Research Article

The inevitability of physician burnout: Implications for interventions

Anthony Montgomery*

University of Macedonia, Greece

1. Introduction

Burnout is especially problematic for individuals who are at the frontline of their professions. The impact of this chronic condition on physicians is particularly important given that their actions are so directly linked to the mortality and morbidity of patients. The medical profession is acutely aware of this problem and many interventions have been developed to ameliorate the antecedents and consequences of burnout. However, there has been a tendency in medicine to view burnout from a pathogenic perspective which has lead to solutions that seek to “treat” it either via modifications in the work environment or up-skillling for the individual (or a combination of both). All three approaches are rooted in the notion that burnout is ailing a system that needs a cure.

Burnout should be viewed as an obvious outcome of systems that are developed within medical education and fostered all through the career of physicians. Ironically, we could view job burnout as an indicator that the system is operating ‘correctly’. Therefore, researchers need to view burnout as the by-product of a well-organised system, and congruently interventions need to address the process issues involved in the long term development and maintenance of job burnout.

1.1. Rationale, objectives and methodology of the paper

This paper is a conceptual paper that utilises the principles and methods of meta-synthesis (Schreiber, Crooks, & Stern, 1997) to address the central question: Is physician burnout an appropriate and expected response to medicine as a system? The objectives of the paper are to: (1) identify the key elements in the career of a physician that contribute to job burnout, (2) delineate the systematic nature of this process, and thus highlight its incremental chronic nature, and (3) review the implications of treating burnout as a systemic problem for interventions.

This paper has three parts. Part one will review the evidence from medical school, the organisational culture of the hospital and the phenomenon of presenteeism. There are many aspects of medicine that one could examine, but these three elements provide the most compelling examples as to the systematic nature of the problem. The first two cover how education and organisational climate favour particular behaviours, and presenteeism provides the perfect link between education/culture and performance. Part two of the paper will review the implications for interventions in detail. Our implications will have ramifications for other human service organisations, but healthcare is an exemplar industry to focus on. Healthcare professionals represent a significant proportion of the workforce in every developed country, and the need to support them will only increase as we go forward into the future. Indeed, in 2008, it was estimated that 70% of the health budget in Europe was allocated to salaries and employment related costs (Commission of the European Communities, 2008), while roughly 10% of the active EU workforce is engaged in the health sector in its widest sense (European Observatory on Health Systems & Policies, 2010). Finally, part three will provide final reflections on the problem.
1.2. The learning environment of the medical school

Medical schools train future doctors to become successful physicians. The purpose of medical education is to provide medical students with theoretical knowledge, skills, clinical and practical competence, professional and ethical standards (Liaison Committee on Medical Education, 2012). Unfortunately, medical school training is heavily skewed towards the technical skills associated with being a doctor rather than the interpersonal skills associated with being an active member of an organisation (Montgomery, Todorova, Baban, & Panagopoulou, 2013). The two issues have been unnaturally separated, as is highlighted by the recent American Medical Association survey indicating that the majority of physicians do not feel responsible for reducing healthcare costs (Tilbert et al., 2013).

During their medical school years, medical students are actively shaping their professional identity and their perception of what comprises “good and bad doctoring” (Elliott et al., 2009; Hafferty, 1998). Not surprisingly, the critical problems that continuously pervade the profession; burnout and medical error, have their roots in medical education (Dyrbye et al., 2010a; West & Shanafelt, 2007; West et al., 2006). The challenge for medical education is to maintain knowledge about reality in clinical practice, understand what is happening outside the lecture rooms and produce creative solutions using the knowledge and skills of all within the organisation (Gaufberg, Baumer, Hinrichs, & Krupta, 2008; Gaufberg, Batalden, Sands, & Bell, 2010; Hojat et al., 2009). That's the ideal, but the reality is significantly different.

