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# **Clinical Skills in Today's Practice: A Declining Art**

# Pratibha Singh

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#### Abstract

Medical colleges are traditionally teaching the medical history taking and clinical examination to the aspiring medical graduates, which are the fundamental for making the most appropriate diagnosis by reasoning and planning management. Today's world see a decline in these clinical skills and too much reliance on investigations. There are many factors leading to this deterioration, this article is an effort to look into those aspects and suggest a possible solution to it.

Keywords: Clinical Skills; Planning management.

#### Introduction

Medical colleges in India and other countries are the important places where an aspiring medical graduate learns the art and skills of communication, and physical examination. World over this skill has shown adecline [1] over the last 2-3 decades, though reports of declines are present in seventies too [2]. Years back physicians and surgeons were spending a lot of time to learn and master these clinical skills, as it was the backbone for arriving at an accurate diagnosis. The decline of these skills over the years is due to many reasons- less time, more time on computers, boom of diagnostic facilities, which are accurate and reproducible, and becoming easily available though at a cost to the patients.

**Author's Affiliation:** Professor and Head, Department of Obstetrics & Gynecology, All India Institute of Medical Sciences (AIIMS), Jodhpur, Rajasthan 342005, India.

**Correspondence and Reprint Requests:** Pratibha Singh, Professor and Head, Department of Obstetrics & Gynecology, All India Institute of Medical Sciences (AIIMS), Jodhpur, Rajasthan 342005, India.

E-mail: drpratibha69@hotmail.com

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The deteriorating skills at history taking and clinical examination has gained attention all over the world as evidenced by many publication and discussions. Many medical colleges have introduced courses and assessments to include physical examination and communication skills, and in-turn stress the importance of clinical skills [3,4].

Equally important is to look into the factors responsible for the declining clinical skills and to take necessary measures to keep this versatile art alive as it the backbone for the medical training and practice.

This article suggests few ways to perpetuate and enhance these skills for medical students.

#### Medical interview

Medical interview or history taking is most powerful, sensitive and versatile tool a physician has. Early clinical exposure in medical school exposes these students to this skill and is continued throughout the course. A good history, which is generally taught in a structured format so that all relevant and important points are included to arrive at a clinical diagnosis. Often a poor history leads to poor or inaccurate diagnosis. Many studies have demonstrated that inaccurate and incomplete patient histories are among the leading causes of diagnostic errors [4,5]. History taking can get 60-80% of information to make a correct diagnosis [6,7]. History taking not only gives important information about the patient but is also an important tool to build rapport and trust. Effective communication during the medical interview is critical to the formulation of a positive physician-patient relationship, which can result in better health outcomes [6].

It is important to stress the importance of this skill, and to examine causes for decline of this skill. Often history taking involves lot of time, and lack of time in today's busy world is a genuine reason. But the time spent in history taking is well rewarded, hence it is important to spend sufficient time to get relevant information.

Poor, insufficient, or absent history taking can lead to incorrect diagnoses, unnecessary testing, delays in treatment, and a compromised physicianpatient relationship, with the potential for disastrous outcomes. It is thus important to identify the causes of this deficit in essential clinical skills in order to intervene in medical educations[4,8]

### Physical Examination: missing art

Complete head to toe examination of patient gives important clues not only for making a diagnosis, but may also give information which the patient thought as not important or is hiding from the physician. A good clinical examination narrows down the diagnosis and helps in planning relevant investigation which may help in clinching the accurate diagnosis and planning treatment. There are many stories in literature where wrong investigation or medications were prescribed due to lack of examination. A middle aged person coming with chest pain and burning may be prescribed ECG or treatment for Acid-peptic disease, while an examination of chest might have revealed the cause to be Herpetic lesions at chest wall ! A women being prescribed treatment of Urinary tract infection for complaints of retention urine, while the cause was prolapse of uterus which an examination would reveal.

Physical examination requires time, keen observation and gentleness from treating doctor, qualities an aspiring medical students must have and learn. Many skills in medicine are learnt by observing seniors doing them, the art of good clinical examination is one of them [9,10,11].

The importance of clinical methodical examination is well understood, and has been included in assessments of students too. Bed side clinic are ideal to impart these skills to a small group of students, and traditional teaching heavily relies on it.

