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Burnout in surgeons: talking the talk but not walking the walk

Can intervention programmes reduce levels of burnout?

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Despite previously having been a slow burner, the concept of burnout has become a hot topic in recent years, even featuring on the BBC.[1] Once relatively ignored in the medical profession, the issue is ready to become part of the zeitgeist. Erin Dean discussed the issue in the May 2019 issue of the *Bulletin*, focusing on support available to surgeons.[2]

Unfortunately, there remains a dearth of evidence-based interventions to prevent and tackle burnout among surgeons. Even less is available on the subject of system and/or organisation failure as a cause of burnout. A meta-analysis published in 2016 in the *Lancet* found that current interventions trialled in doctors had, at best, a modest effect.[3] In addition, while individual and structural interventions had some impact, there were no studies looking at a combined approach and few studies looked at long-term outcomes. Surprisingly, a literature search for interventions designed to alleviate burnout in surgeons specifically yields few results, despite the considerable research on the topic in general.

The most prevalent definition of burnout simply describes its various components: a state of depersonalisation (loss of empathy), emotional exhaustion (emotional fatigue) and a sense of reduced personal accomplishment (competence and achievement). This is a useful starting point as it upholds the inventory that is most commonly used to measure it, the Maslach Burnout Inventory (MBI).[4] However, this definition is by no means universally agreed on. The Copenhagen Burnout Inventory re-characterises burnout in terms of fatigue and exhaustion,[5] while some researchers support the notion that burnout should be considered a depressive disorder.[6] The 11th edition of the *International Classification of Diseases* defines burnout in similar terms to the MBI, but states that it is not a medical condition in and of itself.[7]

The vast majority of studies that use the MBI tend to apply different criteria to define burnout severity, with many ignoring personal accomplishment, and placing differing emphasis on depersonalisation and emotional exhaustion. The lack of consensus and differing methods for measuring burnout severely limits reliability of outcomes, reducing generalisability of results.

One way to counter this could be to separate emotional exhaustion and depersonalisation into distinct components, as suggested by Eckleberry-Hunt *et al*.[8] Emotional fatigue (emotional exhaustion) and lack of empathy (depersonalisation) are very different, with presumably differing causes and effects. Separating the two could bypass the issue with defining burnout as well as allowing for focus on their distinct pathways. An intervention to target exhaustion will look very different from one that tries to combat a loss of empathy and its detrimental effects. Designing interventions to target these individually could yield more beneficial results compared with trying to reduce levels of overall burnout.

Schwenk and Gold point out that there is a lack of longitudinal research in relation to burnout.[9] This is a serious shortcoming of the current literature. We now know plenty about the factors associated with burnout, but not enough about the relationship between these factors and burnout. How are we to design effective interventions to reduce burnout if we do not know whether the target of any given intervention is a cause or consequence? In addition, current research articles tend to report different levels of statistical analysis. Some results reported are controlled for confounding variables while others are simple correlations. This limits translatability of results, further contributing to the lack of information assisting in the design of effective interventions.

The majority of research with regard to burnout has taken in place in the US. Given the significant heterogeneity in the prevalence of burnout, it may not be possible to translate results across from specific systems or cultures. The NHS is a unique organisation, and surgeons in the UK have a unique training pathway through the foundation, core and specialty training system. Further research into the conditions surrounding burnout within this system is needed in order to gain a more accurate understanding.

In the *Bulletin*, Erin Dean highlighted support and advice networks currently available as well as reflective practice groups.[2] Although these are valuable and perhaps underutilised tools, more needs to be done in surgical departments and training programmes. However, the elephant in the room is the impact of the health system as a whole and the various employing organisations, in particular on individuals. Much is made of the resilience or 'grit' that individuals need to demonstrate. Emphasis is usually placed on the role of the individual and how he or she copes, which one could view as heaping blame for the situation on that individual. This is not helpful and could in fact make the situation worse. It may even lead to a sense of victimisation and helplessness.

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Cultivating positive environments at work where all staff feel supported could help mitigate burnout

Plenty of work has been undertaken to improve the system that trains medical students. This is where a lot of the stress begins. Workload will clearly be difficult to reduce and must be balanced with the training needs of surgeons. Despite this, more should be done to make sure that trainees do not work excessive hours and have access to mechanisms to highlight this. The recent introduction of the exception reporting system for trainees as part of the new junior doctor contract is a step in the right direction. Yet, anecdotal evidence suggests that there is significant stigma associated with using the system and concern that those in charge do not respond adequately to issues raised.

Alongside this, simply cultivating positive environments at work where all staff feel supported could help mitigate burnout. Hospital boards are trying to focus on the wellbeing of their staff by showing that the organisation cares. Having a psychological 'safe space' is very much in vogue at many big corporations and this may have a place in medicine.[10] Reflective practice is another element and encouraging attendance at Schwartz Rounds® or introducing Balint groups could be beneficial. Indeed, psychiatry trainees are required to attend and present at Balint groups as part of their training programmes.

Formal mentoring programmes have been found to reduce burnout and could be embedded in existing supervisor systems or introduced parallel to these. Medical managers and administrators realise that there is a significant staff retention issue with the NHS running at 5–7% short of the budgeted staffing. Helping build lives outside of the hospital is another important area that needs attention. Given the increasing isolation of modern life, supporting surgeons to create families through part-time training could reduce burnout.[11]

On an individual level, psychological factors such as emotional intelligence and resilience are also associated with lower levels of burnout. There is therefore a case for including some training related to these matters through either departmental teaching programmes or deanery training schemes. This problem will not go away and (as with society in general) the mantra that 'it is OK not to be OK' has not filtered into the caring professions. At The Royal College of Surgeons of England *Illness to Wellness* conference hosted in Oxford in October 2019, the themes that emerged were representative of the increasing concern among members of the profession. Identifying your own weaknesses and being able to discuss them is a major step forward. Feeling that you are empowered to make a change, not only for yourself but for others, does not appear to be on the immediate horizon.

The lack of evidence for interventions and the context of the problem in modern society means that resources and time must be allocated to this important issue. The advent of the digital era will further test our resilience, and the short and medium-term responses on a political, regulatory, organisational and individual level will cast the die on our profession for years to come. We all hope that we will be able to walk the walk.

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