Clinical Surgery Journal

ISSN: 2767-0023

BURNOUT didn't used to be a Medical Issue

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Article Type: Editorial

Compiled date: February 24, 2020

Volume: 1

Issue: 1

Journal Name: Clinical Surgery Journal

Journal Short Name: Clin Surg J

Publisher: Infact Publications LLC

Article ID: INF1000015

Keywords: Burnout; Psychological; Surgery

Cite this article: John J. Gleysteen. Burnout didn't used to be a medical issue. Clin Surg J. 2020;1(1):1–3.

Editorial

Burnout is a psychological state of mind which arises from distress and disfavor with a work-related course of life. Burnout has been linked in recent years to life in the medical world, during schooling, training, and subsequent professional practice. In fact, burnout has become an in-word for any topic of medical exasperation today. For those of us older folks in medicine, the question seems to be "did we face burnout at some earlier time and not perceive it?". And so the definition seems to have changed. To me it has meant "I've had it! My fascination or drive is gone, and I want no more!" Contemporary literature suggests that burnout today means "I'm in over my head! I've made a mistake and this is too demanding!" My general surgery career has been spent entirely in academic surgery (two different institutions). My father was a successful trial attorney, and I was a first son and his only child to pursue a medical career. During my schooling and training, I was never overcome by the various elements described as parts of physician burnout. That doesn't mean it was a lovely experience. I wish to make some comparisons of my developing years in medicine to those of other persons whose time spent in the same effort has led to displeasure, struggle, and termination. Many men and women with aspiration for a surgical life have had goals or rationale that were similar to mine of 40-50years ago. Perhaps attitudes were different or some other element appeared during this interval. Perhaps it's the change in definition. I feel qualified to write about these comparisons because my career has always been alongside surgical residents (and students).

My own aspiration for a medical career began with a high-school Vocations course assignment; I chose heart surgery at a time in the 1950s when the field was just beginning. That surgical interest, and even the cardiac specialty, persisted into my actual training. Thus when my college years started, I signed up during the first year for a pre-medical science curriculum. After four years I received a college liberal arts degree, but I felt prepared to begin medical school. That excitement significantly diminished when confronted with the academic difficulties of the first and second years, but my aspiration and goal never waned. I was a member of a medical fraternity in those years that provided lodging, meals, and some companionship against the rigor of the study schedules. I recall considerable stress with the extra study hours required, and I used a small amount of amphetamine (Dexedrine) when studying for several large tests. I faced difficulties with an interest in finding a resolution, and believed the resolution would leave me still determined. I never considered quitting or modifying my goal. The causes for burnout or chronic stress in the early years in medical school seem to arise from study exhaustion primarily, and strained finances secondarily. The latter was not

an issue of concern for me. Exhaustion is caused by heavy study requirements, sleep and exercise deprivation, and by overlooking meal and nutritional requirements. Most likely my fraternity life helped to reduce some of this. The frequency of some element of burnout in medical school has been reported as high as 50% [1], and it has led to both academic and goal disinterest, substance abuse, depression, medical school failure and even suicide ideation. When the last two or the clinical years of medical school arrive, burnout can remain but its causes change somewhat. For me, the last two years of medical school were clinical rotations in all medical fields, such that my stress seemed to end, and the potential life of a doctor started to be conceivable. As for my surgical goal, those years provided some enjoyable exposures to several alternative fields (e.g. anesthesiology, psychiatry), but my goal remained fixed. Again I was ready and excited at the end of four years for the next step: surgical residency training. For other students with undeveloped or less clear goals, the last two years may seem a continuum of the first two. Whereas study hours may be less, emotional stress can arise from poor or absent feedback from senior doctors, hostile attitudes toward training, a sense from menial task assignment given to students that physician life may be compassionless, a sense that doctors can't have mental difficulties, and again that financial debt is looming overhead. These could all have been concerns 50 years ago, but my impression is that they have become more pronounced. Why? Perhaps because the number of students in medical school has increased (by 60% in the last 50 years), that more students find themselves alone amidst the multitude, and that clinical demands and patient volume in academic centers have increased such that senior doctors feel too busy to teach those at junior levels. With awareness of this problem, a number of medical schools have developed "student wellness centers" or actual divisions within their Dean's Office hierarchy to address the problems, both potential and real, of student burnout. Also available is an online program entitled the "Medical Student Well-being Index" which can be taken by any student, 100% anonymously and repeatedly, to self-assess their stress and burnout levels [2]. For me at this point, the next step was surgical resident training. I had grown up, gone to college, and gone to medical school in mid-western USA – actually all in Iowa. So now I wanted to go elsewhere. At that time one could travel about and stop in or schedule visits with medical school interviews according to the student's rather than the institution's schedule, and I did so. Although I was primarily exposed to general surgical training at those visits, I chose institutions where cardiac surgical training was developed and noteworthy. I chose and was matched to go from Iowa to Duke University in North Carolina. I spent a year there in surgical internship. The pace was exhausting, it included vascular but not cardiac rotations, and interns had a litany of duties including attendance at operations, but never as a surgeon under instruction. Despite the exhaustion entailed in the daily required waking hours, responsibility was levied only for traditional intern duties (chart dictations, autopsy requests, beeper responses to nurses, patient history and physical write-ups, etc). And because those duties were so uniform between surgical interns, they were distasteful but not depersonalizing. And we knew the year would end. Through the surgical leadership at Duke, and due to the availability of the Vietnam War-era Berry Plan for physicians in training, I was able to obtain a two-year Public Health Service Commission with the Health, Education, and Manpower Training Bureau, National Institutes of Health (NIH), directly after my internship. Admittedly this relieved the stress and potential for burnout that I might have otherwise developed. Those years were not clinical, but "scientist-administrative" in several of the branches of the NIH Bureau. The years also gave me another opportunity to look for surgical (and cardiac) training programs. When my Commission ended, I had seriously considered a number of alternative training sites, and elected to continue my cardiac surgical aspirations in Alabama at UAB. The UAB experience in 1970 was culturally different from life in the Midwest, and it was a pyramidal program through general surgery, before any cardiac training. There were more of us at the start than would finish in five years – my first stress encounter. Though familiar by now with acute care and the surgical theatre, I was not at the technical level as my colleagues which weighed upon the operative opportunities I would get during the next two years. I was married, but we had no children such that home-life became a liberation from the anxieties of those hospital days in training. I was invited after two years to do a year of laboratory research (in a field of clinical interest – gastric surgery) with a congenial surgical faculty member. An uncertainty as to continued surgical training at UAB persisted, and was a source of anxiety; the easier life in laboratory research counterbalanced that worry. My own surgical enthusiasm remained strong, but my cardiac surgical aspiration began to wane. In fact, as I began my fourth year of residency, I had eliminated both cardiac and vascular surgery from my career possibilities, and had decided on an academic gastrointestinal surgical career. My technical comfort had advanced, and I was confident of my surgical skills. Any daily clinical stress was overlooked because I had achieved a spot on the crest of the pyramid. Apart from faculty I was the senior member in each resident rotation, and performance of surgical care was exhilarating. Surgical resident training hours were extensive and unpredictable, but my wife was happy with our life together. I worked on the side in a surgical GI lab, and I wrote some clinical papers. My next step in life was to be my academic career.

