

## From burnout to resilience: a general practice perspective

**Background**—In their recent viewpoint article in the *NZMJ*, Paterson and Adams<sup>1</sup> highlighted the regulatory aspects of burnout in the medical profession. They suggest things that *should* be done to help; I would like to build on this by a suggestion of *how* change could be made, with a particular emphasis on my own speciality, general practice.

Although all medical specialities are prone to burnout, GPs, psychiatrists and those caring for patients with chronic and incurable conditions are reported to suffer most frequently,<sup>2</sup> probably because of their continued involvement with patients to whom in place of cure, all they can offer is care.

Care, however, is a dangerous thing—as Curzer<sup>3</sup> states, ‘caring people get **burned**’, because care involves an emotional attachment to patients, which leaves the doctor vulnerable to hurt, grief, betrayal, and guilt.

This tendency to care too much is deeply embedded in the character of many doctors; it was suggested by Johnson<sup>4</sup> in 1991 that through caring for others some doctors are seeking the approval, even love, lacking in their upbringing.

Curzer<sup>3</sup> suggests that in place of the emotionally risky ‘care,’ a better approach to medicine is ‘benevolence’—a general stance of wishing people well, but only appearing to care, *acting* caring, but keeping emotions restrained and caring for your patients no more than you would ‘the man on the street’.

Eric Cassell<sup>5</sup> wrote in ‘Diagnosing Suffering: a Perspective’ that when exploring the deepest source of your patient’s distress, ‘remember, you are working. It is you, the doctor, doing and being this way, not the personal you’. Some doctors may manage this, but many struggle with the distinction.

The emotional attachment is not just to patients. It is to the profession, to yourself as a doctor, to personal excellence, your colleagues, to a system which often lets you down. Doctors who care about such things will also care about their loving and family relationships; it has been suggested that those who care deeply, also tend to restrict their social sphere to a few close friends, and trying to apply this level of care to a patient population is simply too much for their emotional resources.<sup>3</sup>

Montgomery<sup>6</sup> found a strong relationship between ‘work-family interference’ and burnout—a conclusion I found very validating, as one of things I find hardest as a rural GP is what I have called the ‘work-home interface,’ especially as it relates to after hours work. Being at work is good, being at home is better, and when they pull in opposite directions, problems start.

Most people suffering from burnout are not depressed, though today the terms are increasingly used as if interchangeable. Most health workers suffering from burnout will state that if certain troubling or stressful aspects of their work changed, they would be fine. However, chronic burnout will lead to a lowered sense of personal accomplishment and superiority—positive self-image in relation to others—which is

linked to depression.<sup>7</sup> So institutional or system responsiveness is vital in addressing burnout.

However, the affected doctor must first acknowledge a problem, and seek help.

**Why do some burn out, whilst others thrive?**—There are well-defined character traits which predict doctors' future risk of job dissatisfaction, burnout and psychological distress. These include introversion, conscientiousness, agreeableness, neuroticism, and low self-esteem; these traits have a positive correlation with high pure IQ, are well represented in entrants to medical school, and help their owners pass exams. Similarly, there are well-defined trait characteristics for resilience, including extraversion, gregariousness, positive self-regard, assertiveness, playfulness and ability to form interpersonal relationships. Unfortunately, these traits are associated with a high early exam failure rate.<sup>8,9</sup>

However, this early academic ability becomes less closely correlated to professional achievement in postgraduate years, when the effects of intrinsic motivation and the personal meaning of the work begins to influence success.<sup>10</sup> Are these the doctors who can enjoy the success of their professional lives?

The same characteristics, which make some doctors vulnerable to burnout and distress, are also ones, which may lead to them not having the support systems needed to mitigate stresses. As these doctors may be less outgoing and gregarious than others, they may rely heavily on family for their emotional support. Many doctors will state that their main support is their spouse or partner. This leaves them vulnerable if family discord or illness becomes a source of stress. Additionally, these doctors' introversion, pride and sense of duty may prevent them from accessing what support may be available, turning instead to alcohol or drugs. Remember that admitting to 'not coping' is deeply shameful for most doctors, with a strongly 'macho' culture still prevailing in medicine.<sup>11</sup>

How common is burnout in doctors? Solar et al<sup>12</sup> found that 54% of English GPs, and F. Joseph Lee et al<sup>13</sup> found 47% of Canadian family physicians reported high levels of emotional exhaustion. Personal accomplishment levels remained relatively high, reinforcing the stepwise progress of burnout to depression.

Interestingly, in the Canadian study it was reported that only 8.4% were frequently involved in charity or community work. As patterns of health care provision change, doctors may be becoming alienated from their communities, which can be a vital source of support. In rural communities, there is a positive correlation between 'embedment', job satisfaction and decision to stay,<sup>14</sup> and this wider community involvement may be protective, despite the acknowledged stresses of rural practice. Viktor Frankl wrote in 'Man's Search for Meaning'<sup>15</sup> that man could overcome neuroses by 'forgetting himself and giving himself, overlooking himself and focusing outward'.

So we have a group of vulnerable doctors who are the ones least likely to seek help for burnout or psychological distress, but who also have many of the qualities—caring, conscientious, agreeable—we most value in modern general practice.

What can bolster their resilience?

- Self-awareness. It is essential to care for our patients, but we need to be aware of the impact this has on us as doctors and individuals. Our capacity for care is finite and must be carefully managed.
- Self-knowledge. Doctors should receive confidential psychometric testing early in their education or career, with skilled counselling, to learn about their potential vulnerabilities, and to consider for themselves how these may affect their career and life choices.
- Mastery. Uncertainty will never be removed from general practice. We will never know all we need to, and will make mistakes. So yes, mastery can mean keeping up to date, developing a special interest, but mostly it means understanding what we are doing and trying to achieve in medicine, the importance of our relationships and the process of caring and healing rather than the outcome. General practice should explore ways to facilitate ongoing meaningful education for doctors, with funded study and leave.

On a personal note, I recommend the 'Nature of General Practice' paper offered by Otago University Medical School. This article is distilled from an assignment I produced whilst completing this paper in 2010.

- A trusted, supportive group *already formed and running* to which the doctor can turn, or which can take a guardianship role to safeguard the doctors health if they become aware of problems, through their own contact or through concerns of others. Traditional peer groups may not provide this, as they are often simply learning groups, or there may be significant professional competition or judgment existing. What we need is a group which is a mix of clinical supervision,<sup>16</sup> Balint,<sup>17</sup> and men's group (or 'stitch and bitch!') Trusted and safe enough for therapeutic self-disclosure and a source of unconditional support—in short, friends.

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