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Let Burnout Among Doctors Burn- Bring Wellbeing In

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Rishi Kumar*

Department of Medical and Health Science

***Address for Correspondence**

Rishi Kumar, University of Auckland, Faculty of Medical and Health Sciences, Postal address: 1A/1 Ophir Street, Grey Lynn, Auckland, New Zealand

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Abstract

For a medical student, the realization that stress is an integral part of practicing medicine and burnout reaching epidemic proportions is unsettling. Burnout research may have contributed to stigmatization and delayed help-seeking among doctors. Incorporating wellbeing in the apprentice model of teaching can be a good strategy for making the medical workforce more sustainable.

Introduction

I am a fourth year Medical Student. Almost as soon as I started my clinical attachment, I started hearing that burnout in doctors has reached "epidemic proportions" *[1]*. Many measures of poor mental health such as depression, broken families, alcohol and drug use, suicide are also very high among doctors-even though most of psychosocial determinants of poor mental health such as poverty, poor education, unemployment are not applicable to this population. I am fascinated by this trend and have been reflecting on it. I even pondered, for a brief period of time,"did I do the right thing by entering medicine?". The doubt did not take a stronghold and I am now interested in what can I learn to help me function better when I graduate. I am mindful that burnout and poor mental health among doctors have a range of negative consequences in professional (poor decision making leading to medical errors, hostile attitude toward patients, adverse patient events, reduced commitment to productivity and providing safe clinical care, strained collegial relationships and disengagement) and personal (depression, anxiety, sleep disturbance, fatigue, strained partner relationships, alcohol and drug abuse, divorce, premature retirement and suicide) domains *[1,2]*. I am keen to learn all I can so that these negative associations do not apply to me. I am troubled by a paradox however. While a wealth of literature has accumulated on the phenomenology of burnout, the triggers, the characteristics of those who are at higher risk of burnout, there is paucity of literature on effective, validated strategies for preventing or managing burnout *[3]*. Plethora of workshops and self-help management programs advocating changing work patterns, developing coping skills; enhancing collegial and interpersonal; relaxation strategies; health promotion and fitness; and developing a better self-understanding have appeared. There are two significant issues with them: firstly, vast majority of these strategies are not based on rigorous evaluation and they rely on the individual person to help themselves often in their own time and at their own expense. Systemic issues are seldom explored and the perception that the individual is weak and at fault is perpetuated *[3]*. Focusing on the individual experiencing burnout stigmatizes and delays help seeking among doctors *[4]* who are often not the best-known professional group for looking after themselves. I also feel possibly the reason why we have seen a proliferation in the research on nature of, and, factors associated with, burnout in individuals is possibly because it is easier to study the individual rather than the organization or the system which may be creating or perpetuating it in the first place This stigmatization, focusing on the individual and ignoring the systemic origins of burnout may continue as long as we obsess with burnout. Would we not be better off investing our research efforts into the wellbeing of doctors rather than constantly adding what we know already about the phenomenology and risk factors associated with burnout? Fortunately, studies on wellbeing among doctors are emerging *[5]*. In a recent systematic review, (n=26 studies published between 1989-2014) identified autonomy, perseverance, building of competence, regular sleep, having time away from work and strong social relatedness as factors associated with resident wellbeing. The SR also found interventions focused on health and coping skills improved resident wellbeing. We have however a long way to go with regard to studies on wellbeing. Despite its positive appeal the research literature on wellbeing in residents is limited by cross-sectional design, small sample size, problems with sampling, reporting, and recall bias and limitations in generalizing findings from one subspecialty to another *[5]*. Almost akin to the issues surrounding the literature on burnout in doctors' opinions about what can work for wellbeing have appeared in the literature *[4]* advocated for a balanced approach to health, including focus on nutrition, exercise, mindfulness, and effective stress management and called for a paradigm shift so that a culture of wellness is created and aligned with senior doctors' responsibilities as role models for trainees. While we wait for good quality evidence on wellbeing to emerge, we desperately need such a paradigm shift in medicine. The apprentice model of teaching has enabled junior doctors to learn clinical skills, develop professional attitude and acquire requisite knowledge from their seniors for centuries. Why can't

we apply this time-tested model to create opportunities for medical students and residents to learn from their seniors how to promote wellness and how to manage stress in the day to day life? Having a culture in which senior doctors freely talk about workplace stress and what they find effective in managing it and how they promote their own wellbeing will bring this paradigm shift. After all, stress is integral to being a doctor so why shy away from talking about it? Some caution does need to be exercised in moving away from burnout research and embracing wellbeing among doctors. We must not simply pick findings from burnout studies, reverse them and say the opposite could promote wellbeing. For instance, if studies have reported long working hours and low levels of job satisfaction are associated with burnout *[1]*, we can't extrapolate them to conclude reducing work hours and increasing job satisfaction will enhance wellbeing among doctors simply because conceptually burnout and wellbeing are antithetical. The relationship between opposite poles of an emotion such as happiness and sadness is not necessarily linear. Low scores on sadness scale does not correlate with high scores on happiness. We simply are not in a position to pick a negative construct like burnout treat it as the opposite pole of engagement and infer a more engaged doctor is a less burned out one or vice versa. It is for these reasons that I argue we really need to move away from studying burnout to wellbeing among doctors. We need to start afresh and not apply or extrapolate findings from the burnout literature. If there is one thing, we can learn from the burnout literature and its harmful impact, is to study the environment and the individual that promotes doctors' wellbeing. We also need to bring about a fundamental paradigm shift so that senior doctors routinely discuss stress and wellbeing as an integral part of supervision and mentorship. After all, if a worker is exposed to asbestos at their workplace and develops respiratory problems, we don't consider the employee as weak or at fault. Why should we treat a toxic stressful environment of health care system any differently?

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