Editorial

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Psychological burnout and the intensive care practitioner: A practical and candid review for those who care

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> In a culture where work is a religion, burnout is its crisis of faith. (Jennifer Senios[1])

Introduction

Justice Potter Stewart of the US Supreme Court became famous after stating that while he could not define pornography he 'knew it when he saw it'.[2] 'Burnout' is obviously a less prurient topic, but the analogy is still useful. Burnout is also difficult to pinpoint, but, with basic knowledge, most of us can learn to recognize it. This should not be surprising given that medical doctors have amongst the highest percentage of self-reported burnout.[3–7] All medical staff – and not just doctors – should accept that the chances are high that they will experience it personally, or witness it in their colleagues. Fortunately, it need not be terminal.

Given its prevalence and ramifications (see below), it is reasonable to expect intensive care unit (ICU) personnel to screen for burnout, to remain vigilant, and to be a collegial resource. Accordingly, this review hopes to be practical and candid. Ultimately, whether burnout is present or not, these efforts can support a greater goal: to increase resilience, to aid retention, and to improve career guidance. Doctors are the most studied burnout profession, and will therefore be our focus. However, nurses and others, may experience at least as much distress, especially as they are relatively disempowered. Regardless, this review explains why burnout matters and why efforts should be sustained. After all an ICU career, while privileged and rewarding, can also be exasperating and stressful.

What is burnout and why should I care?

'Burnout' as a psychological term originated in the 1970s.[7] The idea is usually attributed to Freudenberger, Maslach and Leiter,[8,9] and entered common parlance after the novel 'A Burnt-Out Case' by Graham Greene.[6,7] It is commonly understood as an emotional condition encompassing mental fatigue, physical fatigue, frustration, and disengagement.[3–13] It typically results when dedication fails to produce hoped-for results, and is more likely when goals are unrealistic. In fact, it can also be thought of as a ratio where 'expectation' is the numerator and 'reality' the denominator. Burnout becomes more likely – though not inevitable – when expectations are too high or reality too low.[1]

Diagnosis is imprecise because burnout relies upon self-detention, self-reporting and subjective criteria. It can also manifest in various ways: some people will increasingly voice frustrations; others become withdrawn. The incidence might be underestimated because of denial or poor insight, or overestimated because it has no minimum duration. Just as it is important not to ignore burnout, it is important not to assume every that colleague who is upset or oppositional is automatically burnt out. Like many medical conditions, it can wax, wane and flare. Fortunately, it can also resolve. With all of these caveats, studies report over 30% of American were found to be burnt out,[3] more than 40% of Dutch general practitioners[4] and approximately 50% of all type of Canadian physicians.[5,6]

Some conditions can be defined by what they are not. For example, burnout is probably not just 'tiredness', even if this is a chief symptom. Instead, it is more an erosion of ideals and commitment. Burnout is also not just depression, even if there is overlap. Sufferers report not just decreased energy and effort but a loss of concern or respect for others. This can manifest as insensitivity and scorn.[1] Burnout is more than just moral distress, which can be inevitable when caring for those at the end of life. Burnout is more than just being bored, and it also more than just a mid-life crisis.[6–10]

Burnout has been described in all levels of medical practitioners, including trainees. The aforementioned study in American surgeons actually suggested burnout might be more common in younger rather than

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older practitioners: a finding attributed to unrealistic expectations amongst the young.[3] Data are equivocal regarding a clear association with practice specialty, practice setting or even with physically taxing work. However, there is a strong correlation with whether the work is valued, both personally and by others.[12]

For those eager for a simple mnemonic, four C's of burnout commonly occur. These include *c*allousness, the tendency to *c*ut corners, intense *c*ynicism and even *c*ontempt. Regardless, for a profession that relies upon dedication, innovation, volunteerism and caring, this is a significant concern not be ignored. This is because burnout can deteriorate to the point of derogatory or dehumanizing views about colleagues and patients, and staff can end up loathing and resenting the very people that they set out to help. Burnout is also associated with can hopelessness, powerlessness and resignation (in both senses of the word). It might even be proportional to the number of times you have stated 'what's the point'! or concluded that 'you can't change anything'![1,6,8,9]

It is difficult to quantify the cost of burnout to employers or upon patient safety. However, a New York Times article of 2004 suggested $300 billion is expended each year in stress-related healthcare and missed work.[13] A 2014 article estimated hundreds or millions of dollars lost each year, in Canada alone, due to early retirement and decreased clinical hours.[14] In an attempt to understand burnout in terms more familiar to process engineers, Montgomery et al.[15] argued that burnout sits at the nexus of culture, outcomes and performance. If we agree then we really cannot expect to improve quality and safety without addressing burnout.

