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Original article

# Challenges in treating physician burnout: The psychologist's perspective

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## ABSTRACT

**Objective.** – Burnout is a multidimensional stress syndrome that is particularly prevalent in physician populations. While the literature expands on preventive and curative interventions, relatively little is known about factors that may hamper their success. The aim of this study was (1) to identify the specific challenges to treat physician burnout and (2) to explore the origins of these challenges.

**Methods.** – We conducted semi-structured interviews with twelve psychologists who had treated physicians with burnout and performed thematic analysis of data.

**Results.** – Psychologists identified two specific challenges in treating physician burnout. First, physicians were reluctant to seek help from health professionals and tended to do so at more severe stages of exhaustion. Second, physicians were feeling uncomfortable in the role of patient, and many of them had difficulties to accept treatment. Psychologists suggested the following causes of these challenges: (1) most physicians did not have a general practitioner, (2) they felt guilty about reducing their workload, and (3) tended to confuse professional and personal engagement. According to participants, medical education, the professional culture and the image of the profession in the wider community were likely factors contributing to physicians' reluctance to seek and accept care.

**Discussion.** – This research showed that the specific challenges to treat physician burnout are mostly related to their reluctance to ask for help and to put their trust in other caregivers. Among the reasons for this behavior, most are linked with physician's representation of professional identity as enduring and selfless.

**Conclusion.** – Further studies are needed to explore how medical education and professional culture can be changed to reduce the risk of physician burnout and facilitate care when it nonetheless arises.

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## 1. Introduction

Burnout has been described as a work-related syndrome combining emotional exhaustion, depersonalization, and low personal accomplishment [1]. Although we lack systematic procedures for burnout rates calculation, the prevalence of burnout in physicians seems higher than in the general population (e.g., with 22% among Belgian physicians versus 0,8% in the general population) [2,3]. Yet, physician burnout can have serious

professional and personal consequences [4]. Physicians suffering from burnout provide suboptimal care to their patients, characterized by a heightened risk of medical errors as well as reduced professionalism and empathy [5]. They may take prolonged sick leaves or abandon the profession, leading to workforce issues. On a personal level, they are at high risk of depression and suicide. As a consequence, both the research community and stakeholders call for efficient interventions.

According to the literature, both individual-focused and structural or organisational solutions are required to reduce physician burnout [6]. While training programs based on mindfulness or stress management, and group discussion settings have been studied, little research has been done on the individual psychological support that can be provided to distressed physi-

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cians. Beyond the matter of technique, Swensen and colleagues highlight the importance of physicians' engagement and perceived control in the implementation process of an intervention [7].

Interestingly, Walsh and colleagues interviewed hospital physicians about their experience of work stress and burnout, as well as their suggestions and preferences regarding interventions to prevent or reduce work stress and burnout [8]. Aside from adequate staffing levels, access to statutory leave, and cover when on leave, physicians set as a high priority intervention the development of psychological support in the everyday working environment. Such support includes:

- debriefing of everyday challenges and difficult cases with a senior team member;
- regular psychological check-ins by a supervisor or clinical line manager, and;
- a psychological service for self-reflection and professional development as distinct from a treatment service.

At a secondary level of intervention, physicians mentioned teaching of self-care skills (i.e., prioritizing one's health, maintaining boundaries between work and personal life, and cultivating interests outside of work), and considered these to be of equal importance with clinical skills. Furthermore, they expressed the need to break the culture of stigma within medical practice and the normalizing of suffering at work. This will be achieved through health promotion interventions and peer sharing from recovered physicians of the risks and care pathways. At the tertiary level, physicians suggested training professionals in how to identify distress in their colleagues and provide them with adequate support, as well as the development of a more effective line management for sick physicians (i.e., at the stages of help seeking, recovery and return to work).

