Southern African Journal of Anaesthesia and Analgesia. 2020;26(6 Suppl 2):S30-31
https://doi.org/10.36303/SAJAA.2020.26.6.S2.2518

South Afr J Anaesth Analg
ISSN 2220-1181 EISSN 2220-1173

PACSA 2020 CONGRESS SUPPLEMENT

Burnout: is all the talk of burnout causing us to burn out

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Summary

There is a growing public discussion on the prevalence, diagnosis and treatment of burnout syndrome. The unclear definition and diagnostics of the burnout syndrome are scientifically criticised. Therefore, this narrative review covers various dynamics on burnout and provides insights into the objective usage of burnout.

Keywords: burnout, prevalence, diagnosis, treatment

The World Health Organization (WHO) characterises burnout as a condition of persistent occupational stress that has not been effectively controlled, including feelings of energy loss or fatigue, increased mental detachment from work and decreased professional effectiveness.[1] In the context of the workplace, burnout is defined clearly and not in other areas of life, although it is often referred to in social contexts by some authors. The 11th revision of the International Classification of Diseases (ICD 11), included burnout as an 'occupational phenomenon' and not as a medical disorder. This shows the increasing awareness in global mental health of burnout as an essential factor. At the same time, its classification as a phenomenon and not a medical disorder brings some uncertainty as to how the disorder is perceived in the field of mental health.

For more than 40 years, the burnout construct has existed and was first identified by Herbert Freudenberger in subjects employed in people-oriented professions such as health and education, where the syndrome was attributed to the incompatibility of resources with patient needs.[2] Over the years, other scholars have advocated the presence of burnout, to the point that over 20 000 citations can be found on the Pubmed and PsycInfo data search engines with the keyword "burnout".

Usually, professionals are expected to provide continued comprehensive medical and emotional care in the professions where burnout is prevalent, putting the needs of other people first. In addition, the work environment is also rife with sociopolitical imbalances with demands on diminishing resources for ever-increasing production. In the highly charged emergency medicine and critical care fields, burnout in the medical profession has been reported to occur at the highest frequency, followed closely by anaesthesiology. In the more relaxed preventive/occupational medicine disciplines, the lowest prevalence is recorded, indicating heightened stress levels as contributors.

It has been shown that burnout affecting healthcare staff has an effect on patient care quality, rising incidences of life-threatening medical errors, threatening healthy team structures and increasing turnover of employees. Importantly, burnout is seen as a contributor to the recently defined "presenteeism" paradigm that refers to the unproductive existence in the workplace of workers suffering from burnout, which has been found to cost the health system considerably more than the cost of healthcare for managing burnout.[3] Burnout can lead to disruptive conduct that affects peers and family life, leading to disciplinary action that could lead to job loss and family disruption, fuelling mental health concerns. This gives further proof of the need to consider burnout.

In attempting to reduce burnout, it is a necessary step to consider its causative factors. The syndrome has been correlated with six primary domains: job overload, loss of control, inadequate compensation, group breakdown, lack of justice, and contradictory values between work requirements and personal ethics.[4] According to the Areas of Worklife (AW) model, a conceptual structure defining job stressors and risk factors for burnout, work-person mismatches in these domains result in job stress.[4]

The Maslach Burnout Inventory (MBI) is considered the gold standard in the diagnosis of burnout, measuring 22 items on the three dimensions of burnout: mental fatigue, depersonalisation, and reduced personal achievement.[5] Sadly, the instrument is copyrighted and only commercially accessible. Furthermore, the scores are viewed as continuous points and not dichotomous, rendering unclear the differences between definite burnout and risk. Confounders such as childcare tension, spouse support, life and financial problems are also not considered in the tool. The Oldenburg and Copenhagen Burnout Inventories are other measurement instruments, both readily available, measuring only one or two of the three dimensions of burnout, thereby raising questions about reliability. In working conditions that require careful attention to detail, an instrument that goes a step further in determining cognitive disability from burnout will be of added benefit.

There is a paucity of data on the degree to which healthcare staff with burnout symptoms seek support and are actually assessed outside study settings, despite the flood of debates on the burnout definition in the media. Similarly, response rates are frequently suboptimal in study settings; it is, therefore, difficult to determine the presence of burnout in the real world and its effect on the workplace. This is exacerbated by the problems inherent with using the evaluation method referred to above. A cross-sectional analysis of burnout prevalence and risk factors in a public hospital anaesthetics department in Cape Town, South Africa, had a 59% response rate and found that only 4% of respondents met the requirements for diagnosing burnout using the MBI tool.[6]

The existence of burnout in the workplace may be under- and over-estimated without proper diagnosis. Indeed, the original MBI authors recognised the likelihood of different attitudes to affect test scores through burnout, and proposed blinding before and during testing.[7] Subjectivity also plays a part in the understanding of burnout, where no proper instrument of measurement is used. In this climate of declining healthcare resources, other mental disorders, socio-political agendas and weak work ethics are several explanations why healthcare staff would overestimate burnout. The idea of group mentality, which explains how people can be motivated on a mostly emotional rather than logical basis by their peers to follow those behaviours, may also affect the mass diagnosis of burnout without empirical proof. On the other hand, because of the burnout effects impairing their ability to relate symptoms such as poor personal achievement, health professionals suffering from burnout can fail to identify the condition in themselves; supervision by colleagues therefore plays an important role.

In addition, the MBI instrument has been criticised for lacking precision in various dimensions. For instance, there is substantial overlap with pathologic depression with regard to exhaustion.[8] In clinical disciplines related to traumatic events such as critical care and trauma, where death is a frequent occurrence, the depersonalisation factor can be clarified by the often required need to separate oneself. There can be a number of reasons for the lack of personal achievement, such as life events, financial challenges that have no effect on burnout. The weaknesses of the MBI tool should, therefore, be kept in mind, and burnout should be diagnosed after careful evaluation. In addition, it is important to perform longitudinal follow-up research of burnout cases in order to determine the true natural history of the disease and its connection with other medical disorders.

It is also therefore necessary to ensure that it is adequately measured and does not end just in casual conversation, as essential as talking about burnout is. In addition, value can be added by instruments measuring characteristics that have an impact on patient safety in burnout. What happens beyond diagnosing burnout is also relevant to remember, explicitly finding constructive ways to boost well-being. Effective strategies are those that are directed at the organisation as well as the person.[9] Locally designed workflow enhancements and clinical assistance are included in organisational initiatives, while individual tailored strategies include resilience and mindfulness training, small group meetings to facilitate interaction and community support.

As a final point, the Maslach Burnout Inventory could be used as a diagnostic or outcome instrument, but with different cut-off points and revision of the weighted significance of the different domains. It should be remembered that there is no evidence of the validity of the MBI as a diagnostic instrument as it does not address cultural, legal and social determinants.

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