The learning environment of a medical school consists of both the formal and hidden aspects that influence medical students’ professional identity (Haferl et al., 2011). It is widely recognised that a big part of the learning is taking place outside the classrooms and clinical settings as part of a “hidden curriculum” (Hafferty, 1998). Thus, the formal culture may value professionalism, but the hidden one valorises performance and competitiveness above collaboration. The hidden curriculum contributes to the erosion of professional behaviour and an increase in cynicism (Feudtner, Christakis, & Christakis, 1994). Retraining healthcare physicians after they completed medical schools and residency training has limited effectiveness, as certain maladaptive behaviours (e.g., non-reporting of medical errors or inappropriate self-treatment) have become deeply embedded. Therefore, reframing culture and what represents the norm has to happen early on in the medical school (Elliott et al., 2009; Brainard & Brislen, 2007; Cutillo, 2000).

Despite the recommendations of the US Liaison Committee on Medical Education (LCME) (Liaison Committee on Medical Education, 2012) that medical schools should ensure an appropriate learning environment and encourage evaluation and improvement, it remains unclear as to the best way to promote and evaluate professionalism in medical school, given that professionalism seems to be context-related (West & Shanafelt, 2007). Thus, medical schools are still very far away from being a learning organisation whereby clinical practice is utilised as a lever for change. A learning organisation is one that fosters co-operation between individuals and groups, free and reliable communication, and a culture of trust (Argyris, 1982). Such practices are highly desirable in medical schools, but the picture for new physicians is bleak. A systematic review of burnout during residency training indicates that burnout is prevalent among both medical students (28–45%), residents (27–75%, depending on specialty) (Ishak et al., 2009). In terms of what cause burnout, the review is not revealing, with the authors identifying the following factors as contributing to burnout: time demands, lack of control, work planning, work organisation, inherently difficult job situations and interpersonal relationships. In other words, being a member of the organisation causes burnout.

1.3. Looking at the hospital

Hospitals are unique organisational environments where the degree to which professional roles are strongly embedded represent a significant barrier to change (Mintzberg, 1997). Moreover, hospitals are organisations under considerable stress. For example, in the UK surveys show that continuity of care for the patient is being compromised (Hawkes, 2012). This is not surprising when one considers that healthcare professionals are expected to handle structural changes and technical developments, are required to be accessible, provide holistic patient-centred and patient-managed care, develop their own evidence-based competence and achieve an appropriate balance between their work and private life.

Without too much effort, the purpose of a hospital can become self-preservation and not healing, which is reinforced by the way that health care organisations can be organised in silos (Glouberman & Mintzberg, 2001). Indeed, the Institute of Medicine (IOM) in the US has repeatedly highlighted the link between patient safety and organisational culture (Institute of Medicine, 2001; Kohn, Corrigan, & Donaldson, 1999), and burnout has been identified as the crucial link between organisational culture and quality of care (Montgomery et al., 2013; Montgomery, Panagopoulou, Kehoe, & Valkanos, 2011a). Put simply, healthcare professionals are under increasing pressure to continuously improve quality of care in environments that are not naturally designed to contribute positively to either the health of their employees or the recipients of care.

The links between patient safety/medical errors and burnout have been established in the surgical literature (Shanafelt et al., 2010) and in studies of physicians in training (West, Tan, Habermann, Sloan, & Shanafelt, 2009), however there is some conflicting evidence that suggests primary care physicians may shield patients from adverse outcomes resulting from physician burnout (Linzer et al., 2009). It's possible that primary care, which is more rooted in the community, may offer a different model than the hospital.

The culture of medicine is similar (relative to other professions) across the globe, and physicians (especially) are educated to take a very specific role in an organisation. Thus, physicians are primarily trained to treat, and little attention is given to the training needed to be an effective leader and/or a collaborative member of an organisation. This is especially true of medical education where medical schools seek to mimic the exemplar models, and students are reinforced to think of themselves as clinical leaders. Mintzberg (Mintzberg, 1997) has written directly on the issue of hospital cultures in Towards a Healthier Hospital, and strongly insists that real organisational change can be effected only by a gradual bottom up approach that does not threaten the roles that individuals have established within the organisation.

