APPENDIX I

Semi-Structured Focus Group Questions

Preamble for participants:

Thank you for taking the time to participate in this focus group. I would like to first explain how this focus group will take place. My name is XXX and I am a XXX doing a research study on system-level sources of workplace burnout.

We recently conducted a survey on burnout in the Department of Medicine and identified several important things. First, the majority of physicians are experiencing burnout right now. Second, almost 40% of physicians struggle with work-life conflict. And third, members rated reducing work inefficiencies and non-physician clerical work as *the most important* strategies to reducing burnout.

So, the purpose of this focus group is to try to identify those aspects of work including the work inefficiencies and the non-clerical work that contribute to burnout in your {division/department}. We would like to understand your thoughts on what are the system level factors that are challenging and that cause burnout feelings for you and others in your group and what are your thoughts on the potential solutions to these system level factors.

Our discussion should take about 60-90 minutes. With your approval, this session will be audio-recorded and notes will be taken during the session by a facilitator, for analysis later. No personal identifiers will be linked to the recording or the notes—only a code, which is known only to the research coordinator. We may use direct quotes of things you say in the focus group in reports of research findings. If your quotes are used, your name will not be linked to them, nor will any information that would identify any person. We would also like to remind all participants that the information shared today should be treated as confidential and not shared outside of this room.

Please feel free to answer our questions based on your ideas about this topic, or by thinking of examples from your own experiences, or those of your colleagues. There are no right or wrong answers.

Semi-structured focus group questions:

What matters most to physicians at work

1. Before we start talking about the sources of burnout, we want to understand, what matters to you at work? What brings job satisfaction? What creates pride in the organization? What does it look like when we're at our best?

Organizational/work based sources of burnout

2. What are the specific frustrations, impediments or things at work that get in the way of attaining what matters most to you at work.

Probe: What are the pebbles in your shoes? The processes, issues or circumstances that, if we could only deal with them, it would make it so much easier for you to do what you really want to do when you practice medicine.

Probe: What are the frustrations or impediments at work that get in the way of your work life balance?

Organizational/work based Solutions to Burnout

3. Thinking to the pebbles in your shoes, what are some strategies that would help you get to what matters most to you when taking care of patients?

Probe: What are some strategies that would help you achieve better work life balance?

Probe: What could division heads, department heads and hospital leadership do?

APPENDIX II

Category I: Contributing Factors to Burnout

Theme	GIM	ED
Feeling undervalued	- "Leadership, they don't value what I bring to the table, I'm told to do whatever it is, my own leadership in my own department doesn't stand up for me or doesn't seem like they stand up for me because nothing ever changes." - "Our time and our efforts are less valuable than other doctors in the hospital." - "On top of that you have to care for and role model for residents and medical students…and I don't think it's valued or recognized by the organization." - *"When the hospital cancelled those lines, basically telling us, we no longer value you… and as soon as the pandemic numbers come down, we became an expense item. And suddenly the hospital says: you aren't worth it anymore."	- *"I do think our time isn't always valued by some of the consultants."
Workload and scheduling	- "Relationship building with the patient and really showing them that we care about them seems to disappear and the exhaustion of the workload and day to day things that I'm now responsible for… the whole process has become very distant and almost impersonal." - "I could work the same number of hours on a different rotation, and I could function I can even have like, personal life after hours. care for my kids but the CTU I can't."	"Definitely feeling pressed for time in a number of different ways…one because of the demand to move patients quickly."

	- "One is all the calling and the figuring out about scheduling for patients, when they're going to have their scope, when they're going to have their surgery when a surgical service is going to see them, can I get in touch with a surgical service?" - "The sheer number of patients" - "Holding the front and making sure nobody dies until the next day without really having much time to think about the active issues or if an interesting case has been admitted." - "Hard to establish that that relationship, but at the same time, you're trying to get them out of hospital as soon as you can, when a lot of them don't want to." - "There's no such thing as a daycare that opens up at seven. And so you basically, rules out a lot of dual physician family and or people as a kid in daycare and a partner like it makes life extremely more difficult. When really we don't need to be there at 730 for patient care." - *"When you think about your job, as a teacher, your job as a physician, and then also you're kind of having to always engage with the emergency department and deal with what's coming, coming in to see to you, it's almost like you've got three jobs that you're trying to do. And then given the complexity, the social complexity of the patients that you're that you're working with…"	

