Physician Burnout: A Pandemic Uncovered by a Pandemic!

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he 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

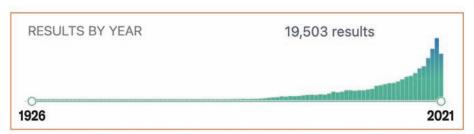


Figure 1: Pubmed search results for 'burnout.'

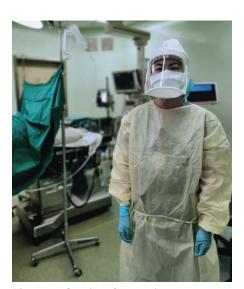


Figure 2: Steeling for tough times – waiting for a COVID case to start in Singapore. Photo courtesy of Sau Yee Chow. MBBS.

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, governmen-

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



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"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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Over the past year, 595 American physicians have died from COVID or suicide, a heart-rending loss (asamonitor. pub/30lIYWd). The scale of burnout is orders of magnitude greater. A Washington Post-Kaiser Family Foundation survey found that 20%-30% of front-line health care workers are considering leaving the profession (asamonitor.pub/3n0ylRm). Anesthesiologists are also choosing to retire prematurely (asamonitor. pub/3qFtHKX). Since February 2020, 30% of U.S. health care workers have either lost their jobs (12%) or quit (18%). Thirty-one percent of those still employed as health care workers have considered leaving their place of employment, and among these, 19% have thought about leaving the field entirely despite years of education, training, and costs. Seventynine percent of surveyed health care professionals said the national worker shortage has affected them and their place of work, increasing workplace stress (asamonitor.pub/3D484qJ).

This exodus of medical professionals is not unique to the U.S. Across the pond, a British Medical Association survey found that 44% of doctors reported depression, anxiety, stress, burnout, or other mental health conditions related to or exacerbated by their work (asamonitor.pub/3kp5jJu). It wasn't just the COVID onslaught that increased stress. U.K physicians reported rising discrimination (reported by Black, Asian, and other minority staff). Junior doctors reported increased intensity of workload, discrepant pay, and reduced personal reward in their work. These factors had been simmering in the NHS prior to the pandemic but came to the forefront during COVID times. Fully half of the survey responders said they planned to reduce hours after the pandemic, and 20% planned to shift careers altogether.

The pandemic has affected the "supply chain" for anesthesiologists. It has also prolonged residency training by limiting access to elective surgeries during the most acute phases and shifting residents away from elective rotations required for completion of their training. Every step in training, from medical school applications and admission, USMLE Step examinations, residency applications, board examinations, and eventually physician licensing relies on travel, logistics, and administrators. Public school closures and lack of childcare services forced many trainees (and practicing anesthesiologists) to stay home, reducing working hours, or delay education. Forty percent of anesthesiologists under 36 years of age are women. These women are three times as likely as their male counterparts to work part time (Anesthesiology



Figure 3: Doctors Nationwide Strike. Guwahati, Assam, India. June 17, 2019. Indian students and doctors of Guwahati Medical College Hospital GMCH hold posters as they stage a silent protest during the nationwide strike held after the recent assault in Kolkata on a physician intern.

2015;123:997-1012). The July 2021 ASA Monitor featured a series of articles on the unequal burden of COVID-19 on women anesthesiologists.

This is a global problem. Chinese anesthesiologists had some of the highest rates of burnout in medical specialties even prior to the pandemic, a statistic that could only

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have worsened with the pandemic (Anesth Analg 2018;126:1004-12). Other countries, such as the UAE and Singapore, have not been sparred, either. These nations have a strong immigrant workforce that has declined due to the pandemic, while demand has surged. There is scarcity of large-scale data on the prevalence of burnout among the various health care professionals in UAE. In an earlier study, Abdulrahman et al. reported an aggregate prevalence of at least one symptom of emotional exhaustion in 70% of medical residents. Awad AL Omari et al., in their cross-sectional study,

demonstrated significant levels of burnout dimensions among health care professionals. They also noticed significantly higher emotional exhaustion among the female participants as compared to males (*Appl Sci* 2020;10:157).

The situation is no different in lowand middle-income countries. According to data from the World Federation of Societies of Anaesthesiologists (WFSA), India has 12,000 providers with qualifications in anesthesiology to address the needs of its population of 1.3 billion people (asamonitor.pub/30bffPZ). This reflects a crisis in the surgical workforce and the large gaps that exist in critical surgical and emergency care, gaps revealed when COVID ravaged the country last year. Many sub-district hospitals have only one anesthesiologist for both obstetric and surgical cases (Ann Glob Health 2021;87:15). Five hundred bedded district hospitals have the "luxury" of four anesthesiologists tackling all types of cases. Working with minimum monitoring and acute shortages in drugs and equipment, and without the support of anesthesia technicians or CRNAs, more than 60% of Indian anesthesiologists report working more than 50 hours each week. Only half of Indian anesthesiologists expressed job satisfaction in a survey by Shidhaye et al. (Anaesth pain & Intensive Care 2011;15:30-7). Punishing hours, grueling schedules, emotional drain, lack of recognition from the public, unlike in other countries, coupled with an apathetic government have been cited as major causes. In addition, India has had many cases of violence against doctors that have only added to discontent and indeed disenchantment with the profession. COVID has only added to this wicked brew. A total of 382 COVID-related deaths and 2,174 infections was reported among doctors in India as of September 10, 2020, with a case fatality rate of 16.7% among Indian doctors, which was 10 times the rate of 1.7% in the general population, further contributing to the decreased workforce and increased stress.

While in most countries lack of recognition to anesthesiologists has been a crucial issue, media notoriety and a constant barrage of false information through social media have added to physician woes. When doctors in Anchorage advocated masks, vaccines, and social distancing, they were booed at the gathering and openly vilified and denigrated. The next day, Alaska's most widely read conservative blog published an article titled "Medical theater: Doctors, nurses coordinate with liberal Assembly to intimidate community over vaccines." As per the article, readers left dozens of comments accusing the medical professionals of lying, withholding effective medical treatments, and deliberately hurting or killing their patients. Nurses in scrubs have been attacked in public places (JAMA 2021;325:1822-4). Assaults from angry patients, acting on COVID misinformation, have caused some medical centers to distribute "panic buttons" to providers (asamonitor.pub/30dDHzx). It is difficult enough to help people with life-threatening illness. The same is true for politically motivated efforts to silence physicians and epidemiologists, which have been linked to increased deaths (BMJ 2021;375:n2552). Anger and frustration, fed by misinformation, may be a significant driver of provider burnout.

Most of the authors of this article had childcare issues that they managed to put aside while schlepping off to work, hoping for a better day than the last. But for anesthesiologists in countries with fewer protections, caring for young families with the daily fear of becoming infected, or passing the infection to one's children, has likely driven many anesthesiologists to leave the global workforce entirely.

The world may be slowly meandering out of the wreckage of COVID, but progress has been halting and unsteady. We are only two years into the pandemic and already physician burnout is creating provider shortages. We don't know if the problem will resolve in the years ahead, or whether the problem will accelerate from the positive feedback of decreased numbers increasing the stress of those still working, resulting in an accelerating loop of physicians leaving the workforce.

On the other hand, the pandemic has seen a greater sense of fraternity among physicians all over the world. Physicians have been united in a common sense of purpose in fighting the good fight. There has been extensive exchange of knowledge and resources. There has been mutual recognition of a burden shared and the need for collegial support and kindness. Only in retrospect will we understand if these are enough to address physician burnout during the COVID-19 pandemic.