We may never demonstrate an unequivocal direct link between burnout and iatrogenesis. However, indirectly, it does appear to be a major contributor to lower productivity, less engagement, higher absenteeism and increased employee turnover.[13,14] It may also be associated with higher 'present-ism'. Namely, people may turn up to work but fail to engage or do more than the bare minimum. On a system level, burnout presumably stifles change, and entrenches old habits. On a personal level, burnout can threaten relationships and encourage substance abuse.[3–13]

Why do so many medical doctors (and nurses and other healthcare workers) exhibit burnout?

Many professions are apt to burnout, especially given society's accelerated pace and increasing expectations. Accordingly, it has been estimated that approximately 40% of the workforce is burnt out.[5,6] Therefore, this is not a unique affliction. However, burnout is especially common in the caring professions, and in individuals who are highly educated, self-motivated and attracted to demanding jobs where risks and rewards are high.[3–9] Burnout sufferers were also the type of people who originally enjoyed promoting change, and previously added substantially to workplace productivity and morale. It has also been argued that burnout does not happen to 'wimps' as it requires people that were initially eager, engaged and concerned, before they deteriorate into disillusionment.[9]

We should accept a few uncomfortable truths about medicine, and its practitioners. Firstly, even the most challenging diseases become routine over time. As such, it is unreasonable to expect every day to be fascinating. Moreover, once the novelty has gone, we run the risk of simply being left with the stress and long hours. In addition, medical science has changed more rapidly than medical culture. In other words, while we may still expect a single person to know and do 'everything', the complexity of medicine makes this impossible.[16] It is estimated that ICU care necessitates approximately 180 steps per patient, per day.[16] In addition, there are now over 13,000 listed diseases and syndromes, over 6000 drugs and over 4000 procedures.[16] There are also over 5500 medical journals indexed by Medline alone[17], and more low quality journals creating distraction and exasperation. It is impossible to be completely up to date in all areas, and increasingly difficult to know which information to trust.

The very personality traits that may be ideally suited to the clinical arena may be just as ill suited to domestic relationships.[18] Doctors and nurses are well known for their need for control, competitiveness, dedication, emotional remoteness and dark humour. We are also quite used to postponing gratification[19] ('graduate on a Sunday; begin work on a Monday').[19] This trait may have maintained us through the years of long hours and short pay cheques. However, assuming that we can also postpone attending to our personal relationships may be dangerous. After all, interpersonal relationships can be a prime source of happiness and resilience. If mismanaged, they become an additional source of anger and despondency.

While doctors are lauded for their perfectionism, this may be accompanied by a need for external validation.[20] We also often buy the 'myth of invincibility' ('my patients get sick, I don't').[21] This discourages doctors from seeking help. In addition, we rarely say 'no', and rarely encourage others to say 'no'. Medicine commonly follows the ethos of 'the better we do, the better we are expected to do'.[22,23] Therefore, high-performing clinicians are expected to teach (also a high-burnout pursuit), and then to research, and then to administer . . . and frequently all at the same time. We also share the 'myth of the imposter';[24] believing that while others have got their lives under control, we are underperforming or we are not intelligent enough . . . and that we will soon be 'found out'. The way people react to this fear is to try still harder, which can result in further exhaustion and resentment.

Overwork is the norm, and our self-definition often comes primarily from being a doctor (rather than as a parent or spouse). Many of us feel 'out of place' when outside of work. We are used to carrying pagers, being on-call, and volunteering during off time. We are used to blurring the lines between work–life and home–life, and letting our job crowd out everything else. We live with an unfortunate combination of compulsiveness, self-doubt, guilt and an exaggerated sense of responsibility.[18-19] Add to this the accelerating pace of life, the ubiquity of email and the new expectations of social media. It means that we are always 'on', and aware that we could theoretically 'do more'.[1] Finally, many healthcare workers are especially antagonistic towards being told what to do, while bureaucratic oversight shows no sign of decreasing. Perhaps it is surprising burnout rates are not higher.

Can 'burnout' be measured? Am I burnout?

Maslach described burnout as the opposite of 'engagement'.[9] Therefore, if engagement equals 'energy', 'involvement' and 'efficacy', then burnout can be measured by 'emotional exhaustion', 'depersonalization' and 'lack of personal accomplishment'. These dimensions are captured in the Maslach–Burnout Inventory.[25,26] There is also a non-validated but shorter test for 'compassion fatigue' (typically described as gradual lessening of compassion over time).[27,28] Electronic links are enclosed in the reference section for those wishing to self-test, and to follow over time.[26,28] These can also be filled out by family, and confidantes on your behalf to compare your internal feelings of burnout against how you appear to the outside world.

