

Please put on your own oxygen mask before assisting others: a call to arms to battle burnout

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“No man is an island, Entire of itself. Each is a piece of the continent, a part of the main. [...] Each man’s death diminishes me, for I am involved in mankind. Therefore, send not to know for whom the bell tolls, It tolls for thee.”

John Donne

Devotions upon Emergent Occasions

Burnout is a silent killer. While the metaphor of the silent killer is often used in conjunction with diseases such as hypertension or ovarian cancer, in organizational psychology it is aptly applied to burnout. Burnout afflicts the workplace, and hospitals, clinics, and doctors’ offices are not exempt. In fact, members of the health care industry have a higher rate of burnout than does the general population.¹ Good patient care, as safety research demonstrates, is a team sport.² Unfortunately, many of our teammates are on injured reserve, putting them, and the safety of our patients, in peril. In this call to arms, we will discuss the breadth of the problem of burnout, explain why it is critical that it be addressed, and then describe steps that can be taken to start restoring the well-being of our colleagues, which will thereby allow them to pursue the best interests of our patients. Every time passengers board a plane they are reminded to put on their own oxygen

THE PROBLEM: Burnout among healthcare workers has reached epidemic proportions. Obstetrician/Gynecologists are not exceptions. Burnout is a phenomenon that can be difficult to distinguish from other entities, but one that has far-reaching consequences that can be deleterious both to physicians and to their patients. Most worrisome are its insidious nature, its contagiousness, and its relationship to depression. To date there has been a paucity of solutions proven to effectively fight burnout, and the implementation of those that may be helpful has been fragmented.

A SOLUTION: An aggressive and multi-pronged approach is warranted that focus at the individual, departmental, institutional and national levels. Potential solutions should take into account external and internal factors, as well as issues of feasibility, impact and cost. Interventions that may play a role include cognitive-behavioral therapy, enhanced communication, physician well-being programs, improving work conditions, and advocacy efforts.

masks before assisting others. Similarly physicians need to be reminded that they can’t help others if they do not first address risks to their own well-being. Burnout is just such a risk.

Definitions and distinctions

There has been a growing interest in burnout in health care in the last few decades, in both the medical literature and in the lay press.^{3,4} The most widely accepted definition of burnout is a syndrome of emotional exhaustion, cynicism or depersonalization, and feeling a lack of personal accomplishment.⁵ Burnout is often confused with other states (eg, work-related stress, job dissatisfaction, fatigue). [Table 1](#) provides a nonexhaustive list of several such conditions. Clarifying the distinctions among these conditions makes it easier for individuals and organizations to address each entity more effectively through proper screening and interventions. There are theoretical frameworks that link some of these concepts to each other but they are beyond the scope of this article.^{6,7} The focus of this call to action will be burnout.

Scope of the problem: widespread prevalence, limited data

Many studies have assessed the prevalence of burnout among different medical specialties; the most recent of which reported a burnout rate of around 50% among obstetrician/gynecologists.^{8,9} That said, most studies on burnout prevalence are cross-sectional, and the rates vary based on the year of study, the tool used in the study, and the different members of the workforce being studied (physicians, nurses, midwives, subspecialists). [Table 2](#) provides a summary of the latest rates of burnout for the different members of the specialty.

In sum, while these studies have many limitations and variations in quality and results, burnout is most prevalent among our specialty’s residents, followed by chairs and physicians, and lastly by subspecialists and midwives. It also seems to be increasing over time.⁸

Consequences, depression overlap, and contagion

Consequences. The consequences of burnout are often indirect, and they have recently been reviewed as part of a discussion of physician wellness,¹⁰ a

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TABLE 1

Conditions that may be confused with burnout

Term	Definition
Burnout	Syndrome characterized by emotional exhaustion, depersonalization or cynicism, and feeling of reduced personal accomplishment that can occur among individuals who work with people, such as patients or colleagues. ⁵
Work-related stress	Response people may have when work demands exceed their knowledge or skills and challenge their ability to cope. It can be exacerbated by poor leadership support or diminished control over work conditions. ⁴⁷
Job dissatisfaction	Job attitude that results from poor quality or lack of certain factors such as working conditions, supervision, benefits, and job security. ⁴⁸
Fatigue	"Feeling that refers to the complex pattern of changes that follow a sustained attempt to maintain task goals under threat from environmental or task stressors." It can be physical, cognitive, or sleepiness related. ⁴⁹
Compassion fatigue	"A combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress." ^{50,51}
Second victim	"Second victims are health care providers who are involved in an anticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base." ⁵²
Posttraumatic stress disorder	Disorder experienced following exposure to traumatic event associated with symptoms of intrusion or reexperience of event, avoidance of reminders of event, negative alterations in cognitions and mood, and alterations in arousal and reactivity for at least 1 mo. ⁵³
Major depressive disorder	Distinct change in mood, and loss of interest or pleasure accompanied by several changes, such as disturbances in sleep, appetite, or sexual desire and suicidality, for at least 2 wk. ⁵³

Atallah. Put on your own oxygen mask first: burnout. *Am J Obstet Gynecol* 2016.

constellation of issues that extend beyond burnout (eg, stress, dissatisfaction, work-life balance). However, burnout in particular has been shown to lead to a panoply of negative consequences. At the personal level, burnout can have serious, possibly lifelong, career and personal repercussions. Risk factors associated with burnout have been shown to be associated with decreased marital happiness.¹¹ Burned-out providers are more likely to experience alcohol abuse or dependence,^{12,13} and suicidal thoughts.^{14,15} Of note, about 400

physicians commit suicide every year in the United States.¹⁶ Clinically, physicians with burnout report a greater likelihood of making errors¹⁷ and providing suboptimal care,^{18,19} and their patients are less satisfied.²⁰ At the organizational and workforce level, burnout has been associated with higher absenteeism²¹⁻²³ and stated intentions to leave practice,²⁴ which can be disruptive to workflow and costly to institutions. These associations suggest that if a way is not found to heal our providers, it will be hard for them to act as healers.

Two particular aspects of burnout, the overlap between burnout and depression, and the contagion of burnout, are particularly concerning, and understanding them may facilitate the development of interventions.

Burnout vs depression. The frequent concomitant occurrence of depressive symptoms and burnout is significant. To some experts,²⁵ the difference in symptoms between burnout and depression, and the presence of work as a fixed context in burnout (in opposition to the lack of a specific context in depression), suggests that burnout is a unique clinical entity. For others, the absence of consensus on diagnostic criteria, and the "paucity of research on the relationship between the *state* of burnout and *clinical* depression," make the distinction between depression and burnout "relatively fragile," and points toward an overlap between burnout and atypical depression.²⁶ Regardless of the nosological dilemma above, suicide and suicidal ideation are more common among physicians than in the general population, and are strongly related both to symptoms of depression and to the degree of burnout.¹⁵

Burnout contagion. Burnout may be a type of emotional contagion.²⁷ Bakker et al²⁸ were able to show in an intensive care unit that, "nurses who reported the highest prevalence of burnout among their colleagues were also most likely to experience high levels of burnout themselves. Moreover, perceived burnout complaints among colleagues had a positive, independent impact on each of the 3 burnout dimensions [...], even after controlling for impact of well-known job-stressors."²⁸ Hence, the presence of a small group of burned-out providers can be detrimental to the whole unit. Unfortunately, burnout interventions are commonly administered at a granular level or in silos directed toward a specific group (eg, physicians). Given the contagiousness of burnout, any approach to ameliorating it needs to be broadened from the level of individuals or specific groups, to the level of the unit or organization.

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