Avoiding burnout in general practice

BURNOUT has been used to describe the syndrome of emotional exhaustion, depersonalization, low productivity and feelings of low achievement.[1,2] General practitioners may be especially vulnerable to burnout compared with their hospital colleagues because of their front line role. They carry the burden of medical care throughout their professional lives without the buffer of junior medical and ward staff.

General practitioners deal with a rapid throughput of patients, exercising all their medical and social knowledge and skills. Their work impinges directly on their home lives, particularly during out of hours on-call duty. They are subject to constant interruptions at work from patients and from practice staff. This impairs concentration and is always irritating, however unavoidable.

General practitioners can become isolated from medical colleagues, either for geographic reasons or because partners in a practice do not relate well together. If general practitioners living within the practice boundary are approached by members of the local community for impromptu consultations or unwanted attentions they may avoid appearing in public, inducing a sense of social isolation.

A study in Australia found burnout to be more common in younger general practitioners than older general practitioners. The younger doctors experienced higher levels of emotional exhaustion and depersonalization.[3] Among doctors required to be medically examined by the health committee of the General Medical Council there is a preponderance of younger doctors, and alleged substance abuse is the most common reason for referral to the committee.[4]

New principals may become disillusioned upon entering general practice: their initial enthusiasm to implement principles of good practice learnt during their training may be frustrated by working in a partnership that is resistant to change or unwilling to invest in more practice resources.

The medical profession is becoming aware of the impact of stress and burnout on performance at work and on quality of life. Three national conferences have been held over the last two years by the Royal College of General Practitioners, the British Medical Association and the Royal College of Psychiatrists to highlight the growing concern. However, they have served to chronicle the existence of problems rather than produce ideas to combat stress or burnout. More recently, the RCGP has run a series of workshops to address problems in practice and discuss ways forward. A survey found that 25% of general practitioners studied had positively considered leaving practice and 45% wished to retire at 55 years of age because of their disillusionment with general practice (*Pulse*, 24 September 1992). The situation is serious and needs to be addressed urgently.

Evidence suggests that burnout scores may be related to perceived rather than actual job stress.[5] Some stress is necessary for optimum performance and a challenge perceived as causing damaging stress in one individual may be positively welcomed by another.

Compulsive behaviour in doctors is a common personality trait.[6] The combination of this characteristic, the setting of high personal standards, a reluctance to delegate and a conscientious approach to work ingrained at medical school, are all potential contributors to burnout.

Doctors also fear being seen to fail to keep up with their colleagues' workload or performance. Howie and colleagues have shown that in practices where general practitioners consult at the same rate, those who are forced to work at a quicker pace than they would choose in order to keep up with their partners record higher levels of stress.[7] As their workload increases, doctors may continue to absorb more tasks, finding difficulty saying no until they reach a point where they are barely coping with the demands made upon them; performance consequently declines, job satisfaction decreases and they burn out.

Patients' complaints about general practitioners can cause great distress to the doctors' mental health. The problem is compounded by the time delays and perceived unfair regulations of the complaints system. It can be devastating for doctors who have genuinely tried to do their best for patients at the expense of their own personal well being to receive complaints that may be unjustified or to have their shortcomings made public, which taken out of context assume enormous magnitude.

For general practitioners to avoid burnout they need to be aware of how they react to stress and how these reactions affect performance at work, patients and the people with whom they work. If maladaptive coping methods are employed, the result is likely to be burnout, with consequent feelings of apathy, helplessness and exhaustion.

Doctors should be alert to changes in their own feelings, behaviour and thinking. Loss of sense of humour, a persistent sense of self-failure or self-blame, frequent anger or resentment, irritability at home and work and a progressively cynical attitude to patients may all be symptoms of burnout.[8] Changed behaviour may include resistance to patient contact and going to work, working harder to achieve less, increasing social and professional isolation and avoidance of contact with colleagues, and increasing use of drugs. Clumsiness and accident proneness are other symptoms of burnout. There may be frequent thoughts about leaving the job, loss of creative problem solving, an inability to concentrate or listen to patients or colleagues, resistance to change, a tendency to dehumanize patients and suspicion and mistrust of others. These behavioural responses to excessive stress are the emotional equivalents of physical withdrawal from a painful physical stimulus.

What can be done to help doctors avoid burnout? First, trainee general practitioners should be encouraged to have realistic expectations of general practice rather than idealistic ones. The standards of practices in which trainees spend their practice year may be far higher than those of the practice they join. They need to learn skills in their vocational training programme that will be useful in influencing and initiating change and motivating colleagues, so that new principals can maintain their initial enthusiasm and be able to make improvements in the practice at a realistic pace.