Importantly, interviewed physicians raised several obstacles to the prevention and treatment of work stress and burnout. As regard to the reasons why physicians do not tend to seek help when necessary, respondents identified a lack of self-awareness (i.e., impact of work stress or burnout on their health), being too busy, as well as fears of consequences at the professional and social levels (i.e., image of weakness). As a matter of fact, stigma against seeking help constitutes a substantial barrier to physician care that needs to be addressed [9]. Furthermore, when physicians do end up seeking help, additional obstacles may be encountered. Although they impact treatment outcomes, these impeding factors and underlying mechanisms have been understudied. For these reasons, the aim of this study was:

- to identify the specific challenges to treat physician burnout and;
- to explore the origins of these challenges from the perspective of clinical psychologists.

## 2. Methods

This study used a phenomenological approach to examine the specific challenges that psychologists experience in treating physician burnout. Through this approach, researchers sought to understand the phenomenon exclusively from real clinical situations encountered by psychologists. Indeed, the phenomenological approach is characterized by the systematic use of experiences' description without referring to a theory [10].

### 2.1. Population

Psychologists were randomly selected from the list of members of the Belgian Federation of Psychologists (available on the

website). Diversity in terms of gender, job tenure and localization were sought. Researchers had no connections with respondents.

A pre-requisite for participants is that they had treated at least two physicians with burnout and agreed to take part in that study.

### 2.2. Data collection

Forty-three psychologists were called. Five refused to participate and twenty-four didn't have the pre-requisite experience. From the qualified pool of respondent, ten were initially selected and interviewed. After completing the analysis of the data, it was decided to add further participants to achieve data saturation, which was reached with twelve interviews.

Semi-structured interviews were conducted by three clinicians with expertise in burnout treatment in a place chosen by the respondent. The interview guide was focused on the psychologists' experience with physicians suffering burnout. Interviews lasted in average forty-five minutes. All of them were recorded, transcribed and anonymized.

After informed consent, psychologists were interviewed about three main themes: specific challenges, their origins and potential solutions.

### 2.3. Data analysis

Thematic analysis was performed by interviewers, under the supervision of the first author [10].

First, the analytical framework was defined depending on the interview guide: challenges, origins, and potential solutions.

Then, two interviewers performed separate inductive coding for each interview. They constructed a codebook by classifying codes into themes. Data triangulation was performed by the first author to yield convergence.

Finally, the first author constructed the coding tree that was approved by the research team.

An overview of the identified causal pathway for challenges in treating physician burnout is represented in Fig. 1.

## 3. Results

As summarized in Table 1, our sample comprised both male and female psychologists with various clinical approaches. Data about the number and kind of physicians treated lacked for most respondents.

### 3.1. Specific challenges

Respondents identified two specific challenges in treating physician burnout.

First, fewer physicians consulted and at a later stage than other professionals. If the risk factors were the same, their burden seemed to be heavier. These factors could differ depending on the context of practice, but psychologists did not make a difference between physicians concerning the challenges and their origins.

"I often hear about physician burnout, but I have few physicians among my patients"  
 "They're waiting longer than other patients. When they consult, they are in a deeper exhaustion."

Second, physicians had difficulties identifying themselves as patients. Some respondents said that physicians hadn't accepted their therapeutic strategies easily. Others didn't feel recognized as competent professional therapists by these patients. For these reasons they expressed that the establishment of the therapeutic relationship had been complicated.

