

Burnout and work engagement levels in community pharmacists residing in three counties of the United Kingdom

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ABSTRACT

The concept of burnout has been ascribed several meanings over the years, and concerns have been raised about the lack of clarity and consensus in the defining criteria. However, the most popular definition to emerge is the multidimensional description by Maslach where burnout is a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who do people work of some kind. Burnout can result from prolonged periods of stress or excessive workload. The aim of this research was to describe burnout and job engagement in a sample population of community pharmacists.

Methods

A mixed method approach of quantitative and qualitative methods was used; both these methods are widely used within organisational psychology. The study was composed of two discrete but overlapping parts, each using a different but complementary methodology: a quantitative first part informing a qualitative second part. A self-administrated questionnaire was posted to all pharmacists residing in the Local Practice Forum covering Dorset, Hampshire and the Isle of Wight (n=1170). Respondents completed a questionnaire pack comprising the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) and the Utrecht Work Engagement Scale (UWES-9) together with questions of demographic characteristics, both survey instruments have been widely used in job burnout and engagement studies. A letter was also included inviting respondents to take part in the qualitative part of this study and ethical approval was granted by the Bioscience Research Ethics Committee at the University of Portsmouth. The *MBI-Human Services Survey* (MBI-HSS) measures the three sub-scales of burnout, "emotional exhaustion," "depersonalization" and "personal accomplishment." The survey consists of 22 items designed to assess the three dimensions of burnout and the items are scored on a seven-point Likert scale ranging from zero (never) to 6 (every day), indicating the frequency of feelings and attitudes experienced. The *Utrecht Work Engagement Scale* (UWES) measures the three constituting dimensions of work engagement: vigour, dedication, and absorption, and consists of 9 items designed to measure the three dimensions. All items are scored on a 7-point frequency rating scale ranging from 0 (*never*) to 6 (*everyday*). Quantitative data were analysed using descriptive statistics (means, standard deviations, skewness and kurtosis) and calculated for all scales and subscales. Non-parametric tests were performed as the data was not normally distributed, and analysed using SPSS V 18.0. Regression analysis was performed to investigate the relative contribution of the different stressors and demographic variables to the variance in burnout and engagement. Internal consistency of the three subscales of MBI-HSS and UWES-9 was computed

using Cronbach's alpha. Qualitative data were obtained using a combination of focus group, semi-structured interviews and electronic interviews and transcribed verbatim. Template analysis was used to develop a hierarchical list of codes representing themes and the relationship between themes.

Results/Discussion

A total of 702 questionnaires were returned from a sample population of 1170 pharmacists residing in the Wessex LPF, giving an overall response rate 60%. Out of which 72.36% (n= 508) indicated that community pharmacy was their main job role. Demographic data of respondents was compared to previous workforce data and showed that 63.2% (n=321) were female and 36.4% (n=185) were male. Respondents showed high scores on the Emotional Exhaustion scale (Mean 35.28, SD 12.10), high levels of depersonalisation (Mean 14.23, SD 6.48) and Low levels of Personal Accomplishment (Mean 42.86, SD 8.14). This gives an overall picture of a high degree of burnout within the sample population. Regarding engagement the mean score of 4.64, SD 3.74 indicates that the sample population has average levels of job engagement. Qualitative data results combined focus group (n=5), semi-structured interviews (n=9), telephone (n=5) and electronic interviews (n=5) and themed into positive/negative work and patient related events. Qualitative data indicated that community pharmacists are finding that paperwork/administration, skill mix, responsible pharmacist regulations, availability of dispensing stock and the demands of patients being factors that might contribute to burnout levels. Possible signs of job engagement included enjoyable patient events such as helping a patient and appreciation of a job well done by line management.

Conclusions

This research has several implications for community pharmacy practice and service development. A significant proportion of pharmacists in this sample population suffered from burnout, and if this data were extrapolated to all community pharmacists and if those pharmacists were unable to detect and acknowledge the signs of burnout, disillusionment with the profession might follow. Employers, professional bodies and employees should become aware of the causes and symptoms of burnout and if possible monitor burnout levels on a regular basis, this could help them become aware of their own and others levels of burnout.

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Abbreviations

BM	Burnout Measure
CBI	Copenhagen Burnout Inventory
CPCF	Community Pharmacy Contractual Framework
DP	Depersonalisation
DSM	Diagnostic Statistical Manual
EE	Emotional Exhaustion
ICD	International Classification of Diseases
LPF	Local Practice Forum
MBI	Maslach Burnout Inventory
MUR	Medication Use Review
NCAS	National Clinical Assessment Service
NHS	National Health Service
OLBI	Oldenburg Burnout Inventory
PA	Personal Accomplishment
PCT	Primary Care Trust
PDA	Pharmacy Defence Association
PLB	Professional Leadership Body
PPRT	Pharmacy Practice Research Trust
RP	Responsible Pharmacist
RPS	Royal Pharmaceutical Society
RPSGB	Royal Pharmaceutical Society of Great Britain
RCT	Randomised Control Trial
SMBQ	Shirom Melamed Burnout Questionnaire
UWES	Utrecht Work Engagement Scale

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Declaration

I, Peter Thomas, declare that the work undertaken for this thesis has not been submitted for any other award.

CHAPTER 1: INTRODUCTION

1.0 Overview

In 2005 the United Kingdom (UK) government introduced a new contractual framework for community pharmacists, and research has indicated that since then pharmacists have shown increased levels of stress due to excessive workload pressure (Pharmacy Practice Research Trust, 2007).

Due to growing concerns over excessive workload, the Royal Pharmaceutical Society of Great Britain (RPSGB) commissioned a report into pharmacist workload and stress, resulting in the publication of the report *Workload pressure and the pharmacy workforce* (RPSGB, 2009). This report focused on workforce pressures within community pharmacy and the NHS, and reported that pharmacists are showing increased levels of stress as a result of increased workload and long working hours.

A recent scoping exercise by the National Clinical Assessment Service (NCAS) investigating possible health issues experienced by pharmacists found that 41% of respondents had experienced some kind of mental illness during the last five years and that stress accounted for 82% of those cases, or 33% of overall respondents (NCAS, 2009). Indeed, in the NCAS report one pharmacist commented: “Stress and anxiety are accepted parts of the pharmacist job role these days. I don’t know any pharmacists who are not stressed and anxious at, or because of work” (NCAS, 2009).

Pharmacists, along with nurses and doctors, have also reported high levels of suicidal thoughts and are more likely to kill themselves than any other group of health professionals

(Melzer et al., 2008). In the same report another pharmacist commented: “Stress and lack of support led to depression with suicidal ideation. My interest in helping my patients and colleagues declined, which led to a couple of dispensing errors going out, at least one of which led to patient harm” (NCAS, 2009).

Pharmacists also seem reluctant to prioritise their own health needs and are unaware of the impact going to work while ill can have (Meltzer et al., 2008). This is an important factor that must be included in research on pharmacist workload and stress-related conditions.

1.1 Burnout

The concept of burnout

The concept of burnout has been ascribed several meanings over the years, and concerns have been raised about the lack of clarity and consensus in the defining criteria. A number of definitions have been proposed, including:

- “A state of fatigue or frustration brought about by devotion to a way of life or relationship that has failed to produce the expected reward” (Freudenberger, 1980, p. 13)
- “A progressive loss of idealism, energy and purpose experienced by people in the helping professions as a result of the conditions of their work” (Edelwich et al., 1980, p. 14)
- “A symptom of physical and emotional exhaustion, involving the development of a negative self concept, negative job attitudes, and loss of concern or feeling for clients” (Pines et al., 1978, p. 233)

However, the most popular definition to emerge is the multidimensional description by Maslach:

- “Burnout is a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who do people work of some kind” (Maslach, 1982, p. 3)

Maslach defined burnout as being characterised by three primary symptoms:

- Emotional exhaustion (EE), which refers to a depletion of emotional resources, leading to employees who seem to be lacking in adaptive resources and who feel that they can no longer give any more to their job.
- Depersonalisation (DP). This often occurs in response to emotional exhaustion and results in employees becoming detached from their job and developing uncaring attitudes to their work. This can affect their own performance, their attitudes towards other employees within the same organisation, and users of the services they offer.
- [Reduced] personal accomplishment (PA), where employees perceive that they can no longer perform as well at their job as they originally could.

A substantial research programme has refined the sub-constructs used in the Maslach model, principally utilising the well validated Maslach Burnout Inventory (MBI) (Maslach et al., 1996). The MBI conceptualises burnout as a continuous variable ranging from low to high, with high scores on the EE and DP sub-scales and low scores on the PA sub-scale indicating high degrees of burnout.

EE is described as the central quality and most obvious manifestation of burnout (Leiter et al., 2001). Its roots are in exacting and emotionally challenging work (Schaufeli et al., 1998), and it amalgamates the feelings of being emotionally overextended and depleted of one's

resources (Maslach, 1996). Although EE appears to represent the stress dimensions of burnout, it is insufficient in itself to encompass the relational aspect of this syndrome, characterised by DP and PA (Maslach et al., 2001). Structural models of burnout have lent support for this argument by assigning a central but not exclusive role to EE (Lee et al., 1996).

The DP component represents the interpersonal context dimension of burnout (Maslach et al., 2001). It emerges as a problem in careers that value personal sensitivity to recipients (Maslach et al., 1997). It refers to negative, cynical and indifferent response to clients and can be accompanied by pessimism about one's work. Maslach et al. (2001) describe DP as a coping strategy characterised by an attempt to distance oneself from clients (or patients) by actively ignoring their unique qualities and treating them as impersonal objects of one's work. Initially, this distancing serves as an emotional buffer of "detached concern" between therapist and client (Leiter et al., 2001, p. 416). The buffer is created as a self-protective strategy to sustain objectivity in the therapeutic relationship. However, achieving an effective mix of compassion and emotional distance can be time-consuming and a depersonalised and dehumanised picture of clients can emerge as a result of maintaining this emotional distance.

The component of reduced personal accomplishment (PA) represents the self-evaluation dimension of burnout (Leiter et al., 2001). Lowered PA can be problematic in professions that emphasise effectiveness and success as having a beneficial impact on people's lives (Maslach et al., 1996). It refers to feelings of lack of fulfilment and productivity on the job (Maslach et al., 2001). These feelings of inefficacy are exacerbated through continued work in stressful and exhausting conditions with clients towards whom professionals feel indifferent (Leiter et al., 2001).

Support for Maslach's theory and its multidimensional character has arisen from two quarters. Initial formulations characterised burnout as a reliable static concept with the discernible symptoms of EE, DP and PA (Maslach, 1982). The stability of burnout in human service workers has been established as up to two years (Lee et al., 1993; Leiter et al., 1994). Recently, more sophisticated formulations that conceptualise burnout as a state but delineate the developmental process underlying its occurrence have also been proposed (Leiter et al., 2001). These models argue that EE, DP and PA develop separately over time (Maslach, 1998; Schaufeli et al., 1998). EE is believed to occur as a consequence of chronic and prolonged stress, and subsequently DP emerges as a response to the overload of EE. In these models, PA is less closely related to exhaustion but appears to develop in parallel with EE (Lee et al., 1996; Leiter, 1993). It has been proposed that they have distinct precursors and that EE is a function of role conflict and work overload whilst PA is associated with lack of resources and social support (Leiter, 1993; Maslach et al., 1996). Structural models have generated some empirical evidence for this perspective, but these hypotheses need additional verification (Leiter, 1993; Leiter et al., 2001).

The process of burnout

Burnout does not occur overnight, but is rather the result of a prolonged and slow process that can last for years. The development of burnout usually begins at an early stage of EE. High levels of EE can lead to a withdrawal from the clients, patients and even other employees professionals work with. Such a withdrawal results in DP, where individuals develop a cynical attitude towards their job, clients and work colleagues (Taris et al., 2005). In other words, EE may lead to the DP stage of burnout (Maslach et al., 2001).

Demerouti et al., however, claim that "the development of burnout follows two processes", and that EE and DP develop rather in parallel and have different antecedents (Demerouti et

al., 2007, p. 501). The first process is related to job demands, which lead to frequent overtaxing, and subsequently to EE. A lack of job resources and a lack of social support can represent a second process which in the end leads to disengagement from work. If resources do not meet job demands, withdrawal behaviour from work will occur. This withdrawal behaviour subsequently leads to disengagement, which manifests itself as “distancing oneself from one’s work, and experiencing negative attitudes toward the work object, work content, and one’s work in general” (Demerouti et al., 2007, p. 501). The third component of burnout, reduced PA, is rather incidental to that process and is not seen as a core dimension of burnout.

In general, there is little agreement on how burnout develops and which stages are included. Although most researchers agree that burnout follows a process of stages, the three-stage process described by Maslach et al. (2001) remains the popular choice.

Risks and consequences of burnout

Burnout has very debilitating effects, including anxiety, depression, insomnia, emotional depletion and suicidal ideation (Johnson, 1995; Maslach et al., 1996). Physical symptoms include headaches, muscle tension, hypertension, cardiovascular complaints and increased rates of mortality (Maslach, 1978; 1982). Cognitive and emotional difficulties such as feeling drained, fatigued, empty and vulnerable and the characteristic cynical perception of clients and lowered professional self-efficacy are also reported (Golembiewski, 1996; Maslach, 1998). Behavioural correlates appear to be withdrawal from other people, increased alcohol intake, absenteeism, poor quality of service, and turnover (Alvarez, 2000; Golembiewski, 1996; Fortener, 1999). These difficulties adversely impact on the professional's ability to maintain therapeutic or personal relationships and emphasise the need for protecting individuals from these deleterious effects. In summary, although burnout theory and research

are less than definitive, there is evidence for a stable multidimensional burnout syndrome with clear conceptual boundaries that can have serious repercussions for professionals, their clients and the organisations within which they work.

1.2 Burnout and related concepts

Burnout and stress

Burnout and stress are often perceived as transposable labels, but they differ in that burnout is the product of a prolonged and unabated stress experience rather than an acute episode of stress (Maslach et al., 2001). Stress is an adaptation process that is temporary, whereas the emphasis in burnout is on the process of psychological erosion, and the emotional and social outcomes of chronic exposure (Leiter et al., 2001; Maslach, 1986). Further, the inclusion of DP and PA makes burnout broader than established ideas of occupational stress. Stress is a predictor of EE (Kaden, 1999; Wertz, 2000), but in itself it does not invariably lead to burnout. Table 1 below shows some of the differences between burnout and stress.

TABLE 1: Burnout versus stress	
Burnout	Stress
<ul style="list-style-type: none"> • Results in disengagement from work • Prolonged and on-going • Comes from psychological erosion • Results in blunted emotions and feelings of helplessness 	<ul style="list-style-type: none"> • Results in over-engagement • Often acute or short term • Usually an adaptive process to life situations • Results in overactive emotions • Can give feelings of hyperactivity

(Adapted from Maslach C., Burnout, the cost of caring, 2003)

Burnout and depression

High correlations of burnout with depression have also provoked much debate, but Maslach et al. (1997) argue that depression is a clinical syndrome that tends to pervade every domain of a person's life, whereas burnout describes a crisis in one's relationship with work, especially the therapeutic relationship with clients (Leiter et al., 2001).

