REVIEW

J. Edward Berk Distinguished Lecture: Avoiding Burnout: Finding Balance Between Work and Everything Else

Christina M. Surawicz, MD, MACG[1]

Burnout has been defined as "a state of mental exhaustion caused by one's professional life." Increasing evidence shows high rates of burnout among medical professionals, including gastroenterologists. Factors that contribute to burnout include work–home conflict and longer work hours. Among gastroenterologists, the risk for burnout seems to be highest during the first three years on the job after fellowship. Strategies to treat and prevent burnout include identifying and balancing personal and professional goals, shaping one's career to optimize meaning, identifying stressors, and nurturing wellness strategies.

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I had the honor of giving the J. Edward Berk Distinguished Lecture on 15 October 2013 at the Annual American College of Gastroenterology meeting. This paper is taken from that talk, and will review definitions of burnout, contributing factors, and ways to recognize, prevent, and treat burnout.

WHAT IS BURNOUT?

Burnout is a term coined in the 1970s by psychologist Herbert Freudenberger, which he defined as a "state of mental exhaustion caused by one's professional life" (1). It is often the consequence of severe stress and high ideals experienced by persons working in the helping professions, typically doctors and nurses who may sacrifice themselves for others but often end up exhausted, listless, and unable to cope.

Here is the paradox. The people who are most prone to burnout are actually the most dedicated. Idealism, perfectionism, and a sense of responsibility are the traits that lead to professional success but also to overwork and to burnout (2).

Burnout has the following three components: emotional exhaustion (feeling overworked and overextended); depersonalization (becoming unfeeling in our response to our patients or peers and treating them as objects rather than as humans); and a decreased sense of personal accomplishment and success. There are several scales used to measure burnout. The Maslach Burnout Inventory is the one that is most commonly used for surveys, consisting of 22 items (3). Although this is a good research tool, it may be too lengthy for a quick analysis. West and Shanafelt identified two questions from that survey, each of which correlated well with the inventory's total score (4). These are as follows:

(i) I feel emotionally burned out or emotionally depleted from my work and/or.
(ii) I have become more callous toward people since I took this job—treating patients and colleagues as objects instead of humans.

Almost everyone surveyed had those feelings occasionally. However, there was a 90% correlation with serious burnout for those who had these feelings several times a week.

Some emotions that lead to burnout are feeling that we do not have control; feeling that we do not have sufficient rewards at work; difficulties in communication; conflicts between work and the rest of life (work–life conflicts); the quality, quantity, and fairness of our workload; and misalignment of our work and our values. As I researched the topic, I recognized that I had experienced burnout but I did not recognize it at the time. The two major contributing factors for me were feeling that I had little control over my work and feeling a lack of support at work.

HOW PREVALENT IS BURNOUT?

Several researchers have been studying burnout among medical professionals for the past 10 years. The most prominent researchers are Tait Shanafelt, and Colin West, whose research has provided excellent data and insight. In their 2012 article, they

[1]Division of Gastroenterology, Department of Medicine, University of Washington School of Medicine, Seattle, Washington, USA. **Correspondence:** Christina M. Surawicz, MD, MACG, Division of Gastroenterology, Department of Medicine, University of Washington, School of Medicine, 325 9th Avenue, Box 359773, Seattle Washington 98104, USA. E-mail: surawicz@uw.edu
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reported that 45.8% of physicians have experienced at least one symptom of burnout (5). In the 2013 Medscape Physician Lifestyle survey, that number was 39.8%, with the highest rates of burnout in emergency medicine (52%) and critical care (50%). The lowest rates were in psychiatry (33%) and pathology (32%); rates for gastroenterology were in the mid-range (37%) (6). Primary care physicians also have very high rates of burnout (7). Also interesting is that medical residents experience burnout at rates of 27–75% depending on the specialty (8). Even 21–43% of medical students experience burnout (9).

Recognition of burnout in ourselves and in our colleagues is an important challenge and an area where we need more help. In one study, the rate of burnout in surgeons was lower by their self-report than when measured by the Mayo Clinic Physician Well-Being Index (10).

WHAT CAUSES BURNOUT?

Some of the most robust data about causes of burnout in physicians come from a 2008 survey of 7,905 surgeons sponsored by the American College of Surgeons. Some of the contributing factors for surgeons are longer hours at work and more nights on call. Of the characteristics of burnout among surgeons, emotional exhaustion was the most common (32%), depersonalization was less common (26%), and a low sense of personal accomplishment was least common (13%) (11). There was a correlation of burnout with increasing work hours. Those who worked less than 60 h a week (should this be our maximum?) had a 30% reported burnout; for those who worked 60–80 h a week, the rate of burnout was 44%; and for those who worked more than 80 h, the burnout rate was 50% (12).