Secondly, the stigma attached to doctors who admit to mental health problems must be removed and there should be more open debate about the issues involved in breakdown. It should be acknowledged as the norm that most doctors suffer from a degree of stress or burnout at some time, and help needs to be available to overcome it. One of the contributory factors to developing stress and burnout may be the low self-esteem and self-respect with which some doctors view themselves. The royal colleges, other professional bodies and especially medical schools need to raise perceptions of all doctors' worth by more positive attitudes and a disavowal of the bigotry and arrogance so commonly a feature of medical teachers until the recent past.

A third way of avoiding burnout is to encourage doctors to give and to expect support from all professional colleagues. Susceptibility to stress or burnout is more likely if a doctor is isolated.[9] Postgraduate centres should concentrate on setting up and

encouraging small educational groups which also have a supportive framework. Stress management courses have been shown to produce significant short-term improvements in stress and burnout test scores.[10] Training programmes can encourage doctors' personal development in self-awareness, in sharing feelings and responsibilities, of a personal philosophy and of non-traditional coping skills; they may also encourage doctors to see things from a new perspective and to set limits upon external demands.[11]

Lastly, we as general practitioners can take practical measures, for instance by not taking on too much extra work, or making periodic changes to work patterns, such as attending conferences that interest us or perhaps initiating a new project. We should positively try to foster good working relationships with other members of the practice team and share concerns and anxieties about patients or working regulations. By monitoring our own feelings and behaviour we should be able to detect early negative changes in good time to remedy them.

The profession as a whole has a major challenge before it. Medical institutions are frequently perceived by their members as divorced from the difficulties and stresses of the real world of medical practice. The time has come for urgent, positive and effective action with a concerted plan from medical schools, the royal colleges and the British Medical Association.

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Exercise and health promotion

PHYSICAL activity is good for doctors and their patients,[1,2] and is of particular benefit in preventing cardiovascular disease.[3] Early studies indicated that physical activity during work or leisure reduced the risk of heart attack,[4–6] a finding subsequently confirmed in many studies including the Framingham heart study.[7] Powell and colleagues, in a review of 43 studies of physical activity, found a consistent inverse association between physical activity and coronary heart disease[8] and a subsequent meta-analysis confirmed the increased risk associated with inactivity in a sedentary population.[9] Berlin and Colditz concluded that lack of physical activity was a potentially modifiable risk factor for coronary heart disease that should receive greater emphasis.[9] There is now increasing interest in the relationship between physical activity and lipid metabolism,[10-12] and population studies show an elevation in high density lipoprotein cholesterol level associated with physical activity.[13] The evidence supporting the benefits of physical activity is convincing, the beneficial effects are dose related to intensity of exercise and there is good evidence that the relationship is causal.[14] The relative risk of physical inactivity may be as great as the accepted risk factors of smoking, hypertension and hypercholesterolaemia for coronary heart disease.[15]

However, the Allied Dunbar national fitness survey found that seven out of 10 men and eight out of 10 women in the age group 16–74 years in England were active at a level below that necessary to achieve cardiovascular benefit.[16] One third of men and two thirds of women had difficulty walking at three miles per hour up a 5% gradient for more than a few minutes and many people aged over 55 years had inadequate strength to carry out the tasks of daily living. This survey also revealed an interesting contradiction in that, although most people believed physical activity was important for health and regarded themselves as fairly fit, only a minority took sufficient exercise.

Clearly there is a need to increase participation in physical activity at all ages among those who are least active. Exercise is included in most health promotion recommendations and strategies,[3,17–19] and while exercise is not included in the targets of *The health of the nation*,[20] it is likely to be introduced in the future. However, it is not enough to recommend to people that they take more exercise, there must be suitable facilities, opportunities, knowledge and expertise available and there must be a culture of participation. Promotion of exercise is an intersectoral responsibility; those involved in education, local authorities, sporting organizations, the regional sports councils and public health bodies all have a part to play, but we as general practitioners also have a role. This need not mean a major change in the consultation or additional intervention in our already busy surgeries, but simply an awareness of the benefits and an acceptance of the value of exercise in health promotion. We could introduce exercise as part of lifestyle counselling, include exercise in the protocol for our health promotion clinics and record exercise participation in patients' notes. We should have some knowledge of the basic principles of exercise, be aware of what is appropriate, and be able to tailor an exercise prescription to meet patients' needs.

The accepted target for beneficial physical activity is 20 minutes aerobic activity on three occasions per week,[21] but recent evidence indicates that exercise need not be vigorous and that moderate levels of physical fitness, attainable by most adults, appear to be protective.[22] Indeed, encouraging moderate physical activity may be more acceptable for patients. Physical activity can be integrated into daily living — walking upstairs rather than taking the lift, walking or cycling to work rather than taking the car and including active tasks into everyday life. Activity may be increased gradually, progressing to active leisure such as gardening and hill walking. As work-related activity declines with modern living, the focus should be on sport and exercise which involve continuous aerobic movements, such as brisk walking, jogging, cycling and swimming. For long term compliance the most important principle is that it should be enjoyable.

In summary, inactivity is a well-recognized risk factor in car-