National Board of Examination - Journal of Medical Sciences
Volume 1, Issue 5, Pages 279–285, May 2023
DOI 10.61770/NBEJMS.2023.v01.i05.005

LETTER TO THE EDITOR

Addressing Resident Burnout Syndrome: Exploring Effective Interventions

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Accepted: 24-April-2023 / Published Online: 2-May-2023

India is globally recognized as one of the largest contributors to human resources in the healthcare industry. In recent years, the Government of India has taken all efforts to increase the training positions in broad and super specialties according to the national needs and ever-increasing market demand. At any given point in time, we have thousands of doctors undertaking their residency training at health university-affiliated teaching hospitals or National Board of Examinations in Medical Sciences (NBEMS) recognized institutions in our country. We are all aware that, admission to residency programs in India is highly competitive, with only the best and brightest medical professionals making it out for these programs. It is a matter of concern that residents experience a high quantum of stress and burnout while enduring their demanding training schedules. Despite being a long-standing concern within the medical fraternity in India, there has been no unified approach to address the issue of burnout among medical residents so far.

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Resident Burnout Syndrome can be defined as a state of emotional, physical, and mental exhaustion caused by prolonged exposure to chronic stress in medical residents. It is characterized by feelings of depersonalization, cynicism, and reduced personal accomplishment. The issue has been viewed from an occupational mental health perspective by several researchers and attempts have been made to compute the burnout-related mortality and morbidity in healthcare practitioners [1]. The Maslach Burnout Inventory (MBI) has been extensively used across the globe and in India to study the prevalence of burnout among medical practitioners. The three subscales under which burnout was evaluated so far included emotional exhaustion, depersonalization, and reduced personal accomplishment [2]. Although, the residents as a group are at risk for mental health issues equally like the general population, the complexity of their work stress can compound their vulnerability.

The inclusion of a comprehensive review of the scientific validity of all studies relevant to the subject matter is beyond the scope of this article, as such a

task is more appropriate for psychiatrists and psychologists in India. In our discussion, we are focused on tackling the challenge at hand, as the problem statement has been clearly defined. Some noteworthy concerns include extended working hours, a significant workload, poorly organized shift schedules, interpersonal conflict due to overbearing attitudes of professional colleagues, bullying, harassment, insensitive hospital management practices, and hectic competition amongst residents for opportunities to learn skilled tasks, etc. to name a few. The list of reasons for burnout is extensive and may vary depending on the field of specialization. For instance, the high levels of stress and emotional exhaustion faced by medical specialists can be attributed to the overwhelming volume of cases they must manage within tight timeframes [3]. Similarly, residents in surgical fields are susceptible to burnout given the highly demanding nature and long duration of their work [4]. Similarly, anaesthesia and critical care specialties, which involve high-stress environments and decision-making under pressure, can lead to burnout among practitioners, who often face emotional and physical strain while managing critically ill patients [5].

The traditional reasons for burnout have been well documented in the literature. We would rather delve into some wicked problems faced by residents rather than re-surveying the explored territory. The issue of long working hours and undergoing training at a high-volume center poses an unavoidable risk to residents' mental health. A thorough examination is required to assess the impact of residents' back-to-back shift work on their performance, as well as its potential to contribute to medical errors and reduced effectiveness. Residents in specialties like emergency medicine, anaesthesia, critical care, and all major surgical specialties are incidentally prone to tremendous pressures at the workplace, which requires no detailed explanation.

The fundamental reason which makes even the most resilient and talented resident suffer mentally is the pace at which he/she needs to master things and pick up the nuances of practice wherein there is often an absence of time to back up the knowledge base in the specialty during the first year of residency. Similarly, the reason for chronic burnout stems from the lack of a transition or switch in the roles of the resident during the following years. Moreover, after undergoing several months of training, it is reasonable for a resident to aspire to advance from a passive role to a proactive leadership position in decision-making, which is sometimes denied leading to an abrasive interpersonal work ethos. The constant scare of inadequate training and delay in gaining confidence to manage cases independently frustrates many residents to the core. For instance, a surgical resident expects more than being a 'retractor holder' in the operating room and a 'patient sitter' in the post-operative wards. The District Residency Programme (DRP), spearheaded by the National Medical Commission (NMC), is a significant initiative undertaken by the government to prioritize practical experience and skills training for medical residents. The DRP in turn will also help the masses in the hinterland with specialist health services. However, the only bottleneck for a successful implementation of this program is the lack of adequate infrastructure at the proposed workplaces for residents.

The actual leave policy of the institutions in 'practice' is a cause of

annoyance for residents as their requests often are denied even during utmost requirement. Similarly, the abuse of academic residents for run-of-mill work beyond the scope of their training at several hospitals is a matter of huge concern which is rarely reduced to black and white. By the same token, inter-departmental tussles at some training institutions make residents soft targets for consultant-level feuds. Needless to say, violence against doctors is also an emotional challenge being faced by all healthcare personnel these days, of which residents face the maximum brunt by being at the front line in teaching hospitals.

The interventions to address the key issues discussed in this article are summarised and tabulated hereunder in Table 1.

