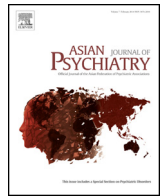




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## Burnout among doctors in residency training in a tertiary hospital

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### ABSTRACT

The mental health of doctors is an issue of growing concern all over the world as it frequently interplays with their professional trainings and responsibilities. This study was done to determine the pattern and correlates of burnout among 204 doctors undergoing residency training. Eligible participants were interviewed using designed questionnaire, General Health Questionnaire (GHQ-12) and Maslach Burnout Inventory (MBI). The mean age of participants was  $33.44 \pm 4.50$ . Ninety-three (45.6%) respondents reported burnout in the dimension of emotional exhaustion (EE), 118 (57.8%) in the dimension of depersonalization (D), and 126 (61.8%) in the dimension of reduced personal accomplishment (RPA). Factors that were significantly associated with all the dimensions of burnout were perceived heavy workload and presence of emotional distress (based on GHQ score of  $\geq 3$ ). The perception of call duty as being not stressful was negatively predictive of burnout in the emotional exhaustion subscale (odds ratio [OR] = 0.52; 95% confidence interval [CI] = 0.29–0.97;  $p = 0.03$ ), while emotional distress was a positive predictor (OR = 6.97; 95%CI = 3.28–14.81;  $p < 0.001$ ). Absence of doctor-to-doctor conflict negatively predicted burnout in the depersonalization subscale (OR = 0.36; 95%CI = 0.17–0.76;  $p < 0.01$ ), while older age (OR = 0.66; 95%CI = 0.47–0.95;  $p = 0.03$ ) and adequate support from the management (OR = 0.45; 95%CI = 0.22–0.90;  $p = 0.02$ ) constituted negative predictors of burnout in the reduced personal accomplishment subscale. Burnout is highly prevalent among resident doctors. Evolvement of comprehensive mental health services, training supports, conflict de-escalation/resolution mechanisms, and periodic assessment are indicated to mitigate work related distress with burn out among resident doctors, while improving their productivity.

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## 1. Introduction

In the context of occupational health, the problems of individual employees related to work stress are often encountered as burnout. Closely linked is that the group of stressors referred to as “daily hassles” are important sources of stress in an occupational setting and implicated in contributing to burnout. Examples of such daily hassles include: heavy workload, role conflicts, inadequate skills, poor supervision, conflicts and lack of enough time to spend with the family among others (Asken and Raham, 1983; Delongis et al., 1982; Yao and Wright, 2000). While it may be quite easy to associate

traumatic events and life changes with stress, the association between these daily hassles and stress may not be so apparent. In view of the foregoing, resident doctors are a group of professionals with vulnerability to develop burnout. This is because the pressure of work during residency training remains very high, especially as residents are expected to be proficient clinicians, educators, and administrators at the end of the residency-training period (Cohen and Patten, 2005; Omisano, 2005).

Postgraduate medical training is a stage of life in which adaptation to different stressful situations, both at professional and personal levels is necessary for acquiring attributes of maturity (Rios et al., 2006). Although it is well known that the medical career is inherently stressful (Mumford, 1983), the stress residents experience during their training due to long hours is accentuated by complex interaction of difficulties in balancing time spent in personal and family pursuits, living on a relatively low income or having huge debts (Rios et al., 2006). Several studies have identified

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factors that constitute stressors during residency training. These include; high patient work load, poor work environment, distant accommodation and a lack of recreational services within the hospital environment (Issa et al., 2009; Ndom and Makanjuola, 2004). Other factors include, indebtedness, the length of time spent in training, lack of social support, problems of relocation, difficult patients, and gender related issues (Levey, 2001; Thomas, 2004; Yussuf et al., 2006). These stressors have resulted in reported incidence of psychological symptoms with feelings of becoming less humanistic, more cynical and “burning out” during residency training (Hillhouse et al., 2000; Thomas, 2004).

While previous studies in this environment have focused on identifying stress factors as perceived by resident doctors (Issa et al., 2009; Ndom and Makanjuola, 2004), there is a dearth of information on burnout among doctors in residency training. This study was set out to determine burnout and the associated work related stressors among resident doctors in a tertiary hospital. Such information will be very useful in planning preventive mental health service for resident doctors and will also be helpful in addressing the sources of stress identified by the study.