Conflicts between obligations at home and obligations at work clearly have an impact on burnout. In this same survey, 52% of the surgeons said that they had had a work–home conflict in the past 3 weeks. Those who had had a work–home conflict in the past 3 weeks had a higher rate of burnout, 37% compared with 17% in those who had not; more depression, 51 vs. 28%; and slightly more alcoholism, 17 vs. 14%. Work–home conflicts were most frequent when surgeons had a two-career family; more frequent if they were married to another physician; and the highest rates were for surgeons who were married to another surgeon (13–15).

There are some data specific to gastroenterologists. A survey by Keswani *et al.* (16), of gastroenterologists who were members of the American Society of Gastrointestinal Endoscopy, provides some data. The burnout rates were higher in junior than in senior faculty, especially in the first 3 years after fellowship, both in academics and in private practice. Burnout among newly minted gastroenterologists correlated with impairment of work–life balance. Burnout was higher for interventional gastroenterologists than for noninterventional gastroenterologists. The associations with burnout for the interventional gastroenterologists were being younger, being men, being foreign born, working more hours, and having fewer leisure hours. The areas of stress for them were procedure related: fear of missing a malignancy in endoscopic ultrasound; fear of the inability to cannulate the bile duct; and fear of misinterpreting fluoroscopic images. For the noninterventional gastroenterologists, the two areas of stress were worry about having their endoscopic skills questioned and pressure by nurses to do their procedures more quickly (**Table 1**).

Table 1. Common factors that contribute to burnout among gastroenterologists

1	Work–home conflict
2	Younger age (first 3 years on job after fellowship)
3	Long work hours and more call
4	Therapeutic endoscopy practice
5	High-risk procedures
6	Having a major complication
7	Pressure to work faster

CONSEQUENCES OF BURNOUT

The consequences of burnout are significant, both for us and for our patients. Physicians who are burned out are more likely to leave the profession early; they are more likely to have substance abuse, depression, and higher rates of suicide (we know that rates of suicide are already higher for physicians than for the general population). Moreover, physicians who are burned out have lower patient satisfaction scores, and there is an association with medical errors (17). However, we do not know whether this is cause or effect. Do medical errors lead to burnout, or does burnout lead to medical errors? In one study, surgeons who worked more than 80 h per week reported a higher rate of medical errors compared with those who worked less, and they were more likely to attribute those errors to burnout (18).

Complications are not the same as medical errors, but both can be major contributors to burnout. Complications are inevitable if you do procedures. To quote a Seattle surgeon "the day you stop feeling bad about your complications is the day you quit." Accepting complications is difficult, but in addition to learning from them we need to support one another and we must learn to forgive ourselves as much as we forgive our colleagues so that we can move on. When you add a malpractice suit, everything is magnified in a negative way. Malpractice suits are devastating for most physicians (19). We take them personally, we are more likely to quit after a serious suit, and we may lose peer support if lawyers forbid us from talking to our colleagues about the case.

WHAT DO WE DO ABOUT THIS? TREATMENT AND PREVENTION

Concrete recommendations for an action plan from Shanafelt's excellent article (20) can be simplified into three steps: (**Table 2**)

(i) Identifying and balancing personal and professional goals
(ii) Shaping your career to optimize meaning and identifying stressors
(iii) Nurturing wellness strategies

Table 2. Strategies to combat burnout

(Adapted from Shanafelt (20))
1. Balance personal and professional goals
• Clarify what is most important in your personal and professional life
• Identify conflicts
• Control your work schedule
2. Shape your career and identify stressors
• Determine whether you need to make career changes
• Identify what energizes you and what drains you
• Decide how these can be modified
3. Nurture wellness strategies
A. Relationships
B. Self-care
Eat and sleep
Exercise
Vacation
C. Mindfulness-based stress reduction
D. Personal interests

Balance personal and professional goals

Identify your professional goals and your personal goals. Ask yourself whether they match—do they need to be integrated or are they completely separate? Why did I choose to be a physician, why did I choose to go into gastroenterology, what do I like most about my job? What are three things that motivate me professionally? By the end of my career, what three things do I want to have accomplished? As for our personal goals, what are our greatest priorities, and do we live by them? Where are we the most irreplaceable: at home, at work, or somewhere else? If we have to sacrifice something, what is it? Some suggest that we think about the spheres of our lives as balls. Work is a rubber ball: if we drop it, it will bounce. But our health and our family are glass balls: if we drop them, they will break.

As we look to integrate our professional and personal goals, we may ask what legacy we want to leave. If you have had a particularly bad year, look back and see how you would change it. We also have to look at what we fear. Do we fear being regarded as less dedicated doctors if we take a day off after being on call? Do we fear what our colleagues think of us more than we value how we think of ourselves? One exercise that I found helpful years ago comes from one of Stephen Covey's books, which is to write your own obituary. It sounds morbid, but I found it very helpful to clarify what was most important to me.

We must be able to control our work schedules. Recall that the three factors that contributed most to burnout were a higher number of hours worked, recent work–home conflict, and the resolution of that conflict in favor of work rather than home.

