotamiento emocional y despersonalización del Maslach Burnout Inventory. Por otro lado, se observa una correlación positiva y estadísticamente significativa entre las dimensiones de las habilidades de comunicación con la dimensión realización personal en el trabajo del Maslach Burnout Inventory y la autoeficacia percibida.

Conclusiones: Las habilidades de comunicación y la autoeficacia percibida de los profesionales sanitarios en los servicios de urgencias hospitalarios y las unidades de cuidados críticos están relacionadas con un menor agotamiento emocional y despersonalización, y una mayor realización personal en el trabajo.

Palabras clave: Burnout; Comunicación; Autoeficacia; Profesionales de la salud; Urgencias; Cuidados Críticos.

INTRODUCTION

In general, health professions are intimately related with work stress and this creates a problem not only at the level of the individual, but at the interpersonal or social levels as well[1].

The Burnout Syndrome is known as the symptomatic response to chronic work stress situations that are commonly found in care professions as well as other professions that require the direct contact with others. Its presence implies deterioration and wear that affects work satisfaction, involvement and performance, as well as at the personal level of the individual. Aside from the health professionals, other groups that suffer from this syndrome are teachers and high-performance athletes [2,3].

Three large sets of risk factors (personal, group and organizational) have been linked to the appearance of this syndrome. The factors related with aspects of the workplace environment and the personal factors have had a greater relevance in most of the research works, with the factors of the relationship with the patient being the least taken into consideration until present time[4].

This syndrome was described by Herbert Freudenberger in the year 1974 while working in a clinic for drug addicts in New York. Here, he observed that in most of the volunteers in the clinic, there was a progressive loss of energy until exhaustion, symptoms of anxiety and depression, as well as demotivation at work and aggressiveness with the patients after a year of working there[5].

Other aspects that could have repercussions on the work environment and on the levels of burnout of health professionals are the communication skills they possess, as they foster mutual understanding, focus on the needs of the patient, share responsibility and establish a clinical relationship characterized by confidence, respect and empathy[6]. On the other hand, it also has repercussions on their emotional state, their level of stress and their perceived self-efficacy, with this last understood as the beliefs individuals possess about their own skills, referring not only to the resources they truly possess, but also to the professional opinion one has about what he or she can do with them[7].

The health professional deals with complex tasks on the daily basis, which are influenced by diverse specific stressful factors related to their profession. These imply a high emotional involvement, and factors related with the organization of work, such as the excess of aversive stimulation (frequently dealing with situations of suffering, death, pain or loss), continuous contact with the ill (which demands a certain degree of involvement to establish a relationship), the frustration of not being able to heal, an objective they have been trained for, among others[1,6].

Therefore, to avoid situations of Burnout in the workplace setting, the professionals should develop personal strategies that are cognitive-behavioral in nature with a self-evaluation character, to eliminate or reduce sources of stress, at the individual and work group levels. The development of adequate communication skills and a perception of self-efficacy can make the health professionals feel more secure, more competent, fomenting the interpersonal relationships with their patients and their work colleagues as well[3,8].

The hospital emergency department (HED) and the Critical Care Units (CCU) require various types of complex technologies, care and treatments, making the task of caring to become mostly focused on keeping the patient alive, setting aside the human quality. It is very common to find the patient isolated from family and friends, naked, full of wires and unknown machines with a multitude of alarms and noises, so that the health professionals face a complex disease in adverse situations[9,10]. Thus, they perform their care work under peculiar structural, emotional and care-providing pressures, which makes them more exposed to a greater amount of risks and work stress, which can favor the appearance of the Burnout syndrome [11-17].

Thus, the main objective of the present study is to analyze the relationship between communication skills, perceived self-efficacy and Burnout syndrome in health professionals from the hospital emergency department and critical care unit of a regional hospital. The secondary objective was to analyze the differences in the scores of the aforementioned variables according to sociodemographic and professional variables.