1.3 Individual aspects of burnout

Burnout and gender

The relationship between gender and burnout is not conclusive, and there do not seem to be reliable differences in burnout levels between men and women. Several studies have found no gender difference across any of the three burnout dimensions (Ben-Zur et al., 2005; Dormann et al., 2004; Rafferty et al., 2001). However, other studies suggest that the genders are differentially susceptible to different dimensions of burnout. For example, women may be more prone to EE and men more prone to DP (Johnson, 1991; Lewig et al., 2003). Dollard et al. (2000) found that DP was associated with being male, but that gender was unrelated to EE and PA. Several studies have reported no gender differences in EE (Giebels et al., 2005; Holman et al., 2002; Tummers et al., 2002).

Where gender differences are found to exist, it is possible that this may reflect a confounding of gender and occupation. It has been suggested that predominantly female jobs, such as nursing, suffer more from burnout, and that predominantly male occupations, such as policing, are more prone to DP (Maslach et al., 1981; Maslach et al., 2001).

Burnout and age

Younger people often have higher levels of burnout (Maslach et al., 1981; 1985) and the demographic norms reported in the Maslach Burnout Inventory Manual (Maslach et al., 1996) show a gradient of burnout decreasing with age across all three dimensions. Zohar (1997) and Dollard et al. (2000) found that age was negatively related to all three burnout dimensions, and Carson et al. (1999) found their low burnout group was significantly older than their high burnout group in a sample of mental health nurses. Zellars et al. (2001) found that age was negatively associated with DP, but not related to EE or PA in nurses, whereas Cranswick (1997) found that EE was significantly negatively associated with age in a sample of rehabilitation workers. Dormann et al. (2004) found that age was unrelated to EE, but negatively related to DP and positively related to PA in a sample of customer service workers, whereas Rafferty et al. (2001) found that age was negatively associated with both EE and DP, but unrelated to PA.

Two studies have found no relationship between age and any of the three burnout dimensions (Ben-Zur et al., 2005; Payne, 2001), while several other studies have focused only on the EE dimension of burnout and have found this to be unrelated to age (Deery et al., 2002; Giebels et al., 2005; Holman et al., 2002; Tummers et al., 2002). De Rijk et al. (1998) measured EE and DP and found no relationship with age for either variable.

In conclusion, although age is sometimes cited as one of the variables most consistently related to burnout (for example, Maslach et al., 2001), the reasons for such an interpretation have not been studied at any great length. For example, it may be that if younger people are quitting jobs early due to burnout, then data on older employees could be skewed and not reflect the true picture of burnout levels.

Burnout and length of employment (tenure)

A number of studies have investigated the relationship between job tenure and burnout and the findings have been mixed, with positive associations, negative associations and a lack of association all reported.

Zohar (1997) found job tenure was significantly positively associated with all three burnout dimensions, and EE has been found to be positively associated with job tenure by Deery et al. (2002), Kop et al. (1999) and Lewig et al. (2003). Alexander et al. (2001) found that sense of accomplishment diminished with increased length of service in ambulance workers, but found no association between job tenure and EE or DP.

Some studies have found an inverse association between job tenure and burnout. However, Holman et al. (2002) found that job tenure was significantly negatively related to EE, and Tang et al. (2001) reported two studies, one of which found that EE was lower amongst more experienced teachers, and the other found no association. Fujiwara et al. (2003) and Omdahl et al. (1999) both found that number of years' experience was unrelated to all three burnout dimensions in home care workers and nurses respectively, and Giebels et al. (2005) found no association between tenure and EE in a sample of social workers.

In conclusion, it would be difficult to reach any definitive conclusion about the relationship between job tenure and burnout.

Burnout and occupation

The original concept of burnout was specific to human service workers and burnout was thought to be a result of the unique demands, in terms of interpersonal interaction, specific to these kinds of jobs. However, burnout research has been conducted in a wide range of occupational settings and the results do not consistently support the idea that burnout is necessarily higher in human service workers.

Brotheridge et al. (2002) compared burnout levels in different types of occupation, looking at human service workers, service/sales employees, managers, clerical employees and physical labourers. This study did not find significant occupational differences in EE levels; the highest value was for service/sales jobs, but this did not differ significantly from the other values. Mean levels of DP were significantly higher for service/sales employees and managers than for clerical employees and physical labourers. Human service workers reported significantly lower levels of DP than did service/sales employees, managers, and physical labourers, which was contrary to the study's hypothesis that human service workers experience higher levels of DP. Similarly, PA was highest for human service workers, significantly higher than that for service/sales employees and physical labourers. Taken together, the findings from this study did not support the hypothesis that those in human service professions or prototypical emotional labour jobs experience higher levels of burnout than managers, clerical employees, and physical labourers.

There have also been findings of surprisingly low levels of burnout in nursing and related health care occupations, which are generally thought to be burnout-prone professions. Payne

(2001) found burnout scores were generally low in hospice nurses, which is consistent with past studies of hospice nurses. Similarly, Carson et al. (1999) found that, contrary to popular belief, burnout was not a significant problem among mental health nurses, only a relatively low 5.7% falling into the high burnout group, as defined by Maslach et al. (1996) in their Burnout Inventory Manual. Hayter (1999) reported remarkably low levels of DP in specialist HIV/AIDS community nurses with 97% of the sample scoring low on DP.

On the other hand, some findings have been in line with expectations regarding the kinds of work that might lead to burnout. Reviewing a number of studies across various professions, Schaufeli et al. (1998) concluded that levels of EE were particularly high among teachers. Johnson et al. (1997) also found high levels of EE in counsellors, particularly those dealing with victims of sexual assault.

In conclusion, the question remains as to whether human service work and/or prototypical emotional labour jobs do in fact cause high burnout relative to other professions. Levels of emotional demands differ widely within professions, and emotional demands are present in many jobs, not just those typically seen as causing burnout.

Burnout and personality

The vast majority of burnout studies choose not to focus on personality variables, according to Pines (2004). Studies which do measure personality find that it can be a significant predictor of burnout, especially EE, although Maslach and Leiter's book *The Truth About Burnout* puts the accountability for burnout "squarely on the shoulders of the organisation" (Maslach et al., 1997).

Research into the relationship between personality and burnout has often looked at trait affectivity. Some studies have found that negative affectivity is significantly associated with higher levels of EE (Dollard et al., 2000; Grandey et al., 2004; Iverson et al., 1998). Zellars et al. (2001), Dollard et al. (2000) and Iverson et al. (1998) found negative affectivity was significantly associated with all three burnout dimensions. However Zohar (1997) did not find a significant association with DP.

Self-efficacy has been found to be negatively related to burnout in teachers (Tang et al., 2001) and in nurses (Greenglass et al., 2002). Type A personality has been reported as a positive predictor of burnout in teachers (Burke et al., 1995). (People with Type A personality have been described as ambitious, aggressive, business-like and controlling, and are often high-achieving ‘workaholics’ who push themselves with deadlines.) On the other hand, hardiness (Alexander et al., 2001) and a sense of coherence (Soderfeldt et al., 2000) have both been found to be negative predictors of burnout in ambulance workers and social workers respectively.

In conclusion, although there is good evidence that personality factors, especially trait affectivity, play an important role in the burnout process, there has been little work exploring personality traits within the health care professions, including pharmacy.

Measurement of burnout

The most common measurement inventory for burnout is the Maslach Burnout Inventory (MBI) (Maslach et al., 1996). This inventory was first developed in the early 1980s as an attempt to add consistency in the measurement of burnout (Maslach et al., 1981).

Historically, several different methods of measuring burnout have been used in research. These include clinical observation, structured interviews, projective drawings and self-reported questionnaires. However, many of the early measures included no psychometric data (Schaufeli et al., 1993).

Although the most widespread burnout questionnaire is the MBI, there are others, namely the Burnout Measure (BM) (Pines et al., 1998), Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2005), the Oldenburg Burnout Inventory (OLBI) (Demerouti et al., 2003) and the Shirom Melamed Burnout Questionnaire (SMBQ). These questionnaires measure different aspects of burnout syndrome, depending on the theoretical framework on which they are based. Table 2 below shows some of the key differences between the various burnout measures.

TABLE 2: Burnout measurement instruments		
Measurement tool	Burnout dimensions indicated	Key features
MBI	<ul style="list-style-type: none"> • Emotional exhaustion • Depersonalisation • Reduced personal accomplishment 	Measures all three components of burnout. Remains the most widely used measurement tool
BM	<ul style="list-style-type: none"> • Emotional exhaustion 	Only measures one aspect of burnout
CBI	<ul style="list-style-type: none"> • Personal burnout • Work-related burnout • Client-related burnout 	The authors use their own framework for burnout. Not widely used
OLBI	<ul style="list-style-type: none"> • Emotional exhaustion • Disengagement 	Only uses two scales. Uses positive and negative wording. More research needed to justify its usage
SMBQ	<ul style="list-style-type: none"> • Emotional and physical exhaustion • Tension • Listlessness • Cognitive weariness 	Focuses on overall mental and physical exhaustion in life rather than the relationship between work and burnout

The MBI has been widely used across a range of professions including pharmacy, and has standardised norms which allow direct comparisons of the data. The internal consistency and validity of the MBI have also been tested widely.

Diagnosis of burnout

Attempts have been made to diagnose burnout in line with other mental health disorders.

Burnout has been labelled as work-related neurasthenia, which is described in the International Classification of Diseases (ICD-10) (Schaufeli et al., 1998).

The ICD-10 definition includes the following criteria of symptoms for diagnosis of burnout:

- Either persistent and distressing complaints of feelings of exhaustion after minor mental effort, or persistent and distressing complaints of feeling of fatigue and bodily weakness after minimal physical effort
- At least two out of the following six distress symptoms: muscular aches and pain, dizziness, tension headaches, sleep disturbance, inability to relax, irritability
- Symptoms are not relieved by means of rest, relaxation or entertainment
- The duration of symptoms is at least three months
- The criteria for any more specific disorders do not apply.

This classification does not include any specific preconditions or causes and does not have a time limit for the appearance or disappearance of the symptoms.

Burnout has also been defined as a mental adjustment disorder as described in the Diagnostic Statistical Manual of Mental Disorders DSM-IV2 (Schaufeli et al., 1998). Mental adjustment disorders are characterised by the development of clinically significant emotional or behavioural symptoms in response to an identifiable psychosocial stressor or stressors. The symptoms must develop within three months of the onset of the stressor(s) and must be resolved within six months of the termination of the stressor(s) (Schaufeli et al., 1998, p. 55). The DSM-IV distinguishes six subtypes of adjustment disorders and the definition of the unspecified subtype is the most similar to the definition of burnout. It is characterised by maladaptive reactions such as physical complaints, social withdrawal, or work or academic inhibition to psychosocial stressors that are not classifiable as one of the specific subtypes of the adjustment disorder. However, using the adjustment disorder definition for diagnosing burnout may be problematic as burnout is not usually an immediate reaction to an identifiable stressor. It is more likely a result of chronic stressors or continuously occurring problematic situations. It progresses rather slowly and does not always resolve after six months.

Burnout is not a recognisable condition on the NHS Clinical Knowledge Summaries website (<http://www.cks.nhs.uk>), which provides primary care health care workers, including medical doctors, with a reliable source of evidence-based information and practical 'know how' about the common conditions managed in primary care. Due to its complex nature, it would be very difficult to provide an exact diagnosis of burnout, in contrast with some other mental health conditions.

Early predictors of burnout

Trying to identify early signs of burnout is seen to be important in current burnout research (Maslach et al.,2008). Identifying the signs and symptoms of burnout is necessary for health. Indicators of burnout include physical, psychological, and social aspects. If such early indicators were indeed valid predictors of future problems with burnout, then they could be used to identify high risk people who could be targeted for early, preventive interventions. Table 3 below shows some of the possible early indicators of burnout.

Physical	Psychological	Social
<ul style="list-style-type: none"> • Exhaustion and lack of energy • High blood pressure and coronary conditions • Musculoskeletal conditions • Headache/backache • Insomnia • Changes in appetite and weight • Accidental injuries 	<ul style="list-style-type: none"> • Anger • Depression • Anxiety • Frustration • Guilt • Cynicism • Irritability • Outbursts of temper • Withdrawn behaviour • Numbness • Inability to concentrate • Lack of drive or enthusiasm • Addictive behaviour with food, drugs, alcohol 	<ul style="list-style-type: none"> • Hostility towards or criticism of co-workers, family, friends • Neglect of family and social obligations • Marital conflict • Altered communication with others

(Adapted from Maslach et al., 2001)

1.4 Burnout interventions

Most intervention programmes have been focused on professionals' use of coping skills such as relaxation techniques, cognitive restructuring, social skills training, didactical stress management, and attitude change (Pines et al., 1988).

Person and organisational approaches to burnout interventions

Intervention programmes on burnout can either be:

- Person directed,
- Organisation directed, or
- Combined: person directed, also organisation directed.

Person directed intervention programmes are usually cognitive-behavioural and include measures such as:

- Psychotherapy
- Counselling

- Adaptive skill training
- Communication skill training
- Social support
- Exercises for relaxation.

Organisation directed interventions usually involve a change in work procedures, for example, task restructuring, work evaluation and supervision aimed at decreasing job demands, increasing job control or the level of participation in making decisions.

Some of the interventions to promote mental health in the workplace have included:

- Changing organisational practices
- Training supervisors and managers
- Changing shift work systems and introducing vacations
- Supporting or training to improve skills or job roles
- Training for better coping, including stress management interventions
- Counselling and therapy
- Exercise and relaxation.

Anderson et al. (2010) studied three types of intervention in organisations. The participants were divided into three groups:

- External reorganisation
- Internal reorganisation. For example, departments merged together or new teams built to increase influence and engagement
- Educational days that improve the psychosocial work environment, with a focus on communication, development of policies regarding sick leave and violence at work, and on increasing predictability.

The authors concluded that reorganisations have a negative effect on work-related burnout, whereas no effect could be seen from educational days or consultancy. The burnout scores for the workplace increased at the first follow-up and decreased at the second follow-up. However, for half of the work sites they finished at a higher level than the baseline scores.

Psychotherapeutic approaches: group therapies

Another intervention programme has suggested the use of two kinds of psychotherapeutic method: experiential group therapy and psychoanalytic group therapy. Both programmes focused on changing the ways in which an individual perceives and deals with unfavourable working situations (Salmela-Aro et al., 2004).

The experiential group therapy: This was based on active therapeutic interventions, such as psycho- and socio-dramatic techniques (Blatner, 1996). Other therapeutic methods used in these groups included creative methods, such as drawing, music, telling stories, body expression and relaxing (Salmela-Aro et al., 2004).

The group analytic therapy: This was based on free associations within the group. The main theoretical idea behind this working model was that participants were assumed to transfer their previous emotional experiences to the therapists and other group participants. The projective level consisted of the most difficult and feared aspects of the experience, most often feelings evoked by conflicts at work. The collective level provided shared new identifications for the group, for example feeling that one is not alone with the problems, and that progress is possible with the help of others (Salmela-Aro et al., 2004). One focus of the intervention was the enhancement of participants' interpersonal relationships, which has been shown to be a key element of burnout (Leiter et al., 2000).

Interventions that focus on decreasing negative effects related to major individual goals help the recovery from burnout (Salmela-Aro et al., 2004). Those whose emotions in connection with their projects became less negative seemed to show a decrease in burnout during the intervention compared with other participants. During the intervention, the number of work-related projects decreased, indicating less preoccupation with problems at work (Salmela-Aro et al., 2004).

Symptomatic intervention and etiological intervention

Interventions can also focus on two areas of burnout characteristics: symptomatic and/or etiological.