Control over work schedule predicted better work–life balance. One of the solutions is part-time work; another solution is a better work schedule including flexible work hours.

We should also have backup systems for emergencies and call schedules that make sense. We should schedule the day off after being on call. Take a day off after you travel before going back to work. Maybe we should take some lessons from airline pilots and our residency programs about work-hour restrictions.

Having children or other responsibilities at home adds many layers of complexity, but there are also many ways of making it work. One colleague said, "I really limit what I do so that my children don't have too many activities, and our weekends are only for our children." We cannot manage time—there are only 24h in a day—but perhaps we should budget it. Another colleague said that she plans her days backward. First, she figures out how many hours of sleep she needs. Next, she figures out how much time she needs to take care of herself and relax, and the number of hours she wants to spend with her family having dinner and doing homework, and she subtracts those hours from 24 to get the number of hours she can devote to work. She admits that it does not work every day, especially if she is on call, but it is a really good strategy.

Think about your schedule and attack it. Be realistic, but be generous with yourself. Block time off, random days off, or half days off. Schedule those date nights and keep them sacred. Decide what other activities are sacred and honor them as well.

Shaping your career to optimize meaning and identifying stressors

By shaping our career and identifying our stressors, we can enhance the work that is personally meaningful to us. Should we eliminate some of the things we do if they are causing too much stress? For instance, one study showed that doctors who do lower numbers of ERCPs (endoscopic retrograde cholangiopancreatography) are more likely to find the procedure stressful (21), and thus maybe they should leave them to doctors who do a higher volume of ERCPs. For those in mid-career, we can identify what we are really passionate about, because that may have changed over the years. Maybe it is time to learn a new clinical skill or get more training. Maybe it is time to start teaching or to stop teaching. Maybe it is taking a leadership role. For me in 2002, when I became assistant dean for faculty development, I was energized by a steep learning curve and a sense that I might be able to make things better for the next generation.

Next, we should identify things that energize us and that drain us. We all have many potential energizers. High on my list are family, friends, many (but not all) patients, walking, and reading. There are fewer drains but one that is worth mentioning is conflict at work involving employees or colleagues. As physicians, we naturally want to fix problems. But we do not have to fix everything and do not have to own other people's problems. I have learned that the most important first step in problem solving is to listen and to reserve judgment. There is an old Chinese saying that every pancake has two sides. However, a lawyer friend told me that actually there are three sides: your side, my side, and the truth. I hate conflict, but in my 20 years as section chief at a county hospital I learned to embrace it by realizing that without conflict there is no change.

Nurture wellness strategies

We need to nurture ourselves both mentally and physically through personal wellness strategies. These strategies include

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sleeping, eating, our vacations, our hobbies, time for personal relationships and personal reflection, aerobic exercise, and even seeing our primary care physician for routine medical care (22). As they say on the airplane, put your oxygen mask on first before helping others.

We cannot eliminate stress but we can determine how we handle it. One technique is mindfulness-based stress reduction. Think of it this way: "the degree to which you do not believe you have time to spend even 10¦min sitting quietly is the degree to which you desperately need to spend 10 min sitting quietly."

Mindfulness-based stress reduction is bringing one's complete attention to the present experience on a moment-to-moment basis: being nonjudgmental and being consciously aware during everyday activities (23). Components used to teach mindfulness-based stress reduction include reflective meditation, narrative writing, and appreciative inquiry. With narrative writing and appreciative inquiry, one uses personal stories to focus attention and awareness, both through writing and discussion.

There is evidence that mindfulness-based stress reduction does help physicians practice. Three highly publicized studies of primary care physicians trained in mindfulness showed significant improvements in their well-being with lower rates of burnout, depression, anxiety, and stress. Importantly, they had better communication with patients and more patient-centered care (24–26).

CONCLUSIONS

There are many places to look for support. For me, the American College of Gastroenterology has been very important, with its collegial and supportive environment. The college is at the forefront of our profession in developing programs to improve wellness, balance, and patient-centered care.

Let's pledge to review our priorities, take charge of our lives, recharge our batteries, and take care of one another. Our younger colleagues are at a higher risk, and we need to mentor them. Let us protect them from things that caused us to burn out that we somehow survived. Mentoring will help, both locally and nationally.

Let's try to be resilient and find meaning in our work, remembering that we are important and that what we do does help people, not just patients. For those of us who are senior, mentoring our junior faculty and making life better for them will be one of our legacies; this should help us on the days when work really does overshadow everything else. Let me encourage you to take a few minutes after you read this to jot down what has just come to mind, what changes you might make tomorrow, even if it is just finding time to take stock of your life.

I will end with two quotes. The first quote is from the American College of Gastroenterology president Dr Ronald Vender: "remember that for each patient, their visit with you is the most important thing in their life on that day." This is easy to forget on a busy day.

A quote has been attributed to Maya Angelou: "People will forget what you say. They may remember what you show them how to do, but they will never forget how you make them feel." These are truly words to live by.

CONFLICT OF INTEREST

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