The boom of medical investigations have seen a downslide of clinical examination. Many of these investigations are accurate, reproducible and better quantified. But they come with added cost, and may involve radiation exposure or discomfort to the patient. Even non-invasive investigations requires some additional time of the patient. However these investigations are best interpreted in the light of clinical scenario which requires clinical history and examination.

#### Decline of Clinical Skills- multi-factorial

Traditional, bedside teaching is ideal clinical teaching method, where history taking and physical examination skills can be demonstrated along with professional behavior, traditional teaching relies deeply on it. The attrition of bedside clinics and the resultant decline of clinical skills have several causes: excessive dependence on investigations, a large time spent at the computer, and resultant less time for ward bedside rounds and teaching. Often attending doctor, medical students and post graduate trainees, are pulled simultaneously in diverse directions [11,12]. Perception that certain clinical skills are not valued (diagnosing a murmur with a stethoscope rather by echocardiogram).

Appropriate and inclusive history taking often is more challenging, a medical student is required to take and present history multiple times in order to master this art. Direct observation of students and residents indicates they have difficulty taking a pertinent history and deciding which data of the review of systems, past medical history, and psychosocial/family history are relevant to a specific patient's case [8,12]. As a result, it becomes somewhat cumbersome if not impossible. Barriers in language and understanding is often encountered in students coming from different states of India as many states have their own spoken language [13].

The history required for medical evaluation is very variable with different patients and the presenting symptoms, patient concerns, and the past history. Inadequate knowledge often leads to ineffective history taking skills and lack of clinical exposure. Residents and medical students may need more exposure, guidance, repetition and training in choosing the most important components of the history and physical exam to achieve suitable diagnosis. Bed side teaching includes clinical reasoning exercises, during which small groups of students are guided to work through several of the most common complaints and symptoms and reaching to most appropriate differential diagnosis through reasoning followed by feedback and discussion. All these are time-intensive processes which requires the active participation and commitment of many faculty members, who may be already overextended. Teaching physical examination skills in a large group setting using computer technology, simulators and audiovisual modalities requires less faculty involvement [14] and may be more cost-effective in western countries but may not be suitable for countries like India.

Oversights in history taking and physical examination can cause delayed diagnosis, unnecessary and potentially harmful investigation and treatment, escalating medical costs. There may be potentially life-threatening consequences for patients.

Pre-PG entrance examination in India has taken a high toll in teaching these important clinical skills to students. Medical students instead of learning these important skills are missing their bedside clinics to crack the entrance examination, as these MCQ based examination relies on theoretical knowledge; clinical skills of history taking, examination, communication are not assessed in these exams. If these issues are not addressed, there may be a significant loss of value associated with the positive patient-provider relationship, which has been shown to produce better health outcomes [12].

The underpinnings of this gradual yet steady deterioration of clinical skills are complex and represent a significant challenge to academic medical institutions. While a multifactorial phenomenon, often medical schools create an environment which, does not offer the proper bedside clinical skills. Students are busy as their target is to compete for pre-PG exam.

Medical education may sometimes take a backseat to the other activities of research and clinical work which medical teachers are expected to do. Medical teachers performance is evaluated on basis of research publications and clinical skills, evaluation for teaching is often marginalised. Clinician-educators receive less recognition for working with students / interns than for research and clinical work despite their hard work and appear to be profoundly undervalued which leads to frustration and dissatisfaction with job. Their promotion and career advancement is also difficult as being a good teacher is generally not evaluated [14,15].

Medical school administrators and stakeholders (Medical council of India, government) should consider re-evaluating their stance on highquality medical education and invest resources in programs to adequately prepare clinicianeducators to teach. Though MCI has suggested all medical teachers must be trained in medical education technology but has failed to arouse desired interest of medical teachers. Providing clinician-educators with true protected time, financial incentives, academic rewards, and a path to promotion and recognition may rekindle their interest in enhancing medical education and imparting all inclusive essential skills to the budding doctors of tomorrow [15]. Students too should be assessed for clinical and communication skills in post graduate examination.

