Burnout in the medical profession: not a rite of passage

Establishing mentally healthy workplaces will reduce the risk of burnout

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It is an attention-demanding tragedy when doctors' deaths are attributed to their work, which, after all, is in the service of others. "Epidemic", "crisis" and "urgent need" are words accompanying discussions of burnout and doctor suicides. Yet, despite this bombardment, there has been no sustained approach to achieve an effective national response. Recently, responding to calls for action, the Victorian government launched a workplace mental health strategy and the New South Wales government held a junior doctor wellbeing forum. Some colleges and medical organisations have websites, forums, action plans, conferences and seminars on doctors' mental health. Doctors develop mental illness for the same reasons as any other person. Yet burnout, which is a risk factor,[1] is highly prevalent in doctors. Why not address the burnout? Who should address it?

Burnout was first articulated in 1975 by Freudenberger, a psychiatrist who described observations about himself and others at his workplace.[2,3] The Maslach Burnout Inventory: Human Services Survey (MBI-HSS) measures burnout in health professionals and has been adapted for use in other professional settings.[4] Three main domains quantify the concept: exhaustion, cynicism (role negativity, feeling callous and detached) and professional efficacy (self-evaluation of competence and achievement). Burnout in health care, measured by the MBI-HSS, has been found to be a viable, valid and reliable construct.[4] Although there is support for the three-factor structure, there are also studies that support collapsing exhaustion and cynicism into one dimension.[5]

When the doctor has symptoms severe enough to also qualify for a mental illness, they are likely to be diagnosed; burnout is regarded as an aetiological factor. If the doctor falls short of a clinical diagnosis, burnout becomes the explanation and problem. However, as a syndrome rather than a mental disorder, it is not accepted in workplace compensation claims in Australia.

Although not a diagnosis, the concept of burnout nevertheless resonates. Most doctors recognise it in a colleague's uncharacteristic irritability, drowning fatalism and loss of belief in professional identity and efficacy. Work is the key accumulating chronic factor that overwhelms emotional resilience and leads to a state of physical and emotional exhaustion. Increasing distance from patients and others can be a way to manage emotional exhaustion, compounding the doctor's belief about performing inadequately, creating a perpetuating spiral. Features mimic anxiety and mood disorders. However, instead, the focus is on work, patients and interactions, and it does not permeate all areas of life. The consequences of the feelings and thoughts lead the doctor to behave differently at work.

These emotional and behavioural responses, and manifest exhaustion, will disappear with sufficient time off, or, if necessary, following workplace and work practice changes. Recovery is expected if the right steps are followed to remediate the work–resilience imbalance.[6] If not, burnout may progress from low to high levels, and perhaps to mental illness or suicide.[1]

Sadly, whenever more than two working doctors meet, it is likely that one will have at least some burnout. Of 7288 participating physicians in a United States survey (27% response rate), 46% reported at least one symptom of burnout and were significantly more likely to have this compared with working adults in the general US population.[7] In the United Kingdom, burnout rates among doctors range from 17% to 52%.[8]

The *beyondblue* national mental health survey of doctors and medical students[9] reported notable percentages of Australian doctors with high levels of emotional exhaustion (32%) and cynicism (35%). Reported emotional exhaustion levels were higher among female doctors (38%) than males (27%). The most common sources of stress were reported as "work–life imbalance" (27%), a major factor for young females, and "too much to do at work" (25%). Only 6% of doctors surveyed reported a current diagnosis of depression and 4% reported an anxiety disorder. Work stress may be an important factor for an individual in developing a mental illness, but burnout does not always result in a diagnosable disorder.

The *beyondblue* survey found young doctors to be at greatest risk, with those aged under 30 years most likely to report burnout (high exhaustion, 48%; high cynicism, 46%).[7] There was a steady reduction across older age bands, with 11% of doctors aged over 61 years reporting emotional exhaustion. Accumulated stressors over a medical career did not compound to burnout. In fact, the *beyondblue* research showed the opposite. Perhaps those who burn out, get out — of the profession. Also, in the life cycle of the doctor, the levels of external evaluation and autonomy also change favourably with years of experience. Unhelpful avoidance-oriented coping

diminishes.[10] In burnout research generally, younger age is a more consistent variable than personality in determining burnout.[3]

Do some doctors' personality styles render them prone to burnout? For example, a predisposition to perfectionism may be a formula for professional fragility that leads to crisis when unacknowledged beliefs of omnipotence combine with work demands and patients who do not do so well. An external locus of control (seeing others as responsible), avoidant coping, resistance to change, and high levels of neuroticism are major risk factors in burnout.[3,8,11]

It remains to be seen whether students who enter medicine are more, or less, vulnerable to burnout. Australian medical school selection criteria vary, but the selection of desirable personality traits at intake interviews has not been approached with scientific rigour or stated intent. Generally, interviews seek to identify the characteristics that a layperson would associate with the idealised doctor — altruistic, caring and durable. We might ask: what predictive validity and reliability does this approach have in identifying individuals able to withstand the stressors of working in medicine? Perhaps we are selecting those who are more prone. In a 12-year prospective study, doctors reporting high levels of burnout were partially predicted by learning style and personality scores that reflected neuroticism measured when they were medical students.[11]

