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Burnout and moral injury among Consultation-Liaison Psychiatry trainees

Paulo M.G. Sales[*],

Arslaan Arshed[*],

Camila Cosmo,

Paula Li,

Michael Garrett,

Mary Ann Cohen

Paulo M.G. Sales, MD, MSc is an Assistant Professor of Psychiatry at the University of Alabama, Birmingham. Arslaan Arshed, MD, MHA, MS is a Clinical Assistant Professor of Psychiatry at the NYU Grossman School of Medicine. Camila Cosmo, MD, MSc, Ph.D. is a Psychiatry Resident at the Department of Psychiatry and Human Behavior, Alpert Medical School of Brown University, and VA RR&D Center for Neurorestoration and Neurotechnology, Providence VA, Providence, RI USA. Paula Li is a Medical Student at The Warren Alpert Medical School of Brown University. Michael Garrett, MD is a Clinical Professor of Psychiatry at SUNY Downstate. Mary Ann Cohen, MD is a Clinical Professor of Psychiatry at the Icahn School of Medicine at Mount Sinai.

Abstract

Burnout and moral injury within medicine have steadily increased over the last decades, especially while providing care during the COVID-19 pandemic. The term burnout has been used to describe clinician distress and a syndrome of emotional exhaustion, a diminished sense of personal accomplishment, and depersonalization. Burnout has a significant impact on both job performance and patient care. Moral injury occurs when external circumstances interact with a person's cherished beliefs and standards. When the tension between them cannot be reconciled, the felt integrity of the individual is disrupted and the person experiences distress. The consultative aspect in Consultation-Liaison Psychiatry (CLP) presents challenges that may predispose the young clinician to burnout and moral injury, especially during fellowship training. CLP psychiatrists also have a liaison role that could catalyze system-level change to enhance the mental wellbeing of their colleagues. This article reviews clinically relevant psychodynamic aspects of burnout and moral injury during CLP training. In addition, the authors propose strategies to enhance career growth and prevent and address moral injury during training to generate fulfilling professional development.

Keywords

PTSD; stressful workplace; medical training; psychiatric education

[*]Authors have equally contributed to this manuscript.

Burnout was initially described in 1974 by Herbert Freudenberger as a “state of mental and physical exhaustion caused by one’s professional life” (Freudenberger, 1974). Maslach and colleagues subdivided burnout into three domains: emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (Maslach et al., 1996). While commonly described symptoms of burnout overlap with psychiatric diagnoses such as major depressive disorder (MDD) and post-traumatic stress disorder (PTSD), the concept of burnout lacks a unifying definition (Oquendo et al., 2019).

Burnout is not commonly recognized as a formal diagnosis, although the ICD-11 includes burnout (diagnostic code QD85) as a “factor influencing health status” with anxiety and depressive disorders as exclusion criteria. Summers argues that burnout is a normal response to a stressful workplace, which is distinct from depressive disorders (Summers, 2020). Contrarily, other studies challenge that the artificial distinction of burnout as purely job-related does not make it nosologically unique from depressive and anxiety disorders (Bianchi et al., 2015) raising the concern that the artificial dichotomy may delay the diagnosis and treatment of MDD and anxiety disorders (Koutsimani et al., 2019). Despite this nosologic dissonance, burnout results in numerous individual and occupational adverse outcomes, including somatic symptoms (musculoskeletal pain, gastrointestinal issues, headache, fatigue), depressive states, anxiety, substance abuse, and suicide (Moss et al., 2016; Patel et al., 2018; Wright & Katz, 2018), while also increasing the risk for hypertension, hyperlipidemia, and other chronic stress-related diseases (Salvagioni et al., 2017; von Känel et al., 2020). The professional consequences of burnout include work dissatisfaction, absenteeism, increased medical errors and reduced quality of care. There is a bidirectional relationship between burnout and malpractice, with occupational distress resulting in increased medical errors and vice versa (Patel et al., 2018).