#### Conclusion

The declining clinical skills at history taking and clinical examination are disturbing and needs to be preserved to make better doctors of future. The many reasons for this, needs to be adequately addressed. Assessment of medical trainees for these skills in their pre-PG examination should be included. Medical teachers must be adequately rewarded for their efforts, and governing authorities should invest resources for producing good medical educators.

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# PBL vs. Non-PBL Approach and Assessment in Biomedical and Medical Education: A Recent Update

## Ahmed El-Hashash

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#### Abstract

Both real-life problems and resolution efforts are widely seen as the natural early steps in the learning processes in humans and, therefore, the problem-based learning (PBL) strategy is considered as a more powerful teaching method in Biomedicine. Recent biomedical/medical educational systems incorporate teaching methods, including PBL, which support students' learning by improving their critical thinking, practical skills, knowledge achievement, and continued professional learning. PBL is a self-directed learning and educational approach facilitating the development of learning abilities and skills that are essential for biomedical/medical students, hence there are increasing interest by biomedical and medical schools in developing and adopting PBL approach. The goal of this article is to compare the benefits and limitations of PBL vs. non-PBL approach within biomedical/medical education, describe recent update and improvement of PBL strategy such as hyprid-PBL curriculum and team-based learning method, and review assessment methods for PBL and non-PBL approaches in biomedical/medical education.

**Keywords:** Biomedicine; PBL; hybrid-PBL; Conventional learning; Team-based learning; Multiple-choice questions; Short-answer questions; Active learning groups; Project-based learning.

#### Introduction

The influence and importance of instructional guidance on the learning outcome(s) in the biomedical education have long been a *subject of debate*. In the biomedical education, there are mainly teacher-centered (conventional/traditional) non-

Author's Affiliation: Professor, Department of Biomedicine, Stem Cell & Regenerative Medicine, The University of Edinburgh- Zhejiang International Campus, (UoE-ZJU), ZJE Building, Haining, Zhejiang 314400.

**Correspondence and Reprint Requests:** Ahmed El-Hashash, Professor, Department of Biomedicine, Stem Cell & Regenerative Medicine, The University of Edinburgh-Zhejiang International Campus, (UoE-ZJU), ZJE Building, Haining, Zhejiang 314400.

E-mail: hashash05@yahoo.co.uk

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PBL learning and teaching methods, and studentcentered (with minimal guidance) problem-based learning (PBL) methods.

### Problem-based learning (PBL) in Biomedical/ Medical Education

As an active and self-directed strategy of learning, PBL teaching method was first introduced by Barrows and Tamblyn in 1969 and can promote and enhance the abilities of biomedical and medical students at different levels to analyze and integrate both basic science and clinical data and concepts. It can also foster student life-long learning skill development. Many research studies show evidences that the student-centered PBL facilitates the development of learning abilities and skills that are essential for biomedical/medical students and, therefore, is more effective than non-PBL conventional learning strategy for preparing medical and biomedical practitioners [1,2]. The non-PBL (teacher-centered) conventional/traditional learning includes teacher-centered learning such as lecturers (lecture-based learning; LBL) and short discussions with students.

There are currently 5 key PBL categories, which are self-determination, cooperative learning, problem-solving, information processing, and contextual learning [3]. Both the case quality and preparatory materials are essential for the success of PBL approach, which becomes a popular medical education model worldwide [4]. Each PBL case dependents on five important characteristics, that are the case relevance, feasibility, engagement, instruction and challenge [4-5].

The application and effectiveness of PBL in different medical programs are well-investigated. A comparison of perceptions of medical education between PBL and non-PBL (conventional/ traditional) approaches shows that students with PBL methods have better education and interpersonal skills [6]. However, some early studies comparing students' academic achievements of PBL and conventional medical learners using many measures of knowledge acquisition have concluded that there is no clear advantage of one curriculum over the other [7] or there is a significant trend that favors conventional teaching methods [8].

In both biomedical and medical education, quantitative and qualitative studies aimed to explore the learning satisfaction of PBL vs. non-PBL approaches/learning environment among students show that the PBL students clearly perceive their learning environments to be more positive than their counterpart students in conventional program(s). This uniformly positive view by participating students on the PBL approach is reflected in their comments that PBL is interactive, enjoyable, practical, relevant and holistic. Nevertheless, there are some limitations for the PBL approach such as the interference of the group process issues with student learning, differences between tutors in their expectations of PBL learners, and the need for confirming that essential contents are being learned by the PBL approach [9,10].

