

Burnout in the ICU: Playing with fire?

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The intensive care unit (ICU) work environment is demanding and challenging. Doctors, nurses, and technicians all form part of a multidisciplinary team that strives to improve outcomes in sick patients, many of whom are likely to die. However, in this quest for good outcomes for patients, we often overlook the impact of intensive care on health care workers (HCWs). In the ICU, there are often moments of intense accomplishment and reward, but there are also many moments of emotional turmoil, frustration, and defeat. Doctors and nurses are faced with the burden of making difficult decisions, breaking bad news, and bearing the emotional impact of dying patients and their families. These factors undoubtedly contribute to stress and burnout amongst HCWs in the ICU.

Stress is a feeling of strain and pressure, whereas burnout is a multidimensional syndrome comprising emotional exhaustion, depersonalization (establishment of detached, distant, and cynical relationships with patients and colleagues), and a diminished sense of personal accomplishment.^[1] Chronic stress can lead to burnout, whereas burnout can also be due to other causes such as lack of job support and appreciation.^[2] Burnout can have several negative consequences both for the 'burned-out' HCWs and for their patients, as well as team morale and the overall work environment. Consequences for patients include reduced patient satisfaction and suboptimal patient care, including greater probability of infection. Among HCWs, depression, poor health, increased medical errors, decreased cognitive function, absenteeism, decreased professionalism, and substance abuse have been reported.^[3-8] Therefore, it is vital to acknowledge that working in the ICU can lead to HCW burnout. Having acknowledged that burnout exists, it is important to understand the magnitude of the problem

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and risk factors to devise effective methods to prevent and treat burnout. Although there is data on burnout amongst HCWs of ICUs from various countries, there are no such reports from Indian ICUs, nor are there reports in the Indian critical care literature. From this point of view, the article by Guntupalli *et al.*,^[9] in this issue of the *Indian Journal of Critical Care Medicine* (IJCCM) is an eye-opener. The authors investigated the incidence of burnout amongst nurses and respiratory therapists in a single US hospital, using the well-validated Maslach Burnout Inventory. They found that 54% of 213 subjects scored "Moderate to High" on the emotional exhaustion scale, 40% scored "Moderate to High" on the depersonalization scale, whereas 40.6% scored "Low" on the personal accomplishment scale. The authors could not identify the factors that may be independently associated with burnout, though surprisingly they did find that night shifts were associated with less burnout and that working overtime hours was not associated with burnout.

It might be tempting to dismiss the results of this study as being of little relevance to Indian ICUs. Indeed, there may be significant differences in nursing education, training, working conditions, and remuneration of nurses in Indian ICUs compared with those in the West. Many ICUs in India face shortages of nurses, resulting in frequent overtime duties. In addition, there are different cultural and societal perceptions about nurses, as well as domestic and family-related pressures. Respiratory therapists are not common in Indian ICUs. There is no

information on burnout among doctors working in the ICUs that were studied, which would have been of great interest to the readers of the IJCCM. Some studies have shown that ICU nurses suffer from relatively more stress and burnout compared with ICU physicians,^[10] whereas others have shown the contrary,^[11,12] perhaps reflecting differences in work intensity and job staffing.

High levels of stress and burnout are well-known among doctors and nurses in western countries. Publication of this study brings the problem of burnout straight to the desk of the Indian critical care specialist. It reminds us that it is essential that we perform these studies in our setting. The problem of burnout is universal, but given the socioeconomic and cultural differences and the individual and organizational factors that may be associated in India, it may well be different from those reported from other countries. Empirical data on risk factors in Indian ICUs can then help devise interventions to alleviate the problem. Interventions include organizational changes to affect individual solutions.^[13] Individual-level methods include physician well-being programs, improvement of communications about end-of-life care, management of conflicts, and workshops on various stress management techniques.^[14-16] Changes in the pattern of intensivist staffing may help.^[17] Two-week rotations have been shown to reduce burnout compared with four-week rotations for general medicine attendings.^[18]

As critical care continues to progress in India, it becomes even more important to look after the health and welfare of doctors and nurses working in our ICUs. Gathering data using validated instruments to determine the incidence and risk factors for burnout will be an important first step.

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