Burnout with its three progressive subscales: 1- emotional exhaustion, 2- depersonalization, and 3- sense of low accomplishment has a vexingly high frequency among residents in training: 65 – 75% [3-5]. Most individuals suffer from the first two subscales listed, whereas a few have all three. The frequency of this is higher in the surgical fields (52-54%) versus internal medicine or pediatrics (43%), or anesthesiology (42%) [6]. Yet the higher frequency in surgical fields may actually be lower than expected due to typical surgical resident sentiments: limited familiarity with symptoms of depression, perception that some of

those symptoms may be normal in surgical residents, and fear of being labeled inadequate, underperformer, or the weakest link. 5Perhaps this last sentiment is a reason to favor a pyramidal program. The objective is to promote attrition in the first years for residents who become less fascinated with a surgical career. Yet as I've recognized in my academic career, success with this system requires senior faculty to be critical but open, fair and receptive; otherwise, residents seek advice from junior faculty and begin to get lost and disgruntled. I've worked closely – clinically – with a variety of personalities – both men and women – who were driven by their aspirations to be a caring physician and a skilled and confident surgeon. Gender has often signaled a disparity in accommodation to surgical training requirements. I recall several women, none of whom were married during training, who sought to project their social and knowledge skills as greater than those of their male colleagues, in order to attract attention and more opportunity from their male surgical teachers. Some of them accepted nicknames and all of them overlooked exhaustion in order to display camaraderie with their surgical team. One particular surgical resident, older than her trainee peers and a Catholic nun, was determined to become an international mission surgeon. This was a drive that surmounted all criticisms and derisions she encountered during her four years of training. Another difference today from 45 years ago involves the course a resident might follow to become an academic surgeon. Whereas the older track required two to three years of laboratory research during a five to six-year residency, more recent trainees may have limited laboratory or entirely clinical research assignments that can lead to a university academic position. The change has occurred partly due to altered funding sources, but also due to increased clinical demands on academic faculty. It has had a favorable effect on surgical trainees because it supports their clinical role at the hospital, i.e. a reason they wanted to become a surgeon. Several residents, particularly in the later years of my career, changed very strong intentions of private practice into decisions to seek a university position, even if temporarily. Nothing (for them and for us) has been lost; we need to promote that new outlook. I don't want to say that we had different views or experiences 45 years ago as surgical residents. The training environment was just as demanding and unforgiving as it is today. Admittedly technology is more advanced today such that one could live and perform in greater isolation years ago, perhaps less aware of alternatives or comparisons in lifestyles or opportunities. We recognized and accepted our trainee position, observing and admiring those who had achieved the "surgeon" title and who had surgical successes in front of us. This provided us with appeasement and ambition to continue and to accept. Lebares et al. [5] talk about 'disposition mindfulness' or awareness to what one is thinking or feeling at the moment as a means of reducing or avoiding burnout symptoms. Perhaps this was a critical part of our ability to tolerate stress as a means to achieve the demands we faced. But we did it. It wasn't easy, but it seemed worthy. We expected difficulty, and we were set to surmount it. Amidst this there were disappointments, times of personal failure, and erroneous decisions, but always a strong desire to learn and do better. We were spurred on by doctors or teachers who wanted us to succeed in order to make them feel justified in taking on an educational mandate. Why should that be any different now?

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