Rates of burnout have increased over the past few decades, with an impressive uptrend during the coronavirus (COVID-19) pandemic (Hartzband & Groopman, 2020; Kane, 2020). As many as 85% of all physicians report burnout throughout their career (Faber et al., 2016; Rotenstein et al., 2018), and the rise of burnout in medicine has serious implications for patient care, physician health, and the field of medicine at large. Recent reports indicate increased prevalence of substance use disorders, depression, and suicidal ideation in physicians, illnesses that remain highly stigmatized in medicine (Mihailescu & Neiterman, 2019). In fact, the stigma associated with mental illness is higher for physicians when compared with non-physicians (Schwenk et al., 2008), and physician burnout has even been labeled an additional pandemic, with advocates calling for more resources dedicated to burnout prevention, especially among front-line trainees and early-career physicians (Lasalvia et al., 2021).

Moral injury results from an individual’s experience that their core moral and ethical values are challenged while caring for patients within constraints beyond the clinician’s control. The amount of moral distress increases proportionally to the difference between one’s course of action against what is perceived to be an ideal and morally sound result that was based on core personal ethical directives. Psychologically, it may manifest as cynicism, irritability, physician dissatisfaction, and a loss of joy or passion for the healing aspects of medicine, and these thoughts and feelings may endure after the precipitating event

transpired, in what is known as the moral residue. Particularly important for trainees are the external manifestations, as moral injury may impact humanism, empathy, and rapport-building capacity, as well as cynicism towards supervisors or supervisees with a perceived break of trust.

The concept of moral injury emerged from work with combat veterans who reported feeling betrayed by society and leaders who had sent them into combat (Shay, 1995). Although the stresses of practicing medicine are slight in comparison to the trauma of combat, in the recent "battle" against COVID-19, military metaphors with references to medical staff as "front-line" workers have reframed the relationship of medical staff to the virus as that of an army defending against an invader. While frightened "civilians" offer public thanks to medical "front-line" workers, overwhelmed physicians feel as though they are being sent off to war without protective helmets and with ineffective weapons. Inability to supply sufficient personal protective equipment to protect staff and failure to anticipate the need for additional ventilators became widespread during the first wave of the pandemic, causing external strains to individual clinicians. When equipment supplies began to increase, distribution was not always well managed. Early in the pandemic before vaccinations were available, trainees were asked to utilize transportation that risked personal exposure to appear on-site when there were few or no patients to treat, while telemedicine had yet to be operationalized. Some were redeployed to practice outside of their clinical area of comfort or expertise. Although the clinical challenge of treating large numbers of severely ill patients constitutes a transient stressor that all physicians would be expected to embrace, the perception that the medical community was being poorly led fostered a sense of "moral injury" akin to that experienced by soldiers poorly led in combat or conflicted about their role.

Consultation-liaison psychiatry (CLP) is a subspecialty in which clinicians interface with a myriad of other teams and disciplines within the healthcare system while caring for the medically ill. The CLP psychiatrist attends to vulnerable patients, who may be regressed, uncertain of medical outcomes, and relinquishing autonomy. Consultations that are urgent intensify the complexity of care.

This article explores psychodynamic ways to understand and explain moral injury and burnout as part of CLP training during medical school, residency, and fellowship to develop prevention and treatment strategies that will enhance professional development and result in enduring job satisfaction.

Addressing burnout at the individual and systemic levels

Dr. A[†] was a newly graduated resident who did fellowship training in a busy academic center. His program director described him as someone who "has difficulties delegating and trusting the work of others and often gets so lost in trivial clinical details that he rechecks to ensure their quality and completion, instead of focusing on key treatment decisions to assist his patients". Dr. A felt he needed to make all telephone calls himself to obtain collateral information and was often overly critical about the work of the medical students

[†]All case illustrations have been deidentified or subjects provided informed consent in order to protect confidentiality

he supervised, giving as an example the way they incorrectly gown themselves before seeing patients diagnosed with COVID-19. He felt that despite all his hard work, he has developed a feeling of spite towards his supervisors who he felt failed to recognize all the hard work he did. Over his fellowship year, he began to miss days of work due to headaches and vague abdominal discomfort and became less and less motivated to come to work.

