CJEM Debate Series

CJEM Debate Series: #Burnout – Burnout is inevitable in clinical emergency medicine practice

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INTRODUCTION

Paul Atkinson (@eccucourse)

This series of editorials will provide *CJEM* readers with the opportunity to hear differing perspectives on topics pertinent to the practice of emergency medicine. The debaters have been allocated opposing arguments on topics where there is some controversy or perhaps scientific equipoise.

We begin with the topic of burnout, a concern to all who practice clinical emergency medicine. Statistics from North America seem to show that physicians practicing emergency medicine are at the top of the burnout risk league table.[1] Is burnout inevitable or avoidable? Does the problem lie with the job or with the worker? Are there workplace modifications or training programs that can help us avoid this threat?

Dr. Jim Ducharme, Editor-in-Chief at *CJEM*, and working clinician, makes the argument that burnout is in fact inevitable in clinical emergency medicine practice, with Dr. Sam Campbell, a clinical department head in emergency medicine, countering that a clinical emergency medicine career is sustainable.

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BURNOUT IS INEVITABLE IN CLINICAL EMERGENCY MEDICINE PRACTICE

For: Jim Ducharme

Decades ago, physicians did not suffer from burnout. They "sucked it up" or changed their practice focus; they turned to alcohol, or pills, or became depressed, but that was because they were "weak." Thankfully, the understanding of the human psyche has improved; we recognize that burnout did exist back then but was not identified as such. As the world around us has become increasingly more stressful, so, too, has the practice of medicine. Our ability to cope is not less than it was; rather, we are increasingly overwhelmed by that with which we are involved. Fortunately, we are able to better discern the maladaptive behaviours that define burnout and take steps to prevent or treat it. In emergency medicine, where death and acute illness and injury are the norm, it is not surprising – and is to be expected – that we as caregivers suffer from burnout.

The specialties that have the *lowest* incidence of symptoms of burnout are preventive medicine and occupational medicine, with a rate hovering around 30%.[2] The same 2014 U.S. survey identified that emergency physicians topped the specialty list, with burnout symptoms in more than 70% of all responders. The Canadian Association of Emergency Physicians (CAEP) Resident Section has identified that wellness and burnout are serious concerns during training, and have come out with a position statement on how this needs to be addressed during that training.[3] The statistics are clear.

Many may suggest that this high rate is not clinically important, or that this is due to over-diagnosis, as this happens in many medical situations. Have we widened the definition too far or have we improved it? The 2000 publication highlighting the average rate of close to 400 suicides per year amongst physicians in the United States suggests that this indeed is a critical problem.[4]

Why are we as a group suffering symptoms of burnout? It seems that this is self-evident. Almost yearly, working

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conditions are deteriorating – closure of acute care beds without corresponding increases in alternative level of care and long-term care ones; worsening of emergency department (ED) crowding; aging of the population that in turn steadily increases social demands on the ED, given the failure of the health care system to adapt and prepare for their increasing needs; increasing impression that the ED is the focal point for entry of non-emergent conditions into the health care system: consultation referrals, community care access centre (CCAC), addiction assessment and referrals, and so forth.

These worsening conditions have not been paralleled by equivalent improvements in physician training and support; physicians are rarely offered formalized debriefing after tragedies in their departments, despite it being the norm for nurses in many hospitals. Few of us have received training on coping skills or have had resources made available to us in a practical fashion. Training programs are just now forming curricula for their learners about managing and avoiding burnout. Without these infrastructural tools, we have been set up to fail.

Emergency physicians are highly motivated, with an ability to juggle multiple patients and their care at the same time. This means, however, that we may be asked to leave the bedside of an infant who has died unexpectedly to go on immediately to provide moral support for an elderly patient (and a family that has taken no steps for placing that person) who is no longer coping at home, to then care for a victim of intimate partner violence…. We have no time to reboot and re-establish emotional equilibrium, and are often criticized by families or staff because our "communication skills" are improper as a result. As a resident, I had a gun held to my head by a patient but was told I could not go home after resolution of the situation because "there were patients to be seen." My next patient was suffering from an acute myocardial infarction; his first comment to me was, "I am having a heart attack, the least you can do is smile when you introduce yourself." I went home and cried myself to sleep that morning and received no offer of help after the event.

