OPEN ACCESS
Saudi Journal of Medicine
Abbreviated Key Title: Saudi J Med
ISSN 2518-3389 (Print) |ISSN 2518-3397 (Online)
Scholars Middle East Publishers, Dubai, United Arab Emirates
Journal homepage: http://scholarsmepub.com/sjm/

Original Research Article

Burnout Syndrome in Medical Fraternity

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| **Received:** 03.03.2019 | **Accepted:** 15.03.2019 | **Published:** 31.03.2019
DOI:10.21276/sjm.2019.4.3.13

Abstract

Till date there is no definite basis of burn out syndrome. There is vast difference in the bookish knowledge and practicability of this particular so called syndrome or disease. It's the aftermath of over work, loss of self confidence and reduction in satisfaction. But till now it's counted as a result of inadequate treatment of chronic stress. In this publication I have tried my level best to explore the current concept of this syndrome which could affect the future and contemporary generations. A variety of factors play into burnout among healthcare professionals, many of which are non-modifiable such as gender, socio-demographic variables, personality, and age [1]; however, the top cited reason for burnout is work overload [2]. When a person works in a high stress field such as healthcare they are exposed to emotionally draining experiences all the time so the added pressure of working while the hospital is understaffed only piles on to that stress. Many studies within hospitals have found a direct link between reducing workload and reduced burnout among healthcare professionals [3] which led to a significant drop in patient deaths [4]. It is impossible to expect for us as healthcare professionals to do the work of two or three people and still give the same quality care to a patient as usual. Burnout only leads to mediocre patient care and a poor work environment, which continue the vicious circle to only cause more burnout. and Medical institutions across the world have attempted to provide both preventive and curative care for healthcare workers who are at risk for experiencing burnout; however, many of these attempts were unsuccessful and do not address the underlying problem: overworked staff. Goal: The goals of this study were: to identify the specific stressors of high intensity in the hospital physicians work environment, to discover whether and how certain stressors can affect the appearance of burnout syndrome at work in a hospital physician, to determine whether certain individual factors influence the occurrence of burnout syndrome at work. Methods and subjects: Study was conducted on medical professionals working at Govt. Medical College, Amritsar. Results: The study comprised 64.8% hospital doctors (specialists and doctors on specialization) of a total 321 employees in various departments. High level of emotional exhaustion was recorded in 45.9% a high level of depersonalization in 54.8 %, and a low level in perceptions of personal accomplishments in 45.2% of respondents. Conclusions: Continuous exposure to stressors at the workplace, such as work at shifts, excessive workload, poor communication with superiors, and lack of continuous education of hospital physicians can lead to mental and physical exhaustion, professional burnout. Socially there was no source to make amendments in the working conditions of the professionals. High-quality controlled studies on burnout syndrome are lacking. A standardized and internationally accepted diagnostic instrument with a validated rating scale should be developed. The etiology and pathogenesis of burnout should be studied with special regard to the possible role of neurobiological factors. Treatments for it should be studied systematically so that their effects can be judged at a high level of evidence. In view of the current lack of knowledge about what is called "burnout," the term should not be used as a medical diagnosis or as a basis for decisions regarding disability or other socioeconomic matters.

Keywords: Hospital doctors, stress, stress at work, burnout syndrome at work.

INTRODUCTION

"Burnout syndrome" is now a common reason for medical excuses from work, and thus an important topic in health-related economics. Much research is still needed to establish the scientific basis for this entity, the criteria by which it might be diagnosed and classified, and how it should be treated. A systematic review of this topic, previously published as an HTA report, is presented here together with a selective overview of pertinent literature. Burnout as a phenomenon has probably existed at all times and in all cultures. Without mentioning burnout explicitly, Bäuerle [5] gave a very accurate description of the phenomenon resulting from experiences in supervising social education workers and social workers. She observed "the reduction in psychological resilience only halfway through their career; the appearance of a resigned attitude and resentment as a consequence of having more demanded of them than is humanly possible; the formation of an authoritarian character

structure and a tendency to repressive behavior as a consequence of professional disappointments; an inner withdrawal from all people and all human problems as a defense mechanism on the part of those who – without receiving any help themselves – spend their professional lives having to find socially acceptable solutions for difficult personalities in hopeless situations." Psychiatry as a medical science has so far avoided addressing the phenomenon of burnout, whether because it is put off by the fuzzy definition of the syndrome, or because the overlaps between it and established psychiatric diagnoses such as depression or adaptation disorder seemed so large that it appeared unnecessary to validate burnout as a diagnostic entity. As a result, burnout is not even mentioned in DSM-IV, and in ICD-10 it is listed in the residual category "Z 73, problems related to life management difficulty" as "burnout: state of vital exhaustion". So far as the authors know, there is no intention to include it in DSM-V or ICD-11.