## 2. Methods

### 2.1. Study participants

The study population consisted of postgraduate medical doctors in residency training in a foremost sub-Saharan African tertiary hospital, hereafter referred to as residents. Those included were residents who agreed to participate in the study and had been in training for at least six months to ensure that the resident was familiar with the dynamics of the day to day activities of the training. The location of study, being a foremost facility in the region with medical and dental postgraduate training across numerous fields conferred advantages in terms of the variety of resident doctors that were engaged in the institution workforce. A sample size of 196 participants was arrived at using sample size calculation formula for cross-sectional studies,  $n = Z^2 p (1 - p) / d^2$  (Araoye, 2004; Kish, 1965). Where ‘n’ is the required sample size, ‘Z’ is standard score corresponding to 95% confidence level [1.6], ‘p’ is the probability that a resident will have burnout [0.7] (Olley, 2003), and ‘d’ is the precision of the study, which is [0.05]. An additional 40% of the desired sample size (78 residents) was added in order to increase power and to compensate for those who may not respond. This is because, response rate of studies among doctors have been reported to be generally poor, and ranging between 35% and <50% (Agrawal et al., 2009; Barclay et al., 2002). Therefore, a total of 274 resident doctors were administered the research instruments. However, only 204 participants who returned the questionnaire were included in the final analyses.

### 2.2. Ethical consideration

Ethical approval was obtained before commencement of the study from the institutional research and ethical committee of the Lagos University Teaching Hospital. Informed consent was obtained from each participant after a detailed explanation of the study’s objectives with no negative consequences to those who declined. All information pertaining to the participants was treated with confidentiality. Participants with significant level of impairment due to burn out and work related stressors were counselled and referred to appropriate sections for further support.

### 2.3. Research instruments

These include a designed questionnaire for socio-demographic profile as well as relevant work related characteristics (including:

length of training, perception of work load, call duty, remunerations, preparation for exam, management support, work effects on private life) and General Health Questionnaire (GHQ-12) (Goldberg and Williams, 1988) to elicit emotional distress. Subsequently, participants were administered Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1996), a 22-item self-report inventory designed to measure the presence of burnout. MBI (Maslach and Jackson, 1996) was validated for use in Nigeria (Coker and Omoluabi, 2009). Direct scoring was used for the items in each subscale (emotional exhaustion, depersonalisation and personal accomplishments) by adding together the values of the ratings shaded. A high degree of burnout is represented by high scores of emotional exhaustion ( $\geq 27$ ) and depersonalisation ( $\geq 13$ ) and a low score of personal accomplishments ( $\leq 33$ ).

### 2.4. Study procedure

All residents were grouped according to their specialties of training for the purpose of comparison. The number selected in each department was obtained by the proportional sampling method. Participants were recruited through their respective departmental office. The chief residents were duly informed in order to ensure that the study did not interfere with the routine clinical work of the resident doctors. A covering letter indicating and outlining the purpose of the study was also given to each participant and written informed consent was obtained. In each department, residents were listed and allocated tallies. The first doctor in each department was selected by simple random technique and subsequent participants by systematic random sampling method until each quota was satisfied. The study instruments were administered over a period of eight weeks. Overall, four doctors declined consent to participate in the study.

### 2.5. Data analyses

The data collected was analyzed using the Statistical Package for Social Sciences (SPSS) version 17.0 (SPSS, 2008), with the level of significance set at 0.05. To analyze the correlates of burnout for predictiveness, the ratings of burnout were dichotomized. Logistic regression analysis was also conducted to examine the effect of confounding variables on each of the three items of the MBI (Maslach and Jackson, 1996).

## 3. Results

### 3.1. Socio-demographic and work related characteristics of the participants

The respondents age ranges between 24 and 51 years with a mean age of  $33.44 \pm 4.5$  years. One hundred and nineteen (58.3%) were males, 120 (58.8%) were married, and 98 (48%) had no children. Majority were Christians (174 (85.3%)). Approximately a quarter of the residents (50 (24.5%)) had additional academic qualification to a degree in medicine. Fifty (24.5%) respondents had been in the training for less than a year, while 23 (11.3%) for over 5 years. Two thirds (130 (63.7%)) were registrars.

Over half, 120 (58.8%) of the respondents reported various difficulties with their examinations. Such difficulties were not having enough time to prepare, lack of resources and an ambiguous curriculum. Only 58 (28.4%) of the respondents were of the opinion that their workload was not heavy. More than half, 120 (58.8%) of the respondents perceived their call duty as stressful while 14 (6.9%) participants observed no duty call due to the nature of work in their department (this applied to community medicine and family medicine departments). The majority, 173 (84.8%) respondents reported that their salary was not commensurate with their

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