	- "Sometimes when you're just too busy, I find sometimes like, I don't really get that fulfilment from patient interactions, like, it's nice to have that time to, like, be present and, you know, get something personally out of that interaction as well." - "I think coming back to our structure and function on the CTU, I think weekends are some of the worst times for faculty. We're here on the weekends, we are expected to round on the weekends when we're there. We typically are not assigned residents… you're taking in reviews from two other teams from the night before managing your whole team. So I think weekends are pretty brutal. And then you're often on call that night, then have to be back the next morning. So I think weekends are a major source of burnout or stress for the attendings. Because we don't have another person to help us yet we're carrying actually more responsibility on weekends than we do during the rest of the week." - *"I feel like as a young faculty, I don't give away my weekends, because that's where I make most of my money… there's a benefit to being there. And that doesn't contribute to my wellness. I'll say that. But it's hard to resist because the system is structured like that, right." - "I think it's interesting how it's pretty consistent all across the board whether or not you know,	

	we're single, or have a partner or have a dog or kids, I think everybody's life is on hold. I think it affects people differently. I have three kids. And, yeah, and my husband's also in medicine. So it's very, very chaotic. And when I'm on service, I feel like, I feel like, I take a deep breath and go under water for like two weeks, and then come out the other end and mess up everything, many times. dinners, games, extracurriculars for the kids all the weekend stuff, family stuff, it's tough, it's really tough. I had to do less call, I have to give away as much of it as possible or take on less weekend work. " - "Just want to emphasize that phrase that life gets put on hold when you're on service. Because that's, I think, is a very abnormal way of working. You know, everybody else has, you know, a balance where they work and they have their life… like I don't answer my emails, I don't clean my home, I like don't eat well, I don't exercise. And then I try and make up for it on my like week off, which, again, it's not, it's not necessarily the best way to live." - "And that's partially due to agency and lack of control over what we do and do not do. But if you can't take a minute to think through things really thoughtfully. We're internist, we like to think so that's a big part of what we do, or I think wellness, for me."	

Out of scope practice and assembly line medicine	- "We're asked to look after patients that are sort of outside of the range of expertise that we were actually trained in (i.e., trauma patients)." - *"IM doctors are not able to solve their problems - housing problem or an addiction problem." - *"That's not internal medicine complex. That's just socially complex." - "I have lots of institutional pressure that's coming at me to move people through and be efficient." - "You kind of get reduced to like a mechanical check, check, check. And on to the next one, like, I find, I really don't get that fulfilment, from, you know, the interaction as much as it should be anyways."	
Interruptions and noise	- "I get woken up, and I have to like deal with some, you know, something like that we're fighting back or disposition issue, like, I can't go back to sleep for a while." - "The number of times my phone rings in a day and the number of thoughts that gets interrupted and conversations that get interrupted, that I that is really something that takes energy away from me rather than giving value." - "The Emerg doc at the 11th takes five minutes to interrupt my review with the patients who present this patient, the residents which you know, whatever, but then we say, well, this patient would be more appropriate with	- "An overhead paging system that really sometimes just interrupts you so many times that it interrupts your train of thought." - "The other thing that has been a real pebble in my shoe lately is the fact that in terms of electronic devices and telephones in the hospital, yes, I find where you know, in the bank, in the restaurant, ordering a coffee, going shopping, you're not on your phone, speaking loudly on FaceTime, or watching a video and hear in a crowded emergency in a stretcher next to a stretcher where I'm trying to take a history, people are doing face time watching videos without headphones.

