

A CLINICIAN'S EXPERIENCE OF BURNOUT

The experience of burnout may be insidious in onset, as Dr. P. reports. Years ago, while attending a professional meeting, he found himself in conversation about the pressures working for large hospital systems. With the others, he commiserated about how little interest there was in anything beyond the diagnostic and pharmacologic aspects of psychiatric care. He realized in the course of his conversation with his colleagues that the hospital system where he was employed was underestimating his value. The long hours, low pay, poor benefits, and the realization that he was taken for granted had resulted in his feeling irritable and devalued.

Dr. P. has always been interested in applying psychodynamic concepts to clinical practice. Over many years, his dedication to teaching psychodynamic psychiatry to residents had become legendary. On one occasion, a surprise party was thrown in his honor by scores of former residents. Newly encouraged, he decided to interview elsewhere in the hope that his skills as a teacher and his conscientious devotion to patient care would be recognized.

Dr. P. applied for a promising position, sailed through the interview, and was immediately accepted. The salary would be adequate. He looked forward to a full out-patient practice in the hospital clinic and the opportunity to teach residents – and he looked forward to working with several like-minded psychiatrists in a clinic for indigent, disenfranchised people.

Over the next few years, Dr. P. found he was absorbing the care of patients as other clinicians resigned. Also, he found that his paychecks were considerably lower than had been promised. There had been a misunderstanding. Then, Dr. P. suggested to the Director or

Psychiatry that since he was the recipient of the annual Best Teacher awards that perhaps this achievement merits an announcement in the hospital newsletter. That did not happen.

Increasingly, he found this hospital system was repeating the mix of excessive demands for administrative and patient care responsibilities, inadequate pay, and insufficient recognition that he had found before.

He decided to avoid hospital politics. He would keep his head down, teach residents who valued his lectures and supervision, and continue providing good patient care. Before long, the hospital-associated methadone clinic was sending him most of its patients. Often, these patients sought benzodiazepines. Acknowledging that he was susceptible to flattery for his clinical competence and diligence, Dr. P. accepted the increased responsibility. He realized only slowly that his work hours were lengthening, his sleep suffering, and his mood darkening. Still, his caseload grew. The cumulative demands from housing counselors, vocational programs, and SSI lawyers for updated evaluations steadily increased. Dr. P. commuted to the hospital to complete paperwork at 5 a.m. in order to be ready for the 8 a.m. onslaught of the methadone addicts with their inveterate complaints about shelter accommodations or benefits checks.

Dr. P. recognizes that his conscientiousness, perseverance, and compassionate attention to patient care were not solely a function of his professional identity. He notes that he did much of this not from goodness of heart, but because it was easier than facing confrontations with the murderers, drug-dealers, or other felons that constituted much of his patient group. To insist on setting limits on these patients' demands was often futile. Patients would find ways to work around limits, including complaints to pliable administrators. Though Dr. P. was once again finding himself descending into burnout, the administration was delighted: he worked hard,

completed required paperwork, and was well-liked by patients, staff and residents. He was told, "Why, you earn us more money than all the rest of the staff put together." Later, he learned that staff were sent to homeless shelters to "drum up business."

Dr. P. acknowledges that he was told by the administration to "take it easy." Yet in practice, if he took a day off, he would face double the number of angry regressed patients the next day. His daily challenge was to maintain a professional attitude even as he was cursed and threatened for attempting to set limits, or adored and flattered if controlled medications were renewed on request.

Several years into this employment, Dr. P. was told during a routine medical exam that he had suffered a silent myocardial infarction. He was told that a second MI could be fatal. His work routine needed to change. Though his Director heartily agreed that he needed to slow down, the administration continued to invite more and more patients to come for Dr. P.'s "excellent compassion." The Director insisted that it was for the doctor to place limits on the hours of patient care he could offer. It was up to him. But this was not possible for Dr. P. He says that it was his own psychological deficiency. He couldn't say 'No'. The administration continued to send more patients, with compliments like, 'Oh, you love it and you're so good! Nobody else could take it.' The administration could not stop the increasing flow of work. Neither could he.

