Stress and burnout in intensive care medicine: an Australian perspective

A call for a multilevel response to an evolving challenge

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Intensive care medicine (ICM) is an evolving high stakes specialty. Emerging evidence raises questions about the welfare and sustainability of the ICM workforce. Clinician burnout is a phenomenon resulting in consequences for both intensive caregivers and patients.

While resident doctors, fellows and new consultants across many specialties display high levels of stress and burnout relative to the general population,[1] ICM clinicians are disproportionately affected, rating higher on stress, burnout and compassion fatigue indices.[2] Paediatric intensivists have markedly higher burnout rates than general paediatricians.[3] An Australian ICM study described an 80% rate of psychological stress and discomfort in a practising ICM specialist population, with many reporting burnout symptoms.[4]

Burnout is a state of psychological distress related to chronic stress. Prevalence estimation using different tools, alternate metrics and cut-off points have made epidemiological studies of ICM clinician burnout challenging.[5] The Maslach Burnout Inventory is the most commonly used burnout instrument in this area and scores three major characteristics of burnout: emotional exhaustion, depersonalisation and low levels of personal effectiveness.[4] Intensive care unit (ICU) physicians and nursing staff have similar rates of burnout symptomatology, with ICU nurses reporting higher emotional exhaustion rates and ICU physicians reporting higher rates of depersonalisation and reduction in professional achievement.[6] These trends suggest specific risk factors within the ICM environment.

The burnout syndrome has been described in Australian emergency medicine clinicians.[7] Some protective influences appear to be ongoing professional development, dedicated non-clinical time, and a feeling of teamwork.[7] Burnout does not necessarily correlate with job satisfaction, with predisposing factors in this group including younger age, workplace conflict, a lack of exercise, and excessive alcohol consumption.[7] In addition to many of these stressors, intensive care clinicians are repeatedly exposed to high stakes, ethically challenging decision-making processes. The high "density" of ethical decision making in ICM contributes to moral distress and may be exacerbated by the provision of "disproportionate care", where there is a perceived inappropriate or harmful mismatch between the level of care provision and a patient's needs.[8]

Care of the health care provider and quality of patient care are interconnected. Physician burnout has been associated with lower patient satisfaction, reduced health outcomes and medical error.[2] Burnout symptoms reduce potential ICM workforce capacity through increased sick leave and decreased staff retention.[2] The consequences of burnt out clinicians may ripple through an entire organisation, compromising interactions between individuals and teams.

Evolving trends in Australia may further exacerbate the problem of burnout. These changes include greater intensivist coverage and shift work, an increasingly fractionalised workforce with unequal gender balance, and an evolving external and ward ICM responsibility. The move towards physically larger Australian ICUs has coincided with enhanced societal expectations of clinical outcome and an increase in interventional medicine.

We advocate for a multilevel strategy in order to address ICM workforce sustainability and welfare. The prevention and remediation of burnout requires consideration of both individual and systemic factors.[9]

At an individual level, a holistic approach to the ICM clinician, not just as a service provider, is required. A balance must be facilitated between work, life, clinical and

non-clinical duties and career progression. Stress prevention and resilience strategies include mindfulness and cognitive techniques, coaching, mentoring and, perhaps most importantly, peer discussion.

Leadership from clinicians will be important to drive change at an institutional level. Compassionate staffing, flexible rostering, ensured leave and ongoing employee assistance programs should be broadly available. Clinicians themselves will need to foster an acceptance of their own vulnerability and cultivate an environment where open dialogue about stressors is respected.[10]

The College of Intensive Care Medicine and the Australian and New Zealand Intensive Care Society have roles to play in the development of performance indicators for workplace stress and burnout, with complementary advocacy for a safe, sustainable workplace. The ICM training model should encompass self-assessment and resilience skills, supported by commensurate training of trainee supervisors and senior staff.

A broader societal discussion about the antecedents of moral distress and disproportionate care is required. Shared health goal setting before crises and preparing for realistic, appropriate decisions at the end of life continue to be of great importance. Such projects may be supported at government level, with direct expert input from ICM clinicians.

While there is increasing evidence of the physical and emotional effects of the unique ICU environment on inter-professional practitioners, there remains a paucity of coordinated interventions aimed at understanding and addressing ICM clinician burnout. We advocate for a multilevel response in order to improve the welfare and sustainability of the Australian ICM workforce.

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