This Article Corrects: "Burnout, Drop Out, Suicide: Physician Loss in Emergency Medicine, Part 1"

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Burnout, Drop Out, Suicide: Physician Loss in Emergency Medicine, Part 1
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Erratum in
West J Emerg Med. 2019 November;20(6):840-841. The authors would like to revise the description on the evolution of the definition of burnout in the Introduction. The introduction formerly stated, "Based on his research, Freudenberger used "burnout" as shorthand for a psychological syndrome with three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment.[2] Maslach subsequently summarized the dimensions of burnout as "exhaustion," "cynicism," and "inefficacy," providing more identifiable definitions of each dimension that align well with her measurement tool.[3]"

This should be revised to the following: "Based on his experiences, Freudenberger described the phenomenon of "burn-out", subsequently defined by Maslach as a psychological syndrome with three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment.[2,3]"

Abstract
Each year more than 400 physicians take their lives, likely related to increasing depression and burnout. Burnout—a psychological syndrome featuring emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment—is a disturbingly and increasingly prevalent phenomenon in healthcare, and emergency medicine (EM) in particular. As self-care based solutions have proven unsuccessful, more system-based causes, beyond the control of the individual physicians, have been identified. Such system-based causes include limitations of the electronic health record, long work hours and substantial educational debt, all in a culture of "no mistakes allowed." Blame and isolation in the face of medical errors and poor outcomes may lead to physician emotional injury, the so-called "second victim" syndrome, which is both a contributor to and consequence of burnout. In addition, emergency physicians (EP) are also particularly affected by the intensity of clinical practice, the higher risk of litigation, and the chronic fatigue of circadian rhythm disruption. Burnout has widespread consequences, including poor quality of care, increased medical errors, patient and provider dissatisfaction, and attrition from medical practice, exacerbating the shortage and maldistribution of EPs. Burned-out physicians are unlikely to seek professional treatment and may attempt to deal with substance abuse, depression and suicidal thoughts alone. This paper reviews the scope of burnout, contributors, and consequences both for medicine in general and for EM in particular.

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INTRODUCTION

"Burnout" evokes images of harried, sleep-deprived, hungry physicians, overwhelmed with "paperwork," administrative complaints of missed metrics, and pending tasks for family and patients. For the physician suffering from burnout, recovery can seem daunting or even impossible. For healthcare, burnout has been branded an epidemic, with societal and human economic and personal costs.[1] This article, the first of two parts, synthesizes information on burnout—the scope of the problem, its causes and consequences—from the perspective of the emergency physician (EP). Part II will focus on wellness and seek to make recovery less daunting.

Burnout: Definition and Measurement

Burnout is a complex condition with a history in many disciplines. Based on his experiences, Freudenberger described the phenomenon of "burn-out", subsequently defined by Maslach as a psychological syndrome with three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment.[2,3] Those who score high in "exhaustion" feel over-extended, their emotional and physical resources depleted.[3] High scorers in "cynicism" (depersonalization) appear more callous or detached than would be expected for normal "coping."[3] Those lacking confidence or feeling they have achieved little work success score high in the "inefficacy" (reduced personal accomplishment) dimension.[3] Overall, sufferers from burnout are frequently exhausted, diminished in their ability to care, and feel as though their work makes little difference.

Maslach used these definitions to create the most frequently used assessment tool for identifying burnout, the Maslach Burnout Inventory (MBI). This tool contains 22 questions addressing the three dimensions and provides scores in each. The higher the score, the higher the burnout in that dimension.[4] Rather than a dichotomous cutoff score of burnout as a diagnosis, the MBI describes a spectrum with higher scores equating to more severe symptoms and consequences.[5] While the MBI has been modified and abbreviated for specific populations and ease of use, it remains proprietary. The next most common tool used in healthcare burnout research, the Oldenburg Burnout Inventory, focuses on emotional exhaustion and depersonalization/ disengagement, while leaving out personal accomplishment.[6] A list of burnout assessment tools appears in Appendix 1; however, readers may consider simply asking physicians if they are burned out: In one study, self-reported burnout accurately predicted meeting MBI burnout criteria 72% of the time.[7]