MATERIALS AND METHOD

The study was carried out in Govt. Medical College, Amritsar. This was a comparative cross sectional study of the prevalence of Burnout Syndrome and Depression between clinical and non-clinical staff groups of subject were studied. They were 1) An index group of clinical staff 2) Comparison group of non-clinical staff matched for gender and age. Participants gave informed consent. The sample size was therefore calculated using prevalence of 50% & at a confidence level of 95%. Sample size for estimated population of 500 which is < 10,000 was utilized to arrive at the 216 for clinical and 216 for non-clinical staff. The sample was selected using a proportional stratified sampling technique with the help of disposable 5 cc. syringe with extra needle. The population of clinical staff was then grouped, according to job description, into doctors, nurses, pharmacists, occupational therapist/ physiotherapists and social workers of staff GMCH, Amritsar. The non-clinical staffs were grouped into senior staff of central administration, finance/hospital records, engineering/works & maintenance, hospital library, hospital security. The proportions were 180/450, 101/450, 50/450, 21/450 65/450, respectively, (450 being the sum total of senior non-clinical staff in the GMC, Amritsar. The subjects for the two groups were randomly selected and matched for age and sex.

RESULTS

The study population consisted of 31 subjects, 161 clinical staff and 162 non-clinical staff. However, among the clinical staff, 19 did not return their questionnaire, 11 returned incomplete questionnaire with missing data. Among the non-clinical staff, 20 did not return their questionnaires, 12 returned questionnaire with missing data. This left a total of 370 questionnaires (186 clinical and 184 non-clinical) for analysis, amounting to 84.86% completed and analyzable responses. Out of the 161 clinical staff, 68.3% were males and 31.7% were females. And of the 160 non-clinical staff, 63.5% were males and 36.5% were females. The ages of the respondents ranged from 24 to 64 years with a mean age of 36.84 years (SD ±7.412) for the clinical group and age range of 21 to 60 with a mean age of 36.76 years (SD ±7.492) for the non-clinical group. Among clinical staff that had overall burnout 17(40) belong to the group with 30 years in service, the observed difference within the groups was found to be statistically significant 2 (χ = 6.035, df=3, p = 0.049) (Table-3) In this study frequency of burnout among females is higher than that of males (33.9% versus 15, 7%) and 2 with a statistically significant difference (χ = 7.872, df=1, p = 0.005) (Table-4). Prevalence of overall burnout was higher among clinical staff than the non-clinical staff 21.5% versus 12.5% and the difference 2 was statistically significant (χ =5.31, DF=185 p=0.021).On the emotional exhaustion subscale the prevalence were 77.4% versus 63.6% for clinical and non-clinical groups respectively. But the difference was still 2 statistically significant (χ =8.516, DF=1 p=0.004) (Table-2,) Out of the 216 clinical staff, 68.3% were males and 31.7% were females. And of the 162 non-clinical staff, 63.5% were males and 36.5% were females. The ages of the respondents ranged from 20 to 65 years with a mean age of 36.84 years (SD ±7.412) for the clinical group and age range of 21 to 60 with a mean age of 36.76 years (SD ±7.492) for the non-clinical group. Among clinical staff that had overall burnout 17(40) belong to the group with 30 years in service, the observed difference within the groups was found to be statistically significant 2 (χ = 6.035, df=3, p = 0.049) (Table-3) In this study frequency of burnout among females is higher than that of males (33.9% versus 15, 7%) and 2 with a statistically significant difference (χ = 7.862, df=1, p = 0.005) (Table-4). The prevalence of depression in male and female was 7.8% versus 26.9% and difference 2 was statistically significant (χ = 3.427, DF=1 p = 0.043). Prevalence of overall burnout was higher among clinical staff than the non-clinical staff 21.5% versus 12.5% and the difference 2 was statistically significant (χ =5.31, DF=185 p=0.021).On the emotional exhaustion subscale the prevalence were 77.4% versus 63.6% for clinical and non-clinical groups respectively. But the difference was still 2 statistically significant (χ =8.516, DF=1 p=0.004) (Table-2) Nine (22.5%) of those found positive for overall burnout had depression in contrast to 11(7.5%) of those who were found to be negative for overall burnout and had depression with a 2 statistically significant difference (χ =7.238, DF=1, p=0.007), Twenty 20(10.7%) respondents of the clinical staff had depression on the BDI scale, while 14(7.6%) respondents of non-clinical staff had depression on the BDI scale, and the difference 2 was not statistically significant (χ =1.096, DF=1, p-value 0.295).

