



How surgeons might cope with burnout

by John D. Zelem, MD, FACS, Bethany, CT

"I am so burned out!"

"I hate what I am doing!"

"I would quit yesterday if I had something else to do!"

Have you heard such statements before? Maybe you have even said such things yourself. I myself said them with intensity for several years, even going so far as to investigate alternative means of income. Yet, I have always drifted back toward my love of medicine and surgery. Thoughtful encouragement from my wife and kids frequently contributed to that return.

Burnout is not limited to the medical profession—I believe it is seen in any intense, time-consuming occupation. I remember once talking to a plaintiff's malpractice attorney I knew, who said, "I hate what I do, but I have a family to support." This is not a very reassuring comment, is it? It made me consider the defense attorneys who represent us and how much burnout they might be feeling.

People within many professions experience burnout, but I am going to limit my discussion to physicians because so many of them talk about

leaving but so few do. There are lots of stories about those physicians who were able to get out of the profession. They have gotten into politics, medical directorships, and administration, and even some as far removed as acting. The problem for the rest of us is that we have gone through long years of intense, specific training. Our training never allowed us to learn any diversification, so we have very few other talents. Tennis and golf were about the only activities we may have had time for, but such excursions were for necessary downtime.

The main question to consider is why do we physicians burn out? Why do we burn out when the vast majority of us love what we do? We have gone through prolonged periods of schooling and training to achieve our goal of being physicians. Shouldn't we have burned out during that period? Yet, the vast majority doesn't burn out at that time. Are reasons for burnout physical, mental, financial, or spiritual, or related to boredom, fear, or outside pressure? The resounding answer is "yes" to all of these possibilities in varying degrees. Life itself carries all of these challenges, but I don't believe we get burned out with life itself. Yes, there are some who may consider suicide, but it is a very, very rare occurrence. Suicide becomes an alternative when one thinks that it won't get any better. But I am not a proponent of this solution.

The simplicity of an earlier time

Look back to years ago: a “country doctor,” an “old-time family doctor,” a “general practitioner” may have been paid in the form of money—or maybe a bag of fresh-grown corn or a home-cooked meal for the doc’s entire family from a thankful patient. That doctor may have delivered you, taken out your appendix, fixed your hernia, treated your pneumonia, given you your shots, and delivered your own kids. These physicians knew their patients and their patients knew them. Physicians spent time talking to their patients and were not pressured by the factory-like atmosphere that those currently in practice are forced to endure. They did not have to spend wasted minutes talking to insurance companies to justify their decisions. They did not spend hours and dollars on staff to assign a code number to a procedure or diagnosis so they could get paid, maybe. They did not have to deal with trying to reverse a payment denial. They didn’t worry about getting sued because it was essentially unheard of. They loved what they did and didn’t get burned out. They practiced until they couldn’t anymore. Those days are gone, though it was not that long ago.

Internal pressures

I am not naïve enough to not acknowledge the financial pressures, the fast pace, the “big brother” atmosphere and our litigious society in today’s practice environment. However, physicians seem to be keenly aware of these factors, whereas the emotional and mental pressures of the daily experience are not as readily known.

In many professions, the mental pressure of boredom can be significant, even in medicine. Repetition can lead to routine and, without any exciting new changes, boredom will occur. This cause and effect will erode our enthusiasm for what we do. In today’s environment of practicing, we are forced to comply with protocols, pathways, and predefined treatment plans. We get pressured from non-peer personnel—such as nurse-reviewers or hospital and insurance company administrators—all the time, who make statements such as, “You didn’t follow the protocol,” and “Your patient is two days over what’s allowed—when are you going to send him or her home?” There are so many more influences that take away our

excitement for our profession. Today’s physician may find it difficult to maintain daily enthusiasm in trying to work up a complex problem when a protocol or pathway needs to be followed. Doing this same thing every day can lead to boredom, complacency, and eventual burnout.

