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Research Article

The inevitability of physician burnout: Implications for interventions

Anthony Montgomery*

University of Macedonia, Greece

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ABSTRACT

For physicians, burnout is the inevitable consequence of the way that medical education is organised and the subsequent maladaptive behaviours that are reinforced in healthcare organisations via the hidden curriculum. Thus, burnout is an important indicator of how the organisation itself is functioning. A central theme in this paper will be the degree to which the organisational systems are responsible for the disconnect between performance and physician health. Healthcare pays considerable 'lip-service' to systems approaches, but in practice it valorises the role of the individual physician in terms of both success and failure. Thus, this contradiction needs to be addressed.

1. Introduction

Burnout is especially problematic for individuals who are at the frontline of their professions. The impact of this chronic condition on physicians is particularly important given that their actions are so directly linked to the mortality and morbidity of patients. The medical profession is acutely aware of this problem and many interventions have been developed to ameliorate the antecedents and consequences of burnout. However, there has been a tendency in medicine to view burnout from a pathogenic perspective which has lead to solutions that seek to "treat" it either via modifications in the work environment or up-skilling for the individual (or a combination of both). All three approaches are rooted in the notion that burnout is ailment that needs a cure.

Burnout should be viewed as an obvious outcome of systems that are developed within medical education and fostered all through the career of physicians. Ironically, we could view job burnout as an indicator that the system is operating 'correctly'. Therefore, researchers need to view burnout as the by product of a well-organised system, and congruently interventions need to address the process issues involved in the *long term* development and maintenance of job burnout.

1.1. Rationale, objectives and methodology of the paper

This paper is a conceptual paper that utilises the principles and methods of meta-synthesis (Schreiber, Crooks, & Stern, 1997) to address the central question; *Is physician burnout an appropriate and expected response to medicine as a system?* The objectives of the paper are to: (1) identify the key elements in the career of a physician that contribute to job burnout, (2) delineate the systematic nature of this process, and thus highlight its incremental chronic nature, and (3) review the implications of treating burnout as a systematic problem for interventions.

This paper has three parts. Part one will review the evidence from medical school, the organisational culture of the hospital and the phenomenon of presenteeism. There are many aspects of medicine that one could examine, but these three elements provide the most compelling examples as to the systematic nature of the problem. The first two cover how education and organisational climate favour particular behaviours, and presenteeism provides the perfect link between education/culture and performance. Part two of the paper will review the implications for interventions in detail. Our implications will have ramifications for other human service organisations, but healthcare is an exemplar industry to focus on. Healthcare professionals represent a significant proportion of the workforce in every developed country, and the need to support them will only increase as we go forward into the future. Indeed, in 2008, it was estimated that 70% of the health budget in Europe was allocated to salaries and employment related costs (Commission of the European Communities, 2008), while roughly 10% of the active EU workforce is engaged in the health sector in its widest sense (European Observatory on Health Systems & Policies, 2010). Finally, part three will provide final reflections on the problem.

* Correspondence to: Department of Education and Social Policy, University of Macedonia, Thessaloniki, Greece. Tel.: +30 2310809381.
E-mail addresses: antmont@uom.gr, monty5429@hotmail.com

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1.2. The learning environment of the medical school

Medical schools train future doctors to become successful physicians. The purpose of medical education is to provide medical students with theoretical knowledge, skills, clinical and practical competence, professional and ethical standards (Liaison Committee on Medical Education, 2012). Unfortunately, medical school training is heavily skewed towards the technical skills associated with being a doctor rather than the interpersonal skills associated with being an active member of an organisation (Montgomery, Todorova, Baban, & Panagopoulou, 2013). The two issues have been unnaturally separated, as is highlighted by the recent American Medical Association survey indicating that the majority of physicians do not feel responsible for reducing healthcare costs (Tilbert et al., 2013).

During their medical school years, medical students are actively shaping their professional identity and their perception of what comprises "good and bad doctoring" (Elliott et al., 2009; Hafferty, 1998). Not surprisingly, the critical problems that continuously pervade the profession; burnout and medical error, have their roots in medical education (Dyrbye et al., 2010a; West & Shanafelt, 2007; West et al., 2006). The challenge for medical education is to maintain knowledge about reality in clinical practice, understand what is happening outside the lecture rooms and produce creative solutions using the knowledge and skills of all within the organisation (Gaufberg, Baumer, Hinrichs, & Krupat, 2008; Gaufberg, Batalden, Sands, & Bell, 2010; Hojat et al., 2009). That's the ideal, but the reality is significantly different.

