COMMENTARY

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Burn Bright I: Reflections on the Burnout Epidemic (Part One of a Two-Part Series)

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I'm not alone in having experienced burnout and its consequences. One of the hardest working and most successful in my medical school class, I experienced early predictors of later struggles: I would get anxious whenever I had to go on away rotations, partly because of being far from my family, friends, and community support network for 6-8 weeks at a time. I felt ashamed and humiliated when called out in front of others for not knowing the answer to a question about anatomy during an operation. I had a hard time showing empathy to patients when I got little or no sleep after being on call before 5:30 AM rounds and the day's operating room schedule.

My medical school Dean required me to seek counseling to cope with the stress reactions I was experiencing and warned me that what I was going through could put me at risk of struggling later in internship and residency training. I found counseling helpful in understanding my patterns, needs, and preferences; it certainly got me through medical school.

However, soon after I entered my internship, I again felt like I was dreading going to work. I felt anxious and emotionally exhausted and filled with shame that, somehow, I was not cut out for the work I had spent years preparing for. While experiencing all-nighters every third or fourth day, my sleep cycle gone haywire, and again far from my support system, I had no time to reflect on the experience or attend to basic self-care needs, which I later learned are fundamental to becoming a healthy, effective, thriving physician and human being. I even got into a car accident one morning after a 24-hour shift as an intern. Feeling paralyzed by even thinking about the possibility of having to take a leave of absence, I tried so hard to persevere. It was like jumping off a cliff, with little hope of surviving the fall from an identity and path that had consumed my entire being since childhood.

Speaking with my Family Medicine mentor and with the residency training director, I found my way to a psychiatrist and psychotherapist. They helped me see the wounded parts of me that had never had a chance to heal since childhood, perhaps even from generations prior, the survival mode I had been in for my entire life, and the vulnerabilities that sent me over the edge of burnout, anxiety, and depression when the demands of medicine as a career overcame the protective factors that had sustained me until then. Despite selective serotonin reuptake inhibitors to address the depressive episode and more therapy to assist me to return to work, eventually I left the residency program entirely. The shame I felt around that experience was excruciating, to the point I didn't think I'd ever have what it takes to return to medicine.

It took nearly 5 years of healing, treatment, personal reflection, volunteer work, fostering 3 kids with posttraumatic stress disorder, and a research job to pay the bills before I got to a point where I had built a toolbox of skills, insights, and strengths to allow me to find my way back to residency training, this time in Psychiatry. Now, a decade later, I find myself an ardent advocate for physician well-being and burnout prevention. I'm filled with awe and gratitude for the journey, and I present my story as an introduction to the insights that follow in this 2-part article co-authored with a friend and colleague (the second part will be published in the next issue of this journal).

The notion of burnout originated in the 1960s, when those with extensive chronic substance abuse were deemed "burned out," describing the toxic effect of substance use. Research by Herbert Freudenberger and Christina Maslach originally explored the phenomenon, and Dr. Maslach's research led to the development of the Maslach Burnout Inventory,[1] a tool that enhanced the capacity to study burnout and its contributing factors and manifestations.

The Maslach Burnout Inventory has been used to gauge levels of burnout in various contexts and is considered the gold standard in measuring the phenomenon. Burnout is defined as a syndrome of emotional exhaustion,

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Requests for reprints should be addressed to Noshene Ranjbar, MD, Department of Psychiatry, University of Arizona, College of Medicine, 2800 E Ajo Way, Behavioral Health Pavilion, 1st Floor, Tucson, AZ 85713.

E-mail address: noshene@psychiatry.arizona.edu

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depersonalization, and reduced sense of personal accomplishment in one's work. Measured by its effects on the individual, burnout is defined as a condition that arises specifically in response to an occupational context;[2] it is a problem in response to the environment, not one of individual susceptibility.[3]

In this piece, the wide-ranging impact of burnout, which ripples out from the devastating consequences for individual physicians, is further discussed. In the second article, we outline ways to alleviate the pervasive problem of burnout and promote professional satisfaction and engagement.