Table-1: Estimate By Frequency of Three Dimensions of Professional Burnout & Intensity % Mean Values in Subjects

PERSONALITY DIMENSIONS MBI	N (%)	Mean ±SD*
Personal Accomplishment (PA)		38.11±11.39
High Level	26 (16.8)	
Moderate Level	47(31.9)	
Low Level	74 (46)	
Emotional Level		10.9±6.9
High Level	54 (32.9)	
Moderate Level	34 (26.8)	
Low Level	49 (34.8)	
Depersonalization (DP)		6.65±5.6
Low Level	65(44.8)	
Emotional Level	51 (54.9)	
High Level	38(27.6)	

Observation

Table-2: Effect of Age, Sex, On Clinical Vs.Non Clinical Group

	Socio-demographic Variable	Nonclinical group Frequency	Clinical group Frequency (%)
Gender	males	117(65.99)	127(68.0)
	Females	68(34.7)	101 (32.0)
Age groups (Years)	<35	(76)45.9	77(42.7)
	35-49	98 (32.9)	109(56.9)
	50-65	13(7)	6(3.09)
	>65	13(2.5)	2(1.7)
Marital Status	Married	123 (16.0)	143 (76.9)
	Single	39 (21.8)	41 (23.8)
	Widowed	5(3.2)	8 (4.9)
	Divorcee	5 (1.8)	5 (2.8)
Profession	Doctors		54 (32.8)
	Nurses		98.9(2.4)
	Pharmacists		16(7.4)
	Physiotherapists		12(5.3)
	Work (Engineers)	70 (43.9)	
	Security	42 (23.8)	
	Library	9(4.6)	
No. Of Years in service	11.6	118 (65.9)	
	21.6	45 (23.7)	
	31.9	16 (7.9)	
	10.7 (6.8)	6 ()2.1	

Table-3: Comparison of Emotional Exhaustion (Ee) In Clinical and Nonclinical Staff

Category	Emotional Exhaustion (Positive)%	Emotional Exhaustion (Negative)%	Total (%)	Chi square	P Value (P)
Clinical staff	144	42	186	7.765	0.005
Non- Clinical staff	117	66	184		

Table-4: Socio-demographic correlates of overall Burnouts in Clinical Staff

Variables		Overall burnout Freq %	No Overall burnout Freq %	Chi square	Degree of freedom (d_f)	pvalue
Gender	male	20(32.8)	20(34.6)	7.342	1	0.005
	female	20(20)	107(50.87)			
Marital status	Married	27(32.7)	27(12)		1	.870
	Unmarried	13.8 (32.6)	14(21)	0.044		
Age group	35	13.6(43)	12(4.4)		3	0.434
	35-49	26.8(45.8)	28(23.8)	3.56		

	50-65	1(11.7)	13(7.9)			
	>65	0(0)	10(18.7)		3	0.049
Years In-service	10	17(23.9)	17(2.6)	11.45		
	11-20	17(32.8)	17(45.7)			
	21 30	4(5.9)	27(09.98)			
	>35	1(2,6)	1 (2.8)			
Professional Category	Doctors	10(54.0)	10(8.98)	5	4	0.211
	Nurses	24(54.87)	24(32.8)			
	Pharmacists	2.98(3.7)	2			
	Physiotherapists	3.98(6.98)	3			
	Social Workers		1	0	1	
Supervisory role	yes		11	38	0.027	0.211
	no		29	108		

Table-5: Comparison of burnout elements among health professionals

Profession DP	Number (N)	X±SD	df	F	p	Remark
Doctors	56	9.89±7.97	277	4.06	0.003	S
Nurses	165	12.30±7.97				
Psychotherapists	3	4.33±4.51				
Radiographers	5	7.60±2.41				
Lab Technicians	52	14.83±8.18				