	psychiatry." - "So it's not like you're always standing at a computer where you can enter an order. So you can't you're interrupted, to put in something instead of just saying, Can you give them whatever? And then saying yes, no problem. You have to then interrupt whatever you're doing, go find a computer and do it before you forget, because it's one of 1000 interruptions that has happened in that last hour." - *"It's very frustrating having to deal with all the noise issue..." - "I think one of the strongest visceral reactions I have is when I am distracted in the middle of doing something that I think is important like reviewing it case with a resident or learner. And we're sort of deep in thought and we're having a good time kind of discussing some of the interesting aspects of a case. And then to be pulled away from that by a phone call, or, you know, a nurse coming by and, and just demanding kind of your attention, when you really were kind of in a flow state. And it's hard to have a sustained flow state in the hospital setting, I get it, it's an acute place. But I certainly think there are better ways of managing the distractions and triaging the distractions so that it's not all the time always."	And it's very disruptive." - "When you dictate and somebody else dictates next to you, they will dictate into your system. So you actually have to like because it's so loud." - "Definitely feeling pressed for time in a number of different ways. One because of the constant interruptions…"
Bureaucracy and inefficiencies	- "Battling the bureaucracy, so to speak, bushwhacking through the bureaucracy just to get	- "Some of the technical issues, like having to log in to different systems, I guess you

	basic patient care completed."	have to log into Paris separately from logging into Cerner." - Dictaphones breaking - Cerner freezing - Broken equipment
Interdepartmental conflict	- *"It's very frustrating having to deal with … the politics and fighting with different services." - "Talking to eight different surgeons to find out somebody who's willing to look after this patient." - "It's hard for me to understand why the opinion of every other consultant in the hospital is more important than my opinion as an internist." - "You're fighting with your specialist colleagues, you're having to nag people to do their job, get the tests done. Make sure that the procedures are completed in a timely manner." - "One area that I still fear and hate is when you're on call, and then you get pulled into a turf war. Right? You get the patient that bounces no one wants, and you're really getting pressure to admit, because internal medicine, we have such a broad mandate, there's almost nothing we can't manage short of cutting someone open. Right? Many of these cases, we don't offer much. And the fact that everyone else has the ability to refuse a case and we don't, we are then expected to see the case. This is particularly made worse when our trainees are facing really	- *"I do think our time isn't always valued by some of the consultants." - "One of the things would be the fact that for a lot of our consultants, the day ends at about 430. And everything, held overnight, which means, you know, we're managing complex elderly patients." - "But I know the person that just checked in with an eye problem at 11pm. They might get seen at 10 in the morning, like literally, he says it is so discouraging to go into there.

	heavy loads in the emergency department." - "It takes up so much more of your time to try and deflect a consult and a fight back and to push against the system, that the path of least resistance is often just doing the work and admitting the patient. And you have to decide in that moment, are you going to engage? Or are you not going to engage?" - "I always ask what is the best thing for the patient, right? But at the same time, you don't want to reward the system for handing us crap, right? And so I feel that real problem, that tension and like I said, most times I tell the team just take it because I still think we in the end probably are the best person, but it still feels like we've been abused a little bit, right?" - "You know, one of the big issues that the hospital has dealt with, and our department in particular has dealt with for quite a few number of years, is this pay for performance of the emergency department, which basically forces the department to push patients towards any admitting service. And since internal medicine is the greatest service in the world, that can take care of everyone, we are usually the default when no other service is willing to take patients, because they are either too complex or too sick, or, you know, they are too multi system, or, you know, they're too young. There's been instances where patients are	

	not adequately evaluated, or worked up and then just deflected or deferred to Internal Medicine Service to do their job, because they feel the pressure to push them along, because they get paid more, you know, that that department makes more money for their activities. So it's a way and it doesn't benefit us in any way, except just adds to our stress - "Like the number of times where I've just been pushed to admit somebody that I'm not done assessing or just maybe needs a few hours in the ER and could avoid being admitted, is incredible. And that it just it defeats logic. Sometimes, it's just simply like, 'Get out of my Emerg I don't care if the patient only needs two more hours.' You know. it's actually really an important part of something small, that could be fixed that would add a lot of positivity to our quality of life"	
Social problems	- "I think part of the problem is that people don't have to be as accountable with some of our individuals who cannot advocate for themselves." - *"IM doctors are not able to solve their problems - housing problem or an addiction problem." - *"That's not internal medicine complex. That's just socially complex."	- "Sometimes people come in, because they're hungry, or because they want a cheese sandwich or a blanket or something. And even though I know they need that, for me, it doesn't give me a sense of satisfaction at the end of the day, as opposed to having someone who's medically ill."
Non-physician roles	- "We need to move patients, we need to make room, we need to have ways to discharge people.	- "I'm constantly coming up against logistical barriers, like I can't find the patient, I have