METHOD

Design

Observational and cross-sectional study conducted at the Vega Baja Hospital in Alicante, Spain.

Population and area of study

The sample was selected with non-probabilistic sampling, at the hospital emergency department (HED) and the critical care unit (CCU) from a regional hospital.

As inclusion criteria, all the participants had to 1) be older than 18, 2) be currently working as a care worker at the HED or CCU, 3) be a physician, nurse or nursing aide, and 4) sign an informed consent form.

To ensure that the sample was representative for a target population of 130 health professionals, the following formula was applied: $n = \frac{N.Z^2.p(1-p)}{(N-1)e^2 + Z^2.p(1-p)}$, with a level of

confidence CI= 0.95 (95%) a deviation of Z=1.96, a margin of error e=0.05 (5%), and a standard of deviation of p= 0.05 (5%) as utilized in previous studies [18], with a sample size of 47 health professionals needed, although a final sample of 90 was obtained.

Data collection

In first place, the authorization from the center's management was solicited, and the supervisors from the HED and CCU were contacted. Once the center had accepted to participate in the study, a meeting was conducted with the supervisors in order to present the project and to provide them with the questionnaire material needed (online and physical copy), as well as the period for its completion.

Two formats of the questionnaire were presented to facilitate the adhesion of the personnel to the study, one in digital format through the use of the Google Forms, and another in paper format.

After the data collection period was finished, which lasted a month and a half, a participation rate of 90% was obtained (90 questionnaires completed), a total of 63 in physical format, and 27 in digital format. The paper questionnaires were collected by the nursing supervisors from both hospital units.

Instruments

For the evaluation, the participants completed diverse self-administered instruments which included: Sociodemographic (age, sex, marital status) and professional characteristics (professional category, type of contract, service and work history), designed ad hoc for the present study. Communication Skills Scale for Health Professionals (CSS-HP)[19]. A self-administered scale composed by 18 items, with a Likert-type response scale with 6 possible responses, composed of four dimensions: Informative communication: composed by 6 items (5, 8, 9, 14, 17 and 18), showing the manner in which the health professionals obtain and provide information, in the clinical relationship they established with their patients. In this dimension, the minimum score is 6 and the maximum is 36. Empathy: composed by 5 items (2,4,6,11 and 12), shows the ability of the health professionals to understand the patient's feelings and making this palpable in their relationship, as well as its behavioral dimension, named empathic attitude, composed by active listening and empathic response. In this dimension, the minimum score is 5 and the maximum is 30. Respect: composed by 3 items (1, 3 and 15). It evaluates the respect shown by the health professionals in the clinical relationship they established with the patients. In this dimension, the minimum score is 3 and the maximum is 18. Social skills: the 4 items in this dimension (7, 10, 13 and 16) show the ability of the health professionals to be assertive or have skillful social behaviors in the clinical relationship they establish with the patients. In this dimension, the minimum score is 4 and the maximum is 24. This tool had good psychometric properties with respect to the analysis of the items, internal structure, reliability (Cronbach's Alpha was 0.65 to 078 in all the dimensions) and external evidence of validity, relating the communication skills with the level of burnout perceived by the health professionals [20].

The Spanish version of the Maslach Burnout Inventory Human Services Survey (MBI-HSS) is the most utilized for evaluating the frequency and intensity of the Burnout syndrome within the healthcare work context. It is composed of 22 items, and the three dimensions that comprise the syndrome can be observed: emotional exhaustion (EE),

depersonalization (DP) and personal accomplishment at work (PA). These 22 items are evaluated with a Likert-type scale, in which the subject scores the frequency with which one experiences the feelings that shape the syndrome. The frequency range is shaped by 7 categories ranging from "never" (0) to "every day" (6). The minimum and maximum score range from 0-54 in the EE dimension, from 0-30 for the DP dimension, and from 0-48 in the PA dimension. The internal consistency (Cronbach's α) was satisfactory for the dimensions EE (α=0.85) and PA (α=0.71), and moderate for the DP dimension (α=0.58). The structure of three oblique factors had a good fit [21].

