Special Article

Physician Burnout Syndrome

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Abstract:

Background: The medical profession is the second largest official profession in Sudan. The fast spread of information technology in the eve of the second millennium has created an atmosphere of great expectations, that medical doctors should be updated, skillful, enthusiastic, kind, treat patients, train registrars teach medical students and develop high moral and ethical attitudes.

Objectives: The purpose of this paper is to high light the Physician Burnout Syndrome and its relation to unintentional medical errors and society lack of satisfaction.

Methods: Brief literature review and observations from the current atmosphere of medical practice in Sudan.

Conclusion: Early detection is the responsibility of the administration and medical colleagues to save victims of the Physician Burnout Syndrome and prevent medical errors, unintentional laxity, disregard and/or malpractice.

Key words: Physician burnout.

The medical profession is the second largest official profession in Sudan after the teachers. Up-to-date according to the Sudan Medical Council the number of the registered doctors is 32,900 plus 3955 dentists and 3197 pharmacists. The Federal Ministry of Health claims to have 8,642 doctors working countrywide in addition to the staff of 30 Medical colleges and an unknown number of medical doctors working in the private sector and with the non-governmental organizations. Also, about 3250 doctors are annually graduated. This is compared 155,023 teachers working in the elementary schools and 41918 the higher secondary schools[1]. The numbers of these two working forces bear high responsibility in the move towards development. The poor chances for continuing education and professional development associated with the meager technical facilities in the era of global dissemination of information and flourishing culture of blame, all have created high psychological pressure on both teachers and medical doctors and made these professions rather insecure and unattractive.

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Objectives:

The main objective of this paper is to high light the Physician Burnout Syndrome (PBS). A second objective is high light the share of the working policies in bearing part of the responsibility for prevention of medical errors.

Methods:

We have reviewed the literature through internet search, collection of crude data from officials in Sudan medical Council, Sudan medical Specialization Board, Federal of Ministry of Health, and Ministry of High Education.

Definition:

Physician Burnout is a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work as human service providers[2].

The syndrome consisting of:

1- Emotional exhaustion: symptoms of tiredness, and poor emotional resources.

2- Depersonalization: skeptical, pessimistic, cynical attitude toward persons and existing functioning systems.

3- Lack of personal accomplishment: feelings of incompetence covering the inefficiency, and inadequacy with lots of grumbling grievances.

The early symptoms of PBS are diminished desire to get engaged in the active work, becoming suspicious of others particularly the senior officials in general, and colleagues and administrators in particular. This is followed by clear expression of "I don't care" associated with frequent complaints for trivial reasons that reflect signs of disinterest.

Literature review:

Prevalence of Physician Burnout

In a study for prevalence of stress as related to patients' safety in the medical profession Elfering, A et al reported that 23 nurses from 19 hospitals in Switzerland over a period of two working weeks have reported 314 daily stressful events in their pocket diaries. Of these 62 events were related to patient safety. The most frequent safety-related stressful events included incomplete or incorrect documentation (40.3%), medication errors (21%), delays in delivery of patient care (9.7%), and violence with patients (9.7%)[3].

A study for "Perceived Stress, and Depression among 106 Cardiology Residents in Argentina as compared to controls of nonmedical professionals reported that 31.3% of the Cardiology Residents were women, with a mean age 29.1 years, and half were married with an average of 64 hours of work per week, and 60% of the residents needed a second job. High emotional exhaustion and depersonalization was found in the majority of respondents. Significant depressive symptoms were found in less than half of residents, and stress was on average 21.7 points on the Perceived Stress Scale. Residents who had a second job showed high levels of depersonalization. No other association was found with socio-demographic characteristics. There were no differences in socio-demographic characteristics of residents compared with nonmedical professionals, but nonmedical professionals worked less hours per week, had a lower percentage of second jobs, and higher salary rates. Burnout, depressive symptoms, and perceived stress were significantly lower in the control group[4].

Katrina J. Lawson et al in a study aiming to determine the effects of work characteristics and organizational justice perceptions on employee wellbeing reported four justice dimensions (distributive, procedural, interpersonal and informational). The procedural justice and distributive justice were significantly related to job satisfaction and health promotion strategies[5].

In a self-administered questionnaire mailed to members of a local branch of the Japan dental association a total of 261(53%) dental practitioners responded. Psychosocial job demands were measured by a Japanese version of the Copenhagen Psychosocial Questionnaire, which comprises five sub-scales: quantitative demands, cognitive demands, emotional demands, demands for hiding emotions, and sensorial demands. The outcome was defined according to whether the their patients experienced one of the following adverse events due to dental mismanagement at least once during the previous one year: dropping of dental instrument, broken injection needle, soft tissue or nerve injury, accidental bleeding, loss of a tooth root into the maxillary sinus, and emphysema. Emotional demands and sensorial demands were found significantly associated with the experience of adverse events. Other than the indices, male gender, younger age, practice alone, many dental chairs (five or more), and many patients (30 or more per day) were the risks factors[6].