	And so that's what makes it like a s to me, because I'm just the manager, you know, I'm, I'm not practicing medicine at that point." - "… you're also kind of playing social worker at the same time."	to change the bed myself. There's no nurse to help." - "Portering, changing sheets, cleaning up garbage. Other things I've heard are things like doing nursing assessments, because there's maybe not enough time, even for the nurse to do an assessment." - "Having to run around and find the patient, changing your own sheets cleaning up through, you know, cleaning up the bay or the room for the patient." - "Having to bring them into a stretcher that is messily made by me with garbage on the floor that I've tried to clean up but haven't had time to clean up completely." - *"There's no money for overtime nursing. There's no money to call in an extra nurse, there's no money. And so I feel bad for our nursing staff too."
Violence Risk		- "I have seen a bit more agitated patients that are placing staff at risk - like we're just held to the standards, it's versus we don't have a system in place to make us feel safe to assess that patient." - "Biggest thing that is not working is our approach to violence in the emergency department."
Waiting room medicine		- "We do have a problem with the triage and because we don't have enough physical space to put patients into

		beds, so sometimes the triage is quite questionable. So for example, suicidal patients put in the waiting room." - "a care space that is not appropriate for their illness, and then have to ask them to go back to a waiting room full of people who are maybe intoxicated or experiencing other illnesses and maybe not an appropriate space for them." - "There's literally not a single space where you can assess a patient. So it's like, how are we supposed to be to our job if we don't have spaces to assess patients" - "Patients have no privacy. There's nowhere to examine them. There's nowhere to address them."
COVID-19 pandemic effect	- "And I'm hearing like, we may be asked to even offer more because we were able to take COVID like a champ. That worries me… like we could burn out and we can become more and more inclusive of what we're doing and not have our boundaries and not be a specialty anymore. So as we do restructuring, as we talk about our capacity to take care of our patients, we also have to talk about our, our skill set, what our, what our boundaries are. "	- "We in the emergency have piled on risk upon us, like we are facing more risk than we did in the past. And I just, that became very obvious to me in the pandemic."
Sexism in the workplace	- "This may not be a very popular thing to say. But I think sexism does still exist to in the workplace... But as a woman, I think there are potentially more opportunities	

	to get frustrated because of the way you might be treated, or the nurses not respecting your authority as much as your white male colleague, for example, or pushback you get on the phone. So I think that might also play into kind of wearing down faster.“ - “Ya, like [they] said, I definitely see a difference in the workplace in the way my female colleagues are treated than how I'm treated from other physicians. Definitely from nursing staff and allied health. And so I think that that It has to contribute to how people end up experiencing burnout.” - “I would also echo that there's a lot of intimidation from surgeons, male, older, towards female physicians. And it might not be very, it's not like very discreet necessarily. It's just, it's kind of like microaggressions. And, yeah, it's definitely there.”	
Financial structures and remuneration	- “And so that struggle between how much should we make for the work versus how much work is reasonable for us to do at once? I think is really is really tough… But I think that that tension is really hard to get away from. And, and it always feels like oh, if I just see one more, or if I stay a little bit longer tonight than I can make a bit more of it. But a lot of that doesn't lead to good care and doesn't lead to us feeling healthy.” - *“Recently on CTU, we moved	- *“There's no money for overtime nursing. There's no money to call in an extra nurse, there's no money. And so I feel bad for our nursing staff too.”