Doctor P. became increasingly angry, curt, sarcastic, and unempathic. Outside of work, he ceased all creative pursuits including work at his easel, and was unable to experience sexual or intellectual satisfaction. He had lost physical strength and energy. He had little appetite. As he lost weight, he became increasingly haggard. His sleep became interrupted. At home, his wife

was concerned about his increased moodiness, apathy, his excessive hours of work, and his growing disinterest in his adult children's lives. Whereas he had had been a loving and available grandfather, he had become morose and distracted. Only during extended vacations did his symptoms remit.

He was burned out. After seeking support, he took the next step and resolved that he must slow down. Yet he was trapped in his hospital job. Over years, he had established a reputation among patients and administrators all of whom had a claim on Dr. P.'s sustaining the same level of effort. Although pulling back was necessary in the abstract, the specific needs each day of individual patients and administrative tasks proved impossible to decline.

Dr. P. learned of a new job opportunity. It promised a much higher salary and far better working conditions than he imagined possible. He applied and was hired. Though he knew leaving his current job was necessary, he had bonded ambivalently with patients and staff. With the encouragement of his family and friends—and awareness of health concerns—he served notice and arranged to start in his new position.

Within a week of moving forward, his appetite returned and he began to gain weight. He started walking more, returned to his easel, and regained libidinal interest. He became hopeful and showed renewed interest in friends and family. When he started at his next position, he found he interacted well with patients and staff. He feels hopeful that he can recognize the signs of burnout if they appear and, if they do, to prioritize the need to make midcourse corrections.

COMMENTARY

We are grateful for Dr. P's account--for his courage in speaking forthrightly about his circumstance. He is a diligent professional, an outstanding teacher, and a clinician generous in his work with the indigent. He perseveres professionally despite insufficient recognition, excessive administrative demands, and inadequate remuneration. He is aware that he is exploited by the hospital administration and yet is inhibited in effectively addressing the many inequities.

Some of us might shout out, "Stand up for yourself! Insist on getting good pay and limit the clinical work they are demanding of you!!" Why is that accusation an impulse we might have? Why are we prone to 'blame the victim,' in this case the victim of administrative oppression? We know the answer. He is right here, a target messy with human imperfection. We are spared needing to consider the blurred abstraction known as the administration. Our easy impulse is to blame him. We must look harder. We must remind ourselves, this is Kafka's world.

Still, it is also true that standing up to the administration is not Dr. P's way. Aggressive confrontation is not a notable characteristic of most physicians. Physicians tend to assume that clinical competence, diligence, and caring will be appreciated. As a consequence, Dr. P endures and endures. Over the course of years, his work life satisfaction erodes. His personal life is impacted. He becomes a victim of burnout and arguably meets the criteria for major depression. (See Messias' and Flynn's article, "The Tired, Retired, and Recovered Physician: Professional Burnout Versus Major Depressive Disorder," (Am J Psychiat 175:716-719).

He is fully aware that he is characterologically resistant to speaking up to a mostly intransigent administration. He wishes, instead, to keep his head down. Rather than speak up, eventually he chooses to take his skills and talents elsewhere.

Dr. P. is like us all. Whether or not we care to admit it, we are all more-or-less damaged. Mostly, we are blind to just how much. But unlike many of us, Dr. P. owns his difficulties as they apply here—he is flattered by the administration and inhibited in setting limits. Both weaknesses conspire with administrative overreach to cause a downward spiral in his work life.

Our task is to recognize Dr. P's strengths, namely, his generosity, excellence as a teacher, perseverance, general goodwill, and courage. At the same time, we need to underscore how administrative greed to exploit these same traits erodes Dr. P's wellbeing. We hasten to remind ourselves that this is also the story of countless other physicians.

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