EMOTIONAL EXHAUSTION

Emotional exhaustion can reduce the ability to be emotionally present for patients, friends, and family; it can also contribute to a sense of irritability or misplaced anger or frustration both at work and at home. No wonder then that burnout often has an impact on physicians' relationships; for example, burnout is associated with higher divorce rates.[4] Broken relationships, in turn, damage one's sense of self, contributing to shame, loneliness, reduced self-efficacy, and reduced sense of mastery. Managing the emotional work of having a family becomes even more challenging when one is in a stressful medical career, and women physicians have higher rates of burnout than men; 48% vs 38%.[5]

REDUCTION IN SENSE OF PERSONAL ACCOMPLISHMENT

Many of us have experienced getting messages from the clinic director or department administrator about not meeting revenue value unit expectations. It is easy to feel frustrated, helpless, and defeated when one is working numerous hours caring for patients, with even more hours to document each visit and attend marginally productive meetings, among many other administrative tasks. Burnout can leave physicians feeling less effective in family dynamics and financial well-being, especially when long work hours eat into time at home nurturing personal relationships and affairs. There is evidence that women residents are more likely than men to experience a loss of self-confidence and feelings of worthlessness, which may contribute to their higher rates of burnout.[6] As in Dr. Ranjbar's story, being forced to step back from one's career because of intense pressures can lead to feelings of shame and failure. A reduced sense of efficacy at one's job can lead to an erosion of vibrancy, energy, and enthusiasm toward work and life. Those experiencing burnout can turn to unhealthy coping behaviors in the form of substance use, unhealthy eating behaviors, and other addictive tendencies in an attempt to "numb" their own suffering; these behaviors further contribute to personal suffering, interpersonal conflict, and illnesses, including depression, anxiety, increased rates of cardiovascular disease, obesity, and reduced life expectancy.

DEPERSONALIZATION

Have you ever noticed nodding like a robot to patient after patient's stories, without much empathy or caring for their ailments or for colleagues' or staff's struggles and stress levels? Burnout contributes to reduced morale among physicians, making them less able to care about or feel loyal to their workplace, profession, and patients. Not only that, but physicians, who lead the team, set the tone for other team members including nurses, medical assistants, and office staff. These dynamics have turned our health care systems and facilities into places that are not conducive to inspiration, healing, and wholeness. The inability to provide quality care within the context of the current health care system is so disturbing to many physicians that it has been described as a moral injury.[7] Many burned-out physicians also describe a loss of spiritual connection. An alarming burnout factor is a sense of isolation and loneliness for the physician, feeling disconnected from one's social network, close friends, and family.[8,9] The deadliest, perhaps, is the impact on the physician's relationship to self, as depicted by the higher rates of physician suicide compared with the general public, particularly in women. In the United States alone, nearly 400 physicians die by suicide each year, equivalent to 2 entire classes of medical school.[10]

BURNOUT CONSEQUENCES

Burnout for physicians has risen to staggering levels over the past few decades, while rates in other professions have remained largely stable. According to the Medscape 2018 survey of 15,000 physicians from 29 specialties, prevalence of burnout among respondents was found to be 42%.[5]

Many physicians who experience burnout go on temporary leave or altogether leave their practice; their turnover rate is more than double that of those not experiencing burnout.[11] Yet burnout is not a recognized clinical diagnosis, which may impede proper treatment.[2] Loss of productivity due to attrition, sick days, and Family Medical Leave Act time is significant; the cost of replacing a physician amounts to nearly $1 million.[11]

The consequences of burnout are devastating for physicians who suffer from it and detrimental to patient health, health care organization integrity, and the fabric of society. With a shortage of physicians to meet US health care needs, particularly with the rise in the elderly population needing medical care, the loss of physicians to burnout and suicide is of special concern.

Among the complex factors contributing to physician burnout are stress inherent to the job, workplace demands, and predisposing characteristics. Most physicians are drawn to medicine by a sense of meaning and purpose related to

reducing the suffering of others. Such a commitment is required, because the work of being a physician is inherently stressful. Caring for the sick and witnessing suffering on a daily basis can take a toll on mental and emotional well-being. Compassion fatigue, secondary traumatic stress, and vicarious traumatization can result when treating patients who have experienced trauma. Dealing with patients' families can contribute to emotional exhaustion and depersonalization.[2] The realities of the contemporary health care business, with its emphasis on revenue and productivity, can feel at odds with the values, ideals, and inspiration that led many physicians to the work in the first place.

The US health care system, one of the most technologically advanced—and costly—in the world, continues to lag behind many other countries in outcome ratings and effectiveness.[12] This is in part a result of physician burnout, which is associated with reduced quality of care for patients in terms of safety. Multiple studies have shown a consistently significant relationship between burnout and medical error.[13] Resident physicians who perceive themselves to have made a medical error are likely to suffer from distress,[14] and rates of medical error are higher for physicians who experience burnout, making for a vicious cycle.