	off of the set amount [during COVID] and back to fee for service. And I've never seen the teams look happier when we're on a set amount of money… you had more time to teach, more time to look after patients. And we were in the thick of COVID, with no vaccinations. And I've never seen my faculty and teams actually look more satisfied. And then when that was pulled away, you go back to the grind. I agree money doesn't drive everything. But let's face it, we're all here to do a job and earn money and earn an income, pay our bills. That's probably one of the most important reasons as we work." - *"When the hospital cancelled those lines, basically telling us, we no longer value you… and as soon as the pandemic numbers come down, we became an expense item. And suddenly the hospital says: you aren't worth it anymore." - *"I feel like as a young faculty, I don't give away my weekends, because that's where I make most of my money… there's a benefit to being there. And that doesn't contribute to my wellness. I'll say that. But it's hard to resist because the system is structured like that, right."	
Lack of camaraderie for difficult cases	- *"I talked about this, the council of the elders kind of thing, where faculty and attendings once a week, BC Cancer Agency does this really well, they have tumour rounds,	-

	where they all get together and say this is a puzzling case. They talk about right. And something that because we all will face some diagnostic uncertainty, or just am I in the weeds here on this case, like I've inherited this case, this has been a door to door like a short to shore kind of case has been now on three CTUs, and I'm picking it up, am I missing something right? It's a safe space where we say, here's what I'm struggling with. And people can say that no, you actually, you know what, I can't think of anything else that feels okay. Right, but also just to be able to bounce it off of each other… And even if that week, nobody has a case, we can just check in on each other."	

*Text shown in black corresponds to data collected from focus groups in hospital 1 and text shown in red corresponds to data collected from the focus group at hospital 2.

APPENDIX III

Category II: Protective Factors that Bring Joy and Satisfaction to Physicians

Theme	GIM	ED
Being rewarded and valued	- "It's good to feel like you could make a difference in a patient population." - "When my skill sets are valued."	- "You're a valued member of the organization, that if you if you left, you would be missed." - "You're rewarded for bringing value to the organization."
Having time to build rapport with patients	- "To connect with the person, and they felt they felt sort of heard in the end, we were able to sort of events, events, things, and it was that connection with the patient that, that I found sort of satisfying." - "The sense of connection that I had to the patient and the gratitude that this patient expressed." - "And having a patient actually know who I am and remember who I was, it was just incredible."	- "Positive interactions with the patients'
Reducing interruptions	- "Having time to interact with patients without being interrupted."	
Staff collegiality	- "I love my colleagues"	- "Positive interactions with the staff" - "Such wonderful colleagues everywhere. Like, literally everyone is friendly, smiling, and helpful." - "Just the interaction I got with all the staff and the collegiality." - "Colleagues that you can trust and turn to bounce things off"
Doing physicians' work	- "Sense of getting to use my skills and training to help this person"	- "When someone's sick, might actually do something meaningful to resuscitate somebody makes me happy… I

		feel good about myself and feel tired physically, but I feel satisfied at the end of the day." - "Interesting cases and good medicine, as well as, as well as patient satisfaction, but and, you know, and good outcomes."

*Text shown in black corresponds to data collected from focus groups in hospital 1 and text shown in red corresponds to data collected from the focus group at hospital 2.

APPENDIX IV

Category III: Actionable Interventions to Reduce Burnout.

Theme	GIM	ED
Workload and scheduling	- "Communication app, basically where individuals would sign in to their role in the hospital every given day" - "Having a hospitalist to help with the load." - *"Answering phone calls, like perhaps there's a way to redirect phone calls so that they're batched or prioritized." - Flexibility in scheduling (having locums to take unwanted call shifts/weekends) - "post-call" days or wellness days	- "Rather than us calling five different there should be a service that takes like a hospitalist service - it's expensive, but it's an easy, low lying fruit that is contributing to our burnout, for sure."
Interruptions and noise	- *"Answering phone calls, like perhaps there's a way to redirect phone calls so that they're batched or prioritized."	- "I think we need to, you know, alert the public to how they're supposed to behave in an emergency department or where they're accepting patient care in the hospital. Because that kind of behavior is not even acceptable, like at a family doctor's office at the dermatologists."
Bureaucracy and inefficiencies	- "More computers would be nice, but also coming up with a system where there's some leeway for order entry or verbal orders." - "Reducing like the amount of administration with order entry with Cerner."	
Interdepartmental conflict	- "Develop sort of interdisciplinary or cross cultural, cross disciplinary	- "It'd be nice to the culture change to accept that that when someone's on call there should

