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BURNOUT: PUTTING YOUR OWN OXYGEN MASK ON FIRST

PART 2

CONTINUATION FROM THE PREVIOUS ISSUE

BURNOUT AS A CLINICAL DIAGNOSIS

There has been a drive to “medicalise” burnout by some medical professionals. The driving force appears to be the goal of establishing a clinical diagnosis for burnout in order for health professionals to receive reimbursement for treating individuals suffering from the

condition.

This shift to diagnosing burnout as an individual disorder has mostly been taking place in Northern Europe, primarily in Sweden and the Netherlands. Sweden began using “work-related neurasthenia” as a burnout diagnosis in 1997 which soon became one of the five

most frequent diagnoses.

In 2005 Sweden revised the ICD-10 burnout diagnosis (Z73.0) as a difficulty in life management characterized by “vital exhaustion”. The signs of vital exhaustion include two weeks of daily experiences of low energy, with difficulties in concentration,

irritability, emotional instability, dizziness, and sleep difficulties. Additionally, these symptoms must interfere with the patients' capacity to perform their work responsibilities.

In the Netherlands, the term "overspannenheid" or "overstrain" is used to indicate burnout. This diagnostic approach estimates burnout prevalence at 3-7% across various occupations, with psychotherapists at 4%.

America has been reluctant to recognise burnout as a clinical diagnosis, partially due to concerns about a flood of requests for disability coverage. Regrettably, the lack of an official diagnosis of burnout limits access to treatment, disability coverage and workplace accommodations. An unfortunate consequence is that inaccurate diagnoses may reduce possibilities for successful recovery and return to work.

The World Health Organisation (WHO) has taken to classifying burnout in the next International Statistical Classification of Diseases and Related Health Problems (ICD) as an "occupational phenomenon". The statement was followed by a frenzy of articles in mainstream media, erroneously proclaiming that "burnout is now recognised as a medical illness".

Currently the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) does not acknowledge the term burnout, as sufficiently valid and internationally agreed upon diagnostic criteria are lacking. Hence it is not recognised as a diagnosis or clinical entity at this time.

The ICD-10 already recognised burnout under 'Problems related to life-management difficulty' (Z73.0) which details reasons for people contacting health services. However, these reasons are not classed as illnesses or health conditions.

Burnout is defined in the ICD-11 as follows:

"Burnout is a syndrome conceptualized as resulting from chronic workplace stress



that has not been successfully managed. It is characterised by three dimensions:

- feelings of energy depletion or exhaustion
- increased mental distance from one's job, or feelings of negativism or cynicism related to one's job
- reduced professional efficacy

Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life."

The phenomenon is increasingly recognised and likely to gain momentum in the future as it is regarded as impairing and consequential.

TREATMENT AND PREVENTION

Interventional strategies have come to the fore as the burden of burnout is increasingly recognised, on both a personal and organisational level.

On a personal level, a Canadian study of physicians identified resilience as a dynamic, evolving process of positive attitudes and effective strategies. The study found

four main aspects of physician resilience:

1. Attitudes and perspectives: this includes valuing the physician role, maintaining interest, developing self-awareness, and accepting personal limitations
2. Balance and prioritisation: setting limits, taking effective approaches to continuing professional development and honouring one's self
3. Practice management style: sound business management, good staff and using effective practice arrangements
4. Supportive relations: including positive personal relationships, effective professional relationships and good communication

No measures to prevent burnout will be effective unless attention is paid to enhancing a positive work environment. Isolated strategies directed at individual doctors may prove of limited benefit. A positive work environment is defined as one "that attracts individuals into the health profession, encourages

them to remain in the health workforce and enables them to perform effectively to facilitate better adaptation to the work environment”.

Key features of a positive work environment include where work-life balance is achieved by providing a family-friendly work environment and flexible working hours. Protection from exposure to occupational risks, enhancing job security, provision of childcare opportunities, compensation for reduced employment and maternity/parental leave were identified as attributes of work environment that prevent burnout. **MHM**

References available upon request



SOME OF THESE PRACTICAL SUGGESTIONS MAY HELP IF YOU FIND YOUR CANDLE BURNING OUT AT BOTH ENDS:

1. Communicate with colleagues about it: in the setting of a regularly scheduled group or simply informal conversations about the stressors of work
2. Minimise administrative work: possibly involving investment in an assistant. The cost can be minimal, especially hiring a virtual assistant, who may work a few hours a week from a remote location.
3. Develop new professional skills: for example, teaching, consultation or business management
4. Conscious efforts to re-engage with clinical work: rediscover the idealism and intellectual curiosity that attracted you into medicine initially
5. Meditation and mindfulness: 5–10 minutes scheduled into your day may go a long way

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