Self-efficacy Scale, contains 10 items that encompass the dimension of the work self-efficacy within them, and evaluates the stable belief of individuals on their ability to adequately manage a wide gamut of stressors found in everyday life. The minimum and maximum scores of the scale are 10 and 40. The scale showed an internal consistency (α) of 0.87 and a split-half correlation of 0.88[22]

Data analysis

For data processing, a database was created with Microsoft Excel®. All the questionnaires collected were introduced into this database and the variables were codified. These were posteriorly analyzed with SPSS© v23, with the following analyses performed: descriptive statistics (mean, standard deviation) of the different scores obtained in the quantitative variables by the health professionals (dimensions of the different instruments and age), as well as frequencies and percentages of the sociodemographic variables and professional categories. Also, Pearson's bivariate correlations were performed between the variables studied, as well as differences in means (Student's t-test and one-way ANOVA) between the different dimensions of the MBI, the CSS-HP and the perceived Self-efficacy with the sociodemographic variable sex and the professional variables professional category and work area. Lastly, in the ANOVA tests where significance was found, a post-hoc Tukey's test was applied to identify the significant differences between the professional category variable pairs.

Before performing Student's t-test and the one-way ANOVA, the assumption of normality of the variables was verified with the Kolmogorov-Smirnov test and the homoscedasticity of the variances with Levene's test.

Ethical considerations

The Personal Data Protection guidelines were followed in this study, as established for health-related data[23], and the international recommendations: guarantee of the voluntary and informed participation, confidentiality of data and informing the participants about the results. For this, they were given instructions to provide an anonymous "Alias" in the written questionnaires for their posterior analysis.

RESULTS

The final sample was composed by 90 health professionals, of which 47 were nurses (52.2%), 19 were physicians (21.1%) and 24 were Nursing aides (26.7%)

The average age of the sample was 42 years (SD=7.40), with 27.8% being men and 72.2% women. Table 1 shows the descriptive data of the sociodemographic and professional variables of the sample (Table 1).

Of these, 52.5% (n=47) of the health professionals worked as the HED, and 47.8% (n=43) at the CCU, obtaining an adequate response rate from both units: 67.1% from the HED, and 71.7% from the CCU.

Medium-high scores were found in all the dimensions of the CSS-HP, and a high score in the dimension personal accomplishment at work from the MBI-HSS and perceived self-efficacy. On the other hand, intermediate scores were found in the dimension assertiveness and the dimension emotional exhaustion of the MBI-HSS, and low scores in the dimension depersonalization of the MBI-HSS (Table 1).

Table 1. Descriptive statistics of the sociodemographic and professional variables and the dimension of the instruments utilized.

Sociodemographic variables	n (%)
Sex	
Man	25 (27.8)
Woman	65 (72.2)
Marital Status	
Single	27 (30)
Married	55 (61.1)
Divorced	7 (7.8)
Widower	1 (1.1)
Type of contract	
Undefined	29 (32.2)
Temporal	54 (60)
Part-time	5 (5.6)
Training and learning	2 (2.2)
Professional Category	
Nurse	47 (52.2)
Physician	19 (21.1)
Nursing aide	24 (26.7)
Time worked	
0-3 months	0 (0)
3 months to 1 year	0 (0)
1-5 years	4 (4.5)
5-10 years	10 (11.1)
> de 10 years	76 (84.4)
Service	
Emergencies	47 (52.2)
CCU	43 (47.8)
Age (Years) [M (SD)]	42 (7.40)
Dimensions	**M (SD)**
Communication Skills Scale (CSS-HP)	
Informative communication	27.36 (4.46)
Empathy	23.18 (4.05)
Respect	15.61 (2.12)
Social Skills	15.84 (3.73)
Maslach Burnout Inventory (MBI-HSS)	
Emotional exhaustion	30.69 (11.5)
Depersonalization	13.48 (6.01)
personal accomplishment	45.98 (8.91)
Perceived Self-Efficacy	32.14 (4.15)

