
Burn Till You're Out



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When using the technical definition of burnout: "The reduction of a fuel to nothing", it clearly describes the state of being of the few people that I have met who are having a burnout. The problem is huge and almost every leader in healthcare agrees that this is a major problem (Swenson et al. 2016). Although many problems arise from using surveys to estimate the incidence, there is no doubt that the current organisation of healthcare has a major effect on the reported rising incidence. Intensive care is especially prone to a high risk of burnout with reported incidence of more than 50% in the U.S., resulting in a recent call for action by many critical care organisations (Moss et al. 2016).

See Also: [Burnout Syndrome in Critical Care: What Needs to Happen Now?](#)

In general, burnout is a result of an imbalance between job demands (negative) and job resources (positive). The most important reasons for burnout are the increased clerical burden, the increased workload and loss of control related to the increased managerial organisation of bedside care and exposure to end-of-life issues (Swensen et al. 2016). Interestingly, burnout, when present in colleagues, has also been reported as an important risk factor, making it what has been called "a contagious condition" (Bakker et al. 2005). Other research (Haeffel and Hames 2014) has shown that cognitive vulnerability to depression can be contagious as well, linking it to burnout, as some have characterised burnout as: "Burnout, at its core, is the impaired ability to experience positive emotion (Bryan Sexton, Duke University School of Medicine)". On the other part of the spectrum are the job resources and positive emotions/social contacts that increase resilience and motivation and have even been associated with increased length of life (Danner et al. 2001).

In a point prevalence survey study in 2013 (46% response rate), we found a very low rate of burnout (4.4%) in Dutch intensivists, where their medical directors reported an incidence of 7.4% in that year (Meynaar et al. 2016). These numbers are strikingly different from any other study in critical care, even when corrected for differences in scoring methods. What could be the key differences between the ICU care in the Netherlands and the U.S. that make up for this difference.

Differences between the Dutch and U.S. Systems

When looking at the job resources, I don't think that basic intrinsic resilience and motivation are significantly different between doctors and nurses in the two systems. Also, financial incentives do not seem to be significantly different. When looking at the job demands, the U.S. system is very different from the Dutch system. A few major differences stand out. First, the extensive use of protocols and the almost absolute requirement to adherence to many of them, contribute to a less personalised care for patients. Hospital committees on "zero tolerance to divert

from protocols" ignore the fact that protocols, in many cases, are not designed to fit all patients. Second, the vast majority of ICUs in the Netherlands that use an electronic health record, use one that has been specifically designed for critical care. Especially during the time of the survey (2013) big general electronic healthcare systems had not been implemented in Dutch hospitals and ICUs. Currently many academic hospitals, but very few non-academic hospitals, are implementing systems in the ICU that are not specific for the critical care environment, and most even lack user friendliness in general healthcare. It would be interesting to see the effect of these changes on burnout, as these systems are reported to be a major cause of work-related stress and burnout. Third, working hours, number of patients covered and dedicated time spent in the ICU are significantly different in the Netherlands. In general working hours are less, the number of patients covered is significantly lower than in most US ICUs and, most importantly, the majority of Dutch intensivists work full-time in the ICU. Fourth, in the Dutch healthcare system the intensivist is universally in charge of all patient care. In other words, the intensivist is in charge and thus in control of his /her working environment. This is not about challenging expertise of referring specialists, but more or less guarantees a level playing field. In addition, in the Netherlands, the nursing staff is in the majority of ICUs part of the department. In many ICUs the leadership, budget, protocols etc. of the department are equally shared by nurses and doctors. This may result in sharing the burden and stress of the complexity of care in the ICU between doctors and nurses.

However, many of these aspects were not different between intensivists with and without burnout in the Dutch survey. There were, however, two elements that stood out in the intensivists with burnout. Good cooperation with hospital management was significantly more present in the practices of intensivists without burnout. This may be different in U.S. ICUs, especially in the academic ones. Where in the Netherlands the medical school and university hospital have merged, this is not the case in many U.S. academic hospitals where the doctors are employed by the university and the nurses and residents are employed by the hospital. This organisational format does not contribute to 'care as a group effort' and might increase the risk of conflicts. The other element that characterised intensivists with burnout in the Netherlands was the occurrence of complaints having been filed against the intensivist in the last year. The incidence of one or more complaints in the last year was almost double in the intensivists with burnout. This might of course have been the result of the pre-burnout period, as this is characterised by loss of compassion, increased depersonalisation and increasing emotional exhaustion that all have impact on quality of care and interaction with patients and families. Nevertheless, unlike in the U.S., lawsuits against intensivists in the Netherlands are rare and complaints that are filed to an institutional hospital committee are frequently resolved internally. I have been part of only one lawsuit in my entire career, related to withdrawing life support in a young patient. Interestingly, this seems to be a major factor in the risk for burnout (Swensen et al. 2016). We have not surveyed this in our study; however, the organisation of end-of-life care in the Netherlands is very different from the U.S. system in that the intensivists in the Netherlands almost completely deal with this together with the nurses without involving other healthcare workers who have hardly v involved in the previous care process of the patient.

End-of-life care is thus a group process where patient/family, nurses and doctors are equally involved. In the case mentioned, we had a conflict with the mother who did not agree to withdraw life support. However, the contact with the mother and her lawyer was good so that we even helped them to write the case for the court hearing. The patient, however, died in intractable septic shock before the scheduled hearing. Considering the impact on the life of two of my colleagues that have been subjected to lawsuits, it's not difficult to imagine the huge impact, or maybe even the perception of a likelihood of such an event, on the risk for burnout.

In my perception, the significant organisational differences in the critical care systems, the differences in the judicial systems and the culture of claims between the U.S. and the Netherlands make up, for a large part, for the major difference in burnout between the systems. Current organisation of critical care in the U.S. drains the fuel of nurses, doctors, residents and fellows. Changing the organisation of care and improving the integration of hospital management in the process of care are key to solving a problem that endangers patients, doctors, nurses, residents and fellows alike.

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