The 'burnout complex' in surgical practice

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Burnout among healthcare professionals is a growing problem. Surgeons appear particularly vulnerable and the consequences can be significant for both the sufferer and those around them. In this article the author describes burnout, its manifestations, and how institutions and individuals can avoid it.

Stress is often portrayed in a negative light as a harbinger of ill health. It is, in fact, a very important and evolutionarily beneficial mechanism by which the body and mind quickly adjust to present and anticipated demands, and leads to a characteristic ‘fight/flight response’ with increased awareness and potential energy stored up in fast-twitch muscle fibres. This readiness takes its toll on the body. Much like a spinning top running out of spin, the response to an actual or perceived chronic stressor becomes detrimental, with an increase in circulating cholesterol/fatty acids, higher serum levels of glucose and insulin, gastric ulceration, a decrease in protein synthesis, and an increase in clotting factors, hypertension, headaches, anxiety and depression. Whilst this can affect work productivity and performance, it does not constitute burnout. The main differences between burnout and chronic stress are shown in Table 1.

Freudenberger was the first person to coin the term ‘burnout’ in 1947, describing it as ‘the extinction of motivation or incentive, especially where one’s devotion to a cause or relationship fails to produce the desired results’. There are three main components to burnout:

• Emotional exhaustion
• Depersonalisation
• Lack of personal achievement.

Much of the foundation of burnout research is attributed to the work carried out by Christina Maslach, who lent her name to the internationally validated Maslach Burnout Inventory.
In the current climate of healthcare, the recognition of burnout as a real entity is essential. The acceptance of burnout as a real entity in recent years has led to an unparalleled increase in detection rates. JAMA published a study in 2010 of 2500 medical students, which found a correlation between unprofessional behaviour and mental factors such as burnout, emotional exhaustion and detachment. The authors felt that findings which suggested an association between cheating/dishonest clinical behaviours and students’ views regarding physicians’ responsibility to society were more specific to burnout, rather than simply stress in general. Unfortunately, the end result for many physicians who suffer from high levels of burnout, and who remain unwilling or unable to seek help, is suicide.

It is therefore clear that occupational burnout can have a significant impact on personal lives. Doctors affected by burnout can experience increased levels of depression, anxiety and suicidal ideation. There is also evidence for an associated increase in the number of medical errors and litigation, decreased empathy, job withdrawal, decreased productivity and increased absenteeism. Despite this, doctors affected by burnout can remain relatively efficient compared with other professional groups, but may take a pronounced cynical attitude towards their colleagues and tend to treat their patients with a lack of empathy.

Many surgeons may think that they are less susceptible to the effects of burnout compared with other specialties. However, the traits that may define some of their success, such as commitment, drive and self-sacrifice, place them in a position where they are particularly vulnerable to the effects of burnout. These findings highlight the need to determine the incidence and causative factors, and to engage in prevention of burnout from both a health and safety and an economic perspective.

**BURNOUT IN UROLOGY**

Most burnout research in surgical departments has focused on general surgery, surgical oncology, orthopaedics and transplantation. Until 2015, there were only two small
published reports focusing specifically on burnout in urological surgeons. Burnout was described in 25% of non-consultant doctors within a French cohort. A study of a German cohort, comparing consultant urologists in hospital and private practice, described reduced burnout in those >45 years and working in the private sector.

The largest study assessing burnout in urology was published by O’Kelly et al in BJU International, in a joint collaboration between the British Association of Urological Surgeons and the Irish Society of Urology, to determine the prevalence of burnout among UK and Irish urological consultants and non-consultant hospital doctors. They also attempted to identify possible causative factors and to investigate the impact of various vocational stressors that urologists face in their day-to-day work, and to establish whether these correlated with burnout.

On multivariate analysis, those consultants who were predominantly private-based, aged under 44 years and involved in management were 70% more likely to demonstrate feelings of overall burnout. Doing research appeared to confer protection from burnout, with lower levels of depersonalisation and overall burnout, and higher levels of personal achievement. Consultant staff were significantly more likely to access professional help and require time off work. In addition, the overall self-reported level of burnout experienced by urologists using the exhaustion +1 rule was 52% – one of the highest measure levels to date across any specialty. Adjusting for overlap, 12.9% required time off work and/or sought professional help for symptoms of burnout, while 12.4% of consultants resorted to self-medicating with drugs and/or alcohol (28% amongst non-consultant hospital doctors).

