The impact of burnout on medical education

One does not simply wake up one morning at the age of 49 and decide to start a PhD. Despite coming from an extensive line of teachers, no one in my family had ever pursued a career in academia or completed a PhD, so it was never something I thought about as I finished my medical degree and later obtained my fellowship with the Royal Australasian College of Physicians. In retrospect, I wish I had gained the insights in research methodology developed during a PhD; however, at that time, I had no real passion to look at any single topic for three to five years of my life.

I have been working at my health service for over 15 years in a consultant capacity and have been the Director of Physician Education twice over that time for eight years. During this time, I have seen some trainees flourish and others struggle. I have seen the system throw challenges at both educators and trainees alike. I have bought countless tissue boxes for my office before realising that doctors crying in my office should not be a regular occurrence. I have experienced too many heart-stopping moments where I was genuinely concerned about the safety of some of our doctors in training. More recently, I have noticed an increased difficulty in recruiting consultants to contribute formally to teaching and mentoring programs and had candid discussions with other Directors of Physician Education around Australia and New Zealand commenting on similar concerns and anecdotal observations.

The word "burnout" is now in our everyday vocabulary and has been used indiscriminately in conversations about workers, particularly in health care. Burnout was first described by Freudenberger in the early 1970s and then further work was done by Maslach to define the phenomenon.[1,2] Burnout is described by Maslach as a combination of emotional exhaustion, depersonalisation, and low personal accomplishment caused by stressors over time in the health care environment. Burnout is not simply the opposite of wellbeing, which tends to focus on the individual and is not clearly defined but rather about the impact of the workplace on the individual. Thanks to the work done over the past few decades, we know that burnout is a real entity. We know quite a lot about the prevalence rates of burnout, which are now typically seen in more than 50% of physicians and physicians in training programs.[3] What we do not really know is how burnout in the trainee affects our ability to teach them. We also do not know what is the impact of burnout in the physician educators on their ability to train physician trainees, or what happens when both educator and trainee are burnt out. Is this a factor in the documented poor patient outcomes recorded with higher rates of physician burnout? Surely items such as depersonalisation or cynicism are likely to adversely affect either trainee or educator in achieving the required education outcomes.

In 2021, I was asked what one thing I would do for this observed problem of physician burnout within my education sphere if I had unlimited resources and influence. I had no answer. So many major and minor issues flashed through my mind ranging from trainee shifts to the use of electronic medical records, dedicated working spaces, workplace bullying and incivility, and dedicated time for education. We know that burnout is related to worse outcomes in our health care workers and the patients for whom they care.[4,5] However, I had no idea which would have the most positive or protective impact on our doctors in training or for educator retention, as there are few interventional studies on burnout. As a rheumatologist, if I were asked what the single best intervention for the prevention of gout is, I would have some evidence on which to base my response. However, in response to how can I reduce burnout in physician trainees and their educators, there was extraordinarily little literature for evidence-based successful interventions. And this is how, at the age of 49, I embarked on a PhD with a topic to which I finally felt I could contribute quite a few years of my life.

Our personal journeys often dictate how we see a problem or how we frame it. The past few years have been challenging and I have asked myself whether in fact I am currently burnt out, and the answer is no (I tested myself to make sure as I have been noticing increased cynicism creeping in). However, on looking back at my registrar years, I realised there was a year of my training during which, I have no doubt in retrospect, I was burnt out. There were so many factors contributing to this, ranging from inadequate orientation to a new hospital and job, being on call, unit dysfunction, workplace bullying, and fatigue. I also noticed a significant decline in my ability to function at the level that I was used to and a powerful desire to quit medicine. Fortunately, I had supportive family and friends as well as a later change in the workplace to one that inspired me, and I have never looked back. These experiences have provided me with better personal insight into how the work environment can alter the performance of an individual and much of my approach has been on creating system changes and providing safe and productive working environments for our doctors in training.

Lately, I have noticed a tendency of managers to roll their eyes when the word "burnout" is used. There is talk about how we should avoid the term, as it is negative and that the constant negative talk is making the situation worse. However, I think documenting and discussing burnout is not negative, but, instead, the lack of drive to find workable solutions and improvements is the problem. In addition, moving to the term "wellness" often seems to move the discussion back to the individual rather than the health service environment, with the inevitable barrage of free coffees. A manager being told that 50% of their workforce is burnt out is not particularly helpful unless they are also given a toolbox of proven strategies to lower this rate. In Victoria, the

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Occupational Health and Safety Act 2004 means that employers and employees have a joint responsibility to identify and manage psychosocial stressors with an increased awareness that a safe workplace is not just about an absence of physical injury. To do this, we need to acknowledge the problem and work towards practical solutions.

If you are currently burnt out (yes, I am talking to 50% of you) or working with colleagues that are burnt out (the other 50% of you), what can you do as we work towards evidence-based solutions? I suggest that the first step is to acknowledge it as a work environment issue; make sure you talk to your family doctor, family, mentors and, ideally, your work managers. Sharing issues can help create wider system changes to your working environment that may end up helping more than just yourself. Never assume that your manager realises there is an issue. If you are the consultant or director, call out the elephant in the room and acknowledge that reducing burnout is something that will lead to a more productive and sustainable team. Please do not roll your eyes.

So, I am not ready to give up on the term "burnout" just yet. However, I would like to look at actual solutions instead of just recording the rates of burnout. A positive and proactive plan would be to identify potential protective and adverse factors contributing to burnout in our physician group and then study targeted interventions with the aim of giving our health services a toolbox of evidence-based interventions to tackle the issue of burnout.

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