Symptomatic intervention: This involves the use of intervention programmes to help with particular symptoms that the person may be experiencing, using behavioural methods to achieve objectives, such as:

- Physical relaxation (“simple solutions for fatigue”)
- Life programme reorganisation (“highlighting your favourite activities”)
- The use of external resources: for example, social support or task reorganisation.

Intervention at the causal level (etiological): Intervention at the causal level uses mainly cognitive methods, for example:

- Distinguishing and developing rational ideas about self-beliefs and how people interact with other people and with their job
- How best to manage emotions related to exhaustion and fatigue, and irrational ideas
- Reappraisal of the person’s perception of the organisation and of the systems employed by the organisation

- Training to help with self control and coping with symptoms, and with the organisation in which the person works.

The Cochrane Collaboration (2006) has evaluated the effectiveness of work and person-directed interventions in preventing stress (including burnout) at work in health care workers. They identified 14 randomised controlled trials, three cluster-randomised trials and two crossover trials involving a total of 1,564 participants in intervention groups and 1,248 controls. Only two trials were of high quality, and interventions were grouped into:

- Person-directed: cognitive-behavioural, relaxation, music-making, therapeutic massage, and multi-component
- Work-directed: attitude change, communication, support from colleagues, participatory problem-solving and decision-making, and changes in work organisation.

Data analysed showed there is limited evidence that person-directed interventions can reduce stress and the components of burnout, and the authors concluded that limited evidence is available for the effectiveness of interventions to reduce stress levels in health care workers, and they suggested that larger and better quality trials are needed.

Awa et al. (2010) conducted a systematic search of burnout intervention studies to evaluate the effectiveness of intervention programmes at the workplace or elsewhere aimed at preventing burnout. A total of 25 primary intervention studies were reviewed. 17 (68%) were person-directed interventions, two (8%) were organisation-directed and six (24%) were a combination of both intervention types. 80% of all programmes led to a reduction in burnout. Person-directed interventions reduced burnout in the short term (six months or less), while a combination of both person- and organisation-directed interventions had longer-lasting positive effects (12 months and over). In all cases, positive intervention effects diminished in

the course of time. The authors concluded that intervention programmes against burnout are beneficial and can be enhanced with refresher courses. Better implemented programmes, including both person- and organisation-directed measures, should be offered and evaluated.

1.5 Burnout in the workplace

Work engagement and burnout

People's psychological relationship with their job has been conceptualised as a continuum between the negative experience of burnout and the positive experience of engagement (Maslach et al., 2008). However, there is a lack of consensus of opinion defining work engagement. For example, in literature, work engagement is also called employee engagement, personal engagement or even job engagement. Kahn (1990) defines employee engagement as "the harnessing of organization members' selves to their work roles; in engagement, people employ and express themselves physically, cognitively, and emotionally during role performances". The cognitive aspect of employee engagement concerns employees' beliefs about the organisation, its leaders and working conditions. The emotional aspect concerns how employees feel about each of those three factors and whether they have positive or negative attitudes towards the organisation and its leaders. The physical aspect of employee engagement concerns the physical energies exerted by individuals to accomplish their roles. According to Kahn (1990), engagement means being psychologically as well as physically present when occupying and performing an organisational role.

Most often employee engagement has been defined as emotional and intellectual commitment to the organisation (Baumruk, 2004; Richman, 2006; Shaw, 2005) or the amount of discretionary effort exhibited by employees in their job (Frank et al., 2004). Although it is acknowledged and accepted that employee engagement is a multi-faceted construct, as previously suggested by Kahn (1990), Truss et al. (2006, p. 12) define employee engagement

simply as “passion for work”, a psychological state which is seen to encompass the three dimensions of engagement discussed by Kahn (1990), and to capture the common theme running through all these definitions.

Work engagement is often considered to be the antithesis of burnout. Contrary to those who suffer from burnout, engaged employees have a sense of energetic and effective connection with their work activities and see themselves as able to deal well with the demands of their jobs. Work engagement has also been defined as a positive, fulfilling work-related state of mind that is characterised by vigour, dedication, and absorption (Schaufeli et al., 2002).

Vigour is characterised by high levels of energy and mental resilience while working, the willingness to invest effort in one’s work, and persistence even in the face of difficulties. Dedication refers to being strongly involved in one’s work and experiencing a sense of significance, enthusiasm, inspiration, pride, and challenge. Absorption is characterised by being fully concentrated and happily engrossed in one’s work, whereby time passes quickly and one has difficulty detaching oneself from work. Vigour and dedication therefore are often considered direct opposites of the core burnout dimensions of exhaustion and cynicism respectively (Maslach et al., 2001).

Community pharmacy workforce and stress

Work stress can be a major issue leading to significant costs for employers, the individual and society. Stress experienced at work appears to be the most significant occupational health problem in the UK, and the cost has been estimated at £4 billion a year (Gray, 2000). In 2001 for example, 13.4 million working days were lost to stress, depression and anxiety.

Research has established that burnout is a stress phenomenon, which shows the expected pattern of health correlates, such as headaches, gastrointestinal disorders, muscle tension,

hypertension, cold/flu episodes, and sleep disturbances (Leiter et al., 2000, p. 416). Work-related stress that is left unaddressed has the potential to develop into burnout over a long period of time (Maslach et al, 2001 and Buelens, 2002, p.485).

The Health and Safety Executive (2005) suggest that the key sources of stress at work include: the demands inherent in the job, such as workload and work patterns; a perceived lack of control at work with little improvement in decision-making; a perceived lack of support from colleagues and managers; and poor management of change. A report by UNISON, the public sector union, in 2002 listed the following common causes for stress at work:

- Long hours or shift work
- Too much or too little work
- Lack of control and conflicting demands
- Poor management
- Bad relations with other work colleagues
- Lack of job satisfaction
- Organisational or job change
- Jobs with significant emotional demands, such as health care worker
- Poor working environment.

Over recent years the demand for pharmaceutical services has increased as we face an ever-growing and ageing population, increased morbidity, new technologies and higher patient expectations from health care services. With this in mind, in April 2005 a new community pharmacy contractual framework (Department of Health, 2009) was introduced. This new contract provided a new framework by which community pharmacies are managed and also monitored by primary care trusts (PCTs). The framework consists of three tiers:

- Essential pharmacy services, such as dispensing
- Advanced pharmacy services, such as medication use review
- Enhanced services, such as minor ailments schemes, funded by PCTs.

All community pharmacists have to offer essential services. Advanced services require accreditation of the pharmacist and/or the pharmacy premises. These two tiers form the national pharmacy contract. On top of these is the third tier: enhanced services. These are commissioned locally by PCTs. The new contract focuses on high-quality services rather than on the dispensing of large volumes of prescriptions, and provides an incentive for community pharmacists to expand their roles.

In June 2007, the first national evaluation of the new pharmacy contract was published (Blenkinsopp et al, 2007). Initially, this evaluation was intended to concentrate on how the new contract was introduced and implemented. However, it also included some workforce and workload elements. The evaluation reported that 30% of pharmacists showed decreased satisfaction under the new pharmacy contract and that respondents felt under pressure from the daily demands of work. Following on from that report, Bond et al. (2008) studied the effect of the new community pharmacy contract on the community pharmacy workforce. This study concluded that, although the vast majority of pharmacists were engaging with the new contract, 57% of respondents reported being stressed at work due to increased workload and the paperwork demands of the new contract, and that this was having a negative effect on job satisfaction. In 2009, the then RPSGB published its report *Workload pressure and the pharmacy workforce* (RPSGB, 2009). This report focused on workforce pressures within community pharmacies and the NHS, and reported that pharmacists were showing increased levels of stress as a result of increased workload and long working hours.

A survey of pharmacists' health, undertaken for the National Clinical Assessment Service (NCAS, 2009), showed that stress was a key health problem for the 907 respondents, and it was cited as a health concern for most of the 41% who had experienced a health problem in the previous five years. The NCAS report also included qualitative data. This data revealed that pharmacists believe that their role has changed over the years, and attributed their stress to the following elements of the job:

- *Workload*
 - Although the number of prescriptions dispensed has increased there has been no increase in staffing levels.
 - Pharmacists are working longer hours.
 - Employee pharmacists often have targets to achieve such as medication use reviews (MURs).
- *Expectations*
 - Pharmacists feel that their job is more demanding and expectations have increased, for example with the introduction of compulsory Continuing Professional Development (CPD) from March 2010.
- *Financial concerns*
 - Community pharmacy owners are increasingly concerned over decreasing dispensing profits due to changes in NHS funding.
 - Community pharmacists are concerned about increasing staffing costs due to changes in regulation (i.e. levels of dispensing staff for the number of items dispensed is reflected in practice payment costs).
 - Community pharmacists are concerned with increasing locum pharmacist costs.

- *Responsibility*
 - Pharmacists are concerned about the threat of being criminalised following dispensing errors.
 - There is increasing pressure from employers concerning taking time off work.

Pharmacists also expressed concerns over the physical aspects of the role, many pharmacists experiencing some kind of physical illness during working life.

Unpublished data from research commissioned by the Pharmacy Practice Research Trust (PPRT) comparing pharmacist workforce data from 2004 to 2008 has provided support to the NCAS data. This data indicated that:

- Stress among pharmacists was rising to levels above the national average in 2008 and that workload was the main predictor of stress in the data
- Stress was associated with a range of negative consequences such as job dissatisfaction, anxiety and fatigue, and concern was raised about long-term damage to personal and professional life
- Workload, overall, had not increased between 2004 and 2008, but the effects of a high workload have worsened.

Further data from the Pharmacy Defence Association (PDA) have indicated that around 50% of community pharmacists believe they have no choice about how they do their work and feel demoralised. Many consider they are not treated with respect, leading to increasing stress levels. Research into stress levels amongst independent pharmacy contractors has shown that 75% of pharmacists feel stressed on a daily basis. Data from a similar survey in 2007 indicated that only 13% felt stressed or under pressure during their working day (Richardson, 2008).

Concern has also been raised about the lack of support given to community pharmacists by employers in respect of support with stress (Richardson 2010). In this survey, the majority of pharmacists believed their employers did not provide them with support for workplace problems such as stress, depression, poor motivation or bullying. They felt increased pressure from management, and intimidation from colleagues, and a third of employee pharmacists felt they had not been given enough support to deal with the 'Responsible Pharmacist' legislation which came into force in October 2009. This new regulation has placed more emphasis on the personal responsibility and accountability for professional matters of pharmacists working within community pharmacy.

According to Smeaton (2010), increased workplace pressures might affect the ability of community pharmacists to deliver patient services, 85% of employed respondents reporting that they had experienced stress in the past year, and that this had affected patient services.

More recently Gidman (2011), using qualitative methods, explored English pharmacists' experiences of increasing workloads between February 2005 and February 2008. This study of 59 pharmacists involved semi-structured face-to-face interviews. The author found some evidence of rising workloads leading to decreased health and well-being, and also concerns over patient safety as a direct result of increased workloads. She concluded that workloads have increased in community pharmacy, and that the work environment has become increasingly stressful.

Pharmacists' experiences and perceptions of management within community and hospital pharmacy, and the implications for job satisfaction, were explored using qualitative template analysis by Ferguson et al. (2011). Semi-structured interviews were conducted with a sample of 11 community and 15 hospital pharmacists in the North West of England (n=26).

Dissatisfaction with management emerged as a dominant aspect of pharmacists' job dissatisfaction. Of the 26 pharmacists interviewed, 24 commented on their dissatisfaction with management, whereas only 8 participants commented on positive experiences. Both hospital and community pharmacists expressed dissatisfaction with their line management, and how the organisations they worked for were managed. The researchers concluded that satisfaction with management is an important and significant contributor to job satisfaction overall, and it would appear that pharmacists' job satisfaction is compromised by poor line management, lack of recognition and support from management, which may lead to an increase in turnover and a reduction in job satisfaction.

Although current research has looked into community pharmacy work-based pressure, there has been no research linking outside influences such as family life pressure and social interactions to burnout (Maslach et al., 2001).

1.6 Burnout in pharmacy literature

Burnout first appeared in pharmacy literature in the 1980s. The majority of publications have been prescriptive or based on anecdotal evidence (Reeves, 2001; Zanni, 2008). They have mainly concentrated on the descriptions of burnout, its consequences, preventative measures and remedies. Review of empirical research into burnout in pharmacy shows that most research has focused on the effects of demographic variables, career variables, job settings and work activities and has been limited to quantitative studies using various versions of MBI. Table 4 below lists the most recent examples.

TABLE 4: Relevant pharmacy literature

Study	Study period	n	Sample population	Measure	Key Findings
Calgan et al.	2007	146	Community pharmacists working in Ankara, Turkey	MBI	Low levels of EE (69.2%), low levels of DP (82.9%). 60.3% had a high level of PA
Muir et al.	2005	266	Hospital pharmacists in Australia	MBI	High levels of EE (39%) and PA (49%). 60% had low levels of burnout based on DP. No significant differences in burnout and demographic data
Rothmann et al.	2002	48	Pharmacists working for a corporate pharmacy group in South Africa	MBI and others	In this small sample the researchers tried to link burnout to job satisfaction. 20% of the pharmacists in the sample experienced average levels of burnout in the EE sub-scale, and low levels of burnout on the DP sub-scale
Rothmann et al.	2001	67	Community and hospital pharmacists	MBI	Low levels of EE (62%) and DP (72%). 64% had a high level of PA
Gupchup et al.	1998	251	Pharmacists working for Health Maintenance Organizations (HMOs) in New Mexico, USA	MBI	Respondents experienced moderate levels of EE and DP, and high levels of PA
Gupchup et al.	1994	83	Pharmacists in Health Maintenance Organizations (HMOs) in the USA	MBI	Results provided empirical support for the reliability and validity of the MBI to measure burnout within the profession of pharmacy. As regards PA, the mean sub-scale score for HMO pharmacists was significantly higher than the normative score. The authors noted that more research was needed

Empirical research has concentrated on the magnitude of burnout experienced by respondents using the MBI. The main advantage of using the MBI is that normative data and criteria are used to interpret burnout levels, so in theory it is possible to compare pharmacists' burnout levels with those of other health care professionals. Calgan et al. (2007) investigated burnout using a cross-section of 251 community pharmacists taken from 1504 pharmacists registered in Ankara, although only 206 pharmacists completed the survey. The authors used a Turkish version of the MBI which, although comprising the same basic questions, uses a smaller Likert scale of 5 points, 2 points lower than the normal MBI scale. The authors found low levels of EE (69.2%), low levels of DP (82.9%), but a high level (60.3%) of PA. No gender differences were observed. However, they did find differences due to age, marital status, work experience, work commitment, workload time pressure and stress. In particular, they

found the under-35 age group showed higher levels of EE, DP and PA. The authors concluded that it was not possible to extrapolate the results to national level due to the limited number of respondents, and that it was worth monitoring burnout on a regular basis. Bearing in mind they used an adapted version of the MBI, it is perhaps difficult to compare the results with any other pharmacist study.

Muir et al. (2007) sampled a group of hospital pharmacists in Australia (n=528). Only 266 responded to the survey. Respondents experienced high levels of EE (39%) and PA (49%), although 60% had low levels of burnout based on DP. Low levels of DP are an indication that pharmacists in this study had high levels of professional attitude towards patients. Recent pharmacy graduates, however, showed significantly higher levels of PA, indicating greater burnout levels within this scale. Overall one in 20 pharmacists displayed high levels in all three scales of burnout. The authors concluded that evidence of severe burnout was identified in this study, that young hospital pharmacists appear to be the most vulnerable group, and that strategies need to be put in place to help prevent burnout.