Given the rigorous training to become a physician, one could argue that many of us endorse obsessive-compulsive personality traits to succeed in medicine. In CLP, the required rigor to conduct a thorough chart review and cross-sectionally evaluate a patient comprehensively both from a psychiatric and general medical standpoint requires significant orderliness and benefits from obsessional traits.

Dr. A's ego strength was challenged during his C-L fellowship with new work demands and early career status. From an identity standpoint, being "almost an attending" while receiving the salary, clinical, and legal responsibilities of a post-graduate fifth-year resident caused anxiety. High-achieving individuals may fail to internalize their accomplishments during times of transition and struggle with self-doubt and the fear of being exposed as a fraud. The "impostor syndrome" has been associated with comorbid depression, anxiety, job dissatisfaction, and burnout (Bravata et al., 2020).

Dr. A is described as someone reluctant to assign work to others, presenting with perfectionism, preoccupation with details, meticulous standards, and rigidity, all of which are features of obsessive-compulsive personality disorder (OCPD). The diagnostic criteria for OCPD in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) require the presence of perfectionism and interpersonal control, indicated by the presence of four or more symptoms, beginning by early adulthood, and resulting in significant functional impairment in different contexts, such as social, occupational, or/and familial (Association, 2013; Atroszko et al., 2020; Rowland et al., 2017). Among the symptoms of OCPD, there is ego-syntonic inflexible behavior, commonly associated with a pervasive need to control and achieve orderliness, in addition to dichotomous thinking, fixation on details, obsession with perfection, devotion to work, and difficulty in engaging in leisure activities (Atroszko et al., 2020; Rowland et al., 2017). It often causes damage to interpersonal relationships, lack of empathy, criticism of oneself and others, as well as emotional and physical exhaustion, ultimately resulting in a paradoxical reduction of efficiency and productivity. Some studies have suggested that individuals with OCPD are more susceptible to burnout (Atroszko et al., 2020; Rossler et al., 2015).

Among the therapeutic strategies to address burnout at the individual level, psychotherapy that combines psychodynamic, mindfulness, and cognitive-behavioral techniques is effective to manage distress and exhaustion (Wiederhold et al., 2018). Obsessive-compulsive personality traits are associated with avoidant attachment (Wiltgen et al., 2015). While secure attachment is characterized by expectations that others will be trustworthy, dependable, and available, avoidant attachment results in inherent mistrust and withdrawal (Mikulincer, 1998). Psychodynamic interventions serve as opportunities to develop secure attachments and could shift the trainee's defensive structure to combat avoidance, isolation, and distress.

Discourse on burnout often involves a search for blame, either gravitating towards system-level or individual-level problems (*see* Table 1). Much of the current literature on burnout prevention among physicians focuses on the implementation of wellness and mindfulness modules to enhance resilience, the effective response to environmental challenges, and ultimate resistance to the deleterious effects of stress. For some, this may be perceived as wrongful blaming of trainees. Other strategies include the restructuring of medical training and policy change in the form of government legislation and insurance reform. Table 2 summarizes recommendations for the prevention and treatment of burnout.

The high rates of physician burnout (Fred & Scheid, 2018; Shanafelt et al., 2015) could result from high commitment and expectations, extensive working hours, administrative requirements limiting time spent with patients, billing and productivity requirements, and other systemic demands. Rotenstein et al. estimated the prevalence of burnout among physicians to be close to 81%, after pooling data from 182 studies in 45 countries. Variable rates across cohorts of core symptoms of emotional exhaustion, depersonalization, and low personal accomplishment, could be due to poorly established diagnostic parameters and the use of different assessment tools (Rotenstein et al., 2018).

