Burnout entre Médicos

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The health and well-being of Australia's future medical doctors: protocol for a 5-year observational cohort study of medical trainees

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Abstract

Introduction Clinical training in the undergraduate medical course places multiple stressors on trainees, which have been held to lead to heightened distress, depression, suicide, substance misuse/abuse and poor mental health outcomes. To date, evidence for morbidity in trainees is largely derived from cross-sectional survey-based research. This limits the accuracy of estimates and the extent to which predispositional vulnerabilities (biological and/or psychological), contextual triggers and longer-term

A recent meta-analysis of 195 studies from 47 countries highlighted that 27% of medical student respondents screened positive for depression or depressive symptoms, and 11% reported experiencing suicidal ideation.[1] These estimates are between two and five times higher than that reported in the general population.

Psiquê dos Médicos

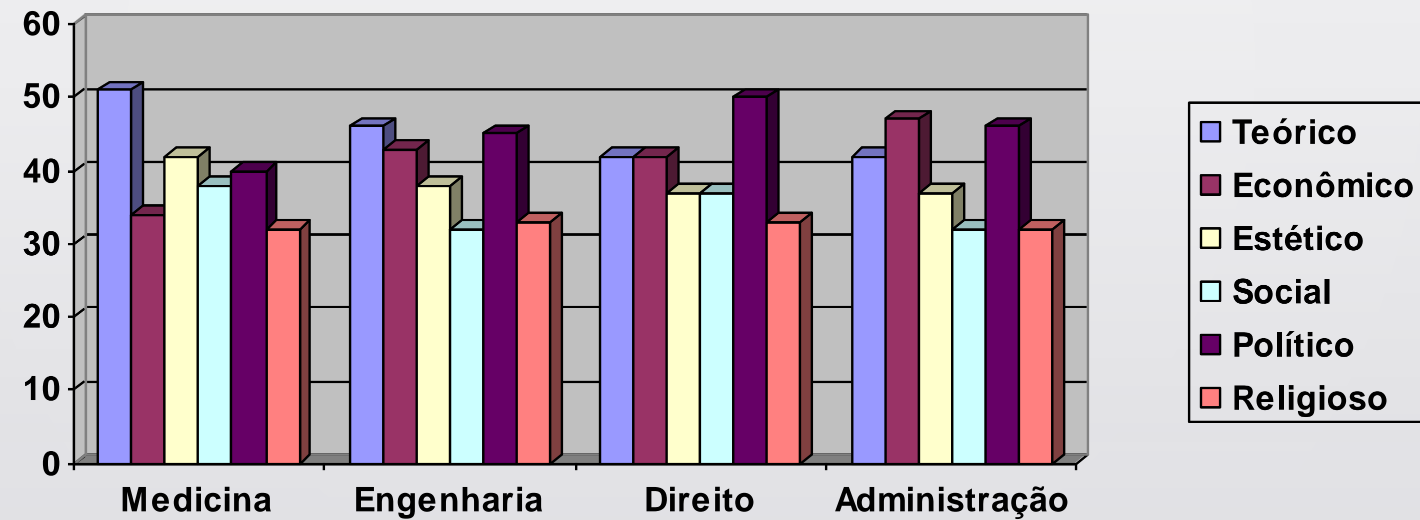
- Altruísmo
- Mecanismo de defesa perante ao adoecer e à morte
- Auto-estima baixa,sentimentos de inferioridade,insegurança
- Defesas Narcisistas

Personalidade tipo A ou Make up

- Obssessividade, competitividade, pensamentos antecipatórios, altos índices de ansiedade
- *Work a holic :* negação da existência de uma outra vida que não a médica,como negação da morte
- Dependência,pessimismo,insatisfação nos relacionamentos afetivos

Quem mais sofre?

- Personalidade tipo A
- Traços de personalidade(Allport,1966)



1 em cada 10 estudantes já pensou em suicídio no período de 1 ano do curso médico

(Martins,2002)

Gráfico 5 – População de estudantes da FAMEMA, sem e com estresse do primeiro ao sexto ano, que respondeu ao ISSL, em 2003.