Rothmann et al. (2002) sampled 48 pharmacists working for a corporate pharmacy group in South Africa. They used a number of survey instruments, including the MBI. The researchers tried to link burnout to job satisfaction. In this sample 20% of the pharmacists experienced average levels of burnout on the EE sub-scale, and 31% of pharmacists experienced low levels of burnout on the DP sub-scale.

Rothmann et al. (2001) used the MBI in a sample of community pharmacists and pharmacy assistants in South Africa. Pharmacists showed low levels of EE (62%) and DP (72%), and a high level of PA (64%). The authors concluded that managers and employees should be

aware of the causes and symptoms of burnout and that more research was needed into the individual and organisational factors that contribute to burnout.

Gupchup et al. (1994) investigated the factor structure of the MBI in a sample of pharmacists working in Health Maintenance Organizations (HMOs) in the USA. Results provided empirical support for the reliability and validity of the inventory to measure burnout within the profession of pharmacy. As regards PA, the mean sub-scale score for HMO pharmacists was significantly higher than the normative score. The authors noted that more research was needed into burnout. Gupchup et al. used the MBI in a sample of 251 pharmacists working for HMOs in New Mexico, USA in 1998. Respondents experienced moderate levels of EE and DP and high levels of PA.

1.7 Conclusion

Research on pharmacist burnout to date appears to have been limited to a few studies on a limited number of pharmacists. Most articles lack detail on overall numbers and regression analysis in each of the three subsets of burnout. This lack of conclusive research into pharmacist burnout makes it difficult to draw any overall conclusions, and indicates that more research is needed to address this important issue, which can affect both individuals and the organisations they work for. It is also difficult to relate research conducted outside the UK to UK community pharmacists due to differences in training, regulation and job role.

The introduction to this thesis has demonstrated that in the UK national context, there is a lack of research into community pharmacist burnout and work engagement. This study aimed to fill this gap by exploring the views of community pharmacists within the Wessex Local Practice Forum.

1.8 Aims and objectives

The specific objectives of the project were:

1. To conduct a literature review of the workload problems experienced by community pharmacists
2. To conduct a literature review on pharmacist burnout and work engagement
3. To assess the level and nature of burnout and work engagement amongst community pharmacists residing within Dorset, Hampshire and the Isle of Wight
4. To review further areas for research.

CHAPTER 2: GENERAL OVERVIEW OF THE RESEARCH

METHODS

2.0 Introduction

Study design

A mixed method approach of quantitative and qualitative methods was used. Both these methods are widely used within psychology including organisational psychology and, indeed, to include either quantitative or qualitative methods only falls short of the major approaches being used in the social and human sciences (Creswell, 2002, p4). The study was composed of two discrete but overlapping parts, each using a different but complementary methodology: a quantitative first part (Part 1) informing a qualitative second part (Part 2).

Ethical issues

The study was conducted within the auspices of the new Wessex Local Practice Forum. Local Practice Forum (LPF) is a term that is used in the localisation of the new professional leadership body (PLB) representing pharmacy. In essence the forum is a local structure that forms part of the PLB and its purpose is to bring together pharmacists from across all sectors of professional practice. Part of the remit of LPFs is workforce- and practice-based research. All pharmacist members were asked to participate as part of the development of local support to prevent burnout and encourage work engagement. The study population works for independent contractors rather than for the National Health Service (NHS) and, as such, does not need to be scrutinised by the local NHS research ethics committee. However, the protocol was submitted to the Bioscience Research Ethics Committee at the University of Portsmouth for opinion and was deemed to be acceptable.

It is possible that some community pharmacists will already be suffering from mental health issues, so further investigation into conducting research with vulnerable people/professionals was undertaken prior to conducting interviews, to ensure this area was covered during the interviews.

Resources, equipment and funding

Time was required by both the researcher and the study subjects to conduct and participate in interviews and to devise and complete postal questionnaires. This work was undertaken both in and out of work time. In general, research interviews were conducted during work hours and this seemed to encourage participation. Researcher time was also required for interview transcription. Money was required to fund equipment, including a tape recorder, tapes, batteries, stationery, printing costs, and stamps. These requirements were funded personally by the researcher. Degree funding was also paid by the researcher.

2.1 Part 1: Quantitative research

A quantitative approach is one in which the researcher primarily uses post-positivist claims for developing knowledge (Cresswell, 2002, p 18). In this case, data were collected using an established survey instrument that yielded statistical data that were then analysed.

Method of data collection

A self-administrated questionnaire was posted to all pharmacists residing in the LPF covering Dorset, Hampshire and the Isle of Wight during September and October 2010 (n=1170), with a covering letter explaining why the research was being carried out, and providing information for pharmacists regarding help and support, bearing in mind that the questionnaire itself might raise some health concerns. Concern for participants who could already be regarded as vulnerable in terms of mental health was taken into account.

The questionnaire consisted of two parts. The first part concerned the demographic and personal details of respondents. This mirrored previous workforce surveys by the RPSGB, to allow direct comparisons to be made (RPSGB, 2008). It also included a question asking whether the respondent works within community pharmacy, as no data are available on the exact job roles pharmacists undertake. The second part consisted of the MBI-Human Services Survey (MBI-HSS) (Maslach et al., 1996) and the 9-item version of the Utrecht Work Engagement Scale (UWES) (Schaufeli et al., 2006.)

The MBI-HSS measures burnout as it manifests itself in workers in human services institutions and health care occupations such as nursing, social work and psychology, and has previously been used within the pharmacy profession. It is divided into three sub-scales, which independently measure levels of burnout: emotional exhaustion, depersonalisation, and personal accomplishment. The instrument consists of 22 items designed to assess the three dimensions of burnout and the items are scored on a seven-point Likert scale ranging from 0 (never) to 6 (every day), indicating the frequency of feelings and attitudes experienced. As stated previously, the MBI is the most widely used and validated instrument used in burnout research.

The UWES measures three constituting dimensions of work engagement: vigour, dedication, and absorption. This instrument consists of 9 items designed to measure the three dimensions. All items are scored on a 7-point frequency rating scale ranging from 0 (never) to 6 (always).

Sample population

The sample population was based in the newly-formed Local Practice Forum (LPF) of Dorset, Hampshire and the Isle of Wight (n=1170). It is unclear how many pharmacists work within community pharmacy, so the letter sent encouraged people to return the questionnaire regardless of sector of main job.

Pilot Study

A pilot study was undertaken in August 2010 before the survey instrument was distributed, to check the basic aspects of the design and procedure work for the full study. Pilot studies are regarded as important to check that participants understand the instructions and to estimate how long the survey will take to complete (Clark-Carter, 2002, p.33). The pilot study was conducted using a small number of people (n=32) from the target population known to the researcher, and the results are not included in the final data. The pilot study indicated that the survey tool would take 10 to 15 minutes to complete. Concern was raised concerning the wording of some questions taken from the original MBI-HSS survey and this resulted in some minor changes. For example, the item '*I feel as though I'm at the end of my rope*' was changed to read '*I feel as though I'm at the end of my tether*' as that wording was deemed to be more acceptable to the UK population. Some concern was also raised over question 8 in the Questionnaire, as many pharmacists have more than one job. However, as that question was taken directly from the RCGP workforce survey it was left as originally written, but data analysis concentrated only on the main job role.

Data Analysis

Data were analysed and reported using descriptive statistics (means, standard deviations, skewness and kurtosis) and were calculated for all scales and sub-scales. Non-parametric tests were performed on the data to assess any associations between the data. Regression

analysis was performed to investigate the relative contribution of the different stressors and demographic variables to the variance in burnout and engagement. The internal consistency of the three sub-scales of MBI-HSS and UWES was computed using Cronbach's Alpha, and the data were analysed using Microsoft Excel and the statistical software SPSS 18.0

Non- respondents

The survey was conducted during the cross-over period between the RPSGB and the new regulatory body, the General Pharmaceutical Council (GPhC). Unfortunately this meant that non-respondents could not be contacted, since the information needed to contact the sample population was no longer available due to data protection issues.

2.2 Part 2: Qualitative research

A combination of focus group and semi-structured interviews with community pharmacists was used to collect qualitative data and this was analysed using template analysis. Template analysis refers to a particular way of thematically analysing qualitative data. It is seen as an appropriate method in organisational psychology and has been previously used in the subject area (Waring et al., 2008).

Template analysis involves the development of a coding 'template', which summarises themes identified by the researcher(s) as important in a data set, and organises them in a meaningful and useful manner. Analysis often starts with some *a priori* codes, which identify themes strongly expected to be relevant to the analysis. These codes may be modified or dispensed with altogether if they do not prove to be useful or appropriate to the actual data examined (Cassell, 2004, p. 256). Template analysis can be used within a range of epistemological positions and also within a 'contextual constructivist position', where the researcher assumes there are always multiple interpretations to be made of any phenomenon.

Template analysis offers a flexible approach to qualitative data analysis as, unlike grounded theory, it is a flexible technique permitting researchers to tailor it to match their own requirements (Cassell, 2004, p. 256).

Template analysis is similar to Interpretative Phenomenological Analysis (IPA) as an approach to psychological qualitative research in that it has an idiographic focus. This means that it aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon. Usually these phenomena relate to experiences of some personal significance. The difference between the two methods is the use of *a priori* codes in template analysis, making it less time-consuming, able to handle large quantities of data, and useful when comparing different groups of people within the same broad area of practice (Cassell, 2004, p. 256).

Method of Data Collection

A focus group (n=8) was used to discuss possible workplace stressors. Individual semi-structured interviews (n=9) consisting of open-ended questions and an interview guide were used to gather information from participants about their experiences. The same questions were used for telephone interviews (n=5) and electronic interviews (n=5). Semi-structured interviewing is the most widely-used method of data collection in psychology (Willig, 2009, p. 23), and was selected because it serves as a focused, flexible aid to understanding the area of study without rigid adherence to a predetermined interview structure.

Kvale defines the qualitative research interview as “an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena” (Kvale, 1983, p.174). The goal of any qualitative research interview is therefore to see the research topic from the perspective of the interviewee, and to

understand how and why this individual has this particular perspective. To meet this goal, qualitative research interviews will generally have the following characteristics: a low degree of structure imposed by the interviewer; a preponderance of open questions; and a focus on “specific situations and action sequences in the world of the interviewee” (Kvale, 1983, p. 176), rather than abstractions and general opinions.

The process of constructing and using qualitative research interviews was split into four steps:

- Defining the research question
- Creating the interview guide
- Recruiting participants
- Arranging an interview schedule and carrying out the interviews.

The research question focused on how participants described and made sense of the research topic, namely burnout, in their lives. It is important that the researcher does not frame the question in a way which reflects his/her own experiences (Cassell, 1994, p.18). The interview guide was established using results from the quantitative data, the literature review and the pilot study (Bowling et al., 2005, p.403; Cassell, 1994, p.19).

Study Setting

As with the quantitative element of this research, the study setting was the newly-formed LPF of Dorset, Hampshire and the Isle of Wight.

Pilot interview

The interview schedule was piloted with two pharmacists known to the researcher to determine whether the questions would elicit the type of information regarding burnout or work engagement needed by the researcher. This is a useful procedure to determine whether there are errors in the interview process (Bowling et al., 2005, p. 403). The resultant data have not been used in the main study.

Sampling

Stratified purposeful sampling was used to illustrate characteristics of particular subgroups of interest and also to facilitate comparisons between the different groups (Panton, 1990, p.162). This sampling method also allows the researcher to identify those who live the experience of the phenomenon of interest, in this case burnout.

Recruitment and consent for pilot study, focus group and main study

Pharmacists residing in the study setting were invited by letter to participate. Interested respondents were provided with an information sheet detailing the purpose of the study, what would be involved, and how they might withdraw from the process if necessary. The information sheet also contained details of the Pharmacy Support Group (www.pharmacistsupport.org). This organisation provides help and support for pharmacists and their families in times of need, and has developed a variety of programmes in consultation with pharmacists, to offer a helping hand to pharmacists who find themselves confronted by difficult circumstances, for whatever reason.

Written consent was obtained, and participants were assured of confidentiality throughout the process. During the interviews access was maintained with two academic supervisors as, should any psychologically distressing information or ethical concerns arise during the interview, the researcher would need to seek advice from the two academic supervisors as to how the interview should proceed. The prime concern was always the welfare of the participant.

Data saturation

Participants were recruited until the researcher considered that no new information was emerging from the data, this being part of the process of data analysis.

Data analysis

Data were analysed using methodology recommended by King when using template analysis (in Cassell, 2004, p. 259-268), which is as follows:

1. Define *a priori* themes.
2. Transcribe the interviews, and read through the transcripts to thoroughly familiarise yourself with them.
3. Carry out initial coding of the data and identify those parts of the transcripts that are relevant to the research question(s). If they are encompassed by one of the *a priori* themes, attach the code to the identified section. If there is no relevant theme, it might be necessary to modify an existing theme or devise a new one.
4. Produce an initial template from a sub-set of transcripts that have been coded. Having been identified in the selected transcripts, themes are grouped together into a smaller number of higher-order codes which describe broader themes in the data.
5. The template is then developed by applying it to the full data set. If a relevant piece of text does not fit comfortably in an existing theme, a change to the template may be needed.
6. The 'final' template is then used to interpret and write up findings.
7. At one or more of the coding stages described above, quality checks should be carried out to ensure that analysis of the data is not being systematically distorted by the researcher's own preconceptions and assumptions.

Quality checks

Qualitative research is concerned with meaning in context, and involves the interpretation of data by the researcher and therefore a certain amount of subjectivity (Willig, 2009, p.149). As a result of this subjectivity, qualitative research should undergo evaluation and quality checking. This can involve identifying guidelines for the evaluation of data, and the use of an

audit trail. Elliot et al. identified seven criteria that can be used as guidelines for the publication of qualitative research studies in psychology and related fields which are useful for the analysis of research data (Elliot et al., 1999). These are:

1. *Owning one's perspective.* The researcher should disclose his/her own values and assumptions to allow the reader to interpret the analysis and consider possible alternatives.
2. *Situating the sample.* The researcher should describe participants and their life circumstances in some detail to allow the reader to assess the relevance of the findings.
3. *Grounding in examples.* The researcher should use examples of the data to demonstrate the analytic procedures used.
4. *Providing credibility checks.* The researcher should check whether his/her accounts are credible by referring to other interpretations of the data.
5. *Coherence.* The researcher should aim to present analysis that is characterised by coherence and integration.
6. *Accomplishing general versus specific research tasks.* The researcher must be clear about the research tasks, and base these on an appropriate range of instances.
7. *Resonating with readers.* The researcher should ensure that the material is presented in such a way as to stimulate resonance in the reader.

Template analysis lends itself well to quality checks, as it is relatively straightforward to display successive versions of the template, accompanied by commentary on what changes were made at each stage and why.

CHAPTER 3: RESULTS

3.1 Quantitative results

Demographics

A total of 702 questionnaires were returned from a sample population of 1170 pharmacists residing in the Wessex LPF, giving an overall response rate of 60%, which compares favourably with other surveys within pharmacy (Thomas & Rutter, 2008). 72.36% (n=508) indicated that community pharmacy was their main job role.

The demographic characteristics of the respondents that indicated community pharmacy as their main job role are presented in Table 5, in which demographics are compared with the community pharmacist data extracted from the 2008 survey completed by the then RPSGB.

Demographic data of respondents show that 63.2% (n=321) were female and 36.4% (n=185) were male. This differs significantly from the 2008 survey ($\text{Chi}^2=17.6$, 1df, $p<0.05$).