Summers et al report a burnout prevalence rate of 78% among 2,084 American Psychiatric Association (APA) members, measured by the Maslach Burnout Inventory, with 20.2% of subjects presenting depressive symptoms ranging from moderate to severe (PHQ-9 scores ≥10) (Summers et al., 2020). Residents (relative risk=1.25, 95% CI=1.08–1.46) and early-career psychiatrists (relative risk=1.14, 95% CI=1.01–1.28) had higher levels of depression. Summers and colleagues (2020) hypothesized that this was due to work overload, emphasis on productivity, impaired work-home balance, and uncertainties concerning career path, in addition to distressful interactions with supervisors.

There is a paucity of literature addressing burnout management and prevention in psychiatry, especially in the early career stages of residency and fellowship. Health care institutions and training programs should invest in burnout prevention by promoting health, well-being, and personal and professional fulfillment through the implementation of strategies that promote a more supportive, non-judgmental environment, respectful interpersonal relationships and supervision, flexible work hours, guidance in career planning, and by increasing autonomy and participation in decision-making (Coverdale et al., 2019; Wiederhold et al., 2018). Furthermore, the prioritization of educational experience with a focus on academic activities, and less emphasis on clinical workload, has been identified as a protective mechanism (Agius et al., 1996).

When considering the determinants of burnout, it is important to not only bear in mind workplace stressors but also the unique characteristics that contribute to one's relationship with work. In a study of community mental health clinicians, Fukui *et al.* examined the differences among those who intended to leave a job compared to those who departed from two nonprofit community mental health centers in the Midwest during a burnout intervention trial (Fukui et al., 2020). Their data suggest that turnover intention was more closely related to higher emotional exhaustion scores and reduced job satisfaction, while an actual departure from the job was more closely associated with individual characteristics

from the mental health providers, such as career stage and responsibilities outside of work with the emergence of significant work-life conflicts.

Practical strategies, such as the periodic application of surveys assessing occupational stress and satisfaction, may facilitate the early recognition of burnout, and consequently the need for intervention in the initial stages, minimizing the chance of absenteeism. Epstein and Krasner identified self-awareness and the ability to self-monitor as important prerequisites before employing strategies to increase resilience (Epstein & Krasner, 2013). Positive outcomes have also been observed when using a more comprehensive approach, including relaxation techniques and communication skills training (Krasner et al., 2009; West et al., 2016; Wiederhold et al., 2018). Other institutional interventions such as stress management, group activities, and optimization of working hours have reduced physician burnout. In cases where the presentation of burnout is complicated by psychiatric comorbidities, psychotherapeutic and pharmacological treatment should be considered for the management of symptoms and functional restoration, following the guidelines available in the specialized literature (Slee et al., 2019; Trivedi, Fava, et al., 2006; Trivedi, Rush, et al., 2006).

As a clinician working within larger hospital systems, the CL psychiatrist is constrained by treatment plans, insurance reimbursement requirements, and the sheer volume of patients seen during brief amounts of time. Burnout in most medical specialties tends to decrease in the mid-career stage. According to Freudenberg, depersonalization may serve as a protective strategy to prevent further depletion of emotional resources (Freudenberger, 1974). This coping mechanism may serve to preserve the therapeutic relationship. One misconception is that burnout manifests due to the burden of empathy. However, empathy is protective against burnout, allowing for self-other distinction as opposed to the self-oriented position of sympathy (Thirioux et al., 2016; Wilkinson et al., 2017).