Levels of confidence in the US health care system declined from 73% in 1966 to 34% in 2012.[15] Laboring within a system not regarded with trust undoubtedly affects physician morale. Rates of patient satisfaction are also lower for doctors showing symptoms of burnout.[11] With up to 42% of physicians suffering from burnout, no wonder patient trust and satisfaction are compromised. When one is ill, fearing loss of function or one's life, one needs a caring and effective provider able to attend fully to the diagnostic and treatment requirements. Burnout affects the physician's capacity to be fully present, empathic, and able to motivate patients to take charge of their own health care, self-care, and well-being.

Workplace factors and dynamics contributing to physician burnout are many. Health care organizations are undergoing significant changes in health care delivery and financial pressures; thus, the need for a workforce with high morale and sense of commitment to the organization is at an all-time high. But as budget cuts are made to health care, public health efforts, and prevention-focused resources, the burden of disease in the population is enhanced; the effect is a relative shortage of the health care workforce and additional stress on the physician.

Pressures contributing to burnout include the increased burden of documentation to meet medical-legal demands and billing/coding standards to generate revenue. Numerous hours are spent grappling with electronic health records documentation, which frequently reduces the opportunity to interact with patients in meaningful ways; recordkeeping has been shown to take 2 hours per hour of patient care.[16] Given frequent changes within health care systems and organizations, transitions from one electronic health record to another are all too common, requiring staff to learn a new system, which complicates the workflow. Low staffing ratios, partially caused by burnout and poor management practices, can increase the burden of all workplace stressors for the physician, further contributing to inadequate opportunity to rest and rejuvenate between work times.

For many health care organizations, lunch- and dinnertime meetings, after-hours work, being on call, and working extra shifts are the norm. This is part of a professional culture that encourages long hours and self-sacrifice. The physician is constantly faced with the dilemma of balancing work demands with family, self-care, and down time. With the cost of medical education at an all-time high and physicians graduating from medical school with massive debt, there is even more pressure to work long hours.

As the above account indicates, burnout should be considered a result of external pressures, not an individual syndrome.[2] But internal and personal factors can also contribute to vulnerability to burnout, some of which played a role in Dr. Ranjbar's experience. Many individuals drawn to medicine tend toward perfectionism, pleasing others, or holding themselves to extremely high standards. Dr. Ranjbar was a high-achieving student whose identity was wrapped up in her success in medical school. While such tendencies can help a physician succeed in medical education, they can also contribute to burnout, driving one to work harder to maintain status. When the hard realities of burnout lead to a crash, those with very high standards may experience deep feelings of shame, which can have further devastating consequences.

Predisposing factors include those related to the physical, mental, emotional, social, and spiritual lives of the physician. A personal history of trauma and adverse childhood experiences can affect the ability to self-regulate in the face of later life stressors. Unmet needs for quality of nutrition, physical activity, adequate amount of quality sleep and rest, and a sense of connection to family, friends, and community bring greater risk of burnout. Individual personalities can also play a role. The emerging science of resilience points to genetic and epigenetic factors that make some individuals more vulnerable to stress and adversity.

Lack of emotional intelligence can place the physician at risk for burnout. Paucity of opportunity to reflect or process challenging personal and professional events can eat away at a sense of meaning and purpose in one's life, with day-to-day tasks becoming more mechanical and robotic. Risk of burnout increases when physicians lose connection to natural rhythms of life and when work is not tempered with self-care, self-compassion, and activities that bring a sense of playfulness, joy, youth, and lightheartedness.

Burnout is not inevitable. Steps can be taken to prevent it and to support physicians who struggle with it. Enhanced awareness of the predisposing, precipitating, perpetuating, and protective factors of burnout has laid the foundation for the expanding literature on how to address it. The next article in this series, entitled Burn Bright II, explores what can

be done to reduce rates of burnout, halt its progression, and increase engagement and satisfaction in our work.

Noshene Ranjbar, MD[a]
Mari Ricker, MD[b]
[a]*Department of Psychiatry*
College of Medicine
University of Arizona
Tucson
[b]*Department of Family and*
Community Medicine
College of Medicine
University of Arizona
Tucson

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