Finally, hospitals are organisations that reinforce a pathogenic approach to health. Not surprisingly, the pathogenic approach has dominated our approach to health. We have a tendency to focus on disease and illness, which prompts us to think in terms of risk factors and disease amelioration. Such a tendency is even stronger in healthcare professionals, who are continuously reinforced to view health through a pathogenic prism. Antonovsky (Antonovsky, 1996) has questioned the objective of health promotion as being severely limited, in that it has “exposed the ‘bias of the downstream focus’, i.e. the devotion of the disease care system to saving swimmers drowning by heroic measures, rather than asking ‘Who or what is pushing them into the river in the first place?’ (p. 12)”. The basic idea behind his salutogenic approach to health is that we should work towards facilitating health rather than limiting disease. This approach represents an interesting way for us to look at hospital organisations. The salutogenic model proposes that our goal should be to identify, define, and describe pathways, factors, and causes of positive health and focus our attention on the
organisational factors that contribute to engagement with the organisation, such as dedication and vigour.

1.4. The problem of presenteeism

Presenteeism is the behaviour of coming into work when sick. In terms of economic impact, the costs associated with presenteeism can exceed that of absenteeism for many disorders (Stewart, Ricci, Chee, Hahn, & Morganstein, 2003), especially for conditions like depression (Collins et al., 2005). Healthcare with its strong attendance demands is associated with high levels of presenteeism (Aronsson, Gustafsson, & Dallner, 2000). Physicians report that responsibility to co-workers (McKevitt, Morgan, Dundas, & Holland, 1997), and a sense of being irreplaceable are the key reasons for working when ill (Jena, Baldwin, Daugherty, Meltzer, & Arora, 2010; Caverley, Cunningham, & MacGregor, 2007). However, such behaviours may be also driven by desperation. Mental health issues are the ones that are most likely to be hidden by doctors. When we consider a hidden condition like depression it is quite conceivable that work is a source of structure and routine and continued work attendance represents an important ‘positive’ avoidance strategy for depressed individuals.

The problem of presenteeism among physicians stands in contrast to the European Union attempts to address quality and safety issues via a European work-time directive (Directive, 2003) aimed at laying down minimum safety and health requirements for the organisation of work time. Evidence from 10 years later shows that it was either not adopted or had detrimental effects (especially for healthcare professionals) (McIntyre, Winfield, Te, & Crook, 2010). The failure of the directive to be appropriately adopted by physicians is rooted in the fact that the working less hours is difficult to contemplate by junior doctors who view longer hours as an opportunity to learn and the notion that fatigue is a normative part of work. The picture of physicians staying at work when ill also begs the darker question of what physicians do to maintain performance. A recent paper indicates that nearly 1 in 5 German surgeons use illicit and prescription drugs for both cognitive enhancement and mood enhancement as a way to cope with pressure from both work and their private lives (Franke et al., 2013). Similar research has found that US residents reported using amphetamines to enhance work performance (Hughes et al., 1992).

Presenteeism, as a work behaviour, poses interesting questions for how we approach interventions. Is it mostly driven by negative or positive motivations? If mostly negative, does it ‘inflate’ burnout prevalence figures? If mostly positive, does it contribute to team/unit engagement? Its difficult to really ascertain how serious a problem it really is, as systems have probably evolved to successfully mask certain types of presenteeism.

Evidence from medical school, residency training, hospital design and presenteeism all point to the importance of the system level approach to understanding the progression of burnout. The culture of inappropriate self-treatment among student, residents and eventually physicians points to the fact that becoming a physician is can be an occupational hazard (Montgomery, Bradley, Rochfort, & Panagopoulou, 2011b). Maladaptive coping needs solutions that addresses the system, not just the individual.

2. Interventions to reduce burnout: what have we learned so far?

The second part of this paper will review the burnout interventions that have been conducted and identify the implications for interventions if we adopt a systems view of physician burnout. In order to be as comprehensive as possible, this section will review key research findings from; burnout interventions for healthcare professionals, burnout interventions generally, interventions to improve well being and interventions aimed at improving job control/autonomy. It’s difficult to jigsaw these different areas together, but the practical goal is to simply find any clues as to what works best.