Differentiating PTSD from burnout

Dr. B moved to the United States as a political refugee to receive advanced psychiatric training. She left Sudan after being held prisoner for about two years allegedly because of her connections with the opposition group known as the Justice and Equality Movement. While imprisoned, she was kept in a cell with limited access to light and food, before being rescued by a humanitarian mission that facilitated her emigration to the United States. During her psychiatric fellowship training, she decided to pursue a sub-specialty in refugee mental health to re-signify some of the experiences she had back in her home country. Through the course of this training, she would extensively review electronic medical records and prepare detailed notes during the early morning hours while also remaining at work late to see more patients than what was required of her. Her efforts were often recognized and praised by both patients and clinical staff, and her supervisors were impressed with her endless drive and motivation to render clinical care. During one of her case presentations, she became speechless and extremely tearful, while discussing one of her patients who was rescued from an African country with severe traumatic brain injury and a limited functional prognosis. Dr. B’s sleep became erratic, and her productivity dropped. She described the pivotal case presentation as shame-provoking and became concerned about whether she could maintain proper clinical boundaries. She became avoidant of potential triggers.

Dr. B sublimated unique life experiences through her CLP practice, which satisfied a moral and existential drive to resignify otherwise traumatic memories. The direct and vicarious trauma she experienced, coupled with daily triggers during her training led to the development of avoidance and a resurgence of fear.

Multiple features in this trainee's presentation favor a diagnosis of PTSD instead of burnout. She was exposed to organized violence and held captive under extremely stressful circumstances. Besides directly or indirectly experiencing a traumatic event, the diagnosis of PTSD requires the presence of avoidance, intrusive, and hyperarousal symptoms, in addition to negative mood and distorted cognition (Association, 2013) for more than one month resulting in social, occupational, and interpersonal dysfunction. Although it is unclear for how long Dr. B experienced symptoms, her intense distress in the face of an external reminder, avoidance of potential triggers, and sleep disturbance are all suggestive of PTSD and less likely to be associated with burnout. This vignette highlights the importance of differentiating burnout from psychiatric psychopathology affecting work.

The ICD-11 has introduced a new entity, complex posttraumatic stress disorder (CPTSD), that is distinguished from PTSD by the additional presence of dysfunction in three domains: emotional response, self-identity, and interpersonal skills, all following a prolonged and severe traumatic experience (Bryant, 2010; Giourou et al., 2018; Organization, 2018). Initially, this disorder was thought to be exclusively related to childhood adversities, later having also been observed among patients with adulthood trauma history, similar to the one documented in the vignette (McDonnell et al., 2013).

In addition to trauma-related disorders, other conditions should be considered in the differential diagnosis of burnout (Korczak et al., 2010). Among those, depressive disorder, particularly in its atypical form, stands out as elusive, not only because of the overlap of clinical features but also because it is frequently co-morbid. (Korczak et al., 2010; Oquendo et al., 2019; Summers et al., 2020). The early recognition of depressive symptoms is essential as complications such as severe functional impairment and suicidality require a precise therapeutic approach, including consideration of pharmacological intervention (Oquendo et al., 2019). Other mental disorders associated with occupational impairment, such as anxiety, substance use, and adjustment disorders, should be considered when evaluating patients presenting with burnout.

Trauma, depressive and anxiety disorders increase psychological distress and compound suicide risk amongst physicians. In a systematic review conducted by Rotenstein et al, the prevalence of depression or depressive symptoms amongst medical students globally was 27.2% and suicidal ideation 11.1% (Rosenstein et al, 2016). Relative risk fluctuated from 1.1 to 3.4 in males and 2.5 to 5.7 in female doctors, compared to the general population (Lindeman et al, 1996). We believe that burnout and moral injury are additional risk factors for suicide amongst medical professionals.

Psychic suffering and psychological responses are dynamic, as they reflect the relationship between the clinician and the patient, the supervisor, the primary service, prior psychological responses to the trauma, and subsequent identity formation. From an interpersonal

perspective, both the cause and the cure for psychic suffering are found in relationships with others and relationships between self-states (Spermon et al., 2010).

The culture of medicine thrives on and takes pride in the notion that *the patient must come first*, even if that means one must sacrifice self-care and neglect loved ones. When work is so firmly rooted in one's identity, the process of recognizing flaws in the healthcare system may perpetuate an identity conflict, often following internalization of the frustrations experienced. Given the complexity and interrelatedness of the system's moving parts, trainees often fail to identify and use proper channels to mitigate systemic stress. The limited understanding of causative agents involved and the inability to voice concerns may translate into self-blame.