Freudenberger suggested 12 phases in the natural history of burnout.[8] These include (1) compulsion to prove oneself; (2) efforts to work harder; (3) neglect of one's own needs; (4) displacement of conflict (i.e. not realizing the cause of his/her distress), (5) alteration of values (friends, family and hobbies are neglected); (6) denial of emerging problems (i.e. cynicism and aggression); (7) withdrawal (reduction in social contacts); (8) behavioral changes (which can include substance abuse); (9) depersonalization (life becomes 'mechanical' or routine); (10) inner emptiness; (11) depression and (12) frank 'burnout' syndrome. All 12 steps are not experienced by all sufferers, and nor do they always occur sequentially. However, this construct allows individuals to see how far along they are, and what might happen without corrective action.

Burnout probably develops gradually. While it is probably worst in one's late 40 s, it appears to lessen in one's 50 s.[29] The triggers may not change but perhaps our approach does. Some of us learn to avoid stressors, some of us learn to stop taking things personally and some probably accept that while they 'love the work' there are times when they are going to simply 'hate the job'. Regardless, surely we should try to prevent rather than treat burnout, let alone wait it out. With this in mind, Maslach summarized burnout as a disconnect between an individual and an organization in one or more of six areas: workload, control, reward, community, fairness and values.[9,25] Efforts to combat burnout can focus on these six areas, and should include both the individual and the organization.

External strategies to reduce burnout

Maslach stated that burnout says as much about the employer as the employee. He even wrote: 'Imagine investigating the personality of cucumbers to discover why they had turned into sour pickles, without analyzing the vinegar barrels in which they'd been submerged!'[1] Bakker et al.[30] also argued that burnout can become contagious if ignored. As such, non-discriminatory stress management and employee assistance programs may help. These typically include confidential counseling (as well as life-coaches) or simply the offer of time-off. Leaders can trial no-meeting weeks and no-email weekends. After all, getting the *most* of out of the staff is different than getting the *best* out of the staff.[1]

Humans are social animals. Accordingly, social support is central to reducing stress and burnout. Many doctors work alone, or feel either isolated or in competition to those in close proximity. Unfortunately, nowadays, when workplace socializing does occur it is often 'sanitized'. When socializing is forced it often becomes another chore rather than a relief. Burnout appears to be lessened where leadership is seen supportive, collegial and shares the same values. It is also important that leadership is seen as 'one of us'. Not surprisingly, 'fairness' is important, as is the regular opportunity to address perceived inequities.[1,8,9]

Sabbatical (whether from the Greek 'sabbatikos', the Latin 'sabbaticus', or the Hebrew shabbat/sabbath)[30] means taking a break, or altering focus. While this author is ignorant in religious matters, multiple biblical references do exist: Genesis, Leviticus, Exodus and Deuteronomy.[31] The point is that the idea is age old, and therefore applicants should not be made to feel inferior, lazy or guilty. However, leadership could go further. After all, the Sabbath was universal – Jew and Gentile, slaves and free men – and even included beasts of burden.[31] Accordingly, the sabbatical could be an expectation rather than an exception, and built into the 'rota' because many will not ask. If we can juggle schedules for parental leave we can do the same to safeguard our colleagues.

Internal strategies to reduce burnout

If 'happiness truly is an inside job' [32] then we need to focus on internal strategies even more than external

strategies. We need self-awareness as well as self-care. This probably needs scheduling, at least at first, and therefore you may need to reserve regular 'me days'. The philanthropist/entrepreneur Bill Gates apparently enjoys stating: 'we overestimate what we can do in a year, but underestimate what we can do in a decade'. Physicians are often quick to admonish patients for having unrealistic goals, and so we need to take our own medicine. We also need *deliberate* goals. After all, how can we be surprised if we are not where we wanted to be if we never planned where we wanted to go.

Maslow's Hierarchy means that after securing basic needs we eventually need to pursue greater meaning.[33] This was echoed by Carl Jung who wrote of the need to address all parts of our personalities: the need to achieve and the need for meaning.[1] If quoting famous psychologists turns healthcare workers off, the same idea can be conveyed by stressing the need to divide careers into thirds: 'learning', 'earning' and 'returning' (i.e. giving back as well as taking). This time division can occur throughout one's career – each month, each year – and need not be restricted to the beginning, middle and end. If fact, if we wait too long then burnout may preclude us ever doing so.