As for the analysis of comparison of means, it can be observed that the men obtained higher scores that the women in all the dimensions of the CSS-HP except for the dimension empathy, in personal accomplishment at work from the MBI-HSS, and in self-efficacy in general. However, these differences were not statistically significant (p>0.05) (Table 2).

Table 2. Descriptive statistics (mean, standard deviation) of the scores of the sample in each of the dimensions of the CSS-HP and the MBI-HSS according to the variable sex.

	Men n=25		Women n=65		
	M	SD	M	SD	p
Empathy (CSS-HP)	22.92	4.05	23,27	4.07	0.71
Informative Communication (CSS-HP)	28.28	4.14	27	4.55	0.22
Respect (CSS-HP)	16.16	1.72	15.40	2.23	0.13
Social Skill (CSS-HP)	16.28	3.9	15.67	3.68	0.49
Emotional Exhaustion (MBI-HSS)	30.04	12.67	30.93	11.12	0.74
Depersonalization (MBI-HSS)	13.96	6.45	13.29	5.87	0.64
PAW (MBI-HSS)	47.04	7.68	45.56	9.36	0.49
Self-Efficacy	33.24	3.57	31.72	4.30	0.12

M: Mean; SD: Standard Deviation; p: Significance; PAW: personal accomplishment at work

If we observe the variables according to hospital unit, we can see that the health professionals from the CCU obtained a higher score in all the dimensions of the CSS-HP as compared to those from the HED, with these differences being statistically significant in the dimensions empathy (t_{88}=4.158; p=0.000), informative communication (t_{88}=2.520; p=0,014) and assertiveness (t_{88}=2.481; p=0.015). In the dimensions emotional exhaustion and depersonalization, the CCU personnel obtained lower scores, with the scores being similar in the other dimensions and perceived self-efficacy (Table 3).

Table 3. Descriptive statistics (mean, standard deviation) of the scores of the sample in each of the dimensions of the CSS-HP and the MBI-HSS according to the variable service.

	Emergencies n=47		CCU n=43		
	M	DE	M	DE	p
Empathy (CSS-HP)	21.61	4.36	24.88	2.85	0.00
Informative Communication (CSS-HP)	26.25	4.77	28.55	3.78	0.01
Respect (CSS-HP)	15.34	2.35	15.90	1.82	0.21
Social Skill (CSS-HP)	14.93	4.09	16.83	3.03	0.01
Emotional Exhaustion (MBI-HSS)	32.04	10.95	29.20	12.03	0.24
Depersonalization (MBI-HSS)	14.17	6.55	12.72	5.32	0.25
PAW (MBI-HSS)	46.12	9.74	45.81	8.00	0.87
Self-Efficacy	32.77	3.60	31.46	4.63	0.14

M: Mean; SD: Standard Deviation; p: Significance; PAW: personal accomplishment at work

The comparison of means analysis according to the professional category variable provided statistically significant differences in the dimensions informative communication ($F_{2,87}$=4.872; p=0.010), respect ($F_{2,87}$=3.867; p=0.025), and assertiveness ($F_{2,87}$=3.503; p=0.034). The post-hoc analysis showed that these differences were between physician and nurses with the nursing aides in the dimensions informative communication and respect, and also between nurses and nursing aid in the dimension assertiveness. As for the general self-efficacy perceived,

the group with the highest score was the nurses, followed by the nursing aid technicians and physicians, respectively, although the scores were similar (Table 4).

Table 4. Descriptive statistics (mean, standard deviation) of the scores of the sample in each of the dimensions of the CSS-HP and the MBI-HSS according to the variable professional category.