Most recently, a study on biomedical students has proposed that an evidence-based approach to PBL case construction is necessary [11]. In this study, they dedicated 6 hr/week for years 1 and 2 biomedical students to a modified format of PBL, which is called active learning groups (ALG) and composed of small student group of 9-10 and 2 faculty facilitators; one basic science and one clinical science. The ALG cases were designed to address concepts from both laboratory and lecture sessions. For the ALG cases, students were instructed to independently prepare materials that are relevant to each case using the available selfidentified resources [11]. The results of this study are supportive for developing an evidence-based template for the case review of ALG. This, however, still needs further education of and input from end users, including using metrics for assessing the success of the ALG case such as evaluating studentgenerated learning objectives and performance on more related exam questions [11].

A recent improvement of PBL in the biomedical education has been achieved by the development of hybrid-PBL method that merges both PBL and non-PBL (teacher-centered) conventional/traditional learning to advance the biomedical science education. Recent data comparing studies that employ hybrid-PBL vs. pure PBL or conventional non-PBL learning methods in the biomedical education show that applying hybrid-PBL can result in better overall students' perception and performance than other methods [12]. However, more research is still needed to further explore the pedagogical benefits and development of hybrid-PBL over other learning methods.

Another recently developed competing method to PBL and hyprid-PBL curricula, called team-based learning (TBL), has been used in medical education as a student-centered learning method with many positive outcomes. Like PBL, TBL can maintain the small group teaching and learning advantages. However, it does not require large numbers of tutors, in contrast to the PBL curriculum. When comparing students' perceptions of using TBL in place of PBL, Burgess and colleagues [13] found that medical students prefer TBL over PBL, as the optimal teaching approach/strategy. Medical students found the TBL session format and structure more encouraging and conducive to engagement, learning and participation than PBL sessions. However, TBL use still requires an instructional approach, including tutors' directions [13].

# Assessment Methods for PBL and non-PBL approaches in Biomedical/Medical Education

Several assessment methods are developed and applied in biomedical/medical education to test and measure the student ability to both acquire and apply knowledge they gained. These methods include oral, written, practical, and multi-source observations. Each method is well-designed to measure and evaluate different learning outcome(s). Notably, there is no current consensus among academic scholars on which is the best assessment method for testing and evaluating deep vs. superficial learning among students [14].

Comparing the knowledge of biomedical/ medical students enrolled in PBL with that of students in a non-PBL approach can be achieved by evaluating the student scores on the final examination that normally consists of multiple choice or short answer questions, or other appropriate examination question formats. In biomedical/medical schools, examinations are common tools for students' assessment and evaluation. Examination questions have many formats or types such as the selected/objective response format (e.g. multiple-choice questions), and free response format (e.g. short-answer questions, long questions, and the essay). Other question types include true/false, matching, computational and oral questions.

In medical schools, the most common assessment format is the written examination format, in which students respond traditionally using pen and paper, or electronically using electronic assessment methods the written format of examinations freely from what they learnt in their own language, which is referred to as the free response format, or they can transcribe from their textbook(s). The later response method is referred to as the objective, fixed or selected, response format (SRF), in which students can choose their response from a provided/suggested list of options [16]. Despite being the most common assessment format, the written examination format has some disadvantages, including being both time consuming and prone to potential marking errors, and lacking fair assessments due to poor or difficult students handwriting. Moreover, the upfront preparation of the appropriate marking scheme is essential for both improving the reliability of this common assessment format and minimizing the marking bias [17].

In the written examination format, students can respond to multiple choice questions (MCQs), which are used in the assessment of students in medical and medical-related courses for over 50 years since they help instructors and educators with testing a wide range of the curriculum topics. MCQs involve SRF and have several advantages, including asking many questions on a wide range of topics that are covered in the course, and the objective grading for MSCQs in general [18]. Other important advantages of MCQs are their feasibility in large class size and the items of the multiplechoice test can, if well prepared, assess various learning outcome levels, from how students can basically recall the information they studied, to how they apply, analyze and evaluate this information when taking the tests [18,19]. In addition, getting feedbacks for MCQs is timely and easier, sometimes immediately, since the computer-based administration and marking can be used for MCQs tests [20]. Moreover, the analysis of items in MCQs can be properly used for assessing which questions can discriminate between slow and good learning students. The analysis of these items can also show the difficulty index of each question of MCQs [18-21]. Some disadvantages were also reported for MCQs such as the preparation of students to MCQs, which is towards the process of surface learning with opting mainly for crude memorization, and the high chance of students' guessing when using SRF/MCQs [21].