We rarely receive positive feedback yet are routinely criticized for errors that we have committed. Reinforcement is almost always negative in our profession because we have not been trained to do otherwise.

We entered emergency medicine because of the fantastic variety of people and diseases that we see. Yet for such "attention deficit" professionals that many of us are, it soon becomes apparent that most of our patients do better, despite us; a professional "rut" sets in, with risk of dissatisfaction and ennui. Many look for professional satisfaction *away* from the bedside: teaching, research, emergency medical services, toxicology, other clinical practice areas. These other interests protect us from the ongoing clinical barrage of emergency medicine and ultimately serve as a coping mechanism whether that was the original reason. However, they do not serve the full-time clinician who has nowhere else to turn for professional release. Shift work further eats away at our morale and worsens burnout, because we were not taught about how to maintain a proper lifestyle with shift work (or we ignore that teaching). All of this leads to higher rates of addiction[5,6] – an illness that results in disparagement from our peers rather than support and understanding. It results in far higher than average suicide rates.[4] It also leads to change in career orientation for many. Remember, overall, 70% of us have symptoms of burnout; how much higher is that rate in those with more than 20 years of practice?

I have painted a dark picture, yet I am one who has sustained a very happy career in emergency medicine, despite all of the previous. While I currently work 12 to 14 shifts a month, for many years, I, too, was involved in teaching, administration, research, or international emergency medicine as part of my career. I still find almost every patient interesting and deserving of my attention. My motivation to stay current is as high as ever. I advocate for the growth of emergency medicine around the world through my work with the International Federation for Emergency Medicine. And yet, after decades of advocating for our specialty and encouraging students to enter this fantastic field, I have arrived at a point where I see a darker side and can no longer recommend to a young learner in Canada to choose emergency medicine. Vexatious baseless complaints at the provincial college level, where the only goal is to lash out without any risk of consequences to the complainer, are rising by 20% a year (personal communication, Canadian Medical Protective Association [CMPA], January 2017). CMPA fees rise annually because of the increasing rates of lawsuits – a situation related to poor communication and poor conditions much more than poor care. As a cohort, we have not become worse doctors over the past decade. Instead, it is our work environment that has deteriorated.

Burnout seems inevitable. *It does not have to be inevitable*. There are obvious solutions to almost every one of the problems I have listed. The question to be asked is,

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"Are we going to build a *health* care system to replace our current illness-focused non-system to address both patient and professional needs?" Or are we instead going to find "patches" by being taught how to partially cope with the poor conditions, how to manage burnout once it happens? Who will advocate for us to make the necessary changes so that we can provide better care for our patients? Who will lead the way to not treat the burnout so many of us suffer, but to prevent it from happening at all?

Perhaps my colleague, in his commentary, has the solution.

BURNOUT IS INEVITABLE IN CLINICAL EMERGENCY MEDICINE PRACTICE

Against: Sam Campbell (@samcampcaranx)

As one of those annoying people who express everything in metaphors, I will begin my response with the comparison between burnout and icebergs: It was not "inevitable" that the Titanic would sink; it sank because it hit an iceberg. Burnout is a big "iceberg"; it is big, important, dangerous, and most of it is hidden so you may not see it looming in your path. All the same, you can avoid hitting it, simply by building the right boat and sailing it the right way.

Our specialty, one of the newest, is by far the best to be in. Competition for residency places is extreme, with emergency medicine being one of the few specialties that consistently fills all available spots.[7] Not only do we have the most dashing and sexy jobs, but also we have huge flexibility over our schedules, no need to hire or fire office staff, and no need to set up clinics or consulting rooms. When we go home after a shift, in most cases, we are free from having to follow up or continue the management of our patients. The stimulation of our cognitive equipment is amazing; we are constantly challenged by new and unfamiliar problems. Sure, it is stressful making time-sensitive, high-risk decisions with less than adequate information. I am sure that James Bond had the same lament! If what we did was not high-risk/high-stakes, it would be far less exciting and engaging. One of the costs of a stimulating front-line environment is the danger of burnout,[8] but this does not mean that it has to occur.