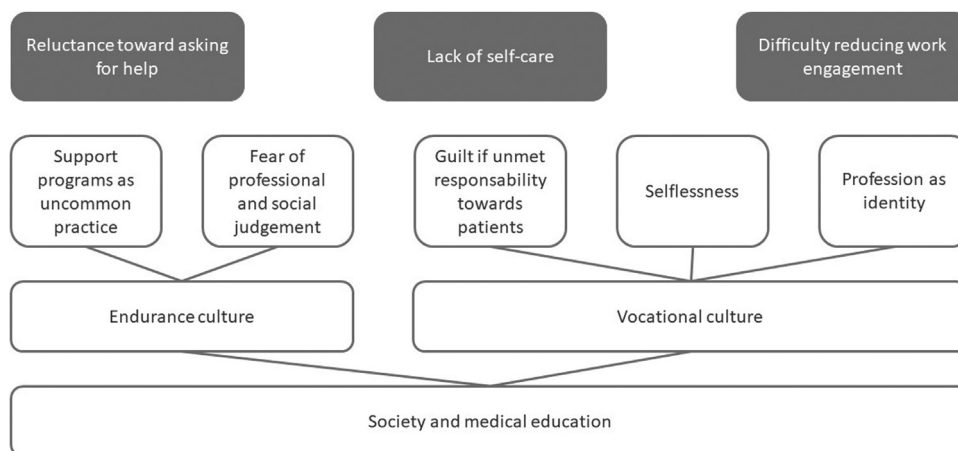


Fig. 1. Overview of the identified causal pathways for challenges in treating physician burnout.

Table 1 Demographic and professional characteristics of the respondents.

Respondent	Gender	Age	Type of psychotherapy	Physicians treated
P1	M	43	Cognitive-behavioral	Hospital doctors (n = 4)
P2	F	52	Psychoanalysis	Hospital doctors and GPs (n = 10)
P3	F	42	Humanistic	Hospital doctor and GP (n = 2)
P4	M	35	Integrative	Hospital doctors and GPs (n = 3)
P5	F	57	Systemic	GPs (n = 2)
P6	F	52	Cognitive-behavioral	GPs (n = 10)
P7	F	37	Cognitive-behavioral	Hospital doctors and GPs (n = 5)
P8	F	42	Cognitive-behavioral	Hospital doctors and GPs (n = 7)
P9	F	65	Systemic	Hospital doctors and GPs (n = 35)
P10	F	60	Systemic	GPs (n = 2)
P11	F	58	Systemic	Hospital doctor and GPs (n = 20)
P12	F	37	Cognitive-behavioral	Hospital doctors and GPs (n = 7)

“At best, I am a colleague. They never accepted to be my patients.”  
 “The creation of the therapeutic relationship is very, very sensitive.”

3.2. Origins of these challenges

According to the respondents, three reasons could explain these challenges.

The first reason was that physicians consider themselves as their own caregiver, with the underlying belief that if they are able to treat patients, they should be equally able to treat themselves. Additionally, asking for help could be considered a sign of weakness or incompetence. These two perceptions can be linked with:

- the fear of professional and social judgement by peers and patients;
- the promotion of an “endurance culture” by medical faculties, and;
- the fact that support programs are not a common practice for physicians.

“A physician doesn’t ask for help from another caregiver. They can treat themselves. It’s very difficult to say, ‘I cannot treat myself’”.

“They are trained to endure a lot of things. They have to bite the bullet and not complain”

Secondly, physicians have strong feelings of guilt when they reduce their working time or have to take sick leave. These feelings seem to be linked with a deep sense of responsibility towards their patients. Indeed, some physicians sacrifice their own well-being to meet patients’ needs. Moreover, society reinforces this selfless behaviour by promoting a representation of the profession as a vocation, with power but also great responsibility.

“There is a societal vision of the physician’s role: the self-sacrifice for other people”  
 “They have a power over other people. For some physicians, that mean that they have to balance that power by being available for patients always.”

Thirdly, some physicians confused professional and personal identity. Indeed, a lot of physicians defined themselves by their professional identity. In some cases, medicine was a vocation since childhood. Furthermore, family, peers and society deem the profession prestigious. As a consequence, career change or reducing work engagement appears almost impossible to physicians.

“For other professional, there are sometimes the openness to thing ‘I could change job’. For physicians, that never happens.”  
 “Everybody dreams that his child become a physician. It’s wonderful to save lives! So, when you become a physician, you need to love your job and never reconsider them.”