The main factors that influence burnout in urology appear to be non-clinical in nature. It would appear that the things we are trained in performing do not appear to influence levels of burnout, and that some of the main triggers are institutional in nature, such as administrative workload, overall work volume and lack of institutional resources (Figure 1).

The authors in this study were unable to explore domestic or personal circumstances affecting burnout in urology. It has previously been shown that having young children or a turbulent home life may predispose surgeons to the effects of burnout. Oberg et al reported an odds ratio of 2.1 for poor health in those with burnout, while a study by Helfand et al in 2013 demonstrated that healthcare workers were likely to exhibit less stress with exercise, and that physicians who complained of symptoms of burnout had 14% higher levels of obesity compared with non-burnout controls. As with all longitudinal studies, it is not possible to explore the effects in those who refused to participate in the study. Is it that such non-responders are more likely to represent an extreme of burnout or do not want to accept or find out answers? Or is it that they are simply content and genuinely happy not to participate? A further follow-up study would allow an assessment of the uncertainties as to whether associative factors are causal or not.

**CLINICAL GOVERNANCE AND BURNOUT**

Despite the wealth of research that has been published in the past five to seven years, there does not appear to be an improvement in burnout rates. This may mean that we
In dealing with those who are undergoing great suffering, if you feel demoralised and exhausted, it is best, for the sake of everyone, to withdraw and restore yourself. The point is to have a long-term perspective. Dalai Lama

have not yet reached a peak or plateau in prevalence. A recent study published by Elmore et al in the Journal of the American College of Surgeons described a 69% burnout rate of general surgery residents, and once again called for efforts to identify at-risk populations and to design targeted interventions to mitigate burnout in surgical trainees.11

Burnout is not a condition limited to western countries. Zubairi et al reported a rate of burnout between 11 and 42% among physicians in their institution in Pakistan.12 This was backed up with a study by Biksegn et al demonstrating a mean burnout rate of nearly 37% in other developing countries.13 The predictors were reported as job insecurity, history of physical illness, low interest in the profession, poor relationship status with managers, worry of contracting infection or illness and physical/verbal abuse.

There are a number of physician assessment and wellness programmes now in existence to combat the effects and perpetuation of burnout. The process of creating healthy organisation–physician relationships is critical to organisational success. Partnerships in process improvement can nurture these relationships and mitigate burnout by meeting physicians’ psychological needs. To flourish, physicians need some degree of choice (control over their lives), camaraderie (social connectedness) and an opportunity for excellence (being part of something meaningful). Organisations can provide these opportunities by establishing constructive organisation–physician relationships and developing physician leaders.

The Listen–Act–Develop model was created in the Mayo Clinic as an integrated strategy to reduce burnout and engage physicians in the mission of the organisation. The intent of the model is to maximise physician wellness by fostering engagement and mitigating the drivers of burnout. This model, it is hoped, will provide a path to increase physician satisfaction and meaning in work and to improve organisational effectiveness.

It has also been shown that the leadership qualities of consultants appear to impact the wellbeing and satisfaction of individual physicians working in healthcare organisations.3 These findings would therefore have important implications for the selection and training of future leaders and provide new insights into organisational factors that affect physician wellbeing, in order to reduce burnout.

Finally, it is important to realise that although urology and surgery can be characterised by times of high stress and intensity, it is not sufficient to cast the shadow of the burnout complex solely at the door of the institutions we work in. Societal and, more importantly, personal factors also need to be assessed. We, as physicians and surgeons, need to accept our limitations and boundaries, and occasionally look inwards to the toxic effects of burnout on ourselves and those around us.

It is important to take care of those we work with and to be open enough to assist them in seeking help where necessary. It has recently been shown that, as a profession, we are poor in supporting colleagues.8 We are also not good at dealing with personal distress – further evidence of a link between personal distress and professionalism. It is time that we openly engage with our colleagues in human resources and occupational health to reduce the incidence and prevalence of burnout.

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REFERENCES