The learning environment of a medical school consists of both the formal and hidden aspects that influence medical students' professional identity (Hafler et al., 2011). It is widely recognised that a big part of the learning is taking place outside the classrooms and clinical settings as part of a "hidden curriculum" (Hafferty, 1998). Thus, the formal culture may value professionalism, but the hidden one valorises performance and competitiveness above collaboration. The hidden curriculum contributes to the erosion of professional behaviour and an increase in cynicism (Feudtner, Christakis, & Christakis, 1994). Retraining healthcare physicians after they completed medical schools and residency training has limited effectiveness, as certain maladaptive behaviours (e.g., non reporting of medical errors or inappropriate self-treatment) have become deeply embedded. Therefore, reframing culture and what represents the norm has to happen early on in the medical school (Elliott et al., 2009; Brainard & Brislen, 2007; Cutillo, 2000).

Despite the recommendations of the US Liaison Committee on Medical Education (LCME) (Liaison Committee on Medical Education, 2012) that medical schools should ensure an appropriate learning environment and encourage evaluation and improvement, it remains unclear as to the best way to promote and evaluate professionalism in medical school, given that professionalism seems to be context-related (West & Shanafelt, 2007). Thus, medical schools are still very far away from being a *learning organisation* whereby clinical practice is utilised as a lever for change. A learning organisation is one that fosters co-operation between individuals and groups, free and reliable communication, and a culture of trust (Argyris, 1982). Such practices are highly desirable in medical schools, but the picture for new physicians is bleak. A systematic review of burnout during residency training indicates that burnout is prevalent among both medical students (28–45%), residents (27–75%, depending on specialty) (IsHak et al., 2009). In terms of what causes burnout, the review is not revealing, with the authors identifying the following factors as contributing to burnout; time demands, lack of control, work planning, work organisation, inherently difficult job situations and interpersonal relationships. In other words, being a member of the organisation causes burnout!

1.3. Looking at the hospital

Hospitals are unique organisational environments where the degree to which professional roles are strongly embedded represent a significant barrier to change (Mintzberg, 1997). Moreover, hospitals are organisations under considerable stress. For example, in the UK surveys show that continuity of care for the patient is being compromised (Hawkes, 2012). This is not surprising when one considers that healthcare professionals are expected to handle structural changes and technical developments, are required to be accessible, provide holistic patient-centred and patient-managed care, develop their own evidence-based competence and achieve an appropriate balance between their work and private life.

Without too much effort, the purpose of a hospital can become self-preservation and not healing, which is reinforced by the way that health care organisations can be organised in silos (Glouberman & Mintzberg, 2001). Indeed, the Institute of Medicine (IOM) in the US has repeatedly highlighted the link between patient safety and organisational culture (Institute of Medicine, 2001; Kohn, Corrigan, & Donaldson, 1999), and burnout has been identified as the crucial link between organisational culture and quality of care (Montgomery et al., 2013; Montgomery, Panagopoulou, Kehoe, & Valkanos, 2011a). Put simply, healthcare professionals are under increasing pressure to continuously improve quality of care in environments that are not naturally designed to contribute positively to either the health of their employees or the recipients of care.

The links between patient safety/medical errors and burnout have been established in the surgical literature (Shanafelt et al., 2010) and in studies of physicians in training (West, Tan, Habermann, Sloan, & Shanafelt, 2009), however there is some conflicting evidence that suggests primary care physicians may shield patients from adverse outcomes resulting from physician burnout (Linzer et al., 2009). It's possible that primary care, which is more rooted in the community, may offer a different model than the hospital.

The culture of medicine is similar (relative to other professions) across the globe, and physicians (especially) are educated to take a very specific role in an organisation. Thus, physicians are primarily trained to treat, and little attention is given to the training needed to be an effective leader and/or a collaborative member of an organisation. This is especially true of medical education where medical schools seek to mimic the exemplar models, and students are reinforced to think of themselves as clinical leaders. Mintzberg (Mintzberg, 1997) has written directly on the issue of hospital cultures in *Towards a Healthier Hospital*, and strongly insists that real organisational change can be effected only by a gradual bottom up approach that does not threaten the roles that individuals have established within the organisation.

Finally, hospitals are organisations that reinforce a pathogenic approach to health. Not surprisingly, the pathogenic approach has dominated our approach to health. We have a tendency to focus on disease and illness, which prompts us to think in terms of risk factors and disease amelioration. Such a tendency is even stronger in healthcare professionals, who are continuously reinforced to view health through a pathogenic prism. Antonovsky (Antonovsky, 1996) has questioned the objective of health promotion as being severely limited, in that it has "exposed the 'bias of the downstream focus', i.e. the devotion of the disease care system to saving swimmers drowning by heroic measures, rather than asking 'Who or what is pushing them into the river in the first place?' (p. 12)". The basic idea behind his salutogenic approach to health is that we should work towards facilitating health rather than limiting disease. This approach represents an interesting way for us to look at hospital organisations. The salutogenic model proposes that our goal should be to identify, define, and describe pathways, factors, and causes of positive health and focus our attention on the