	Physicians[a] (n=19)		Nurses[b] (n=47)		Nursing aides[c] (n=24)		
	M	SD	M	SD	M	SD	p
Empathy (CSS-HP)	24.32	4.44	23.47	3.57	21.71	4.36	0.08
Informative Communication (CSS-HP)	28.53[c]	3.73	28.06[c]	3.49	25.04[a,b]	5.83	0.01
Respect (CSS-HP)	16.16[c]	1.83	15.89[c]	2.08	14.63[a,b]	2.18	0.02
Social Skill (CSS-HP)	16.58	3.81	16.40[c]	3.13	14.17[b]	4.36	0.03
Emotional Exhaustion (MBI-HSS)	27.79	12.62	32.85	10.81	28.75	11.55	0.17
Depersonalization (MBI-HSS)	12.74	5.00	14.02	6.18	13.00	6.53	0.66
PAW (MBI-HSS)	43.53	8.27	47.17	6.90	45.58	12.27	0.31
Self-Efficacy	31.32	3.23	32.72	3.89	31.67	5.16	0.37

M: Mean; SD: Standard Deviation; p: Significance; PAW: personal accomplishment at work.
[a, b, c] indicates the professional category with which the statistically significant differences are found $p<0.05$ in the post-hoc analysis.

The difference in means analysis in the rest of the sociodemographic (marital status) and professional (type of contract and work history) variables did not show any statistically significant differences ($p>0.05$).

As for the analysis of the bivariate correlations, a negative correlation was observed between the dimensions Emotional exhaustion and Depersonalization of the MBI-HSS and the dimensions of the CSS-HP, the personal accomplishment at work from the MBI-HSS and the perceived self-efficacy. This relationship was statistically significant ($p<0.05$) between the dimensions perceived self-efficacy and emotional exhaustion, and on the other hand, between the dimensions empathy, respect and perceived self-efficacy with depersonalization.

On the other hand, a positive and statistically significant correlation ($p<0.005$) was found between the dimension personal accomplishment at work from the MBI-HSS and the dimensions from the CSS-HP and the perceived self-efficacy (Table 5).

Table 5. Pearson's bivariate correlation between the sociodemographic variables (age, sex and time worked), the dimensions of the communication skills (Informative communication, empathy, respect and assertiveness), the dimensions from burnout (emotional exhaustion, depersonalization and personal accomplishment) and the Perceived self-efficacy.

	Age	WH	IC	E	R	SS	EE	D	PAW	SE
Age	1									
WH	0.44**	1								
IC	0.02	0.07	1							
E	-0.03	-0.05	0.60**	1						
R	-0.10	-0.02	0.51**	0.52**	1					
SS	-0.09	0.01	0.60**	0.63**	0.23*	1				
EE	-0.13	0.01	-0.13	-0.13	-0.16	0.06	1			
D	-0.20	-0.09	-0.16	-0.26*	-0.21*	-0.03	0.62**	1		

PAW	-0.11	-0.01	0.31**	0.40**	0.31**	0.21	-0.09	-0.14	1
SE	-0.05	0.04	0.15	0.05	0.04	0.11	-0.34**	-0.15	0.35**	1

WH= Work history; IC= Informative Communication (CSS-HP); E= Empathy (CSS-HP); R= Respect (CSS-HP); SS= Social Skills (CSS-HP); EE = Emotional Exhaustion (MBI-HSS); D= Depersonalization (MBI-HSS); PAW: Personal Accomplishment at Work (MBI-HSS); SE = Self-efficacy.
** The correlation is significant at the 0.01 level.
* The correlation is significant at the 0.05 level.

DISCUSSION

The aim of this study was to analyze the relationship between communication skills, Burnout syndrome and self-efficacy of a heterogeneous sample composed of three professional groups from the healthcare system in Spain (physicians, nurses and nursing aides) and from two hospital services, the HED and the CCU, where the Burnout syndrome and the need to provide training on communication skills between professionals and patients have been found to be high.