The results for age of respondents ($\text{Chi}^2=40.87$, 6df, $p<0.05$), main job role ($\text{Chi}^2=48.7$, 5df, $p<0.05$), and area of practice ($\text{Chi}^2=35.4$, 4df, $p<0.05$) also differ significantly. However it is difficult to compare like-for-like data, as the 2010 survey was not completed due to forthcoming changes in regulation within pharmacy at that time. Also a number of pharmacists decided not to register with the new regulatory body for pharmacy in September 2010, before this survey was completed.

TABLE 5: Demographics of respondents

	n (%)	n (%) of community pharmacists in 2008 census
<i>Gender of respondents</i>		
Female	63.2% (n=321)	54% (n=8407)
Male	36.4% (n=185)	46% (n=7161)
<i>Age of respondents</i>		
29 and under	10.8% (n=55)	20.1% (n=3129)
30-39	25.2% (n=128)	24.2% (n=3768)
40-49	28.5% (n=145)	24.3% (n=3783)
50-59	21.3% (n=108)	20.7% (n=3223)
60-64	8.1% (n=41)	5.6% (n=872)
65-69	4.7% (n=24)	2.8% (n=436)
70 and over	1% (n=5)	2.3% (n=358)
<i>Main job role</i>		
Owner	7.3% (n=37)	12.3% (n=2376)
Manager	33.9% (n=172)	29.2% (n=5656)
Relief	9.4% (n=48)	8.1% (n=1564)
Second pharmacist	15.9% (n=81)	9.2% (n=1775)
Locum	32.3% (n=164)	37.6% (n=7280)
Non-store role	1.2% (n=6)	3.1% (n=601)
<i>Area of practice</i>		
Independent	16.% (n=83)	30.2% (n=5851)
Small chain (2-4 stores)	6.7% (n=34)	11.8% (n=2286)
Medium-sized multiple (up to 25 stores)	10.8% (n=55)	12.9% (n=2499)
Large multiple (over 25 stores)	56.5% (n=287)	54% (n=10462)
Supermarket chain	9.6% (n=49)	12.2% (n=2364)

Descriptive statistics

Overall descriptive statistics of MBI-HSS and UWES-9 are shown in Table 6. This table shows the mean scores of MBI-HSS and UWES-9; measures of internal consistency of the subscales and distribution type are also included.

Cronbach's alpha is a measure of the internal consistency of the questions within each subscale and a figure of above 0.7 is regarded as being acceptable. All four scales show acceptable internal consistency. Skewness and Kurtosis are measures of the distribution type. In this case, both indicate non-linear distribution of the data, which therefore leads itself to non-parametric statistical analysis. Mean scores across the subscales can be compared with nominal data as indicated in the MBI Manual (Maslach et al., 1996) and UWES-9 (Schaufeli et al., 2006).

Interpretation of descriptive results

MBI-HSS conceptualises burnout as a continuous variable, ranging from low to moderate to high degrees of experienced feeling. It is not viewed as a dichotomous variable, which is either present or absent.

- *A high degree of burnout* is reflected in high scores on the EE and DP sub-scales and in low scores on the PA sub-scale.
- *An average degree of burnout* is reflected in average scores on the three sub-scales.
- *A low degree of burnout* is reflected in low scores on the EE and DP sub-scales and in high scores on the PA sub-scale.

UWES-9 is a measure of engagement, and values range from very low to very high. The questions offer a measure of vigour, dedication and absorption and are combined to give an overall measure of burnout.

As regards burnout, pharmacists showed high scores on the EE scale (mean 35.28, SD 12.10), high levels of DP (mean 14.23, SD 6.48) and low levels of PA (mean 42.86, SD 8.14). This gives an overall picture of a high degree of burnout within the sample population. As regards engagement, the mean score of 4.64, SD 3.74 indicates that the sample population has average levels of job engagement.

TABLE 6: Descriptive statistics of the MBI-HSS and UWES-9

	Mean	Mean nominal data	SD	Cronbach's alpha	Skewness	Kurtosis
MBI-Emotional Exhaustion	35.28	20.99*	12.10	0.88	0.039	-0.728
MBI-Depersonalisation	14.23	8.73*	6.48	0.71	0.456	-0.618
MBI-Personal Accomplishment	42.86	34.58*	8.14	0.76	-0.719	-0.618
UWES-9	4.64	3.74**	1.28	0.86	-0.35	-0.71

*Nominal data from Maslach Burnout Inventory manual

**Nominal data from Utrecht Work Engagement manual

Distribution of scores on the MBI-HSS and UWES-9

Table 7 below shows the distribution of scores on the MBI-HSS and UWES-9 compared with the normal range for each scale. The percentages of respondents in each subscale are shown.

TABLE 7: Distribution of scores on the MBI-HSS and UWES-9

	n (%)	Normal range
<i>MBI-Emotional Exhaustion</i> (n=489)		
Low	33 (6.7%)	0-16
Moderate	94 (19.22%)	17-26
High	362 (74%)	27 or over
<i>MBI-Depersonalisation</i> (n=503)		
Low	62 (12.35%)	0-6
Moderate	171 (33.99%)	7-12
High	270 (53.67%)	13 or over
<i>MBI-Personal Accomplishment</i> (n=503)		
Low	359 (73.36%)	39 or over
Moderate	89 (17.69%)	32-38
High	55 (10.93%)	0-31
<i>UWES-9</i> (n=484)		
Very low	8 (1.65%)	0-1.77
Low	47 (9.71%)	1.78-2.88
Average	159 (32.85%)	2.89-4.66
High	129 (26.65%)	4.67-5.50
Very High	141 (29.13%)	5.51 or over

Interpretation of the distribution of scores

This again shows high levels of EE (74%), high levels of DP (53.67%) and low levels of PA (73.36%). However, the combined results for high/very high for UWES-9 at 55.78% are encouraging, indicating that although the sample population shows high levels of burnout, participants remain relatively well engaged.

Demographic comparisons between MBI-HSS and UWES-9

Mean data/scores were performed on the data using the Mann-Whitney U and the Kruskal-Wallis test (a non-parametric test for more than two independent samples). This allows comparisons for data distribution between demographics and sub-scales, and is shown in Table 8.

Interpretations of the demographic comparison results

Gender: The data show similar distribution of gender experience EE (U=25, 903, p=0.266), PA (U= 27,563, p=0.393), DP (U=26,158, p=0.266) and engagement (U=24,986, p=0.235).

Therefore it can be concluded that there is no difference between gender and levels of burnout or job engagement.

Age of respondents: Regarding age of respondents, there are differences in the distribution for EE (Chi²=51.57, p= 0.00), PA (Chi²=16.83, p=0.01) and DP (Chi²=32.64, p=0. 00).

However, the results for engagement (Chi²=8.83, p=0.183) show a similar distribution. It can therefore be concluded that there are age differences for experiencing EE, PA and DP but none in relation to job engagement.

Main job role: Regarding main job role, there are differences in the distribution for PA (Chi²=41.21, p= 0.00), DP (Chi²=57.75, p=0.00) and engagement (Chi²=21.67, p=0.01).

However regarding EE (Chi²=7.42, p=0.191), the distribution is similar. In other words there is no difference in EE experienced across the job roles.

Area of practice: Regarding area of practice, there are differences in the distribution across EE (Chi²=20.43, p=0.00), PA (Chi²=16.77, p=0.02), DP(Chi²=34.72, p=0.00) and job engagement (Chi²=22.60, p=0.00), which is an indication that area of practice is not related to experience of burnout and job engagement.

TABLE 8: Comparison of participants on the MBI-HSS and UWES-9

	MBI-HSS			UWES-9
	EE	PA	DP	
<i>Gender (n=487)</i>				
Female	35.76 (SD11.77)	42.56 (SD8.11)	13.84 (SD6.51)	4.57 (SD1.31)
Male	34.25 (SD 12.58)	43.31(SD8.19)	14.8 (SD6.35)	4.74 (SD1.23)
	Mann-Whitney U = 25,903 p= 0.266	Mann-Whitney U = 27,563 p= 0.393	Mann-Whitney U = 26,158 p= 0.266	Mann-Whitney U = 24,986 p= 0.235
<i>Age of respondents(n=487)</i>				
29 and under	39.51 (SD11.11)	43.98 (SD7.88)	17.42 (SD6.71)	4.66 (SD1.32)
30-39	36 (SD10.83)	42.92 (SD8.55)	14.95 (SD5.53)	4.44 (SD1.12)
40-49	37.65 (SD10.85)	43.8 (SD7.13)	13.74 (SD6.76)	4.73 (SD1.35)
50-59	32.51 (SD12.49)	42.84 (SD8.23)	12.26 (SD6.17)	4.75 (SD1.42)
60-64	35.58 (SD13.87)	39.63 (SD9.54)	14.97 (SD7.64)	4.51 (SD1.22)
65-69	22.75 (SD8.16)	38.75 (SD7.3)	13.66 (SD4.77)	4.54 (SD0.95)
70 and over	17.8 (SD12.05)	51 (SD0)	8 (SD1.09)	5.35 (SD0.79)
	Kruskal-Wallis Chi² =51.57 p= 0.00	Kruskal-Wallis Chi² =16.83 p= 0.01	Kruskal-Wallis Chi² =32.64 p= 0.00	Kruskal-Wallis Chi² =8.83 p= 0.183
<i>Main job role (n=489)</i>				
Owner	34.88 (SD10.5)	41.54 (SD8.77)	9.05 (SD4.23)	5.15 (SD1.40)
Manager	37.49 (SD12.39)	45.01 (SD6.64)	15.29 (SD6.78)	4.68 (SD1.24)
Relief	32.56 (SD11.31)	44.29 (SD7.16)	12.85 (SD4.9)	4.63 (SD1.22)
Second pharmacist	35.1 (SD10.61)	45.08 (SD6.62)	11.83 (SD5.67)	4.91 (SD1.10)
Locum	33.99 (SD12.85)	39.28 (SD9.2)	15.71 (SD6.46)	4.32 (SD1.32)
Non-store role	35 (SD0)	44.33 (SD0.5)	19.33 (SD1.03)	5.70 (SD0.8)
	Kruskal-Wallis Chi² =7.42 p=0.191	Kruskal-Wallis Chi² =41.21 p= 0.00	Kruskal-Wallis Chi² =57.75 p= 0.00	Kruskal-Wallis Chi² =21.67 p= 0.01
<i>Area of practice (n=489)</i>				
Independent	31 (SD9.99)	42.3 (SD8.91)	11.31 (SD6.05)	4.97 (SD1.40)
Small chain (2-4 stores)	31.7 (SD16.76)	39.72 (SD6.7)	14.12 (SD6.86)	3.95 (SD1.38)
Medium-sized multiple	34.31 (SD11.55)	40.3 (SD8.96)	15.85 (SD6.61)	4.46 (SD1.58)
Large multiple	36.36 (SD11.75)	43.94 (SD7.7)	14.22 (SD6.15)	4.75 (SD1.13)
Supermarket chain	39.71 (SD11.67)	42.16 (SD8.0)	17.42 (SD6.74)	4.16 (SD1.17)
	Kruskal-Wallis Chi² =20.43 p= 0.00	Kruskal-Wallis Chi² =16.77 p= 0.02	Kruskal-Wallis Chi² =34.72 p= 0.00	Kruskal-Wallis Chi² =22.60 p= 0.00

Regression analysis

Table 9 shows the results of the multiple regression analysis. Pearson's correlation (ρ) value is used to find a correlation between at least two continuous variables. The value for a Pearson's correlation can fall between 0.00 (no correlation) and 1.00 (perfect correlation). Correlations above 0.80 are considered high.

When Pearson's correlation is close to 1, this means that there is a strong relationship between the two variables, and that changes in one variable are strongly correlated with changes in the second variable. When Pearson's correlation is close to zero this means that there is a weak relationship between the two variables, or that changes in one variable are not correlated with changes in the second variable. When Pearson's correlation is positive, this means that as one variable increases in value, the second variable also increases in value. Similarly, as one variable decreases in value, the second variable also decreases in value. This is called a positive correlation. When Pearson's correlation is negative this means that as one variable increases in value, the second variable decreases in value. This is called a negative correlation.

The standardised regression coefficient or beta value (β) is a measure of how strongly each predictor variable influences the criterion variable and is measured in units of standard deviation. The greater the beta value (positive or negative) the more important the predictor variable is in accounting for the unique variance in the dependent variable. R , R^2 and adjusted R^2 is a measure between the observed value and the predicted value of the criterion. The R^2 value multiplied by 100 shows the percentage of variance in the dependent variable jointly accounted for by the predictor variable.

TABLE 9: Multiple regression analysis predicting burnout and engagement scores

	EE			PA			DP			Engagement		
	ρ	B	β	ρ	B	β	ρ	B	β	ρ	B	β
Gender	-0.06	-	-	0.04	0.64	0.038	0.07	1.97	0.15	0.06	0.093	0.035
		0.37	0.15									
Age	-	-	-	-	-	-0.203	-	-	-	0.04	0.024	0.025
	0.26**	1.83	0.20	0.12**	0.58		0.17**	0.78	0.16			
Job role	-0.92*	-	-	-	-1.2	0.25	0.12**	0.67	0.15	-	-0.095	-0.107
		0.75	0.09	0.21**						0.12**		
Area of practice	0.21**	1.46	0.15	0.08	0.52	0.08	0.2**	0.77	0.15	-0.06	-0.039	-0.04
	R= 0.30 R ² =0.09 Adjusted R ² =0.085			R= 0.25 R ² =0.061 Adjusted R ² =0.053			R= 0.29 R ² =0.087 Adjusted R ² =0.079			R= 0.25 R ² =0.061 Adjusted R ² =0.053		
Table key				**Correlation is significant at the 0.01 level *Correlation is significant at the 0.05 level								

Interpretation of the regression comparison results

Gender: Pearson's correlation is close to zero for EE (-0.06), PA (0.04), DP (0.07) and engagement (0.06), indicating no correlation between gender and experienced levels of burnout or job engagement. Beta values for EE (-0.15), PA (0.038), DP (0.15) and engagement (0.035) are also low, indicating that gender is not a predictor of burnout or engagement.

Age: Pearson's correlation shows weak correlation for EE (-0.26), PA (-0.12) and DP (-0.177), indicating some correlation between age and burnout. However, for engagement (0.04) the figure is close to zero, which indicated no correlation. Beta values are also weak for EE (-0.20), PA (-0.203) and DP (-0.16). All three are negative, which indicated that age is a weak predictor of burnout and that increasing age might cause a decrease in burnout

experienced. The beta for engagement (0.035) is close to zero, indicating that age is not a predictor of job engagement.

Main job role: Pearson's correlation for EE (-0.92) is significant at $p=0.05$ but weak for PA (-0.21), DP (0.12) and engagement (-0.12). Beta values however are low for EE (-0.09), PA (0.25), DP (0.15) and engagement (-0.107). This presents a confusing picture of some correlation between main job role and burnout. However, the main job role does not appear to be a predictor of burnout or job engagement.

Area of practice: Pearson's correlation is weak for EE (0.21) and DP (0.2) and close to zero for PA (0.08) and engagement (-0.06). Beta values are also low for burnout and engagement, indicating that area of practice is not a predictor for them.

3.2 Qualitative results

Focus group

A focus group ($n=8$) was set up to investigate some of the stressors or events that might lead to burnout or engagement and to help with the formation of questions for the interviews.

