

PHOENIX FROM THE ASHES: PHYSICIAN BURNOUT IN PAKISTAN

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*Two roads diverged in a wood, and I —
I took the one less traveled by,
And that has made all the difference.*

Robert Frost - American Poet

CASE VIGNETTE 1:

A senior surgeon (a medical teacher) is referred for psychiatric evaluation by his sibling, also a senior medical teacher. He is reluctant to see a psychiatrist and on initial assessment, claims that nothing is wrong. According to him, after a long, tiring day at work where he lost a patient on the operating table, this experienced, much respected surgeon had a trivial argument with his spouse and, after locking himself in his room, took an overdose of analgesics, antihypertensive medications and sedatives. His family broke down his bedroom door and took him to the hospital where he was kept in the ICU for three days. There is no prior history of psychiatric treatment and he has never sought any help for mental health issues. He confides to his psychiatrist that he is constantly tired, cannot sleep because he worries about his patients, has been irritable with his family and hospital staff and has been thinking about leaving the medical profession altogether.

INTRODUCTION

Burnout is everywhere, or so it seems. From doctors and lawyers to teachers and housewives, it appears that there is an epidemic of burnout all over the world. As a distinct phenomenon, 'Burnout' was first reported in the 1970s by American Psychologist Herbert Freudenberger who initially used the term to describe a constellation of symptoms found within the 'helping professions'; in his case, doctors and nurses.¹ Christina Maslach and others developed one of the earliest tools for measuring burnout, the Maslach Burnout Inventory.² Their seminal work has led to the concept of burnout being broadened beyond just healthcare practitioners and it is now widely known that burnout, with its associated effects on work efficiency, productivity, life satisfaction and mental health in general affects just about everyone.³

THE SCOPE OF THE PROBLEM

There is now a vast amount of published literature on this

topic globally and in Pakistan⁴⁻⁶ and it has been added as an occupation related phenomena in ICD-11.⁷ Burnout has reached the level of a global epidemic with major medical organizations calling it a public health crisis and 'death by a 1000 cuts'.⁸ While the phenomenon of Burnout was widespread in years past, COVID-19 has been the icing on the cake with health care professionals being forced to work long hours under immense psychological pressure. Burnout has caused or contributed to a multitude of problems including dissatisfied physicians changing careers,⁹ suboptimal care of patients, expensive healthcare, increased propensity of being named in medical malpractice suit and doctors reporting more preventable errors in their clinical decision making.¹⁰ Not only that, it has led to an increased incidence of clinical depression leading to suicides, substance abuse, poor self care, road traffic accidents following long duties and stress related sudden deaths in healthcare workers.¹¹ While burnout is a global phenomenon, the common problems of low and middle income countries like Pakistan such as undeveloped or poorly developed healthcare facilities and systems, inadequate staff training and procedures, lack of security at hospitals and healthcare facilities leading to a real risk of injury or death of healthcare workers because of enraged family members or patient attendants, meager doctor salaries, media and social media scrutiny etc. add to the burden of burnout for healthcare workers. Social and political instability, terrorism, crime and law and order problems make things even worse. It is no wonder that studies in Pakistan have reported very high levels of burnout in doctors and healthcare workers in Pakistan, especially in the era of COVID-19.^{12,13}

CASE VIGNETTE 2:

A senior medical teacher, spearheading the COVID-19 fight at her large public hospital confides to her therapist that she feels anxious, stressed, cannot sleep and has recurring nightmares. She has lost weight and feels nauseated when she eats. She has been unwell since her mother died a year before. When COVID started and her medical department became the epicenter of the COVID outbreak with dozens of doctors and nurses becoming infected, her symptoms worsened. She herself has contracted COVID twice during

her duties and even though she is now recovered, her burnout symptoms are not resolving. All medical investigations have been normal.