A psychodynamic framework for trauma highlights that underlying personality factors, which can be a product of trauma, complicates adaptation (Plakun & Shapiro, 2000). Psychodynamic psychotherapy for traumatized professionals can help the clinician recognize the conflict between the *patient-comes- first* ideology and self-care so that compromise becomes possible.

Related to increasing rates of burnout is the workplace paradigm shift during a technologically advanced age that highly values productivity and innovation. As labor has become more impersonal, with employers relying more on numbers and trends over the input of individual workers, there has been a seemingly paradoxical shift towards utilizing work as an expression of one's identity (Adler, 2020). This is especially true among physicians, who are taught throughout training that medicine is not just a job, but also a privilege, a calling, and a responsibility.

This phenomenon was especially accentuated during the COVID-19 pandemic, with increased clinical work demands, decreased rest hours, and patient care shifting to telehealth services. With some professionals working at home, interaction with other members of the treatment team as well as key supervisors and mentors became attenuated, causing a loss of support at a particularly stressful time.

In addition, system-wide changes associated with the redeployment to units strained by COVID-19 cases, uncertainty about the latest protocols, and access to personal protective equipment were some of the key stressors faced by CLP fellows during the pandemic. As discussed in the case of Dr. A, the political refugee physician, these necessary changes may have left a psychological scar that accentuated dysfunctional personality traits in face of unprocessed feelings, experiences, and beliefs surrounding these events, especially when moral conflicts did arise, such as when deciding to place a patient infected with COVID-19 under constant observation while exposing a healthy individual to a significant risk for infection.

Moral injury in the pursuit of a career in Consultation-Liaison Psychiatry

Dr. C was an enthusiastic mother of two, who joined a consultation-liaison fellowship program to attain advanced knowledge in HIV psychiatry and develop long-lasting relationships with her patients. To accommodate her needs as a single mother, she negotiated

with the program director to work part-time as a fellow focusing on the specialized HIV clinic, so that she could finish her fellowship over two years instead of one. From the beginning, Dr. C was diligent in her patient care and presentations and was rapidly integrated into the team. When the COVID-19 pandemic started, one of her colleagues decided to leave the fellowship to assist a family member who was ill. Given significant staff shortages, her program director was redeployed to work in their medical inpatient units and insisted that Dr. C would need to work on a full-time basis to fully staff the clinic. As subsequent restrictions to in-person visits were instituted, Dr. C felt like she was lying, as she told her most active patients that "she would do her best to help them" during the virtual appointments, when, in fact, she knew there was nothing else to be done. She also felt anxious and responsible, as they began to miss the dates to fill their prescriptions and collect tests to monitor their viral load.

Once she decided to escalate the matter, her program director informed her that nothing else could be done and that these guidelines came from high-level leadership. When patients started to drop out of their clinic, Dr. C felt incompetent and had a strong sense of guilt for being unable to help them. She tried to compensate by coming earlier and seeing more patients. As the pandemic progressed, pressures at home increased. Her children pined for her and childcare arrangements foundered. Isolated and depressed, Dr. C started to drink a couple of glasses of wine "to help her relax for another day", and her performance at work deteriorated substantially. She regretted her choice to do a fellowship during a pandemic, as she was now unable to see her HIV patients and felt not only like an ineffective physician but a bad mother. She also felt betrayed and unheard by her program director and her hospital system.

The distress encountered by Dr. C seems to be consistent with moral injury. She presents with demoralization, sadness, and insecurity about the outcome of her negotiations and her ability to trust an educational system that will not meet her core expectations not only as a trainee but also as a single mother.