Focus group attendees consisted of pharmacists known to the researcher. Data were recorded, transcribed and analysed using template analysis. Focus group responses were divided into stressors/events causing positive or negative emotions and these are listed in Table 10 below:

TABLE 10 : Focus group respondents

Negative factors	Positive factors
<ul style="list-style-type: none"> • No appreciation of the role of the pharmacist • No proper clinical role after years of studying • Poor skill mix in pharmacies or lack of staff • Excessive workload • Demanding patients • Poor role perception with other health care professionals • Responsibility for pharmacist regulations • No control over stock ordering • Lack of support from professional body • Non-pharmacist area managers • Excessive paperwork 	<ul style="list-style-type: none"> • Good patient/customer interactions • Positive/supportive line managers • Accredited checking technician available to support pharmacist role • Improvement in fellow professionals' appreciation • Support from colleagues

One pharmacist when asked about workplace stressors and the daily demands of work suggested the following as contributing factors:

‘Let’s start with audits. We have to do them but what purpose do they serve? Standard operating procedures, reading and signing, controlled drug regulations, entering in registers, the daily methadone entries. Staff inductions, appraisal, signposting recording, self care recording, intervention recording, Methotrexate, lithium and warfarin monitoring and recording, meetings, smoking cessation recording, the continual demand from PCTs to undertake CPPE packages before we can e.g. give paracetamol for minor ailments. After hours PCT meetings, PCT child protection meetings, etc, waste disposal regulations. Trying to obtain medicines that should be available (DTP - emergency supplies or can I borrow?) Expensive items, payment checks on the PPA, PCT payment checks, ETP (ups and downs). ETP card expiry problems, sumatriptan sales protocol, tamsulosin sale protocol, etc, DDA assessments’

Independent owner pharmacist M46

The amount of paperwork and regulatory requirements affecting daily working life was also commented on by another pharmacist:

‘37 SOPs to read and sign and update once a year, general business paperwork that needs completing each month. Smoking cessation, vaccines, palliative care, supervised methadone. Staff training and two appraisals a year. Waste segregation, CPD, RP register, 5 health campaigns, 2 audits. Patient survey, read PJ and all the

pharmacy bumpf, MURs (and send list to GPs). Complaint and error logging, IG, ordering (specials and short supply items) from manufacturer, endorsing, checking RX batch for no errors and sending. Stock control, e.g. off-patent, cheaper items, MDS, red card update. CD entering and methadone (approx 25 daily), annual HSE checks, PNA, CD waste, checking the PPD statement (I find mistakes in my favour every month!) - I don't have bags of time to record signposting interventions either'

Independent employee pharmacist M34

The topic of stress was raised by an employee pharmacist working for a small multiple chain pharmacy:

'Stress is part of any job but too much and it becomes pressure - so much could be electronic and we don't need to be monitored like criminals by so many regulators'

Employee F35

A general comment was made by an experienced locum pharmacist:

'Some of us have been hammering on about this subject for six years and more. What is happening now is that conditions are so bad that more pharmacists feel they have to speak out about them'

Locum pharmacist M52

One pharmacist commented on a possible solution to the problem and how it might be resolved:

'What is needed is an appreciation of what a pharmacist needs in order to provide a 'proper' service to the patient including a real clinical - or professional - check of every prescription with an intervention and feedback to the prescriber whenever it is in the patient's interest, and proper counselling, which includes giving the patient the opportunity to ask questions and make comments. The same applies to the sale of medicines. What is needed is an adequate level of resources, including time, staff numbers and skill mix, and a properly calculated workload. Expecting a pharmacist to check 800 items in a day precludes anything but a simple accuracy check. Six dispensers feeding completed scripts to a single pharmacist forces that pharmacist to cut more and more corners'

Employee pharmacist F34

Another pharmacist commented:

'What is not needed is ever more bureaucracy, ever more commercial targets for MURs, blood pressure checks, flu jabs, collection services, etc, etc. What is not needed is corporate bullying by non-pharmacist area managers and a distant and detached superintendent pharmacist who wonders why none of his branch managers

ever report concerns to him. What is not needed is lost bonuses and disciplinary meetings for those who fail to meet commercial targets or dare to question company policy'

Independent owner M34

There were several comments linked to the need for the pharmacy profession to work closer with its members to tackle the issue of workplace pressure. Several comments were also made regarding lack of control:

'What is needed is for pharmacists to take back their profession'

Employee pharmacist F34

'We need the GPhC to issue guidance on what is and is not acceptable regarding workload/workplace pressure'

Independent owner M34

'We need a strong professional body to represent its members (individual pharmacists at the coal face, who have trained to and most of whom want to work to a high standard of professionalism) not those who are prepared to risk patient safety for the sake of even more profit through their greedy self-serving schemes administered by bullying tactics'

Employee pharmacist F31

'We need to remove excess fear as a motivator from our working lives (fear of the inspector, fear of area managers, fear of the PCT, fear of patients' impatience) and instead aim to be motivated by wanting to improve someone's health and wellbeing (including our own), and gaining positive feedback for doing a good job'

Employee pharmacist M45

Another pharmacist suggested that more training was needed to help pharmacists deal with increasing workloads:

'We need to teach pharmacists how to delegate tasks better. Help them develop as managers as well as pharmacists. Workload pressure is not going away so we need to learn how to deal with it in a more effective way. The RPS should be more active in this area'

Independent owner M34

Data from interviews

Results from the focus group were used to formulate the moderator guidance questions for the semi-structured interviews (Appendix 3). A total of 19 interviews were conducted, which included nine face-to-face interviews, five telephone interviews and five interviews electronically via email. Data from the interviews were quantified to give a very broad overview of the patterns (Table 11) and were coded using the methods previously described. The coding template is shown in Table 12.

TABLE 11: Overview of respondents

Gender	Age	Interview type	Job role	Area of practice	Positive patient event	Positive work event	Negative patient event	Negative work event
M	46	Focus group	Owner	Independent	Data recorded as a group			
M	34	Focus group	Employee	Independent				
F	35	Focus group	Employee	Medium multiple				
M	52	Focus group	Locum	NA				
M	34	Focus group	Owner	Independent				
F	34	Focus group	Employee	Large multiple				
F	31	Focus group	Employee	Large multiple				
M	45	Focus group	Employee	Small multiple				
F	36	Face-to-face	Manager	Large multiple	9	8	7	4
M	29	Face-to-face	Manager	Large multiple	6	5	6	5
M	34	Face-to-face	Manager	Large multiple	8	4	5	5
F	29	Face-to-face	Manager	Large multiple	3	6	7	3
F	32	Face-to-face	Second pharmacist	Large multiple	6	3	5	4
F	24	Face-to-face	Second pharmacist	Large multiple	8	7	5	3
M	23	Face-to-face	Relief pharmacist	Large multiple	6	5	6	5
M	33	Face-to-face	Relief pharmacist	Medium multiple	5	4	7	9
F	31	Face-to-face	Manager	Small multiple	9			
M	34	Telephone	Owner	Independent	3	5	6	5
F	40	Telephone	Owner	Independent	2	4	5	4
M	34	Telephone	Manager	Independent	6	3	6	9
M	46	Telephone	Manager	Independent	7	6	7	7
M	44	Telephone	Manager	Supermarket	5	5	6	5
M	46	Electronic	Manager	Supermarket	4	3	8	5
M	33	Electronic	Locum	Various	7	6	6	9
F	29	Electronic	Locum	Various	9	3	5	4
M	32	Electronic	Locum	Various	8	2	4	6
M	47	Electronic	Locum	Various	5	6	7	7

TABLE 12: Coding template

Code	Descriptive Code	Meaning code
Positive patient event		
P1	Enjoyable patient/customer contact	<ul style="list-style-type: none"> • Success/going well • Most important part of the job • Helping client • Seeing client viewpoint/Empathy with their feelings • Good relationship with client or clients
P1.1	Provision of advice over the counter	
P1.2	Dispensing prescriptions	
P1.3	Provision of a pharmacy service	
P2	Patient interaction that had a positive outcome	<ul style="list-style-type: none"> • Effective management of a problem • Engendering positive feeling in a client as a result of actions or words • Better than expected result
P3	Patient interaction that gave positive feedback	<ul style="list-style-type: none"> • Clients expressing gratitude or appreciation • Turning a situation around • Show of affection from a client
Positive work event		
P4	Positive interaction with another health professional	<ul style="list-style-type: none"> • Appreciation from another professional of help/support
P5	Positive interaction with a line manager	<ul style="list-style-type: none"> • Giving support • Successful leadership/management
Negative patient event		
N1	Interaction with a difficult client	<ul style="list-style-type: none"> • Client not listening to advice given • Handling of client • Escalation of problems
N2	Verbal abuse by a patient	<ul style="list-style-type: none"> • Threat of complaint to somebody above • Indirect abuse (aimed at higher level)
Negative work event		
N3	Paperwork or administration concerns	<ul style="list-style-type: none"> • Excessive amounts of paperwork • Time taken to complete • Administration getting in the way of normal work
N4	Working environment	<ul style="list-style-type: none"> • Physical layout of workplace • Access to facilities • Temperature control
N5	Changing role of pharmacist	<ul style="list-style-type: none"> • Responsible pharmacist regulations • Expectations to take on new roles
N6	Physical symptoms at work	<ul style="list-style-type: none"> • Health concerns at work
N7	Staffing issues causing concern	<ul style="list-style-type: none"> • Lack of staff • Lack of trained staff • Dealing with line managers • Demand from other areas of the business • Poor skill mix
N8	Emotionally demanding situations	<ul style="list-style-type: none"> • Pressure to bend the rules from clients/patients • Noisy environment • Time pressure to complete tasks • Lack of stock • Clients/patients wanting more time than can be spared • Angry/cross clients/patients

Events were quantified as positive (inferring engagement) or negative (inferring burnout).

Events giving positive emotions

There were a number of positive comments in this study which could be seen as representing job engagement.

An enjoyable patient/customer contact (P1)

Enjoyable patient contact was frequently reported and is an indication that respondents too pleasure from these interactions. These interactions fell into three main categories:

- Provision of advice over the counter
- Dispensing prescriptions
- Provision of a pharmacy-based service linked to the pharmacy contract.

Provision of advice over the counter (P1.1)

As an example, one pharmacist commented:

'A customer came in asking for advice about buying malaria prophylaxis for a once in a lifetime trip to India. She had already been to another pharmacy and was told to come back later when they were less busy. She couldn't wait and came to me instead. I was able to help her and also sold some extra products to do with first-aid'

Employee pharmacist F29

Another pharmacist commented:

'A young mother visited the pharmacy with her 2 year old child who was suffering with diarrhoea. The mum was very concerned. I asked all the relevant questions I could think of and even remembered some of the danger symptoms that we were told to look out for while I was still training. I managed to reassure the child's mother and sold a packet of replacement fluid sachets'

Employee pharmacist M23

Other respondents also commented on an enjoyable patient contact when the pharmacist felt that he or she had handled it successfully or well.

Dispensing prescriptions (P1.2)

As regards dispensing prescriptions, positive comments mainly arose when the pharmacist was able to supply a particular item that another pharmacy could not, or when a prescription query had been resolved by the pharmacist:

'A woman came to me on her third attempt at getting a script dispensed. She had been to other pharmacies but they didn't have the prescription item concerned. Luckily I had already ordered it for another patient; in fact I ordered two for stock so was able to help her. She was very grateful'

Independent owner M34

'A man presented me with a dental prescription for an item that was not allowed to be dispensed on a dental prescription. He was in a rush and couldn't go back to the dentist. I phoned his dentist, arranged for a new prescription to be posted to the pharmacy and off he went shaking my hand. That's not something that happens very often these days'

Employee pharmacist F32

Provision of pharmacy service (P1.3)

Comments regarding provision of a pharmacy service

'I had recently attended a training event on Parkinson's disease and wanted to find a suitable patient to conduct an MUR. I had known Mrs Brown for about 3 years and rarely dispensed her prescriptions so I asked her! It was fairly time-consuming - about 30 minutes - but we got on well and discussed her family as well as medication. The main outcome was that she needed to have some kind of compliance aid as she keeps forgetting to take some medication and had little support from family members. Two weeks later we started her on a pill-pack system and so far so good'

Employee pharmacist M33

A patient interaction which had a positive outcome (P2)

Most pharmacists regarded a positive outcome as selling an over-the-counter medication or resolving a prescription problem. For example, one pharmacist commented:

'A customer came in with shingles, didn't want any medication as such, only some kind of herbal remedy. I must admit my first thought was why? And I couldn't think of anything as such off the top of my head. I knew however a colleague of mine was into herbal treatments so asked her while the patient waited. She recommended a soothing balm, which we had in stock. This I sold. The patient came in next day to thank me for the time and effort'

Employee pharmacist F24

Another pharmacist described a situation regarding a prescription problem:

'I was working in a supermarket pharmacy in the evening with no support staff. A prescription was presented for piriton syrup for a child, which was fine but the dose was incorrect according to the BNF. It took me over 20 minutes to contact the out-of-hours medical service to confirm the correct dosage, but the patient's mother was pleased that I did as she didn't trust the doctor she saw anyway'

Supermarket pharmacist M44

A patient interaction that gave positive feedback (P3)

Several comments were made regarding the lack of positive feedback from patients. Rarely do patients return to the pharmacy to give positive feedback. However there were a few examples:

'A customer returned to the pharmacy to thank me for helping her the previous week when I sold her some hydrocortisone cream for an allergy rash caused by a new ring. I also recommended a jewellery shop where she could get the ring coated to prevent further problems'

Employee pharmacist F31

'Rarely do customers come back and thank you for helping them with a problem. However one customer actually came in and thanked me for sorting her prescription out and also told me how professional I had been'

Employee pharmacist M33

Positive interaction with another health professional (P4)

There were several examples of a positive interaction with another health care professional:

'The palliative care nurse contacted me and thanked me for arranging for Mrs Briggs' new prescription item to be delivered to her'

Independent employee M34

'I had a diabetic patient who needed help with a painful corn on her big toe, so I contacted a local chiropodist for her and arranged an appointment. The chiropodist phoned me later to say that the patient's foot was in a much worse state than just a corn and he had referred the patient to the diabetic clinic as an urgent referral. I felt pleased that I had made the extra effort in the first place'

Employee pharmacist F36

Positive interaction with a line manager (P5)

Positive interactions with a line manager were seen as motivational and a good way of engaging employees:

'My line manager emailed me to thank me for the previous week's dispensing figures being better than expected. This doesn't happen very often but when it does it makes me feel good about the job'

Employee pharmacist M29

'Following my annual appraisal, my pharmacy manager thanked me for being so co-operative and making her life easier'

Employee pharmacist F26

Events giving negative emotions

Events giving negative emotions were described in a similar way to positive emotions, and could be seen as an indication of potential burnout.