Interventions to reduce burnout among healthcare professionals and consequently reduce medical errors and improve patient safety have tended to target the individual physician with little attention given to the organisational and social context within which the physician is practicing (Dunn, Arnetz, Christensen, & Homer, 2007). Indeed, this focus on the individual over the organisation is consistent with interventions conducted with other professions (Michiel & Kompier, 2001). Stress management interventions for healthcare professionals are informed by work stress theories that place particular emphasis on job control/job autonomy, as informed by the Karasek Job-Demands-Control Model (Karasek, 1979) and which undervalue the role that the hospital culture can play. Interestingly, in a study evaluating work stress among eight hospitals in the European Union, Pislijar, van der Lippe, and den Dulk (Pislijar, van der Lippe, & den Dulk, 2011) found that both work control and job/time autonomy were not associated with the health of hospital employees. Pislijar et al. (Pislijar et al., 2011) conclude that interventions to prevent work stress must look more closely at interventions that will help all hospital employees cope with their growing workload, longer hours and unsocial schedules. This is in agreement with research that shows that work control reduces the impact of work stress on health only when employees cope actively with work stress (Jonge & Kompier, 1997). Indeed, Egan et al. (Egan et al., 2007) in a review of organisation-level interventions that aimed specifically to increase employee control found some evidence to support the demand-control-support model, but control did not protect employees from generally poor working conditions. Overall, the review identified 18 studies of which 8 focused on healthcare professionals. Reviewing these 8 studies indicates that improvement in psychological and health outcomes were marginal. According to a review by Michie and Williams (Michie & Williams, 2003), regarding sickness absence among healthcare workers, intervention studies have focused mainly on staff training, to the detriment of employment practices and management style. Finally, a review of the interventions aimed at the reduction of burnout among physicians highlights that there is a paucity of evidence on what actually works (McCray, Cronholm, Bogner, Gallo, & Nell, 2008).

A more general look at five reviews targeting well being in healthcare professionals reveals little to be sanguine about (Van Wky & Pillay-Van Wky, 2010; Marine, Ruotsalainen, Serra, & Verbeek, 2006; Gilbody et al., 2006; Mimura & Griffiths, 2003; Jones & Johnston, 2000). Van Wky et al. (Van Wky & Pillay-Van Wky, 2010) concluded that there is insufficient evidence for the effectiveness of stress management interventions, either person directed or organisational, focused on secondary prevention level, beyond the intervention period. However, according to the same review, low quality evidence suggests that longer-term interventions with refresher or booster sessions may have a more sustained positive effect, but this needs to be rigorously evaluated in further trials. The same conclusion was reached by Marine et al. (Marine et al., 2006) for the role of person directed or work directed interventions on burnout, work-related stress, general health and psychological well-being. A review by Gilbody et al. (Gilbody et al., 2006) about interventions to improve morale of staff was restricted to mental healthcare workers only. It reached more or less the same conclusion as the previous reviews. The other two reviews by Mimura and Griffiths (Mimura & Griffiths, 2003) and Jones and Johnston (Jones & Johnston, 2000) targeted only nurses, but refrained from drawing clear conclusions based on the studies found. It is noteworthy that in the above reviews no direct comparisons were conducted between the effectiveness of person-directed
and organisational interventions. A more fine-grained reading of these reviews does reveal specific examples of improvements in job satisfaction, reduced sickness absenteeism and turnover. However, the more useful question may be why there is such little evidence to support stress management interventions?