DISCUSSION

In this study, gender and marital status were found to have no effect on depression, burnout and job satisfaction. Among the studies conducted in our country to investigate the burnout, some studies reported the gender as an efficient factor [6-8], whereas others found it to have no effect [3]. In our study, marital status was also found to have no significant effect on burnout and job satisfaction. There were studies that showed that marital status was effective on burnout and job satisfaction [8, 9], as well as other contradicting studies [7]. In a study performed on emergency service personnel, gender and marital status were found to have no effect on burnout and job satisfaction [10]. Age factor was found to be significant for MBIEE and depression scores. It was revealed that 18-24 age group experienced less emotional exhaustion compared to 25-29 and 30-34 age groups and had significantly lower depression scores compared as to the over 40 age group. When working time was considered, those who worked in the emergency service for less than one year had lower depression scores compared to those who worked for at least 10 years, a higher personal accomplishment compared to those who worked for 5 to 9 years and a higher job satisfaction compared to those who worked for 2 to 4 years. These results demonstrated that healthcare personnel who were working in the emergency service had a higher personal accomplishment and job satisfaction within one year and that the level of burnout increased and job satisfaction decreased with prolonged employment time. For this issue, Erol *et al*., [11]. conducted a study on residents and they reported that the level of burnout decreased and job satisfaction increased with advanced age and prolonged employment time [7]. In the study performed on the nurses by Barutçu *et al*., the investigators reported that the level of burnout decreased with advanced age and prolonged employment time [1, 2]. The difference observed in our results might be explained with the fact that the first one-year period might be too short to feel work-related stress that would result in burnout syndrome. Hence, in a previous study, nurses who had worked for less than one year were excluded from the study due to this reason [1, 3]. In analysis performed by the occupations, it was found that paramedics had significantly higher job satisfaction compared to nurses and had less emotional exhaustion compared to both doctors and nurses. This result may be attributed to several reasons. Paramedic position is a new field of occupation in our country. Therefore, employment time in the occupation and mean age of all paramedics were smaller compared to nurses and doctors. On the other hand, as paramedics begin to their career following high school education or a two-year education in a college, they begin to work at an earlier age. Therefore, comparing the results with each other may be misleading. More objective results will be obtained in the new studies that will be conducted in the next years. When the effect of the hospital in which the subject was working was evaluated, it was found that the workers of state hospitals were more depressive, had a lower personal accomplishment and a greater emotional exhaustion compared to healthcare personnel who were working in 112 emergency services. This result might be attributed to more oppressive and controlled working environment of the worker of state hospital and, in contrast, for the workers of 112 emergency services, to greater freedom and the ability to take initiatives to resolve the problems. It was found that emergency department personnel who willingly chose their job had less emotional exhaustion, desensitization and depression and higher job satisfaction compared to those who unwillingly chose their job. These results

demonstrated that willingly choosing the job had a prominent effect on burnout and job satisfaction. As seen in our study, similarly in many studies, significant effect that willingly choosing the job had on emotional exhaustion and desensitization indicated that whether willingly or unwillingly choosing the job markedly predicted the burnout [3, 5]. "Satisfaction with work environment" was detected to be another factor that showed a marked effect on burnout, job satisfaction and depression. As an expected result, a person who is not satisfied with his/her work environment will experience burnout syndrome extensively, will be desensitized toward the patients of whom he/she takes care and will have a low level of job satisfaction. Hence, Taycan *et al.*, reported high depression levels and burnout syndrome rates in the nurses who were not satisfied with their working life [1, 4].

The Limitation of Study

There was a higher prevalence of psychological morbidity among the doctors as compared with the nurses. Burnout levels were also higher among the doctors as compared with the nurses. Our study was constructed just only in one city, the work sufficient criterion that affected the burn out at most was not evaluated fairly. Consequently, evaluating the mental health and working conditions of the people who work in a unit with an intense work pressure, which requires efficient, proper and rapid intervention to the patients, would help to improve the quality of the services given in this field. It is critical to determine the levels of burnout, job satisfaction and depression of the emergency service personnel and to establish and properly. Adjustment of the factors that affect these levels has to be worked out. For example, several adjustments such as the assignment of the people with willing to work in the emergency field in the emergency department, increasing the knowledge and the experience of the workers trough vocational trainings within the first years, during which burnout is relatively less common, ensuring the improvements to increase the job satisfaction of the workers will help the emergency services to proceed better.

CONCLUSION

Our organizations are working in most of the cases under stress, just trying to survive every day to the incessant deal of work [12]. Is global shared with several other countries in public national health services but high-quality controlled studies on burnout syndrome are lacking. Therefore, there is a need for epidemiological and health-economic studies on the prevalence, incidence, and cost of burnout. In some countries, there are some really good examples of National Health Service organizations supporting their staff well and producing high levels of job satisfaction, but there is a need to establish homogenous standards all over the national territory on workload and about the procedures that have to be implemented for the prevention of burn out in our wards. Our profession is increasingly controlled by people not directly involved in day-to-day patient care. It is time for physicians to take back the leadership of their clinical practice [12]. We have to create better conditions for a happy workforce and for happier doctors in our hospitals.

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