An interaction with a difficult patient (N1)

Patients were often perceived as being difficult when the interaction went badly or not as well as expected by the pharmacist. Such events mainly focused around dispensing a prescription or the request for an over-the-counter medicine that the pharmacist felt was inappropriate:

'I had a patient wanting to order his repeat prescription as he had run out. I explained that it would take 48 hours; he told me this was no good as he going on holiday that afternoon. In the end I managed to get a prescription faxed to me but the patient didn't even bother to thank me'

Employee pharmacist M34

'I insisted that I looked at an infected eye rather than just sell chloramphenicol eye drops without seeing the patient. When the patient returned the eye was so inflamed

an OTC sale was not appropriate, so I had two lots of abuse, one initially from his wife and then later from the husband who was the patient'

Locum pharmacist M33

'Whilst I was doing a locum stint on a Friday a methadone patient came to collect his medicine for the weekend. Unfortunately the prescription had run out, and the patient was not happy as he anticipated a weekend without medication. The methadone clinic was closed and there wasn't anything I could do. It was annoying because the normal employed pharmacist should have sorted it during the week'

Locum pharmacist F29

'One thing that annoys me more than anything else are patients that only want a particular make of drug. For example, Mrs X only wants GUK make of mebeverine. It's been out of stock for ages but she refuses to have anything else and blames me for not being able to get it. However she never wants to try another make. Sometimes I just don't know what to do to help her. I've got to the point where I don't care anymore'

Independent employee M46

Verbal abuse by a patient (N2)

Verbal abuse by a patient was reported in several interviews and was often seen as a stressful event:

'Verbal abuse is an increasing problem especially from so-called ordinary customers who are in a hurry, don't listen and are unreasonable.'

Employee pharmacist M33

'A young lady was prescribed the 'wrong' oral contraception pill by her doctor and I was unwilling to supply the pill she wanted without contacting the prescriber. She subjected me to a torrent of abuse and almost physical abuse but the counter saved me'

Employee pharmacist F29

'In the end I asked the patient to leave the pharmacy as he was just shouting at me. He wouldn't go, so I pretended to phone the police. Eventually he went. I just felt emotionally drained'

Employee pharmacist M34

'I was working one Saturday morning when a patient's daughter phoned to complain about her mother's medication. Why had it been changed? I explained that the surgery was closed so I couldn't contact the GP. This wasn't good enough apparently. Three minutes later, after a series of threats of legal action, I just put the phone down, sat down and wondered why I do the job that I do'

Independent owner F40

Paperwork or administration concerns (N3)

In common with the focus group findings, paperwork was seen as a burden in many interviews, and not seen as a positive aspect of working life:

'Everyday there is paperwork to be completed such as interventions and task sheets. They get in the way of the practical side of the job such as seeing patients. Sometimes workload gets in the way of completing paperwork, then I worry that I might get into trouble'

Supermarket employee M44

The value of paperwork was questioned by another pharmacist:

'Interventions, SOPs paperwork is never ending, but has it improved patient safety? I'm not so sure'

Independent owner F40

Many employee pharmacists commented on the fact they have to complete so-called task sheets during the day to justify that a task has been completed:

'Each day I have to fill out a task sheet. It even includes things like 'have you turned on the computer' - how stupid is that! In the afternoon a non-pharmacist duty manager comes round to the pharmacy to check if I ticked the list - what is the point of that?'

Employee pharmacist F29

Stock ordering was seen as an increasing problem, especially the paperwork associated with this. One pharmacist commented on the 'direct to pharmacy' scheme, which is where stock comes direct from the manufacturer, as opposed to coming from the wholesaler:

""Direct to pharmacy"" schemes have added enormous complexity and additional

bureaucracy – and we can spend hours simply trying to obtain products to fill prescriptions’

Independent owner M34

Working environment concerns (N4)

Several pharmacists raised concerns with the general facilities found in a pharmacy.

One pharmacist commented:

‘The physical environment plays a role: lighting, equipment, IT facilities, space - these all contribute to the stressful working environment’

Locum pharmacist M33

Another pharmacist commented in general on independent pharmacies that he often works in:

‘Often places are cramped. The loo is right next to the kitchen and the loo is used as a store cupboard too. It’s not pleasant and not hygienic’

Locum pharmacist M32

The practicality of going to the toilet was commented on by another pharmacist working for a supermarket pharmacy:

‘I work in a busy supermarket pharmacy. The pharmacy itself is great but it’s near the front of the shop and the toilet is about 5 minutes away, so I have to sign out of the RP register, and sign back when I return. Patients are often waiting when I get back’

Supermarket pharmacist M46

The issue of the layout of the pharmacy itself was commented on by several interviewees. For example:

‘The pharmacy recently had a refit. The shelves are now higher than before and I’m not that tall. I need to use a step stool, which doesn’t really help and makes the whole dispensing process take much longer’

Employee pharmacist M34

‘Some pharmacies I go to are often a mess. I usually spend 10 minutes or so clearing things away before I start work’

Locum pharmacist M33

‘I don’t like checking prescriptions in front of patients; I find it very stressful and worry about making errors’

Employee pharmacist M33

The stressful working environment was also raised by other pharmacists and concern was raised over the effect of the 'responsible pharmacist' regulations:

'My main concern is how to survive working until I am 66 in a stressful environment whilst doing the best for my patients and colleagues, and then living long enough to enjoy the fruits of my labour'

Locum M47

'Conditions are out of our control, yet the "responsible pharmacist" regulations infer that it's my problem. It's a joke and depressing'

Employee pharmacist F29

The changing role of the pharmacist (N4)

Several pharmacists commented on the changing role of the pharmacist in a negative way.

Comments mainly focused on the increased bureaucracy resulting from the pharmacy contract, the pressure to achieve targets, lack of communication with other professionals, and the lack of a clinical role:

'Effect of the "new" pharmacy contract – it caused a massive increase in bureaucracy and the pressure from that needs to be fed in'

Independent owner F40

'I feel there is pressure on me to complete MURs and end up doing unnecessary ones just to complete my daily target'

Employee pharmacist F29

'The role has changed from pill counter but I feel that there needs to be a general improvement in communication with GPs to ensure we are supporting each other'

Independent owner M34

'I'm not sure that the role has changed that much. Rather we are expected to do more for the same money that we used to get. There is an expectation from recent pharmacy

graduates that they will be doing more clinical services. However really at the end of the day we are still just dispensing prescriptions'

Employee pharmacist M34

Physical symptoms whilst at work (N5)

Several pharmacists commented on having physical symptoms that could be an indication of stress or burnout:

'I feel depressed when I go to work, while I'm there, and when I get home'

Employee pharmacist M34

'I pretty much feel tired all the time at work'

Independent owner F40

'I often get headaches and even palpitations'

Employee pharmacist M34

'I work 6 days a week as a locum. I travel around 80 minutes each way to work. I find working in shops with one hour lunch are the best as I look forward to the break so I can relax. I also get red eyes towards end of day. And in extreme tiredness my eye twitches'

Locum M47

'I once had such a bad migraine attack and was taken to hospital with a suspected brain haemorrhage. In the end the doctor diagnosed acute migraine brought on by prolonged periods of stress'

Employee pharmacist F29

Staffing issues causing concern (N7)

Lack of staff and, in particular, skilled staff was often raised as a concern. Skill-mix or simply having the right people to do the right job is a particular issue:

'As a locum I never know what staff I will have and what they can do for me'

Locum pharmacist M47

'I have a checking technician, but more often than not she is simply dispensing as we do not have enough ordinary dispensers to dispense'

Employee pharmacist F29

'Good skill mix remains a problem in most shops and some of those people aren't really up to job. I complain to the pharmacy manager but I'm told just to get on with it'

Employee pharmacist M33

Emotionally demanding situations (N8)

Emotionally demanding situations varied from patient interactions, staffing issues, working environment and the pressure to achieve targets.

'I hate it when there is a child crying in the shop and the parents are hassling me to get the prescription done as quickly as possible'

Employee pharmacist F36

'.. when I get shouted at for things that are not my fault. I don't get paid enough for that - it's a real strain'

Employee pharmacist F32

'..staff bitching and backstabbing gets me down. Why can't they just get on with work like I have to?'

Employee pharmacist M23

'I get fed up with the area manager demanding that I do more and more MURs. It's like I'm standing around doing nothing. I wish she would come and do my job for a day and see what it's really like'

Supermarket pharmacist M46

'.. the phone ringing, people waiting for prescriptions, people waiting to see me for advice - it never stops'

Locum M33

'Not being able to get stock that I need. When I send the order off there are usually at least 10 things out of stock that I then have to find from somewhere else'

Independent owner F40

'..patients wanting more of my time than I can spare'

Independent owner M34

'There is always pressure to keep the shop open over lunch time. Sometimes I can't relax when I need to. When we open after lunch the workload is still there - I find it rather demanding'

Employee pharmacist F36

'...success brings more workload without any more resources or staff to cope with it. When I finish work at the end of the day, I'm too exhausted to do anything other than eat and sleep'

Supermarket pharmacist M44

'The things that cause me to be emotionally strained are patients and other health professionals who want me to break the law on their behalf so that they get what they want'

Independent employee M44

'Stock shortages cause enormous emotional and practical demands'

Employee pharmacist M29

'Constant workload. Wages not increasing. Difficult patients. Difficult managers'

Employee pharmacist F31

'Customers waiting to be served or want advice when I really don't have that much time to serve them'

Employee pharmacist M23

'Angry customers and increasing workload without any increase in resources'

Supermarket pharmacist M46

CHAPTER 4: DISCUSSION

Community pharmacy is going through a period of change contractually via the Department of Health, and there is an expectation that pharmacists need to develop new roles within the community (Department of Health, 2008). It has already been stated that community pharmacist workloads are increasing and this has resulted in decreased levels of health and well-being and decreased job satisfaction. More recently, concerns within the profession have been raised about the 'responsible pharmacist' regulations. These make individual pharmacists more accountable for the day-to-day operation of a community pharmacy (The National Archives, 2008) and increase the risk of prosecution following a dispensing incident (Blackstone, 2009). The picture presented is a workforce that is under pressure to perform, yet struggling with increased workload and regulation that ultimately could threaten patient safety.

The results of this study show that burnout is an important issue among community pharmacists in the sample population. Pharmacists showed high levels of EE (mean 35.28, SD 12.10) and DP (mean 14.23, SD 6.48) and low levels of PA (mean 42.86, SD 8.14), which gives an overall picture of a high degree of burnout in this sample population. Levels for job engagement however were encouraging, with respondents showing positive levels of job engagement (mean 4.64, SD 3.74). In this study there were no differences between gender, job role, area of practice and burnout/engagement. However, there does appear to be some correlation between age and burnout, with older pharmacists showing less overall levels of burnout: EE ($\text{Chi}^2=51.57$, $p=0.00$), PA ($\text{Chi}^2=16.83$, $p=0.01$), and DP ($\text{Chi}^2=32.64$, $p=0.00$). This result is similar to that found by other studies within pharmacy (Rothmann et al., 2002, Calgan et al., 2011) and outside of pharmacy (Denton et al., 2008, Sherring et al., 2009), and does cause some concern regarding newly-qualified pharmacists and on-going

support. Currently in the UK pharmacists undergo a year-long period of pre-registration, with support from a tutor pharmacist. Once qualified, however, direct support is often not available. This lack of support has been highlighted by other researchers (Ferguson et al., 2011).

Qualitative data have indicated that community pharmacists are finding that paperwork/administration, skill mix, 'responsible pharmacist' regulations, availability of dispensing stock and the demands of patients are factors that might contribute to burnout levels. Gidman (2011) and Ferguson et al. (2011) also using qualitative data found these to be important concerns for community pharmacists. Ferguson et al. (2011) cited dissatisfaction and lack of support with management as being a major factor in community pharmacist job satisfaction. Lack of support from line managers has been linked to increased levels of experienced burnout (Lee et al., 1996).

On the other hand, several pharmacists had enjoyable patient interactions and seemed to respond positively when line managers gave praise. Social support was seen to be an available resource when managing levels of stress. The majority of community pharmacists within this study are either employed or work for large or medium-sized pharmacy chains.

This research has raised concerns over the pressure to achieve targets such as MURs. Research by Gidman (2011) and Ferguson et al. (2011) has also shown a relationship between target-setting from line managers and increased levels of stress. These are all factors that increase the likelihood of burnout.

Maslach et al. (1997) in *The truth about burnout* list the following reasons for burnout:

- Work overload
- Work intensity
- Increasing work demands
- Increasing complexity of work
- Lack of personal control and insufficient reward.

They cite lack of fairness, fragmented relationships in the workplace and losing the joy of work as being contributory factors. They also make suggestions on how burnout can be prevented. Prevention starts with management building commitment through team work and communication. Maslach in *Burnout - the cost of caring* suggests that individuals also need to take control of their lives by working 'smarter' instead of harder, doing things differently, taking things less personally and caring for oneself as well as others. If community pharmacy is to progress, take on new roles and better engage with the general population the issue of burnout needs to be addressed by employers, professional bodies and individual pharmacists.

Strategies to reduce burnout

Burnout should be viewed not only as a personal problem but also as an organisational one, and the ability to identify developing problems early on before they become more serious and to enable timely, preventive solutions (Maslach et al., 2008) to be initiated is crucial. Some strategies to reduce burnout are shown in Table 13 below.

TABLE 13: Strategies to reduce burnout

Burnout factor	Comments
Stress reduction	Reducing stress and therefore burnout has to be seen as a priority. Conducting a stress ‘audit ‘ followed by a series of interventions at individual level and organisational level such as training programmes designed to help the individual is seen as priority for organisations (Sutherland et al., 2000, p.125)
Workforce pressure	The Royal Pharmaceutical Society has produced a series of tools, guidance and information designed to help with the pressures that pharmacists experience within the workplace. (2011). This is seen as the first step in providing professional empowerment in dealing with workforce pressure. Workloads, targets and deadlines should be reviewed to ensure that these are not factors contributing to stress and burnout (MacDonald, 2005, p 30)
Social network	Building a strong social network, i.e. friends and family and interests outside of work, can help to reduce burnout levels (Maslach et al., 2001)
Wellness at work	Employers have a valuable role to play in protecting and promoting employees’ health and wellbeing (Macdonald, 2005, p.1) and this is directly related to happiness and low levels of stress and absenteeism. Healthy employees are more likely to suffer less burnout and stress (Maslach et al., 2001)
Management/Supervisors	Dissatisfaction with management has been linked to job satisfaction within community pharmacy (Ferguson et al., 2011) and a lack of management support can increase workplace stress (MacDonald, 2005, p 20)
Mentoring and coaching	Finding a mentor and coach to help people through the challenges of personal and professional life can help to reduce burnout (Bruce, 2009)
Work life balance	The 2008 pharmacy workforce survey indicated that one in ten pharmacists have considered quitting the profession and in particular men seem to struggle with work life balance. Work-life balance is an important factor for the individual and organisation in terms of stress management and job engagement (Bratton, 2007,p 149)
Role ambiguity	Role ambiguity is highly correlated with burnout (Schabracq et al., 2003, p 397) and stress (Bratton,2007,p 495), but can be resolved by workers’ job roles being clearly identified (Bratton,2007,p 495)
Job satisfaction	Job satisfaction is closely linked with workforce stress and wellness at work (MacDonald, 2005, p 19). Conducting a review of the job and the way it is done can be a key factor to reduce workplace stress and burnout

Intervention programmes

To date there have been no intervention programmes to reduce burnout in community pharmacists. A review of intervention programmes by Awa et al. (2009) found that person-directed interventions reduced burnout in the short term (6 months or less), while a combination of both person-directed and organisational-directed interventions had longer-lasting positive effects (12 months and over). However in all cases positive interventions diminished in the course of time. Further research is therefore needed to explore the use of interventions within community pharmacy.

Support for pharmacists in need of help

Support is available for pharmacists from Pharmacist Support, an independent charity working for pharmacists, their families and pharmacy students to provide help and support in times of need. Support services include a variety of programmes developed in consultation with pharmacists to offer a helping hand to colleagues who find themselves confronted by difficult circumstances, for whatever reason. Some of the services are delivered directly by experienced volunteer pharmacists located throughout Great Britain (<http://www.pharmacistsupport.org>).