When assessing a clinician's moral framework, we look at both internal and external motivating factors. External factors include and are not limited to institutional prestige, income, and social prestige (Panagioti et al., 2017). Internal motivating factors are directly related to early childhood and adolescent experiences. An existential perspective highlights internal motivating factors as etiologically related to moral injury. This perspective suggests a dynamic interplay between the clinicians' need to find existential significance in their lives and a sense that clinical encounters no longer provide fulfillment (Pines, 2000).

From an object relations theoretical perspective, people are shaped by relationships with important others around them. The anxiety Dr. C experienced may stem from difficulty in the preservation of self-objects while also differentiating herself from them, a pattern that could mirror one from early development. Even in clinicians with a secure attachment style, training often strains the work-life balance, particularly if there is a complex dynamic involving multiple family member dependents and caregiving responsibilities. People are also shaped by their relationships with those around them during early career training.

Another interesting aspect raised by this vignette is whether distress is triggered by maladaptive inner mechanisms such as intrapsychic conflicts or external factors related to excessive occupational burden. Dean and colleagues (2019) argue that several health professionals have been misdiagnosed as having burnout when in fact they are experiencing moral injury, which stems from moral conflicts and psychological distress compounded by the inability to prioritize patient care due to institutional constraints. They also emphasize that the sole source of the stress is not in the individual and one's inner conflicts, as it also derives from a dysfunctional health system that burdens health professionals with an intolerable workload and multiple administrative demands focused on financial-legal objectives.

Once a trainee graduates and officially becomes a psychiatrist, several conflicts may peak during this transition. To seek advanced training, fellows postpone the benefits of independent practice and transition back into a trainee mentality: now with the newly established role of "almost being" an attending psychiatrist. CLP fellows need to form new relationships with members of the consultation-liaison service and learn how to interface harmoniously with medical and surgical care teams – with the caveat that this relationship may only last one year. As training finally concludes and CLP fellows transition into the early career psychiatry category, it is important to integrate and conceptualize the training experience, while finding ways to make solid first career steps to achieve a fulfilling subspecialty practice.

Psychodynamically oriented CL psychiatrists can attune themselves to the discourse of the patient, how the past results in foundational attitudes observed in the patient's relationship with others at home and the hospital. These are invariably manifested in symptomatology, as well as defense structures, projective mechanisms, and countertransference experienced by the consultant and primary teams. This conceptualization allows the interaction with the patient, primary team, and the consultant to be therapeutic in either one session, multiple follow-up sessions, or allows a positive first exposure to psychiatry ensuring outpatient follow-up. The liaison aspect of the field allows the consultant to both advocate for the patient's needs and provide a framework for the patient's behaviors.

Patients who are physically ill are often vulnerable, regressed, and want to be understood. When a consultation is conducted in a psychodynamically informed way, the patient will be more likely to accept a referral for psychiatric follow-up when it is indicated (Blumenfield, 2006). This can be done by using transference in an empathic manner, explaining what needs of the patient are not being met, or simply providing an avenue for psychoeducation. The crux of understanding transference and countertransference for CLP fellows is to become cognizant of their own identity and motivators, so it can be subsequently applied in practice, as well as inherent limitations in the system they practice, especially during unique stressors, such as a pandemic.

Conclusion

The fact that up to three-quarters of physicians surveyed report burnout suggests that they commonly experience professional dissatisfaction and face erosive work environments.

Reasons for burnout may include work environment-related stressors inherent to the practice of medicine that may be a source of distress to many physicians (systemic factors) and psychological factors that may affect a physician's adaptation to the stresses of work (individual factors). This distinction is important because different sources of dissatisfaction have different remedies, as systemic factors require administrative solutions whereas individual factors may benefit from psychotherapeutic or educational interventions. Regarding systemic factors, in recent decades the practice of medicine in the United States has been increasingly shaped by the requirements of third-party-payers. Whereas in decades past, having established individual relationships with patients, doctors commonly initiated referrals to hospitals and other sources of care. Care was doctor-patient centric. Now patients are either "in-network" or "out of network", where the network is an insurance company outside of the clinical sphere. These changes have reduced the ability of physicians to shape their practices according to skills and expertise. The constraints in practice and demands for documentation that accompanied this shift in the locus of control in medicine generally cause professional dissatisfaction.