PHYSICIAN BURNOUT: WHY WE NEED TO PAY ATTENTION

Much has been written about the dangers of burnout. Lower physician productivity, a higher propensity for clinical errors leading to patient harm, mental health issues including frank mental illness and other health consequences for physicians including life threatening cardiac and other events are just some of the sequelae of untreated burnout. In addition, burnout by definition, leads to dissatisfaction and emotional detachment and has been shown to be a factor in inducing physicians to leave the medical profession altogether.⁹

A study by our group recently showed high levels of burnout in medical teachers in a large public medical university in Lahore.⁴ We pointed out that medical teachers are already in very short supply in Pakistan. With the rapid expansion of health services and medical education, this is set to get worse in the near future. Medical teachers are an especially valuable resource since they train the medical workforce of the future. Similarly, physicians and healthcare workers in the community are overwhelmed with patients and their problems. It is not uncommon for a General Practitioner or even a specialist working in private practice to see upwards of 100 patients a day.¹⁴ Patient volumes of this magnitude lend themselves easily to burnout in healthcare staff including physicians. If this escalates to mental health problems, it can lead to tragic consequences like physician suicide or even homicide.¹⁵ Even without the problem escalating to psychiatric emergencies like suicide, physicians and healthcare workers who are suffering high levels of burnout suffer both impaired work efficiency as well as problems in their personal lives which can have a vicious 'add-on' effect leading to increased burnout. There are also the 'ripple' effects of healthcare worker burnout which can affect other healthcare workers as well as society at large by depriving patients of their most conscientious and hard working healthcare providers.

In short, unaddressed burnout and associated mental health problems pose an acute risk to healthcare workers including doctors. But there is also a hidden 'social cost' to ignoring this problem. If well educated, affluent members of society such as doctors are suffering such high rates of burnout, one can well imagine what the situation is like for those who are struggling to make ends meet financially, let alone the poor, those affected by terrorism or natural calamities or vulnerable populations such as women and children.

WHY IS IT HAPPENING?

The profession of medicine has always been viewed less as

a profession and more as a 'calling'. It attracts intelligent, highly motivated people with high levels of altruism.¹⁶ 'Serving ailing humanity' is an answer we often get when we ask our medical students why they want to become doctors. This is a prime example of 'intrinsic motivation', the main driver of high achievement and resilience while performing tasks, especially those that require persistence, hard work and delaying of gratification such as acquiring a medical education or delivering medical care. In a misguided attempt at allaying burnout in doctors and healthcare workers, especially during COVID-19, healthcare administrators and policy makers have attempted to create financial incentives.¹⁷ This is doomed to failure. 'Extrinsic motivators' (both positive, in the form of financial incentives and negative in the form of punitive action against healthcare workers who cannot perform effectively due to burnout) cannot replace intrinsic motivation and, over time, can actually erode and destroy intrinsic motivation leading eventually to 'a motivation' i.e. further burnout.

In the West, where healthcare decisions and policies are generated on the basis of hard data rather than the whims of government officials, it has been demonstrated again and again that financial rewards, workplace 'wellness programs' including yoga, exercise classes at work and other interventions rarely, if ever, provide long term, meaningful resolution of burnout and its associated consequences.

In Pakistan where doctors and healthcare workers are faced with the herculean tasks of seeing hundreds of patients a day with little or no job security, the omnipresent threat of risk to life and limb¹⁸ as well as the ever present challenges of all low and middle income countries (LMIC), it is a wonder that healthcare workers are able to deliver any care at all.

CASE VIGNETTE 3:

Two senior professors, a surgeon and a psychiatrist, meet regularly to discuss the challenges of working in their large public medical university. Hundreds of patients a day, thousands of students and trainees to teach and supervise, multiple stakeholders to answer to, all while balancing a precarious personal life leave little time for leisure or reflection. Both are burned out and often talk about leaving their chosen fields to pursue other activities. Both have always scored high on student evaluations and are often sought out as advisors and mentors by other faculty members as well as senior administrative staff. Both have seen firsthand how the lives and health of their fellow doctors including senior faculty and administrators are being consumed by their work and it's never ending challenges. There have been discussions about setting up a 'physician wellness service' at their university but it seems like yet another in a long 'to-do' list that keeps getting longer and longer.

WHAT IS TO BE DONE?

The phenomenon of burnout has been with us long enough to where, even in Pakistan, there is now increasing recognition that it can no longer be ignored.¹⁹ Financial incentives alone do little, if anything in the long term and, in a LMIC like Pakistan, cannot be guaranteed to be delivered on time or at all.