More recently, new guidance has been published by the National Clinical Assessment Service (NCAS), aimed at ensuring concerns about the health of health professionals are recognised early and handled effectively in the workplace. *Handling concerns about practitioners' health* (NCAS, 2011) describes issues organisations may wish to consider in order to identify and manage ill health in health professionals, including pharmacists. Its recommendations draw on evidence presented in the Department of Health's report *Invisible Patients: report of the working group on the health of health professionals* as well as a decade of experience at NCAS in handling concerns about professional practice.

Limitations of this study

Results from this study cannot be extrapolated to other parts of the UK as the sample population was not seen to be representative when compared with national data. Longitudinal research would be useful to assess which job demands and resources are most relevant in the development of burnout and engagement in community pharmacy. The results may be skewed in that geographic areas within the sample population might have workplace factors not highlighted within this survey. Another important factor is ethnic background, which has not been explored in this survey. Previous research has indicated that ethnic minorities are attracted to careers in pharmacy; for example in 2007, 27% of registered pharmacists came from black or other ethnic minority backgrounds. Research in this area is limited; however, Maslach (2003, p 98) has indicated that black healthcare professionals show lower levels of EE compared with Caucasian workers. In spite of these limitations, it is hoped that the findings can be used to guide good practice.

Implications for practice

This research has several implications for community pharmacy practice and service development. A significant proportion of pharmacists in this sample population suffered from burnout, and if this data were extrapolated to all community pharmacists and if those pharmacists were unable to detect and acknowledge the signs of burnout, disillusionment with the profession might follow. This could lead to community pharmacists leaving the profession. It is also possible that a proportion of these burnt-out pharmacists may be providing poor quality of care to clients/patients, so assessing the impact of burnout on patient care is also important.

Managers and employees should become aware of the causes and symptoms of burnout and if possible monitor burnout levels on a regular basis. This could help them become aware of their own and others' EE, DP and PA, and highlight instances of managers suffering from burnout.

Professional and regulatory pharmacy groups should consider practices to help prevent burnout and encourage engagement. Interventions on an individual and organisational basis should be employed where necessary to cope with possible burnout issues among community pharmacists.

Further support for newly qualified pharmacists needs to be considered in the form of burnout guidance to complement workforce pressure guidance.

Future research

Further research needs to focus on engagement within the community pharmacy workforce. In particular it would be useful to establish the reasons why some community pharmacists cope with excessive workload and some don't. The implications of personality type, ethnic background, career expectations and postgraduate education on burnout and stress need to be explored further, and also what support is needed for the newly qualified pharmacist.

CHAPTER 5: REFLECTION

Introduction

This chapter provides the researcher's own perspective on the professional development which has resulted from this Professional Doctorate in Pharmacy in the context of his career as a pharmacist.

Early professional career

My family history has pharmacy embedded within it, both my father and grandfather having been registered community pharmacists. Even as a child, I decided to embark on a career in pharmacy, and this started at the age of 16 when I worked for a large multiple pharmacy as a 'Saturday assistant'. This was an immensely useful period of working, as the company that I worked for had an active training department and I developed the 'people skills' that I still use in practice today.

I undertook my pharmacy degree at the School of Pharmacy, London University and was awarded the degree of Bachelor of Pharmacy (Hons) in 1985. The degree teaching was delivered by a mixture of traditional lectures, laboratory lectures and group tutorials. I was awarded an upper second class degree, the research project in my final year being a contributory factor.

After completing my degree, I embarked on a period of pre-registration in community pharmacy. The decision to be employed in the community, rather than in a hospital, was based on my previous work experience, and the fact that community pharmacy is more patient-centred than hospital practice. At the time, pre-registration training was conducted by a suitably trained tutor pharmacist and involved completion of assessment criteria during the

training year, the tutor pharmacist being solely responsible for the overall assessment of the trainee.

The company also provided a certain amount of training during the course of the year. However, this was largely related to the management of a pharmacy, and no clinical input was provided. Training was mainly one-to-one coaching, feedback and practical demonstration of a task, and my tutor had a strong influence upon me in terms of standards and values.

After satisfactory completion of this pre-registration year, I embarked on a career in community pharmacy practice, gaining experience on the way and becoming a pharmacy store manager. As a pharmacy manager, my on-going learning related to personal development needs concerning pharmacy operation, rather than to my clinical development needs as a professional pharmacist. Competency-based assessment was used by my immediate line-manager as a tool to monitor my performance, and this often increased my remuneration or resulted in the promise of promotion to another store.

In the year 2000, I decided to advance my professional knowledge and clinical skills by entering a programme of post-graduate study. I decided to undertake a Master of Science degree in Community Pharmacy at Portsmouth University. I chose to apply to Portsmouth as it offered monthly teaching sessions at a convenient location and had a good reputation for providing high quality courses. Course assessment was based on satisfactory completion of assignments rather than examination, and the course offered a wide range of topics from community pharmacy practice to therapeutics. I found this course very thought-provoking throughout my three years of study. I was awarded the Master of Science in Community

Pharmacy Practice in 2004 after completion of a research project. My research dissertation was entitled *The computer literacy skills of pharmacists in Dorset and Somerset*.

Having a post-graduate qualification enabled me to apply for a part-time position working for my local primary care trust (PCT). During this period, I had access to training courses provided by the PCT and had an active role in shaping pharmacy services in the area. This led to my appointment as pharmacist representative on the Professional Executive Committee of the PCT, and I also undertook a number of projects for the PCT. Completion of the MSc and working for the PCT gave me an enormous sense of professional satisfaction and acted as catalyst for my decision to embark on a Professional Doctorate in Pharmacy.

Entry onto the professional doctorate

I applied to undertake the Professional Doctorate in Pharmacy (DPharm) following the completion of the MSc in Community Pharmacy. I had developed an interest in research and had undertaken some projects for the PCT, so the professional doctorate seemed to be a natural extension of prior leaning.

Professional doctorate, Part I (taught component)

Part 1 of the professional doctorate provided an important opportunity to prepare to successfully undertake a research project, with all the associated elements such as advanced research techniques and publication/dissemination.

The Professional Review and Development module is a key one for the DPharm. The module continues over the period of the course, serving to underpin all other modules. Before starting this unit, I assumed that I would find it relatively easy, considering that reflective practice is a concept that I use in my daily life as a practising pharmacist. The unit did

however present many challenges both in terms of understanding the concepts being explored, and my own pre-conceived ideas of what reflective practice actually meant. Completing the unit enabled me to understand how I might link my learning technique to my professional development and ongoing learning needs.

The Advanced Research Techniques module of the DPharm is therefore important not only from the point of view of completing the course, but also for my future professional roles. Prior to undertaking the DPharm, my only experience of research methods was through my MSc dissertation, completed in 2004. Hence, I identified this module as being essential to help fill gaps in my knowledge of research methods and interpretation of results. Qualitative research was something completely new for me. Two of the assignments allowed me to explore qualitative and quantitative research methods, both of which I then used in my Part II project.

Prior to commencing the Publication and Dissemination unit, I had no previous experience of writing for publication, but had some experience of presentation skills through my practice role within pharmacy. The most challenging aspect of the unit was preparing an article for publication, and peer review of an unpublished article.

Professional doctorate, Part II

The value of the research project undertaken stemmed from the fact that I felt personally close to the subject matter, professional burnout and engagement. In my role as primary care pharmacist for the local PCT, I often found myself surprised by the lack of uptake of professional services within community pharmacy, and as a pharmacist working for multiple pharmacy groups I had come across examples of excessive workload and stress that appeared to indicate a workforce that was disengaged. I was not familiar with the term or concept of

burnout until I read an article regarding the experience of burnout within a group of nurses. This became a 'eureka' moment for me, and I began to research the topic further.

The research proposal formed the backbone of the research project. However, I found the process difficult as, due to personal reasons, there had been a two-year gap between Parts I and II of the doctorate. This meant that I had to revisit the idea of academic writing, database searching, quantitative research methods (mainly statistical approaches) and qualitative theory and methods. I did however enjoy the process of interviewing, understanding statistical computer software packages and database searching. What was more complicated was aligning doctorate work alongside family life and other commitments.

I am now committed to ensuring that the findings of this research project are published in the most appropriate journals possible to achieve maximum exposure of the findings to the target audience.

Effect of the professional doctorate on professional practice

The professional doctorate has had a profound effect on my professional life as a pharmacist. During the course of this research I have become increasingly interested in how organisations address the issue of burnout and what measures can be put in place to help employees. I have applied successfully to the Pharmacy Practice Research Trust (PPRT) to commence an MSc in Organisational Psychology at Birkbeck College, University of London. This will provide me with the knowledge and skills needed to take forward my research project. I would hope in the future to plan a project based on monitoring workplace interventions to minimize the level of burnout experienced by employees.

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APPENDIX ONE



Dear Colleague,

I am writing to seek your help and participation in a study into the nature, prevalence and correlates of job burnout in community pharmacists residing in the catchment area of the newly formed Wessex Local Practice Forum. I am conducting this research as a part of my doctoral dissertation at the University of Portsmouth in conjunction with the Wessex Local Practice Forum (www.rpharms.com/midlands-south-west-and-south-central/wessex.asp).

Your participation will involve completing a two-part questionnaire that will take approximately 10-15 minutes to complete. All information gathered will be anonymous and there will be no way of linking your name with the completed forms. Before you begin, however, please read the enclosed Information for Participants sheet.

I would really appreciate your help, as a high response rate is important to the success of this study, and I am hoping that this research will provide useful information regarding pharmacist workplace pressure. I know there are many demands on your time, but I hope you will find time to participate by completing the questionnaire and returning it in the pre-paid envelope provided by..... I am also interested in hearing from any community pharmacist who would be available for an interview on the topic. This would take no longer than an hour, at a time and place convenient to you. If you are interested then please contact me by email to peterthomas1964@gmail.com.

Thank you very much for your valued time.

Yours sincerely

Peter Thomas

Information for participants

Please read this form with important information about the study and your rights as a participant.

- This research is designed to raise awareness about the nature, possible prevalence and correlates of burnout in community pharmacists. Your participation in this study will involve filling out a questionnaire that should take 10-15 minutes in total to complete.
- Your participation in this study is voluntary. You may choose not to answer any question that makes you feel uncomfortable, end your participation at any time or decide not to participate in the study at all.
- The information collected will be non-attributable, that is it will be anonymous. No one will know who filled out the questionnaire. No individual responses will be published or released, and the results will be analysed and discussed at group level.
- All data from this study are confidential. Data will be kept in password protected data files for a period of 1 year after the completion of this study, at which time all data will be destroyed.
- Your participation involves no physical risk and only minimal risk of psychological distress. In the unlikely event that you should experience any psychological distress after filling out the questionnaire, help is available from the pharmacy support organisation (www.pharmacistsupport.org) or please contact me via email (peterthomas1964@gmail.com).

Questionnaire

When you have completed this questionnaire, please return it in the enclosed pre-paid envelope. Thank you.

SECTION ONE – ABOUT YOU

1. Your gender

Female Male

2. What is your age?.....

3. In what year did you register as a pharmacist?

4. Current work situation: Indicate which of the following applies. (Tick one box)

Currently working as a pharmacist
Currently not in active employment
Currently working but not as a pharmacist

5. Please indicate if any of the following applies to you. (Tick one box)

On maternity leave or engaged in child-rearing
Not working due to ill health
Retired and not working
Travelling
Not working due to other reason

6. Do you intend to work or return to work as a practising pharmacist within the next 12 months?

Yes No

If you have answered 'No' to question 6, then no further questions need be answered, but please return the questionnaire in the envelope provided.

7. Sector of practice: Do you currently work in community pharmacy?

Yes No

If you have answered 'No' to question 7, then no further questions need be answered, but please return the questionnaire in the envelope provided.

If you have answered 'Yes' to question 7, then please answer the following questions.

8. As regards your community pharmacy work please indicate which of the following most closely corresponds to your current main job and any others you have. (Tick as many as required)

- Owner
- Manager
- Relief pharmacist
- Second pharmacist
- Locum
- Non-store pharmacist
- Other (please specify)

9. If you work within community pharmacy please indicate in which of the following organisations you practise? (Tick one or more if relevant)

- Independent pharmacy
- Small chain (2-4 stores)
- Medium-sized multiple (5-25 stores)
- Large multiple (over 25 stores)
- Supermarket chain

Please now complete Section Two

Section Two - Community Pharmacy Survey

The purpose of this survey is to discover how you view your job and the people with whom you work closely.

On the following page are 31 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, tick 'Never'. If however you have had this feeling, indicate how often you experience it by placing a tick in the box that best describes how frequently you feel that way. An example is shown below.

Example

Statement	How often						
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel depressed at work							

If you never feel depressed at work, you would tick the 'Never' box under the heading 'How often'.

If you rarely feel depressed at work (a few times a year or less), you would tick that box.

If your feelings of depression are fairly frequent (a few times a week but not daily), you would place a tick in that box.

Section Two - Community Pharmacy Survey

Statement	How often						
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel emotionally drained from my work							
I feel exhausted at the end of the work day							
I feel fatigued when I get up in the morning and have to face another day on the job							
I can easily understand how my clients feel about things							
I feel I treat some clients as if they were impersonal objects							
Working with people all day is really a strain for me							
I deal very effectively with the problems of my clients							
I feel burned out from my work							
I feel I'm positively influencing other people's lives through my work							
At my work, I feel bursting with energy							
I worry that this job is hardening me emotionally							
I feel very energetic							
I feel frustrated by my job							
I am enthusiastic about my job							
I don't really care what happens to some clients							
Working directly with people puts too much stress on me							
I am proud of the work that I do							
I feel exhilarated after working closely with my clients							
I have accomplished many worthwhile things in this job							
I feel as though I'm at the end of my tether							
In my work, I deal with emotional problems very calmly							
I feel clients blame me for some of their problems							
I can easily create a relaxed atmosphere with my clients							
In my job, I feel strong and vigorous							
I've become more callous towards people since I took this job							
My job inspires me							
When I get up in the morning, I look forward to going to work							
I feel happy when I am working intensely							
I feel I'm working too hard in my job							
I become immersed in my work							
I get carried away when I'm working							

APPENDIX TWO

Dear Colleague,

Thank you for offering to participate further regarding research into burnout and engagement. This can be done one to one, via telephone or email. Could you please contact me on the email address below to arrange a suitable time and location.

If you are interested then please contact me by email to: peterthomas1964@gmail.com

Thank you very much for your valued time.

Peter Thomas

APPENDIX 3

Interview moderator guide

- Can you think of a recent enjoyable client contact that you had which had a positive outcome?
- Can you think of another example of contact with a client when you received positive feedback from the client?
- Can you think of an example of an interaction with a difficult client?
- Have you recently had contact with a client who was going through a negative experience in their life?
- Have you ever been subjected to verbal abuse by a client?
- Do you feel that paperwork gets in way of client contact? Or is it an unnecessary burden in your daily work?
- How do you feel about your working environment, does it affect your working life?
- Can you give an example of a difficult interaction with a work colleague or third party, e.g. another health professional?
- Do you feel burdened by dealing with the welfare of clients?
- Is there anything outside of work that affects your working life?
- What kinds of events and situations do you find particularly emotionally demanding at work, and in what ways?
- Have you experienced any physical symptoms that might relate to your daily working life, such as tiredness?
- Has the changing role of the pharmacist caused you any concerns or increased expectations of the role?
- Do you have social support, for example access to work-based support programmes?