A psychodynamic framework helps the CLP fellow understand and reflect their inner psychological processes. The link between past experiences and current difficulties faced in training will help illuminate burnout and moral injury. To prevent or overcome moral injury and burnout, clinicians must appreciate sources of external and internal motivation, normalize the experience of identity formation as early career psychiatrists or fellows in training, and understand the systemic aggressions that lead to internalization or self-critique at the expense of growth and development. We recommend that burnout should not be used as a blanket statement to delay proper diagnosis and treatment of another psychiatric condition, especially in persons with PTSD. Training programs need to proactively identify and offer ways for trainees to mitigate stress. We recommend protected time for supportive supervision from administrators, supervisors, and peers, and facilitating access to psychotherapeutic treatments.

The vignettes are intended to highlight the importance of self-reflection through therapy or supervision, which should be made accessible by training institutions as early career psychiatrists may be more vulnerable to moral injury and burnout. Training should encourage identifying determinants of burnout and moral injury while appreciating external versus internal sources of pressure, normalizing the experience of identity formation for early career psychiatrists who are engaged in fellowship training, while helping navigate the vicissitudes of the workplace collaboratively.

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Table 1 –

Psychosocial factors predisposing clinicians to burnout in consultation-liaison psychiatry.

Systems-Related	Personal
External locus of control leading to diminished control over practices by the individual *(Responsibility without authority)*	Difficulty balancing work, family, and other areas of life
Lack of authority and disempowerment attitude from leadership	Clinician's interests and goals are not aligned with the work environment
Excessive caseload responsibilities with complex presentations in short-term relationships	Obsessive-compulsive personality traits signaling perfectionism and interpersonal control
Excessive time devoted for paperwork, billing, and accuracy of electronic medical records	Post-Traumatic Stress Disorder
Frequent changes in documentation requirements and expectation to be accessible from home	Anxiety disorders
High regulatory demands	Depressive disorders
Lack of rewards and devaluation of contribution when addressing unstable organizational dynamics	Overidentification with patients
Sub-optimal conditions for the practice of medicine (*e.g.*, access to PPE)	Conflicting values when required to practice in stressful conditions
An increasing number of patients with diagnoses of personality disorders and/or substance use disorders	Dissociative experiences with the perception of an unrewarding practice
Witnessing clinical deterioration of patients with risk for death	Difficulties to maintain proper work-life balances due to personal needs (*e.g.*, parental responsibilities, caring for disabled family members)
Poor communication among hospital staff and/or clinicians	

Table 2 –

Recommendations for prevention and treatment of burnout in trainees

• Burnout should not be used as a blanket statement to delay the proper diagnosis and treatment of another psychiatric condition. It may co-exist with or be catalyzed by underlying psychopathology, including OCPD, PTSD, CPTSD, depressive disorders, and anxiety disorders
• Training programs need to proactively identify and offer ways for trainees to mitigate stress and burnout, especially during role transitions (*e.g.*, when shifting from residency to fellowship training)
• Fellowship programs need to facilitate advanced training, opportunities for career development, and self-discovery, recognizing that fellows provide excellent clinical care and are instrumental in the education of residents and students
• Academic activities (*e.g.*, grand rounds, case conferences, group supervision) may provide venues to discuss, demystify, and destigmatize burnout
• Mentorship opportunities that focus on role transitions could be operationalized to help trainees with career development
• Trainees who are practicing in fellowship programs without co-fellows may benefit from joining online groups to enhance peer support, case discussion, and discussion about the “hidden curriculum” of Consultation-Liaison Psychiatry
• Fellowship programs may offer confidential access to clinical support services when fellows present with functional impairment to avoid delaying diagnosis and treatment of underlying conditions that may resemble burnout.