One thought that I try to keep in mind is that although I see a lot of routine situations repetitively, each medical situation may very well be—and usually is—the first time the patient is experiencing it. For example, a surgeon may see an unexciting, routine case of appendicitis for the 200th time in his or her career, but the patient has never before experienced appendicitis. The patient appreciates the surgeon’s experience and knowledge from multiple exposures but needs this experience to be turned into being helped through the process. The diagnosis and treatment may be routine, but the patient is unique. What a great opportunity to look at this situation as uniqueness instead of a “boring” routine.

A significant source of emotional pressure is that it often is said that patients believe their physicians don’t care, that they are only interested in making money. This claim is so untrue, especially when considering the long, arduous hours worked, the sleepless nights worrying about a sick patient, and the time taken away from personal lives and their families. On the contrary, most of us do care. As we get to know and understand our patients, we may even develop a friendship with them. We learn about their health issues that get transferred to us through that personal, professional touch. Our training tells us not to get emotionally and personally involved, but we often do.

We help so many patients through the stages of various illnesses from a common cold to a terminal fight with cancer. We would like to believe that we have all the answers, but we don’t. It can frustrate us for it is not the illness that is terminal—it is our knowledge of the treatment of that illness that is terminal, in that it is limited to our present-day knowledge and research. We just have no more to offer at the time. This pitfall can many times leave us with a sense of helplessness. I have felt it so many times as I watched a patient or friend deteriorate. I recently witnessed a nurse I worked with and who I respected deteriorate from a cancer in six weeks. She went from being

a perfect picture of health to near death in such a short time. She didn't understand it; I didn't know how to medically help her. I knew there was no cure for her. I would tell myself, "Don't get emotionally involved," but empathy is the quality that distinguishes us as caring human beings. After all, we did take the Hippocratic oath to help.

Addressing burnout

Elisabeth Kübler-Ross, MD, in the classic book *On Death and Dying*, talks about the five stages of grief and grieving in illness and death: denial, anger, bargaining, depression, and acceptance.* We must learn to help our patients and their families understand their journey through these stages. We must not only know how to help our patients learn how to live, but we also have an obligation to help them learn how to die. Our problem is also how do we help ourselves transcend these stages in our own grieving of patient loss? You may argue that we cannot allow ourselves the luxury of going through the stages, but that is not correct. We face them whether we are aware or not. We owe it to our patients to understand that which we teach.

Take a typical day in the life of a practicing physician. In the course of seeing and treating anywhere from 10 to 50 patients every day, the following types of scenarios may occur:

- Outlining a plan of treatment for a diagnosed illness
- Meeting a patient for the first time for an acute illness and ordering tests and X rays
- Telling a patient that he or she has cancer and answering the questions of the patient and family
- Pronouncing the expected or unexpected death of a patient who may or may not know and spending time speaking with the family, maybe even crying with them (yes, crying is OK)
- Telling a patient he or she is cured of a malady
- Going through routine hospital and office visits
- Going back to the hospital after office hours to check on a critical or postoperative patient
- Calling the intensive care unit upon arriving

*Kübler-Ross E. *On Death and Dying*. New York, NY: Touchstone; 1997.

[†]Remen RN. *Kitchen Table Wisdom*. New York, NY: Riverhead Books; 1996.

home to find out how a patient is doing

- Making numerous phone calls and/or going back to the hospital in the middle of the night while on call

We go from patient to patient to patient, changing emotions, changing mental pathways, constantly without missing a beat. We never get the time to account for our own emotions and feelings. Doing this day after day after day empties our emotional bank, whether we are aware of it or not, leading to the point of overdraft or even bankruptcy of our own personal ability to continue to deal with this stress. We never allow ourselves to process our grieving and over time we get burned out. We can't take it anymore.

How do we treat burnout? How do we reinspire our love for what we do? We are the best at what we do. My wife and kids tell me all the time, "You are a great doctor. We need doctors like you. You care and it shows." We must allow ourselves not the luxury but the necessity of going through the grieving process. It will decrease the stress. We need to reignite the fire of passion for the practice of medicine and surgery again. If it is good enough to teach and help our patients, then, as the Bible says, "Physician, heal thyself" (Luke 4:23).

In her book *Kitchen Table Wisdom*, Rachael Naomi Remen, MD, says it so well: "It is not that we don't care; we care too much."[†] □

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