Many other professions accept that career changes are typical, even desirable. Instead, we often stay in the same jobs because of money or prestige or commitments, inadequate imagination, excessive fear or an exaggerated sense of importance. When doctors do contemplate career change, we need to be cautioned against the tendency to pick other burnout-ridden areas: education, research and volunteering. Obviously, these are laudable and important. The issue is that if we fail to address our personality, or temper expectations against reality, then nothing is likely to change.[1]

For a profession that sees so much death, we often fail to maximize our own lives. Some of us pursue money and prestige, rather than meaning.[33] We often allow external validation to trump internal satisfaction, and worry about being noticed more than being useful. We could do worse than to avoid the most common regrets of the dying. The top five are as follows: having the courage to live a life true to yourself, wishing you had not worked so hard, gaining the courage to express your feelings, staying in touch with my friends and simply allowing yourself to be happier.[34]

If trying to force happiness seems naïve then we could at least try reinterpretation: 'that patient was rude, but he's probably more scared than angry'. We can also take a moment to mollify an angry response. To quote the psychiatrist, Victor Frankl, 'Between stimulus and response there is a space. In that space is our power to choose our response. In our response is our growth and our freedom'.[35]

Managing burnout

It can be useful to conceptualize 'burnout' as a chronic rather than an acute condition. This means we should not expect a quick fix. Chronic conditions require a multidimensional approach and substantial life change. Moreover, the goal is long-term symptom management – and preventing flair-ups – rather than outright cure. This is important for ICU staff used to solving problems rapidly, and by simply 'working harder'. Unfortunately, psychological issues are rarely that simple.

The relief gained from a short vacation, for example, is unlikely to last if we return to the same triggers. If not understood then the sufferer merely amplifies their unhappiness. This because they experience further disappointment, shame and resignation because their relief was so short lived. In addition, we need to learn to take a proper break. This means not taking work along, not exercising while listening to educational podcasts and not phoning into work while taking a walk.[1] We need to take leisure more seriously, and to learn that by doing less we may achieve more.

'Work–life balance' offers a key strategy to revitalize, to maintain perspective and to 'blow-off steam'. However, 'balance' is also difficult to quantify, and open to interpretation. The analogy of the tightrope may be useful.[33] After all, we all feel the pressure to perform, do not also have an adequate safety net, and rarely feel completely in balance. Moreover, perfect balance is elusive by nature of our personalities. Instead we could strive for *purposeful imbalance*.[33] Like a tightrope walker, we are constantly making back and forth adjustments. It is actually the adjustments that keep you balanced, whereas standing still is when you risk falling.

In medicine, equal time for work and family may be impossible. At times, work will entirely commandeer your schedule and dominate your mind. This means that we must discipline ourselves to compensate later so that family can also (unashamedly) have its turn. This 'purposeful imbalance'[33] might be the best chance of achieving a satisfying career without sacrificing family, and a happy family without sacrificing career. The analogy also reminds us that balance requires effort and deliberate strategies: you rarely achieve it by accident, or necessarily on the first try.

Final comments and caveats

It seems ironic to add the issue of burnout onto the busy physician: after all, he or she is already overtaxed. However, we should accept that the field of physician-health has expanded, and this topic is now firmly in our bailiwick. We might once have trivialized burnout as a 'noble infliction', and only intervened in obvious substance abuse or mental illness.

However, practitioner health has expanded to include disruptive behaviour, and the health of our relationships.[22] Accordingly, screening and counseling for burnout is a natural evolution. Clearly, resources and dedicated time are needed. If not, then efforts will be little more than an additional imposition on our time and patience.

While our jobs, and lives, can predispose to burnout, most of us manage because we also have high resilience, and because we do actually enjoy our work. While the definition of resilience is similarly ineffable, it refers to the ability to 'carry on' or 'bounce back'. It is typically maintained by relationships, spirituality, self-care, work and our general approach to life. It can also be measured and followed over time.[36,37] In fact, an episode of burnout may simply reflect a loss of resilience (i.e. a relationship break-up, poor health, lack or purpose). If resilience can be regained (i.e. a new relationship, exercise, time to retrain) then burnout is quelled. If resilience cannot be augmented then other steps are required. For some, this includes leaving their current job. However, we should not and need not give up without a fight.

It is also important that this discussion not be too maudlin. Medicine is still a wonderful job. Healthcare workers are privileged, and have greater income, security and purpose that many professions. Moreover, medicine requires self-sacrifice, and as such we cannot focus only on our well-being. Certainly, our personal health matters greatly because 'to do well we must be well'. However, it is worth remembering that it is not the patient's job or administration job to provide our excitement and meaning. Ultimately, 'happiness is (largely) an inside job'.[32]

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