An initial response may be that such reviews contain considerable heterogeneity, but this is not a powerful argument as we simply might expect them to be effective in different ways. Awa et al. (Awa, Plaumann, & Walter, 2010) in a review of burnout prevention intervention programmes state that 80% led to a reduction in burnout. However, a closer reading reveals a more complex picture. Firstly, the intervention effects of studies that used RCTs did not markedly differ from those using other study designs, and many studies included high dropout rates. Secondly, strong evidence was attributed to outcomes where a significant positive or negative intervention effect was recorded at low levels of significance (p < 0.05), and non-significant positive or negative intervention effects (p > 0.05) were regarded as limited evidence. Thirdly, in studies which measured other psychological outcomes (i.e., state anxiety, moods, fear, depression, psychological distress, fatigue, negative emotions, and emotional job demands and sleeping problems), positive changes in these parameters usually did not last over 6 months (in concert with the burnout subscales). Finally, the reviewed studies included heterogeneous populations, but it is noteworthy that one study involving general practitioners resulted in an increase in burnout (Margalit, Glick, Benbassat, Cohen, & Katz, 2005), while one involving nursing students involved no change in burnout levels (Kanji, White, & Ernst, 2006). The aforementioned does not nullify the results of the review, where the authors did find that a combination of person directed/organisational directed interventions worked best. However, we need to appreciate that a statistically significant change in burnout subscales is one piece of the jigsaw, and should not pull over focus away from the substantive issue of whether such interventions represent a respite rather than a solution. Finally, the complexity of burnout as an indicator is highlighted by a RCT trial to evaluate whether shorter rotations for medical residents (2 vs 4 week) were beneficial (Lucas et al., 2012). Results indicated that the 2 week rotation results in less burnout for the teachers (attending physicians) but resulted in worse evaluation by trainees. This seems to perfectly illustrate the see-saw relationship between burnout and performance in medicine.

2.1. Burnout as a systems problem: the implications for interventions

Job burnout is an area which is well-known, well-researched, and well-theorized in the field of Work and Organisational Psychology. However, the dominant approach to policy and practice in the area of work stress and well-being has focused on jobs and job redesign rather than system redesign, and has evolved to ignore how workers interpret their work and how they act to shape their work (Aronsson et al., 2000; Stress, 2011). For physicians and burnout, this has meant a focus on supporting them to be better able to cope with the rigours of their work (West et al., 2014), rather than questioning the system that has produced such outcomes.

Workforce planning for healthcare needs to factor in physician burnout. Healthcare systems across Europe and the US have systematically highlighted the importance of treating patients as whole people, not just as diseases, but health professionals seem to be exempt from this holistic view, as indicated by the high numbers of burnout. Today there is enough evidence to suggest that expecting health professionals to deliver safe, efficient and patient centred care, while they are getting more and more burnt-out, is not only ineffective but also costly and dangerous as indicated by the increasing numbers of medical mistakes, and patient neglect. However, this evidence has not been used by policy makers in order to improve health care by combating health professional burnout at a system level. Yet, physicians, and health professionals in general are some of the most educated, expensive cogs in the health care machine.

Workforce planning has the potential to be skewed if the health of physicians (and healthcare professionals generally) is not part of the equation. A recent systematic review of quality of care interventions in the hospital indicates that technical interventions are dominated by physicians and interpersonal interventions by nurses (Conry et al., 2012). The need for a different bottom-up approach to supporting and retaining staff is echoed in a recent EC policy paper on workforce planning that recommends that scenario building, rather than deterministic terms such as forecasting, prediction and planning is the optimal way to approach the workforce planning problem (European Observatory on Health Systems & Policies, 2010). A bottom-up approach has the potential to also involve patients in quality of care, which is desperately needed given the evidence that patients are rarely involved in improving safety (Involving patients in improving safety). Action research, discussed in the next section, is the most appropriate way to build scenarios that link physician health with patient involvement. Interventions that ignore the connection between quality of care and physician burnout are condemned to fail.

2.2. Action research and burnout

Changing the work constraints is difficult given the organisational culture within hospitals, as outlined in our earlier section (see Section 1.3), which means that a bottom-up participatory approach is the most likely to succeed, as top-down approaches have exacerbated the problem. Both in the US and Europe, health-care initiatives, changes or regulations are mainly developed by management boards, or policy making bodies with very little input from frontline staff or patients. This is also due to the fact that no systematic bottom-up feedback mechanism exists between health-care delivery and policy making. As a result the effectiveness of initiatives adopted through the top-bottom approach is limited. The most recent example is the European Work Time Directive whose impact on patients and physicians has been minimal or even detrimental (especially for physicians) (McIntyre et al., 2010). Even more worrying is the fact that physicians responsible for delivering care are not interested in contributing to design, policy or evaluation. For example, a recent American Medical Association member survey indicated that the majority of physicians do not feel responsible for reducing healthcare costs (Tilburt, Wynia, & Sheeler, 2013). Finally, top-down approaches in healthcare as a sector has been largely resistant to reform and change by information technology (Barnett, Vasileiou, Djemil, Brooks, & Young, 2011; Boonstra & Broekhuis, 2010).