The PBS is not unique to medical doctors. It has been reported in "Human service Providers" i.e. those who deal directly with community members such as teachers. The Maslach Burnout Inventory (MBI) was used to study burnout teachers in the USA because teachers are subject to increase pressure by society to correct drug, alcohol and sexual abuse, educate students in academic and skill areas, meet the individual needs of each and every student, and encourage moral and ethical development[7].

High risk factors:

1- Age: Young teachers score higher than older teachers in emotional exhaustion.

2- Sex: Males score higher than female in the depersonalization scale.

3- Professional development: Teachers working with higher schools have lower levels than their counterparts in the elementary schools in personal accomplishments[8]

4- Crowded wards.

5- Culture of blame.

6- Increased work demands.

7- Lack of control over one's practice.

8- Poorly defined roles.

9- Inability to bring about system change.

Predictors of burnout[9]:

1- High work load

2- Inter and intra-disciplinary conflicts

3- Ambiguity of responsibility and functional support

4- Lack of participation in decision making

5- Unbalanced reward system

6- Needs and deficiencies

7- Poor freedom of autonomy

8- Poor social supporting networks.

Usually when doctors start their jobs in Sudan, they have tremendous internal motivation by the fact they are achieving their dreams and are looking forward for a bright future. With these great expectations, motivation and elation they become entirely dedicated for their work, absorbed in the medical activities to the degree that they do not ask about official working hours, do not go on annual leave, and gradually they miss their sports and family entertainment hours. They feel strong ownership of their hospitals and often share part of costs of patient's management. When excellent doctors become completely self-absorbed in the hospital work, some of them develop a degree of obsession and many reflect back in a harsh, unsympathetic way with the junior staff particularly nurses for any delay or reluctance in task execution. They do not accept anything less than timely perfection. This reaction most of the time is not accepted by both the senior staff and the administrators. At this point they feel disappointed because they see others are not very much enthusiastic. Therefore, repeated such pitiless reactions lead to frustrations. Dismissal after the internship year, unjudicial prolonged period of unemployment before and after qualification and working in areas lacking, technical and moral support, associated with building fears of social insecurity together with procedural and distributive injustice all lead to rebound thinking of immigration.

Complication of Physician Burnout Syndrome:

a- Potential complication on the medical doctor him/herself:

1- Unhealthy lifestyle, self-absorption.

2- Disappointment, reimbursement and frustration.

3- Depression.

4- Unhappy specialty status.

5- Bitter tax on physician emotional and physical health.

6- Bitter tax on physician family, increasing the risk for divorce[10,11] and early retirement[12,13]

7- Alcoholism and drug abuse[14]

b- Potential impact of Physician Burnout on patients:

1-Patient satisfaction has been shown to be influenced by physician job satisfaction

2-Physician burnout was linked to lower levels of patient-centeredness and poor decision making and problem solving

c- **Potential impact of Physician Burnout on the healthcare system:**

1- Reduce public trust on the health service and healthcare system.

2- Increase punitive compensations and other financial losses.

3- Loss of active enthusiastic excellent doctors.

Treatment and prevention (Effective measures to reduce burnout):

1- Implementation of System-based changes to reduce the impact of burnout in which physicians themselves and not bodies that claims to represent physicians should participate in policy making of their workplace.

2- Early detection of the association between self-reported physician burnout and increased

likelihood of medical errors with reduced quality of care delivered by burnout doctors[15].
3- Reduce external stressors on physicians by creating a health system that encourages and motivates doctors. Such system can only be built when there is more supportive work environment and lower burnout predictors.
4- Increase patient satisfaction as a potential outcome of reduced physician burnout by early detection and correction of predictors of physician burnout.
5- Positive peer attitude to reduce the "conspiracy of silence" about the problem[16]. This can only be achieved when doctors are part of the policy makers rather than the feeling of being mere servants in civil service. This feeling can only be treated when doctors feel they are proud of a system they own and they are developing their capabilities in a beloved judicial developing nation.
6- Cognitive-behavioral training and other stress reduction techniques for administrators. This can only be achieved when a health system, based on external imbalanced motivations, is fixed right and build on mutual respect and organizational justice[5].
7- Cognitive-behavioral training and other stress reduction techniques for all medical staff particularly doctors suffering of stress and emotional exhaustion who feel less satisfied with medicine as a career.

Conclusion:

Burnout is defined as depersonalization; emotional, physical and mental exhaustion and a sense of lack of personal achievement. Burnout can be identified with validated self-administered measures such as MBI. Factors predisposing to physician burnout include midcareer, loss of control over work environment, lack of continuous professional development, and work in a public institution with heavy workload. Physician burnout has potential adverse effects on patient care, institutional healthcare outcomes, personal health, and family life.

Interventions to address burnout include individual motivated strategies, such as team-based mechanisms for early detection of burnout to provide peer and institutional support. Delay in recognition of PBS may lead to further procedural, interpersonal and informational injustice, physician impairment with a subsequent negative impact on professional practice, and put patient safety and public confidence in the health system in jeopardy.

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