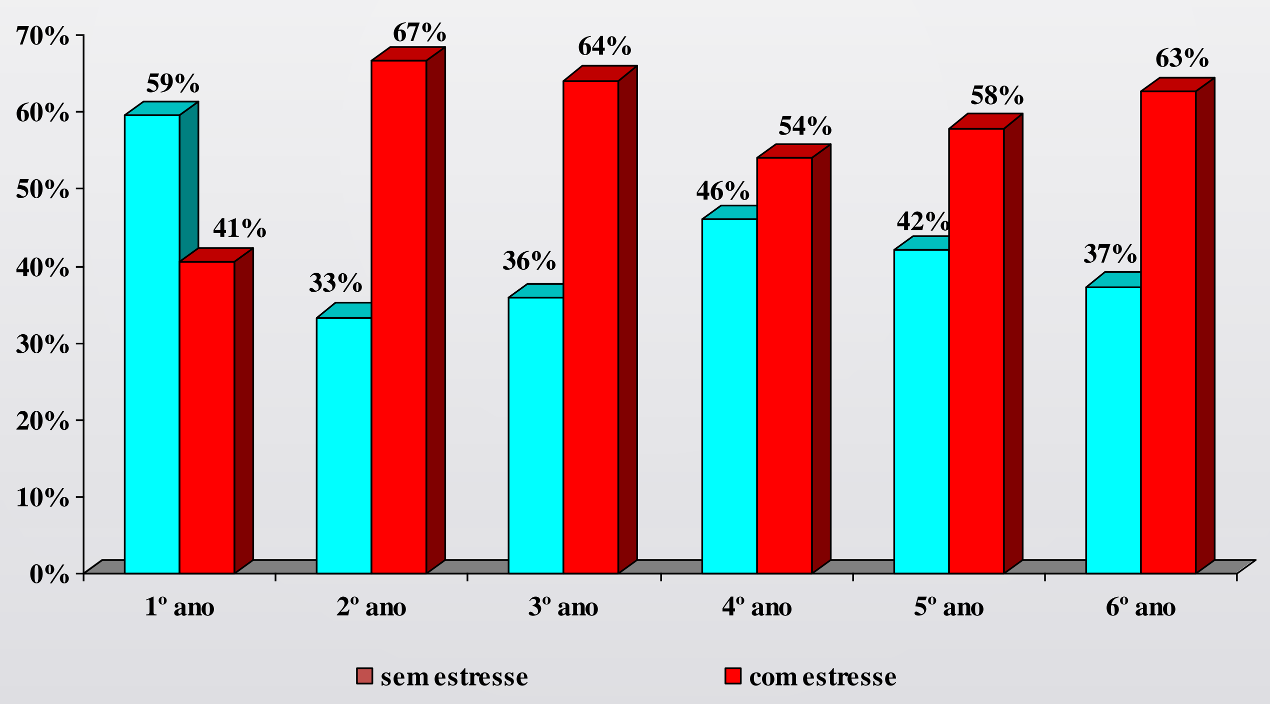


Gráfico 6 – População de estudantes da FAMEMA, do sexo feminino, do primeiro ao sexto ano, sem e com estresse, segundo ISSL, em 2003.