This all means that interventions need to engage with the clinical leadership of the hospital, position quality of care improvement within organisational development, and provide the necessary skills to initiate change. From this perspective, future interventions focused on the capacity for change and innovation needs to come from within health-care organisations, and thus help build the capacity of people within the hospitals (Ham, Kipping, & McLeod, 2003). The methodology most suited to initiating such change is action research. Action research is a reflective process of progressive problem solving led by individuals working with others in teams or as part of a “community of practice” to improve the way they address issues and solve problems (McNiff & Whitehead, 2006). Action research aims to generate knowledge about social systems as well as attempting change (Hart & Bond, 1995). As noted by Halbesleben et al. (Halbesleben, Osburn, & Action, 2006), the most significant limitation of burnout reduction programmes is that they tend to seek out universal solutions for organisational
issues without offering or taking into account the significant variety of stressors that may lead to burnout and the uniqueness of stressors that appear in any one organisation.

The arguments in favour of utilising action research (AR) as a way to deal with burnout are considerable. Firstly, AR has the ability to tap directly into the systemic issues involved in the organisation. Secondly, we can view burnout more dynamically via AR and understand the push-pull of its antecedents and consequences. Thirdly, it calibrates success in that it is driven by the individuals in the organisation and thus more likely to be feasible. These first three reasons are congruent with the guidance of Blumenthal et al. (Blumenthal, Song, Jena, & Ferris, 2013) concerning the need to provide incentives for team-based care, where clinicians engaged in system design is a key recommendation. Following from this, it has an evolutionary character whereby AR team are more likely to identify small wins at the beginning which will galvanise efforts for the bigger problems. Fourthly, to paraphrase Lewin, its a highly practical theory, meaning its theoretically rich but is experienced as practical by participants. Halbesleben et al. (Halbesleben et al., 2006) have demonstrated the efficacy of the approach in reducing burnout among individuals working in the Federal Fire Service, while Häätinen et al. (Häätinen, Kinnunen, Pekkonen, & Kalimo, 2007) demonstrated that a participatory approach was more successful than a traditional intervention in reducing burnout.

Finally, the patient tends to be either passive or non-existent in intervention designs. Ignoring them cannot be tolerated for much longer given the recent meta-analysis of Doyle et al. (Doyle, Lennox, & Bell, 2013), which found that patient experience, is positively associated with clinical effectiveness and patient safety, and supports the case for the inclusion of patient experience as one of the central pillars of quality in healthcare. Action research provides the most appropriate path to include patient perspectives in our interventions. To date, no research exists that directly links patient involvement to reduce physician burnout. However, the literature on emotional contagion (Bakker, Le Blanc, & Schaufeli, 2005) suggests that the doctor–patient dyad could be a source of emotional crossover that feeds into burnout, while the literature concerning the promotion of Public-Patient-Involvement (PPI) in healthcare highlights how involving recipients of care reduces costs, increases learning experiences for physicians (Muething, Kotagal, Schoettker, Gonzalez del Rey, & DeWitt, 2007) and reduces health disparities (Gance-Cleveland, 2006), which all contribute to physician burnout. Finally, research showing that stress fuels concealment in clinical practice (Panagopoulos, Mintziori, Montgomery, Kapoukanidou, & Benos, 2008) suggests that appropriate patient involvement can ameliorate non-disclosure in a non-confrontational manner.