A recent study compared the performance of medical students in MCQs (the true or false format) and SAQs (short answer essay questions) in the pre-clinical anatomy exams and uncovered the relationship between the examination final grade of students with the examination formats (SAQs vs. MCQs) and study level [22]. The mood's median test showed that high number of students achieve scores that are greater than median in MCQs scores. Moreover, more students have scores greater than median in SAQs components of the examination, and the final examination scores correlate higher with essay scores compared to its relationship with MCQs score in year 2 [22].

With the widespread application of PBL in many biomedical and medical schools worldwide that reflects a shift from the non-PBL (conventional/ traditional) approaches such as lecture-based curriculum (LBL) to a student-centered program, there is a continuous demand for developing and updating more effective assessment tools and strategies such as MCQs that can reflect the new curriculum philosophy properly. For example, the MCQ educational goals were limited several year ago since they focused on testing factual knowledge rather than a deeper students' use or understanding of information. In addition, many MCQ educational goals focused on testing a small print in textbooks rather than student cognitive skills. The construction and development of new MCQ styles, which can test higher-order thinking skills, have been well-reviewed [4,23].

For creating successful MCQs that test student cognitive skills, question writers should understand the curriculum philosophy and, therefore, write questions that can address specific educational objectives, test students' understanding, and encourage information integration and application [4,23]. The question writers should also work on factors that affect the questions' validity and pay more attention for both the adjustment of the MCQ question level to the students' needs and preparation of model answers and explanations for each MCQ question [4,23]. In addition, the MCQ question writer should ask his/her colleague(s) to review both the MCQ questions and model answers, give MCQ examples to the students before using these questions in a summative assessment, assess the performance of students on questions, and provide feedback to the students [4,23]. Furthermore, the MCQ question writers should avoid some pitfalls in the design of each MCQ question, including grammatical inconsistencies, imprecise terms or undefined words, doublenegative statements in the distractors, clues to the correct answer and grammatical clues, and using abbreviations, eponyms, acronyms, and long items (distractors) with pairs or triplets of reasons [4,23]. The use of these tips will help question writers to write more effective MCQs for both formative and summative assessments in the PBL curriculum.

Finally, it is noteworthy that PBL refers to both the project-based learning and problem-based learning, despite the differences between these two pedagogies that can both promote 21st century biomedical/medical learning. While problem-based learning students learn about a topic by solving a suggested problem(s) that does not often have one correct answer, and generally work in groups to solve this problem(s), project-based learning is a different instructional approach, in which students can learn through the investigation of a complex question, challenge or problem [24]. Project-based learning students can explore real-world problems and define answers to these problems by completing a project, in which they have some control over their work project, including to decide how their project will finish and what is the end product? In addition, problem-based learning students often jointly set the learning goals and share outcomes with their teacher, while the goals of project-based learning are already set and quite structured in the way(s) that the teaching will occur. Moreover, project-based learning is often multidisciplinary, follows general steps and is longer, while problembased learning is usually a single subject, provides specific steps and is shorter [25]. Thus, while problem-based learning can empower biomedical/ medical students to conduct intensive research, with integrating both theory and practice and applying knowledge and skills to develop a feasible

solution to a well-defined problem(s), project-based learning can promote both active student learning and more engagement, and allow for higher order student thinking [24,25].

