Burnout: Lewin’s Heuristic, Athletes’ Preparation, and Unionization

Stephen A. Wilson, MD, MPH

(Fam Med. 2017;49(7):571-3.)

B urnout is not a word or phenomenon new to medicine. It was in the title of a 1961 Graham Green novel, *A Burnt-Out Case*, about a physician working in the Congo. In 1974 psychologist Herbert Freud- enberger coined the term to describe his observations of staff and personal experiences working in a free clinic, drawing on the dictionary definition: “to fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources.” He described exhaustion resulting from excessive work demands together with physical symptoms such as headaches, sleeplessness, impatience, and closed thinking, and shared his thoughts on approaches to prevention and treatment.

Burnout is now recognized as the triad of emotional exhaustion, depersonalization, and sense of low personal accomplishment that results from loss of emotional, mental, and physical energy due to continued job-related stress. Emotional exhaustion is the depletion of emotional energy by continued work-related demands; depersonalization is a sense of emotional distance from patients or job; and low personal accomplishment decreases sense of self-worth or efficacy related to work.

Physicians in the United States are more likely than the general population (49% vs 28%) to report symptoms consistent with burnout. Physician burnout is on the rise and gaining attention in the professional and public eye. In a 2016 survey of 14,000 physicians across 30 specialties, family physicians (55%) ranked third in burnout prevalence and rated “increasing computerization of practice” as the most significant contributor.

Burnout is associated with medical errors. Suicide, like burnout, is more common in physicians than in the general population.

Current and Future Approaches to Burnout

$B = f(P, E)$ is psychologist Kurt Lewin’s heuristic that sets Behavior as a function of a Person in his/her Environment.

The Accreditation Council for Graduate Medical Education’s (ACGME) Common Program Requirements Section VI “The Learning Environment” states requirements for professionalism and well-being. Residency programs and sponsoring institutions: “...must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients” (VI.B.1); and “...have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.” (VI.C)

For successful athletes, practice and preparation for the game is often more challenging than the game itself. Inadequately prepared athletes are less likely to win and more likely to feel betrayed or disappointed by their training. It is challenging to strike the right balance in attempts to “right-size” medical training. Simply working fewer hours is not a panacea. There are limits to the impact and practicality of reducing duty hours. Lack of preparedness for post-residency realities can lead to dissatisfaction, disappointment, and disillusionment, all breeding grounds for burnout.

Additional attempts are being made at the personal and environmental levels. In US
significant contributors to burnout. When $B = f(P, E)$, it is sensible to consider intervening on as many personal and environmental factors as reasonable to lessen the frequency and impact of burnout.

Focus group analysis of outpatient providers found patient volume and complexity were not perceived as contributors to burnout; seeing patients was felt to be the joy and heart of medicine. Significant contributors to burnout were work environment, work tasks, and “e-stress.”

Loss of agency and autonomy can fuel the burnout triad. With more physicians working as employees, more are becoming like highly skilled hourly workers on an assembly line with a diminishing sense of influence on their Environment and how to best apply their skill set. More and more time is spent doing non-clinical, non-patient-centered, nonphysician tasks. In residency training, the ACGME calls many things of this ilk “service” and negatively cites programs that do this excessively. For employed physicians, it is often called “your job.”

Anecdotes abound of physicians being replaced by management, not for poor quality care, but in favor of a lower cost nonphysician provider, based on financial data and not patient-centered data.

Physicians are not innocent, preyed upon ingenuity. We are highly paid and largely complicit, swapping a larger than expected amount of autonomy, independence, and workplace influence for more consistent hours, less call, and financial consistency of salary and benefits.

Our skill sets make us more akin to professional athletes than assembly line workers. Professional athletes are specially skilled individuals who have used unionization as a tool to decrease variance in treatment across teams and by owners, as well as a way to improve their work conditions. Their unions, however, are for themselves, not for their fans. A virtuous physicians union—the only type worth considering—would have patients and patient outcomes as the primary foci.

Physician burnout impacts the health of patients, families, and communities, and it also impacts the health of physicians and their families. Becoming better rested and more self-aware will not be enough to combat burnout. Loss of agency and meaning are large contributors to burnout. When $B = f(P, E)$, it is sensible to consider intervening on as many personal and environmental factors as reasonable to lessen the frequency and impact of burnout.
CORRESPONDENCE: Address correspondence to Dr Wilson, Director, Faculty Development Fellowship and Medical Decision Making, Education, University of Pittsburgh UPMC St Margaret Family Medicine Residency, 3937 Butler St, Pittsburgh, PA 15201. 412-784-7672. Fax: 412-621-8235. wilsons2@upmc.edu.

References
9. Hall MN. To be well, or not to be well, that is the question: what will we choose? Fam Med. 2015;47(10):819-820.