3. Conclusions

Unlike other professionals, physicians are educated to be clinicians first, and their role as a leader, team member, or manager is secondary. Thus, the majority of physicians have a tendency to view the purpose of a hospital as primarily to support their clinical work. Not surprisingly, this disconnection between their training/expectations and the realities of the need to work with co-workers and patients who have different visions of how the organisation (hospital) should operate means that job burnout is inevitable. The increasingly high levels of job burnout observed among physicians globally is set to continue as fewer resources and tighter budgets ratchet up the personal and professional pressure. The failure of occupational health psychology to find a ‘cure’ for burnout should rid us of the notion that we simply need to train our physicians to be better able to cope with the rigours of their profession. Interventions can only be hopeful to the extent that they recognise the role of the system in maintaining job burnout, intergenerationally. The uncomfortable truth is that we may need to reimage healthcare in a way that views some errors as unavoidable, demystifies the physicians as superheroes, engages real patient participation and steers healthcare professionals away from cultures of self-preservation. The initial selection of medical students is skewed towards scholastic abilities and performance behaviours (rather than mastery behaviours), which contributes greatly to a culture that valorises individual performance over team collaboration. Ironically, physicians have had the mantle of leader hung around their shoulders, but we can use this mistake to our advantage by engaging them as change leaders.

The well researched job stress models of Karasek and Siegrist identify important drivers, but they do not translate easily into interventions. Indeed, there is no reason to expect that causes equal solutions. Interventions research needs its own models and more ecologically valid theories such as Meso-Paradigm approach is more suited to challenging us to understand the impact of an intervention at both the micro and macro levels (Robert House, 1995). For example, at the macro level, career transitions influence burnout levels among individuals, especially emotional exhaustion and depersonalization (Dunford, Shipp, Boss, Angermeier, & Boss, 2012). At the micro level, there is evidence that simply increasing civility in the workplace is a powerful intervention in healthcare settings (Leiter, Laschinger, Day, & Oore, 2011), which is particularly interesting given the importance of communication in healthcare. Not surprisingly, interventions concerning burnout have tended to be stuck at the micro level. Physicians probably view themselves as excellent communicators, but the gaps in the profession are highlighted by what happens when things go wrong in healthcare and the subsequent: reports (Kohn et al., 1999), enquiries (Walker, 2004) and studies (Forster et al., 2004), which all collectively show that a predetermined factor is that patient care is delivered in a fragmented, isolated way, with health-care professionals having failed to collaborate effectively. Its difficult to conclude with a condense ‘take-home’ message, but it should be obvious that interventions that do not provide opportunities for real participation from both healthcare professionals and patients are not addressing the antecedents and/or consequences of burnout.

4. Final reflections

The call for us to study organisational becoming over organisational stability recognises that a focus on process in future research has a better chance of recognising the micro flux that is the ongoing work that individuals need to do in order for organisations to be organised (Tsoukas & Chia, 2002). Theory is obviously useful, but we should always have in mind Dewey’s comments that theories are merely a hunch about how we should proceed (Dewey, 1999). Our notion as to what is a good organisation is skewed by the dominance of US/North European ideals. As noted by authors like Chiaburu (Chiaburu, 2006) the use of organisational theories imported from western experiences, which have a high emphasis on instrumental rationality, are less likely to offer a plausible account of organisational patterns in developing countries. This paper has sought to identify the roots of physician behaviours from the beginnings of medical training to clinical practice in the hospital. A large US study (Dyrbye et al., 2010b) across seven medical schools provides an important insight into the genesis of professional behaviour, were cheating/dishonest academic behaviours were rare (reported by 10%) but unprofessional conduct related to patient care was more acceptable (reported by up to 43%).

The idea for this article was prompted by my attendance at the 2012 International Conference on Physician Wellness in Montreal, Canada. The majority of talks were given by physicians and I was struck by the degree to which the role of the organisation was downplayed (both in terms of consequences and solutions).


Stress, Daniels K. (2011). Well-being are still issues and something still needs to be done: or why agency and interpretation are important for policy and practice. In G. P. Hodgkinson, & J. K. Ford (Eds.), *International Review of Industrial and Organizational Psychology* (pp. 1–45). Chichester, West Sussex: Wiley.