## Conclusion

The benefits and limitations of PBL compared to conventional curricula have been continuously studied, mostly using learners from various biomedical and medical programs. The general conscience is that students from PBL curricula are generally better in both their interpersonal communication and clinical performance. In addition, students from PBL curricula usually report a higher satisfaction level and enjoyment with their program than do the conventional non-PBL curriculum learners. However, there is a general conclusion that non-PBL conventional curricula learners perform somewhat better on standard examinations compared to the performance of PBL learners. These findings highlight the dearth for a continuous and future research into the PBL effectiveness in biomedical and medical curricula. In addition, the use of scenario-based MCQs, particularly in PBL curriculum, can motivate biomedical and medical students to combine the fact learning with understanding several skills, including problem solving skills and analytical skills, as well as both the integration and application of knowledge skills.

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# **Burnout in Health Professionals: Time to Take Care of the Carers**

# **Pratibha Singh**

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#### Abstract

Burnout refers to a state of having no energy or enthusiasm because of working too hard or extreme tiredness or a feeling of not being able to work anymore. It is prolonged response to chronic emotional and interpersonal stressors on the job. All over the world, this is being recognised as an important problem among doctors having an impact on quality of care with economic burden for country. It has been recognised in other high performing fields too. Burnout in medical professionals has been recognised for some time now, and it can have an significant impact job performance, lower productivity and quality of life [2]. Interventions done to reduce this problem is scarce and patchy. This review focusses various causes and suggests holistic approach in corporating variety of therapeutic measures.

Keywords: Burnout; Health Professionals; Physician.

#### Introduction

Burnout is prolonged response to chronic emotional and job stressors manifesting as no energy or enthusiasm for work. Though recognised in many other job profiles too, it is specially important for the medical professionals as it can potentially cause compromised quality of medical care. Job performance, job satisfaction and social relationships are affected due to burnout. Many medical societies eg AAFP [American Association of Family Physician], Canadian family Physicians etc. have recognised it as an important phenomena which deserves attention and management. Burnout can negatively affect quality of patient

**Author's Affiliation:** Professor and Head, Department of Obstetrics & Gynecology, All India Institute of Medical Sciences (AIIMS), Jodhpur, Rajasthan 342005, India.

**Correspondence and Reprint Requests: Pratibha Singh,** Professor and Head, Department of Obstetrics & Gynecology, All India Institute of Medical Sciences (AIIMS), Jodhpur, Rajasthan 342005, India.

E-mail: drpratibha69@hotmail.com

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care and result in physicians leaving practice, thus contributing to the primary care workforce shortage in US. [3,4.5] and some other countries. Studies have reported high incidence of burnout ranging from 17% to 76% [1,5,6] and effects many countries across the world and involves many disciplines of healthcare.

Maslach Burnout inventory (MBI) [8] is the commonly accepted burnout inventory which analyses three main components, namely exhaustion or feeling of being emotionally overwhelmed is considered an important symptom complex; second depersonalisation or inability to care about service recipients and third lack of personal accomplishments and negative attitude in relation to job. Personal characteristics of an individual combined with unique situation factors has a profound factor on burnout, still organisational factors seems to be stronger, suggesting burnout to be more of social and profession related phenomenon [1,9]. The state of burnout has also been covered in popular and mass media. Not all specialities of healthcare are equally affected; anaesthetist, neurosurgeon, cardiac surgeon, obstetrician are said to be high in list for burnout.

#### The State of Physician Burnout

Physician burnout has been a significant area of concern and investigation for decades. Broad body of literature addresses both the causes of physician burnout and potential interventions to prevent or alleviate it. In addition, this issue has been covered in popular media. The literature shows that there is a high risk of physician burnout in the United States, Canada, and many European countries. Data on this regard in less developed countries is lacking. Though we do not know prevalence of burnout in many less developed countries the importance is well recognised. A broad-based study that assessed U.S. physicians using the Maslach Burnout Inventory (MBI) showed that 54.4% of all physicians combined reported experiencing at least one symptom of burnout. The same study found a 63% burnout rate among U.S. family physicians. Further, the study found that only 35% of family physicians report being satisfied with their work-life balance. These striking findings bear out across medical specialties, career phases, and demographics [8].

The classic definition of burnout is- [Job burnout is] a psychological syndrome in response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness & lack of accomplishment [8].

