



The New Normal

Physician Burnout: A Pandemic Uncovered by a Pandemic!

Lalitha Sundararaman, MBBS, MD Sau Yee Chow, MBBS Lenin Babu Elakkumanan, MD, DNB
Vanitha Rajagopalan, MBBS, MD, DNB, DM Amit Verma, MD, DNB, FIPP

The unprecedented morbidity and mortality of the COVID-19 pandemic have been at the forefront of our consciousness. However, the ravages of COVID-19 extend beyond death and disease. The pandemic of the past two years has stressed the economies of every country and placed unforeseen burdens on health care systems everywhere. Health care systems have continuously evolved and adapted to meet the needs of a populace caught in a crisis. However, the health care systems themselves now face an internal crisis: burnout!

As first described by Herbert Freudenberg, an American psychologist, burnout is “a syndrome of emotional exhaustion, loss of meaning in work, feelings of ineffectiveness, and a tendency to view people as objects rather than as human beings” (SAGE Open 2017;7). This definition was updated in 2019 by the World Health Organization, which defined burnout as a syndrome resulting from chronic workplace stress that has not been successfully managed and is characterized by feelings of exhaustion, depersonalization, negativity, and reduced productivity (asamonitor.pub/3D3oxM4).

Burnout has always been disproportionately higher in health care workers than the general workforce. The COVID-19 pandemic exacerbated burnout, which is now protracted and entrenched in health care (JAMA Netw Open 2020;3:e203976). A PubMed search of “burnout” shows a clear trend: from 1981 to 1990, there were 1,043 articles; while from 2011 to 2020, there were 10,451 (Figure 1). Narrowing the search to COVID-dominant years of 2020 to 2021 yielded 3,595 articles. Clearly, if we are to sustain quality health care, governments, institutions, and the public must make every effort to mitigate provider burnout (N Engl J Med 2020;382:2485-7).

Multiple factors have intensified and accelerated burnout among anesthesiologists during COVID. Anesthesiologists have hitherto been largely out of the spotlight in the eyes of the general public. But throughout the COVID-19 pandemic, our procedural skills and our

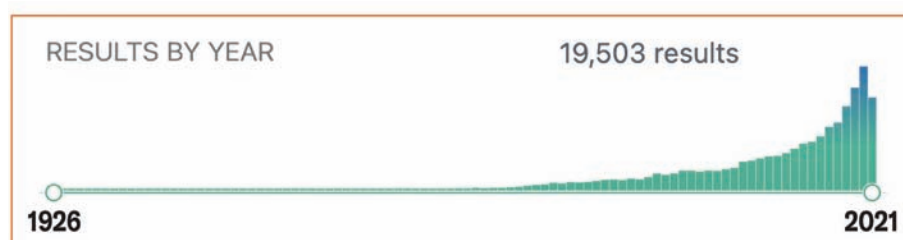


Figure 1: Pubmed search results for ‘burnout.’



Figure 2: Steeling for tough times – waiting for a COVID case to start in Singapore. Photo courtesy of Sau Yee Chow, MBBS.

unique expertise in intubation, ventilation, resuscitation, critical care, and ICU management resulted in our assuming front-line and very public roles (J Clin Anesth 2021;68:110084). Many anesthesiologists were diverted to remote locations. Nearly all of us worked longer and less predictable hours while facing protective equipment shortage and greater occupational hazards (Anesth Analg 2020;131:106-11). Health care workers feared exposing themselves to the virus, becoming ill or worse, and inadvertently infecting loved ones.

Some health care workers decided to live separately from their families, which exacerbated their distress. This was especially common in several European and Asian countries. The stress of managing a new and aggressive illness was compounded by the cognitive burden of ever-changing clinical data, government-

tal recommendations, and hospital policies. Inevitably, these were inconsistent, reflecting how little was known about SARS-CoV-2 in the early days, the rapid gathering and synthesis of new knowledge by clinicians and scientists, and the need for evidence-based guidance despite high levels of uncertainty. Health care providers also grappled with emotionally taxing interactions with families of ill patients, who themselves struggled to understand a new disease and who received conflicting and inconsistent messages from both social media and government spokespeople.

Anesthesiologists were involved in end-of-life decision-making, delivering bad news, and explaining why visitation of dying patients was disallowed. We were tormented by the moral tension arising from triaging limited resources such as ventilators and ICU beds and haunted by seeing large numbers of mostly preventable deaths. Finally, many anesthesiologists suffered financially from cancelled elective surgeries.

Physicians have developed strategies to manage burnout, turning to families, friends, social interactions, and institutional support. The pandemic took away many of the strategies in our arsenal to fortify ourselves. Most discouragingly, even today there seems to be no end in sight. The virus is again surging in many parts of the world, even those countries that adopted aggressive vaccination campaigns. Even Pandora had hope in her box. With the virus constantly mutating, the “New Normal” seems as bleak as a wintery London morning.

Pre-COVID, the United States already faced a shortage of anesthesiologists (asamonitor.pub/3qrb7Gi). The Association of American Medical Colleges estimates a shortfall of 10,300 to 35,600



Lalitha Sundararaman, MBBS, MD

Clinical Instructor, Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Hospital, Harvard Medical School, Boston.



Sau Yee Chow, MBBS

Fellow, Brigham and Women's Hospital, Boston.



Lenin Babu Elakkumanan, MD, DNB

Professor, Department of Anaesthesiology and Critical Care, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER), Puducherry, India.



Vanitha Rajagopalan, MBBS, MD, DNB, DM

Assistant Professor, Department of Neuroanesthesiology and Critical Care, All India Institute of Medical Sciences (AIIMS), New Delhi, India.



Amit Verma, MD, DNB, FIPP

Associate Staff Physician, General Anesthesia and Pain Management, Cleveland Clinic Abu Dhabi, United Arab Emirates.

“other specialty physicians” (anesthesiology included) by 2034 (asamonitor.pub/2STYO6U). The most recent 2013 report commissioned by ASA estimates a shortage of 3,000 anesthesiologists by 2025 (asamonitor.pub/3D7D4WV). Demand is rising while supply is shrinking. An aging, sicker population and greater insurance coverage are increasing demand, independent of the surge in demand during the pandemic. However, the supply is shrinking as the pandemic accelerates the number of anesthesiologists choosing retirement or reducing working hours.

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