Of course, as with any job, there are many less pleasant and less exciting parts to deal with. The crowding of our system has backed up our shops; we deal with shrinking budgets, increasing patient complexity and unrealistic patient expectations; however, as Dilbert says, "All jobs require you to do stuff you would rather not do – it is why they have to pay you!"[9]

So how do we build the right boat and stop it from hitting big, predominantly submerged things? (What we do if we do happen to hit such a thing is important[10] but is beyond the scope of this debate). To build the right emergency physician, we need to choose the right raw material and put it together correctly. Potential emergency physicians are not that hard to identify; we are like a specific tribe. Much has been written on this,[11-13] with adjectives including *inventive*, *efficient*, *energetic*, *friendly*, and *confident*.[13] Considering the stressful environment that we work in, and the gravity of the decisions that we make many times in a shift, I would suggest that *resilience* be added to the list. Of course, an even spread of these attributes is important, with extreme tendencies towards any one attribute likely to be a disadvantage. Coping styles are important, in that task-oriented (action response to stress) styles have been associated with decreased burnout, while emotional response to stress has a positive association.[14] Over-sensitive individuals, those who are thin-skinned, overly cautious or neurotic, or lacking flexibility, are best steered away from a career in emergency medicine.[13] If burnout is inevitable, it is in the subset of doctors who might better have chosen a different specialty. Someone who wonders whether he or she will manage working difficult hours is less likely to manage them well than the person who cannot wait to do nights because of the different environment that they offer.

Now to steer the boat safely through the ice flow: The best way to avoid burnout is to do what you enjoy, and our job is to teach those coming after us about how to enjoy emergency medicine. People with passion for the emergency medicine lifestyle and for solving undifferentiated clinical problems will thrive. I recently heard a young emergency physician say, "I love it when this place comes apart; that is when what I do matters most!"

If enthusiasm is noted to be lacking in residency, efforts must be made to stimulate and teach enthusiasm. Maintaining enthusiasm as you get older is important – burnout rates get higher as careers progress.[14] In some ways, a career is like a marriage – you have to choose your attitude; you decide that the situation is a happy one and then appreciate it, rather than waiting for it to fulfill preconceived expectations. And, like marriage, the embers have to be stoked regularly.

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Further "navigational skills" to teach and demonstrate are the key elements in practicing emergency medicine, critical thinking, professionalism, and procedural competence. The more we revel in the joy of applying these, the more we look forward to the next shift. At the end of the day, perhaps the most important attribute is reflected in the "serenity prayer," which asks that we "accept the things we cannot change, have the courage to change the things we can, and wisdom to know the difference."[15]

Administrators should remember their important role in preventing burnout.[16] Important aspects include ensuring a fair remuneration policy, keeping the work environment and schedule as pleasant as possible, holding consultants to a professional attitude, and advocating for patients in a way that allows emergency physicians to provide patient care to their full potential.

The problem with icebergs is that, although hitting one is not inevitable, when it happens, we still talk about it 105 years later! Sure, we self-report a burnout rate almost double that of other doctors, but let's face it, as adrenalin junkies, we are melodramatic about many things![17] I am part of a group of 36 academic emergency physicians in circumstances typical of large Canadian referral centres. We have the same challenges of overcrowding, belligerent consultants, and patient loads. Although, as their administrator, I have not formally evaluated it in discussions at annual reviews, I can say with a lot of confidence that the level of burnout is less than a tenth of the 65% reported.[18] The vast majority of my physicians are engaged, enthusiastic about their jobs, and appreciative of the fortunate situation that life has bestowed upon them.

The issue is relatively simple. We have entrenched our discipline on the practice of medicine. During the development, we did allow people to burn out. It may have been inevitable that this would happen – it is not now. We know enough to prevent burnout and to make sure that emergency medicine offers a very rewarding career to our younger colleagues – we must just do it!

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