

Alberta Doctors' Digest

Burning out

We're all about burnout now. I hear the word everywhere, perhaps surprisingly, since the term is a recent one, dating to psychologist Herbert Freudenberger's 1974 description of exhaustion¹ associated with work at a free clinic for drug addicts. An earlier association may exist: a 1961 Graham Greene novel, *A Burnt Out Case*, described a physician's work with lepers in the Belgian Congo.

Nevertheless burnout is an apt designation that has gained wide acceptance both in health-related fields and in general usage, referring to the set of symptoms that can accompany chronic, unmitigated stress. It has been called an exhaustion syndrome related to the cognitive, emotional and temporal demands of modernity. Significant here are the social transformations that have accompanied globalized capitalism and new technologies that are unyielding in their demands.

While we've come to notice this state of affairs recently and have renewed arguments that "the world is too much with us," emotional exhaustion associated with living is not new.²

In Greek antiquity, for instance, when out-of-kilter humoral factors were thought to determine disease, an excess of black bile was considered responsible. The Christian monk John Cassian (360-435 CE) described *acedia*, a state of non-caring or weariness of the heart that affected monks in the early Medieval period. Sufferers were described as "worn out and weary," and afflicted with "unreasonable confusion of mind," fatigue, irritability and unproductive activity.

Scottish physician Dr. George Cheyne (1671-1743) described the English malady associated with "lowness of Spirits, lethargic Dullness, Melancholy and Moping." The American physician Dr. George M. Beard added another diagnosis – *neurasthenia* – a vaguely described state of exhaustion that he ascribed to changes in the outside world, including "steam power, the periodical press, the telegraph, the sciences and the mental activity of women."

More recently, and subsequent to the work of pioneers in stress research such as Hans Selye, we have come to realize that stress can devastate our physical and mental health. We've moved beyond explaining burnout in terms of biochemical imbalance, a viral ailment or a spiritual failing. As well, we've moved beyond the macho assumption that our successes are a matter of having "the right stuff," or that overwork and sleep deprivation are the price of success.

If burnout is in our past, we're faced with it again.

I've read the recent National Health Survey of the Canadian Medical Association³ with surprise and concern. The survey, completed by 2,547 physicians and medical residents across the country, found alarming levels of burnout, depression and anxiety. Most disturbingly, reported levels of burnout and depression were higher among residents

than practicing physicians and were more prevalent among female doctors than their male counterparts.

There is a paucity of earlier information for comparison purposes, but we're pretty much in step with our southern neighbors. Two years ago, then US Surgeon General Dr. Vivek Murphy sounded the alarm regarding two looming crises: the opioid epidemic and the spectre of widespread burnout in the medical profession.⁴ The American data are distressing: two-thirds of doctors in the US maintain that they're burned out, depressed or both.

The implications of these numbers are concerning. Stressed out doctors are more likely to make mistakes, for one, and, they are more likely to leave practice. In both clinical medicine and in academia there is now a sub-genre of "quitlit" in which practitioners in either field detail their miseries and their plans to cut their losses and search for happier environs. This couldn't come at a worse time, however, with unhappy doctors leaving practice at the same time that demographic trends promise a glut of retirees coming onstream, bearing their own age-related health care needs.

Opinions vary regarding burnout and possible repair. Older physicians may have developed a grim acceptance of medical practice ("It's just not fun anymore!"), but decry a general loss of autonomy in clinical practice. They often blame the wholesale corporatization of the medical world – new rules and new bosses everywhere – the attendant, pervasive concern with ratcheting up efficiencies, and the appetite for ever-more data regarding the business of medicine, not its healing or palliative intent.

Younger physicians – including residents – likely face the worst of both worlds, for they have typically shouldered a mountain of debt before being dropped into the maelstrom of technical complexity and the stultifying conformity that was predicted a generation or two ago by George Orwell.

My thinking about the genesis of burnout has been helped by reading the recent essay "Doctors have become less empathetic, but is it their fault?" by Dr. David Scales. A resident physician in internal medicine at the Cambridge Health Alliance, Dr. Scales wonders whether the same factors that make empathy with patients so difficult are responsible for burnout.⁵

Dr. Scales refers to a 1973 study involving Princeton seminarians who were divided into two groups. The first group were told they were en route to give a talk about the parable of the Good Samaritan, while the second group were to talk about finding good job prospects. The kicker, if you will, involved another variable – an interruption – in which seminarians had to pass an alleyway where a fake victim was in obvious distress and needed help. The a priori reasoning, of course, was that seminarians in either group would stop to help. But, in significant numbers, they didn't, and those who did were anxious and obviously conflicted regarding the talk they had to give and their needed assistance in the alleyway.

The implications of the Princeton study are profound. Time pressures are able to suspend an ethical or helping response and overwhelm a presumed inclination to help those in need. The analogous situation in the clinic or the hospital, with distressed patients and a system that demands hurry – more patients, faster – is manifestly unhealthy for patients and caregivers alike.

I'd like to see if the need for speed could be unbundled from the needs of patients to see if chaotic clinical environments could be replaced with longer, uninterrupted care appointments. But the practice of medicine doesn't seem to be headed that way.

There are signs of developing awareness. The CMA has hired a vice-president of physician health and wellness. Numerous hospitals have events or programs intended to re-energize physicians and general awareness has grown dramatically.⁴ One innovative program allows physicians to "time bank" certain activities so that time credits can be used for personal use. The Cleveland Clinic has a "Code Lavender" meant to respond to aggrieved and overburdened doctors with snacks, massages and emotional support.

These are all commendable efforts, but I think they will do little to counter the crucible of urgent medical care reinforced with the systemic drive for throughput. I expect that burnout will only yield to major order change in the practice of medicine.

I am skeptical, bordering on cynical. Every little bit helps. The Hippocratic injunction to "do no harm" must be paired with the petition to do no harm to the caregivers.

Not a bad thought for a sustainable enterprise: look after the caregivers.

Editor's note: If you are struggling with burnout or related issues, don't go it alone. The Physician and Family Support Program (PFSP) helpline is available 24/7, toll-free at 1.877.767.4637. Or go to www.albertadoctors.org/services/pfsp.

References available upon request.

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