### 3.3. Proposals of interventions

Psychologists identified several interventions that may improve prevention of physician burnout. These included the introduction of the notion of self-care during medical studies and continuous training, as well as the implementation of support groups.

As for the treatment of physician burnout, specific programs could be developed to address the above challenges.

Finally, some respondents highlighted the need for change at the cultural level of the profession.

## 4. Discussion

This research showed that, according to psychologists, the specific challenges to treat physician burnout were mostly related to their reluctance to ask for help and to put their trust in other caregivers. Among the reasons for this behavior, psychologists identified physician's representation of professional identity as a vocational job where physicians are able to endure work stress and prioritize patient's needs above their own.

These results are consistent with other studies which have shown that physicians tend to neglect their own health [4]. For example, high sickness presenteeism is observed because physicians may have difficulties in evaluating their own health and identifying when they need to stop working [11–15]. Furthermore, physicians would be less inclined to take a break for mental health problems than for somatic reasons [15]. Yet, sickness presenteeism can affect quality of work and physicians' long-term health [5,16–18]. Indeed, psychologists interviewed in our study reported more severe symptoms in physicians as compared to burned-out patients from other professions. They also posited that lacking regular medical care, was one of the reasons physicians were at higher risk of burning out. Indeed, having their own caregiver could be beneficial to physicians as they would get a more objective assessment of their health status. As a matter of fact, a survey among surgeons showed a lower rate of burnout among those who had seen a general practitioner in the previous year [19]. More globally, peers' support seems essential to recognize that they need help, encourage them to ask for it and be open to receiving the help [15,20,21].

Our data also converge with the literature showing physicians' dependency on their work. As expressed by one of Walsh and colleagues' respondents, physicians' work and identity are very closely entwined, putting them at higher risks of work stress and burnout. Indeed, as little energy is invested in activities outside of work, physicians mainly derive meaning and satisfaction from their professional activities. As a consequence, professional shortcomings may weaken physicians' well-being to a greater extent than individuals whose professions are less consuming. Corollary, the matter of sick leave is difficult to handle, as their work is viewed as a core part of themselves [15].

Furthermore, our data highlight the interaction between culture and individual functioning in the medical domain. As suggested by the literature, professional culture has indeed a major influence on physicians' behavior. For example, going to work despite poor health tends to be a shared standard within the medical community, while going on sick leave is typically perceived as a sign of weakness or a lack of loyalty [13,15]. As our respondents suggested, medical studies reinforce sickness presenteeism by conveying intolerance for sick leave [22]. In that sense, Montgomery demonstrated that not asking for help was a normalised behaviour among medical students [14]. Therefore, psychologists from our study echo Walsh and colleagues' statement about the need for a cultural change in medicine: "from stigmatisation and competitiveness to compassion and collaboration" [8].

Overall, our study further demonstrates that physicians' tendency to avoid seeking help is linked with obstacles at the personal, social, organizational and cultural levels. Future studies are needed to find ways around these impediments to physicians' professional well-being.

To our knowledge, this study was the first to approach physician burnout from the perspective of professionals who provide physicians with psychological help. This method allowed us to explore specific challenges to treat physicians and the possible roots of these challenges. Although our data partly derive from respondents' interpretations of physicians' experience, they were relatively consistent across interviews, and strongly align with data extracted from physicians in other qualitative studies [8,23].

### Human and animal rights

Not applicable.

### Informed consent and patient details

The authors declare that this report does not contain any personal information that could lead to the identification of the patient(s).

### Disclosure of interest

The authors declare that they have no competing interest.

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### Author contributions

All authors attest that they meet the current International Committee of Medical Journal Editors (ICMJE) criteria for Authorship.

Anne-Laure Lenoir: conceptualization, formal analysis, supervision, and validation and writing.

Caroline De Troyer, Carole Demoulin, and Ingrid Gillain: investigation and analysis.

Marie Bayot: validation and writing.

## Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <https://doi.org/10.1016/j.lpmope.2021.100006>.

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