Fortunately, tackling burnout does not require huge financial resources. In a seminal paper,²⁰ Gagne` and Deci identified three key factors that enhance intrinsic motivation and psychological well being: autonomy, competence and relatedness. Gagné and Deci define autonomy as healthcare workers having a sense of choice about their work as well as 'agency', the feeling that they are doing what they are doing of their own free will. In Pakistan, for doctors and healthcare workers at all levels, from medical students to practitioners to faculty and senior health administrators, autonomy is severely limited by a number of factors. Medical students are forced to study in educational systems that prioritize 'top-down' learning with students having no say in what is taught or how the instruction is delivered.²¹ Doctors working in the community are overwhelmed by the sheer number of patients needing services as well as the need to generate incomes which can keep pace with high inflation. Medical teachers face labyrinthine bureaucratic procedures, meager salaries and overwhelming work loads.⁴

Gagne' and Deci's second factor supporting intrinsic motivation is 'Competence' meaning a deep fund of knowledge about one's chosen vocation coupled with the ability to apply it appropriately in given situations. Here too, we are failing our doctors and healthcare workers. Medical students in Pakistan, some of the most intelligent, idealistic and hard working youth in the country face an antiquated education system once they gain a much coveted spot in a medical college.²¹ The emphasis is on rote learning with little or no knowledge imparted about correct application of the knowledge. Once they graduate, they are faced with a post graduate training system that is little better than medical college relying heavily on the skill and/or willingness of trainers to train. While structured post-graduate training systems exist on paper,²² their quality varies widely depending on the availability of trainers and faculty. Doctors practicing in the community are so overwhelmed with patient loads that they rarely have any time or inclination to keep their knowledge updated resulting in delivery of medical care that is adequate at best and abysmal at worst. Medical faculty, the teachers of the next generation of doctors are similarly overwhelmed.

The third factor identified by Gagne' and Deci, 'Relatedness', is in fact qualitatively different in Pakistan (and presumably other LMICs). Due to a variety of social and economic factors which are outside the scope of this article, the sense of

belonging, interpersonal attachment and being connected socially is strong. But this comes with a price. Interacting with friends, family and co-workers socially requires time which, in the case of doctors and healthcare workers, is already in short supply due to multiple and often conflicting work commitments. Thus, this too can become a source of stress and further burnout if social and family obligations come in conflict with professional obligations.⁴ With the move towards more accountability in the medical profession in Pakistan (a welcome development), the introduction of management controls at major hospital systems (including electronic records) and other changes, the burden on doctors and healthcare workers is about to increase.

SOME SUGGESTED REMEDIES:

COVID-19 has exposed the fundamental structural flaws in our medical systems which have existed for decades but can no longer be ignored. As a LMIC, Pakistan will continue to face healthcare crises of one sort or another and if we are to face them successfully some urgent changes need to be implemented in our healthcare systems:

- Medical education, both undergraduate and post-graduate, needs to be aligned with modern scientific standards and methods. There is now a huge amount of published literature about this internationally as well as in Pakistan and medical teachers who are formally trained in scientific educational methods now exist in increasing numbers in all institutions in Pakistan. They should be given the responsibility of modifying and updating the curricula of medical colleges/universities as well and post-graduate medical training programs to bring them up to international standards.
- Our healthcare system nationally needs a major overhaul. The existing system is broken and does not serve the needs of the majority of our population, especially those in the lower socio-economic strata. More investment is needed by the government, especially in strengthening grass roots systems starting with Rural Health Centers, Basic Health Units, and Tehsil/District Headquarter hospitals. Staff training, especially of allied health professionals at these facilities can enable quality medical care to be provided in local communities rather than patients and families having to travel long distances to tertiary care hospitals which are overwhelmed and broken down. Once the load on these hospitals declines, they can also be upgraded to handle only the most severe cases.
- Major national initiatives are needed to address burnout and mental health issues in our healthcare workforce. This cannot happen without the commitment (including financial commitment) of provincial and national governments. Any money invested in the well being of our healthcare workforce will be paid back many times over by improved work efficiency, increased morale and

savings in sick days and absenteeism.

Pakistan along with this region of the world is at a major inflection point in our history. While COVID-19 has battered us with many challenges, it has also opened up a world of opportunity. We need to seize this opportunity to make significant changes in our healthcare delivery and management system so that a healthier, happier healthcare workforce can support the well being of the people of Pakistan and take us forward confidently into the 21st century.

CLINICAL PEARLS/TAKE HOME MESSAGES

- Burnout is ubiquitous, both globally and in Pakistan. It should not be ignored.
- Burnout poses multiple personal, professional and occupational risks, including the risk of major mental health issues
- Innovative solutions can be both helpful as well as cost effective
- Addressing burnout in the healthcare workforce can be a major driver for positive social change

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