Both person and workplace contribute to burnout. A mismatch in any or all of six areas is said to predict burnout: workload, control, reward, community (workplace relationships), fairness and values.[6] Improvement in any may address burnout. Yet the comparative high rates at which doctors report burnout suggest that the work system rather than the person is the major causal factor. Excessive work, role ambiguity, conflicting demands and severity of patient problems account for more of the variance in outcome than individual factors.[6]

The best health services allow the doctor to put the patient first, melding clinical care, research and teaching. Doctors otherwise constrained feel tension and unhappiness. Professional freedom has become uncomfortably limited for many; for example, through working in large, corporatised medical practices, dealing with excessive and unrewarded paperwork, meeting Medicare requirements, and encountering managerialism in public health systems. Cynicism becomes protective. However, autonomy in the service of the patient is the antidote.

The medical profession is made up of many different types of doctors and workplaces. The sine qua non is the health of patients. There are stressors that are seldom experienced by some specialties and frequently by others; for example, exposure to violence in the emergency room, the unpredictability of being on call, managing poorly behaved colleagues, the uncontrolled demands by sick patients, harassment, and vicarious traumatisation (which has its own critical and growing literature). Type of practice is important. For instance, oncologists and imaging and pathology specialists were in the top bands scoring high on each burnout subscale in the Australian survey.[9]

Psychological strategies and common sense approaches such as physical activity are recommended to address burnout but are surprisingly difficult to enact. Surgeons who learn to find meaning in their work and actively attend to work–life balance are less likely to burn out.[12] Resilience training to improve "grit" (characterised by perseverance and sustained effort) may also assist.[13] Even increasing civility has been shown to reduce burnout.[6]

A doctor experiencing burnout is likely to withdraw, may consider resignation and can negatively affect colleagues and workplace. *beyondblue*'s workplace mental health strategy guide aims to provide ways for health services to create strategies to ensure the mental wellbeing of their employees.[14] Supervisor support and regular catch-ups between peers to promote collegiality, discuss patients and debrief will protect against burnout. As a personal example, on a busy vascular surgery intern job one winter, once every week the surgical registrar would make us hand over our pagers (no mobile phones then) and we all went to lunch together. This simple act sustained us all.

Health workplaces evolve. Increasing workloads, reduced medical autonomy and the inefficiencies associated with new technologies create environments where burnout can flourish. It is not easy to change workplaces to reduce the likelihood of burnout. Any changes need to be integrated with the individual's own strategies. Avoiding burnout is a shared responsibility: it is too easy to blame the system and, likewise, for the system to blame the doctor. A certain amount of work hardening and experience is necessary, but perhaps older doctors look back on their pressurised junior years through rose-coloured glasses and see it as a rite of passage. Is it not time for senior, influential and experienced doctors to lead action on behalf of our young apprentices?

Competing interests: Michael Baigent serves on the Board of Directors for *beyondblue*, the national depression initiative, a not-for-profit organisation.

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References are available online at www.mja.com.au.

1 Salvagioni DAJ, Melanda FN, Mesas AE, et al. Physical, psychological and occupational consequences of job burnout: a systematic review of prospective studies. *PLoS ONE* 2017; 12: e0185781.

2 Freudenberger HJ. The staff burnout syndrome in alternative institutions. *Psychother Theory Res Pract* 1975; 12: 72-83.

3 Maslach C, Schaufeli WB, Leiter MP. Job burnout. *Annu Rev Psychol* 2001; 52: 397-422.

4 Maslach C. What have we learned about burnout and health? *Psychol Health* 2001; 16: 607-611.

5 Hallberg UE, Sverke M. Construct validity of the Maslach Burnout Inventory: two Swedish health care samples. *Eur J Psychol Assess* 2004; 20: 320-338.

6 Maslach C, Leiter MP. New insights into burnout and health care: strategies for improving civility and alleviating burnout. *Med Teach* 2017; 39: 160-163.

7 Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med* 2012; 172: 1377-1385.

8 Imo UO. Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors. *Psychiatrist* 2017; 41: 197-204.

9 *beyondblue*. National mental health survey of doctors and medical students. Oct 2013. https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report—-nmhdmss-full-report_web (viewed Apr 2018).

10 Kwarta P, Pietrzak J, Miśkowiec D, et al. Personality traits and styles of coping with stress in physicians. *Pol Merkur Lekarski* 2016; 40: 301-307.

11 McManus IC, Keeling A, Paice E. Stress, burnout and doctors' attitudes to work are determined by personality and learning style: a twelve year longitudinal study of UK medical graduates. *BMC Medicine* 2004; 2: 29.

12 Shanafelt TD, Oreskovich MR, Dyrbye LN, et al. Avoiding burnout: the personal health habits and wellness practices of US surgeons. *Ann Surg* 2012; 255: 625-633.

13 Halliday L, Walker A, Vig S, et al. Grit and burnout in UK doctors: a cross-sectional study across specialties and stages of training. *Postgrad Med J* 2017; 93: 389-394.

14 *beyondblue*. Developing a workplace mental health strategy: a how-to guide for health services. http://resources.beyondblue.org.au/prism/file?token=BL/1728 (viewed Apr 2018). ■