#### **Burnout - Whys and wherefores**

The importance of recognising and addressing the source of physician burnout is vital. Despite much research, definitive causes of burnout among doctors still may not exist. Even factors in different stages of career may be effected differently. Studies indicate that common drivers of physician burnout include the following: paperwork; feeling undervalued, frustrations with referral networks, difficult patients, medico-legal issues and challenges in finding work-life balance [10,11,12]. While long hours, frequent calls, exhaustive paper work affects more in early and middle career; at times leading to inability to resolve work-life conflict [11].

In 2013, AMA (American Medical Association) initiated a study to identify high-priority determinants of physician's professional satisfaction [13]. Authors reported electronic health record and physician perceptions of providing high quality services were the two important factors for burnout. Other contributing factors include the following:

- 1. Work Quantity
- 2. Autonomy and work control
- 3. Fairness and respect
- 4. Leadership
- 5. Professional liability concern
- 6. Autonomy for work control
- 7. Support staff and allied health professional

#### Burnout: direct and indirect effects

Over the years understanding towards effects of burnout has increased, still there are many answered issues. Burnout generally is connected to increase in medical errors, erratic prescribing patterns, and lower patient adherence to chronic disease management plans and much more [14]. Long hours and frequent call, results in greater burnout and dissatisfaction among middle career physicians compared with physicians in other career stages. This is a notable concern because the middle career stage health professional is usually the most productive phase in terms of providing patient care, serving as a leader and mentor, and assuming important administrative roles [1,12]. Annual Medscape physician burnout studies reveal an gender gap in burnout [15] Across all specialties, the burnout rate among female physicians (55%) is 10% greater than the burnout rate of their male peers (45%). The reasons for this disparity are unclear and may require additional study, additional familial responsibilities may be one of the contributing factor.

The CDC [Centre for Disease Control] states "In simple terms, well-being can be described as judging life positively and feeling good" [13].

#### Work Happiness

Happiness at work is postulated to lead to professional satisfaction and not just absence of burnout. Potential solutions to improve personal well-being and professional satisfaction must be adapted based on the physician's experience of work culture, work behaviour, opportunities of growth. The following are the five influential elements of the health system and is liable to reforms:

1. Mundane jobs like Reporting and documentation place a significant burden on physicians but do not yield a proportional

improvement in quality of care. These may be minimised or data entry operators may be hired for the same

- Organization Level The values, requirements, and operational policies of an organization can influence professional satisfaction. Hence it is important to incorporate necessary changes in the system.
- 3. *Private Practice Level* The characteristics and efficiencies of the practice environment and the care team can affect physician's well-being. Healthy and compassionate environment at practice level can be major stress buster where difficulties in patient management can be discussed. Peer to peer support must be encouraged and in culcated.
- 4. *Individual Level* Individual wellness habits and resilience capabilities can affect the physician's response to external stressors. These strategies need to taught at the residency level too.
- 5. Society: A culture that elevates self-sacrifice or self-neglect for the service of others can add to feelings of shame and guilt when one is unable to achieve superhuman performance levels.

It may not be possible to implement all these options in all situations, every organisation system needs to identify areas of change which can be implemented without adding to significant cost or major organisational transformation.

#### **Reducing Burnout and Increasing Satisfaction**

Once the drivers of physician burnout is understood, development of intervention models to prevent burnout and support services to help physicians cope with the symptoms and have a positive impact, though not all factors can be addressed. Treatment of individuals (counselling services, meditation, exercise, Yoga etc). Self-awareness and mindfulness training can reduce physician burnout and increase both physician well-being and patient-cantered qualities [16]. System-level interventions, such as implementing institutional success metrics that include physician satisfaction and wellbeing, and developing practice models (group practice) that fosters cooperativeness, and relies on support system is promising and is adapted

at many places. Reducing unnecessary paper work, outsourcing some of the paperwork and computer related work may also help to some magnitude.

#### Conclusion

Burnout affects physicians across all specialties. Physicians, more so, female physicians experience higher-than-average rates especially when compared to the general working population, also the satisfaction with work-life balance is decreasing. Physician burnout is an important issue that must be dealt with openly and proactively because it affects both patient safety and physician well-being. Many societies strongly believes that health professional burnout is a health system, organization, practice, and physician culture problem, not just an individual concern. Therefore, a systems-based approach to identifying and combating root causes of physician burnout at all levels wold be helpful. It will have a long lasting impact on quality of health care and the society in general.

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