The sample obtained a medium-high score in all the communication skills dimensions, with the physicians and nurses being the groups of health professionals with the highest scores. The collective with the lowest scores in communication skills were the nursing aides. These differences were statistically significant, and in agreement with similar studies[3,24].

On the other hand, it should be emphasized that the health professionals from the CCU obtained higher scores in communication skills with respect to those from the HED, with these differences being statistically significant in empathy, informative communication and assertiveness. However, the scores in burnout and perceived self-efficacy were similar. As for the analysis of the scores according the sex variable, the men generally obtained higher scores in communication skills, except for empathy, personal accomplishment at work and self-efficacy, and the same levels in the dimensions emotional exhaustion and depersonalization.

We can consider that these results are a direct result not only of the training received on the different professional skills described, but also the direct involvement of the institution in fomenting an adequate work context.

A possible solution to the problem of stress of health professionals was discussed by a study[4] which stated that the systematic addition of a set of knowledge, resources and communication skills could prevent the burnout syndrome. Thus, training programs where they learn about resources, such as training on communication skills, management of self-esteem, relaxation techniques, coping techniques, etc., could have a positive effect on the prevention of this syndrome. According to our results, the collective with the lowest score in communication skills and the highest score in emotional exhaustion and depersonalization was the nursing aides, who could greatly benefit from these types of programs.

A study[24] which analyzed Burnout in a sample of emergency and critical care nurses from a hospital in Andalusia, Spain, confirmed that the sample obtained low scores on emotional exhaustion and depersonalization, and high scores in personal accomplishment at work, without finding high levels of burnout, in agreement with our results.

Likewise, another study[25] conducted with physicians from the hospital emergencies unit confirmed that self-efficacy played a fundamental role in transforming emotions at work. Thus, the interventions should be aimed at enhancing self-efficacy, when designing occupational health advocacy programs.

On the other hand, the results of our work are in line with another study[3] with a sample of health professionals (physicians, nurses and nursing aides) from various hospitals, both public and private, in the areas of primary care and specialized care, which empirically showed that the communication skills of the health care personnel was a factor of prevention of Burnout. Thus, the results shown in the bivariate correlation analysis of our study are in agreement with other studies[3,26], with a negative relationship observed between the communication skills and the dimensions emotional exhaustion and depersonalization, and a positive relationship between communication skills and personal accomplishment in the area of work.

As the limitations of the study, we could argue that other predictive variables could have been introduced (such as work pressure, self-esteem, stress, among others). Thus, a step forward could be taken and more dimensions could be included that may explain the particularities and specificities of Burnout in health professionals from the HED and CCU.

Other important limitations were that our sampling was not random, the sample was not stratified either according to the service or the type of professional, and the sample was small, despite counting with a great participation of the health professionals. Thus, in the next study, the sample of professional workers included could be increased with those from other health centers. Then, a multi-center study could be conducted, stratifying the sample according to service and professional categories, ensuring that the sample represents all the different professional categories.

CONCLUSIONS

With the results obtained, various conclusions can be made. The health professionals of the sample analyzed had adequate communication skills, a high personal accomplishment at work and perceived self-efficacy. On the other hand, they have a low level of emotional exhaustion and depersonalization. The health professionals with the highest communication skills were the physicians and nurses, with the nursing aides being the group that had the lowest. The men had greater levels of communication skills, except for empathy, personal accomplishment at work and self-efficacy than the women, and the same levels of emotional exhaustion and depersonalization. The health professionals from the CCU had the greatest communication skills, and the least emotional exhaustion and depersonalization with respect to professionals from the HED. The communication skills of the health professionals from the HED and the CCU are related with a lesser emotional exhaustion and depersonalization, and a greater personal accomplishment at work, as well as the increase of self-efficacy acquired.

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