Table 1. Issues and Interventions in Resident Burnout

S.No.	Level of Intervention	Issues/Themes	Measures
1	Resident	Coping, interpersonal relations, training activities, relaxation, and dedication.	• Seek help from co-residents in the event of a huge workload. • Should foster a collaborative approach than a competitive approach towards fellow residents. • Make time for physical activity and follow a healthy lifestyle. • Strive to create a special social niche at the workplace for emotional well-being. • Speak out if they feel something is wrong as early as possible before things pent up and grudges start dawning in. • Participate in occupational health training organized at all levels. • Respond to the emotional needs of their colleagues as suicides don't need strong reasons but weak moments can make people throw away their lives. • Try to adapt to work Schedules and take adequate rest between shifts. • Compartmentalize personal and professional life but gauge the priorities during the training period (because our profession demands some sacrifice). • Speciality training is something one learns while on the job and connects the dots later. So, residents should not worry about the theoretical side of their training because it ensues in due course.

2	Institution	Consultants/Faculty attitudes towards residents, Sexual harassment committee, Inter-departmental tussles, leave policy in practice, recruitment of non-academic residents, motivation of residents, bullying, violence against residents, implementation of post-night duty offs	• The Chief Consultant/Head of the Department is the *loco parent* for the resident and can find any solution for his/her problem. Hopefully, they should never be a source of it. • The head of the institution should constitute sexual harassment at the workplace committee and facilitate reporting and inquiry. • Dean/Management should ensure smooth inter-departmental coordination. • Vacation/leave planning meetings should be organized well ahead regularly, and all the residents should sort this with a consensus. • Comply with the rules and regulations of the regulating agencies. • Organise in-house common dining at least once a fortnight to have an informal discussion about resident-consultant dynamics. Formal meetings are counterproductive as residents rarely speak out in meetings. • Experiment with novel ways to increase socialization amongst the entire medical and paramedical teams. • Initiate programs like rewarding best performing residents every month and also try to publicly display patient's feedback on resident's work. • Institutions should create an online padlet wall to talk about bullying and interpersonal issues freely amongst the stakeholders which can pave the way to openly conduct any inquiry in the event of a complaint. • Institutes should facilitate the conduct of self-defence training for all residents and also have a quick response team support to manage any untoward violence. • Institutions should try to harmonize at stretch working hours of residents and provide post-night duty offs wherever possible. Shift work schedules should be compressive and follow the forward rolling scheduling model wherever possible. • Delineate the functional roles and responsibilities of residents of each

			professional year in tune with the competency-based approach. • Introduce skills lab activities for residents wherever necessary and feasible. • Implement academic activities in letter and spirit.
3	Health University/ NBEMS/ NMC	Awareness, training, and regulation	• Apex agencies should order the implementation of multi-centric job hazard analysis of medical residents' work by using institutional profiles and specializations as two important criteria for categorization and assessment. An action plan for interventions at all levels should be drawn out and compliance ensured. • Organize regular webinars about coping and resilience in fighting burnout at the beginning of every postgraduate academic session. • Create a training module on occupational mental health by roping in experts from the fields of community medicine, psychiatry, and medical education unit (MEU) departments. • Make gatekeeper training for suicide prevention and occupational wellness training mandatory for all residents to appear for final professional examinations. • Ensure swift resolution of resident grievances. All they need sometimes is just an active listener to their concern. • Propose a competency-based delivery of curriculum model so that the training is more structured and uniform. It is a time for the revision of PG regulations by the NMC. • Issue guidelines for hiring non-academic residents in all institutions after thorough research on the subject based on the workload.

The Ethics and Medical Registration Board (EMRB) of the NMC recently published guidelines for the professional responsibilities of medical teachers and students. The guidelines prioritize the holistic development of stakeholders, based on the principle of social responsibility, which is aligned with the national requirements [6,7]. The increased need for extra cautious academic activity in the light of Competency-Based Medical Education (CBME) for

undergraduates has also put the residents under pressure in teaching hospitals where there is a faculty crunch.

Before we conclude, a note on rampant substance abuse among medical residents is worth a mention because it is often viewed as a solution to beat stress (albeit with the potential to become a source of it, if things go astray!). These habits can destroy the personal and professional life of medical residents eventually. Creating a supportive environment to discuss substance abuse issues in a non-judgemental manner without any serious repercussions will help the residents express and fight this challenge. Similarly, the average age of the resident population generally falls within the young adult range. The personal lives of these growing adults are always under the stress of transformation and the prevailing social culture of *Fear of Missing Out (FOMO)* can increase their vulnerability to mental health issues. A proactive and facilitative work atmosphere can help residents tide over the family and relationship stress also.

In conclusion, resident burnout syndrome is a matter of importance not only for the personal well-being of the residents but can also have serious implications for patient care and also increase the likelihood of medical mishaps. There is a strong urgency to recognize and quantify the problem which will pave a way for thinking about interventions at all levels to mitigate occupational burnout among resident doctors in India.

Acknowledgments

I would like to express my sincere gratitude to Prof. Dr. C.B. Jani, Prof. Dr. R. Sudha, Dr. G. Chandra Deepak, and Dr. Anirudh Suseel Nalumaru, for their invaluable input and unwavering support in reviewing the draft. Their expertise and guidance have been instrumental in shaping and improving the quality of this work.

Competing Interests: None to declare.

Financial Support: Nil

Ethics Committee Approval: Not applicable

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