	teams of physicians that work together so that we can actually work with them instead of always working against them. So something like might look like an internist, a GP, a nurse practitioner sort of all working together, instead of just being entirely internal medicine and keeping everybody at bay." - "Cultural change within surgical services." - "More buy in from higher ups in terms of surgical services, like accepting the actual surgical issues, because I've taken care of many surgical issues on CTU, even post op, they come back to CTU. Like it would be nice for the surgical services to take ownership of their patient." - Defining boundaries of our specialty (ie. Admission criteria) - Interdepartmental relationships: Developing personal connections with colleagues, particularly those in the emergency department and amongst other specialties can help to reduce stress and improve patient care. - Having an unbiased clinician to resolve challenging dispositions disputes of patients in the ER (the participant cited that this exists at the Mayo clinic).	be expected to receive phone calls at two in the morning or three in the morning, just like just like we do when we're awake there."
Social problems		- "A social/behavioral ICU" - "Improved social support person."

Non-physician roles	- "Hire extra staff on the wards so that that could reduce our administrative burden. And so that we can focus on the practice of medicine (i.e., social worker)" - "It would be nice to have like a chronic clinical associate or like nurse practitioner on each team." - Workforce planning and hiring enough people for the future.	- "Can we get more cleaners? Could we get more porters, that kind of thing." - "Trying to get us another staff member. to rise to get patients to where you can examine them and have them ready for examination and helping you get what you need to get that patient through so that you're not doing as many non-clinical tasks. -- an LPN is probably the most ideal." - "More housecleaners" - "Have people emerge and help them fill out the paperwork for housing, get them better clothes… get them better food than the sandwiches and things are not made with real food."
Violence Risk		- "Physical barriers to actually protect." - "Offsite opiate overdose unit" - "Offsite sobering units"
Waiting room medicine	- "Having quiet workspace, nice aesthetic workspace, places to meet, places to talk with patients and families, less cluttered hallways, all of these things contribute to the fatigue of the day."	- "Waiting room better staffed, maybe with someone who's like looking after these patients like watching out for, you know, signs of people escalating, people becoming more violent."
Financial structures and remuneration	- *"Recently on CTU (clinical teaching unit), we moved off of the set amount [during COVID] and back to fee for service. And I've never seen the teams look happier when we're on a set amount of money… you had more time to teach, more time to look after patients. And we were in the thick of COVID, with no vaccinations. And I've never	

	seen my faculty and teams actually look more satisfied. And then when that was pulled away, you go back to the grind. I agree money doesn't drive everything. But let's face it, we're all here to do a job and earn money and earn an income, pay our bills. That's probably one of the most important reasons as we work." - "So, I think we still need to find some funding model that is equitable for the time spent, not the clinical load, but the time spent. And that would then allow us to spend more time with our residents with our patients and spread the load. Because really what strikes us as the most stress is when we're dealing with a lot of sick patients, a lot of training needs, and we don't have enough time. " - Improving remuneration to attract fellows to live/work in Vancouver. - Consider moving away from FFS (fee for service) and adopting AFP (alternate funding plan), or a mixed model. - Pay for time and quality, not clinical load	
Lack of camaraderie for discussing difficult cases	- Attending monthly rounds to discuss difficult cases or to just check in => *"I talked about this, the council of the elders kind of thing, where faculty and attendings once a week, BC Cancer Agency does this really well, they	

	have tumour rounds, where they all get together and say this is a puzzling case. They talk about right. And something that because we all will face some diagnostic uncertainty, or just am I in the weeds here on this case, like I've inherited this case, this has been a door to door like a short to shore kind of case has been now on three CTUs, and I'm picking it up, am I missing something right? It's a safe space where we say, here's what I'm struggling with. And people can say that no, you actually, you know what, I can't think of anything else that feels okay. Right, but also just to be able to bounce it off of each other… And even if that week, nobody has a case, we can just check in on each other."	

*Text shown in black corresponds to data collected from focus groups in hospital 1 and text shown in red corresponds to data collected from the focus group at hospital 2.