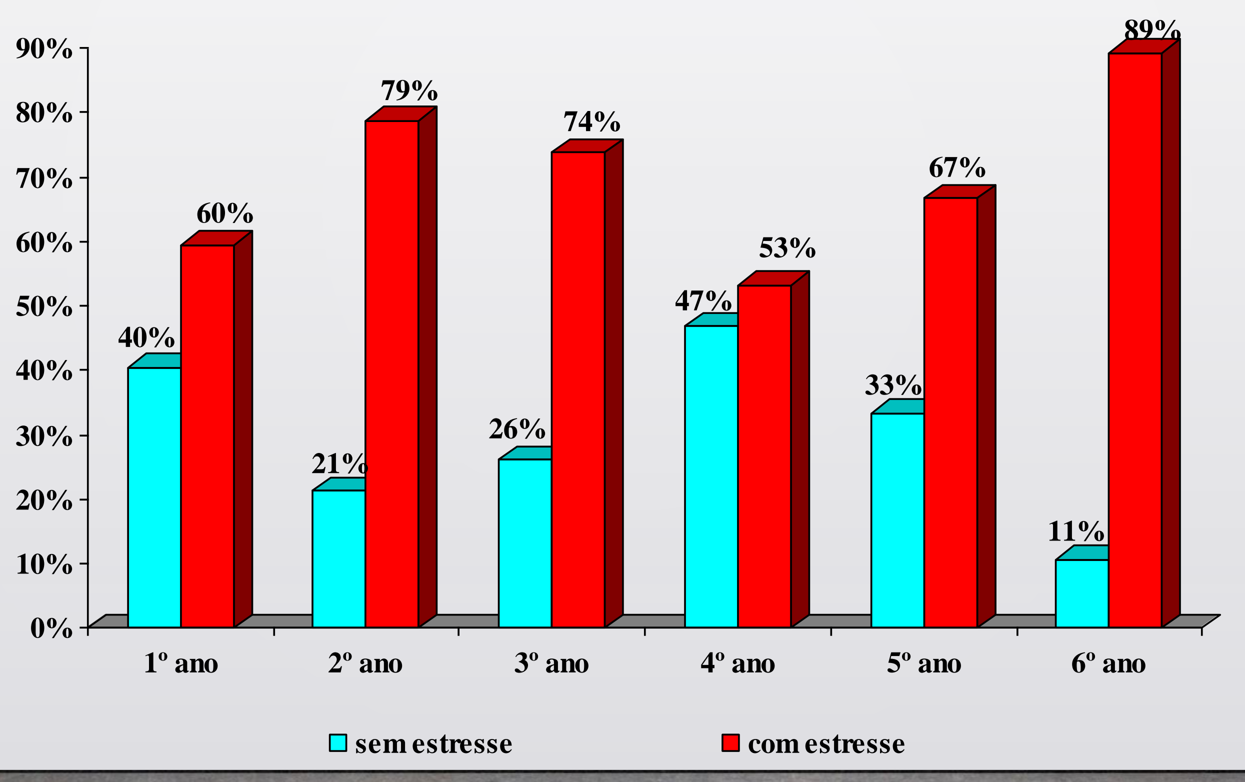


Gráfico 7 – População de estudantes da FAMEMA, do sexo masculino, do primeiro ao sexto ano, sem e com estresse, segundo ISSL, em 2003.

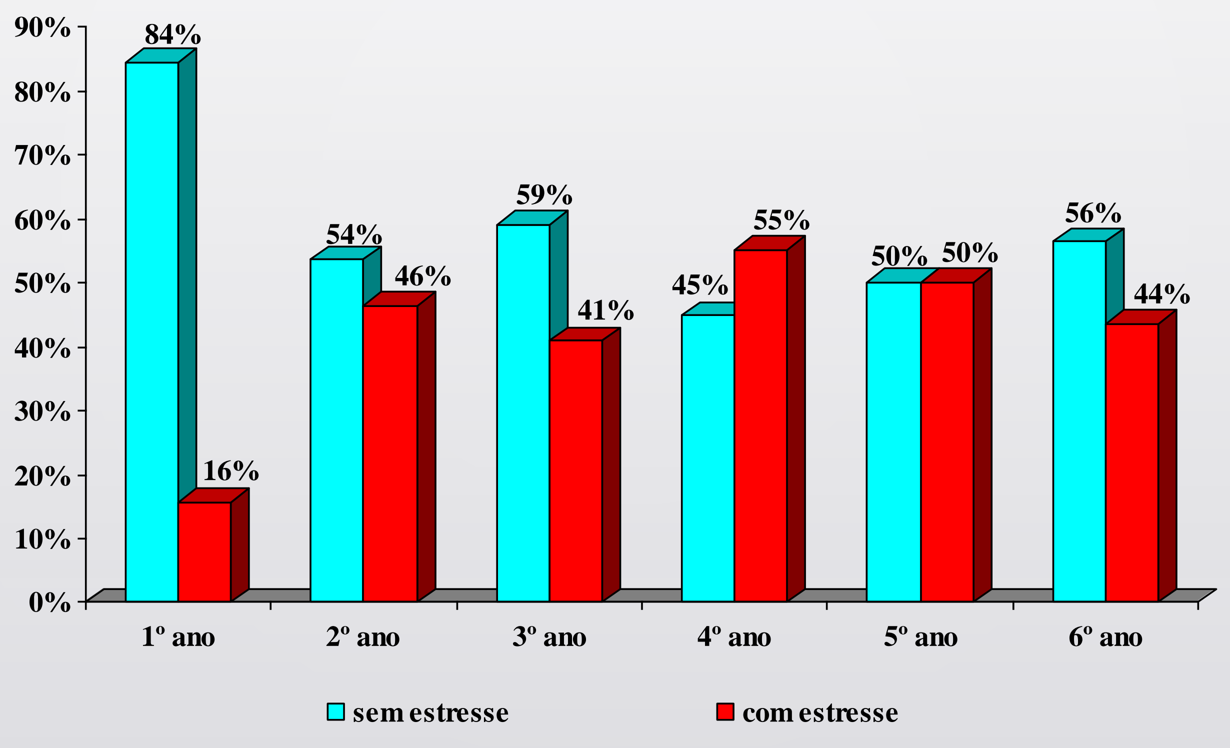
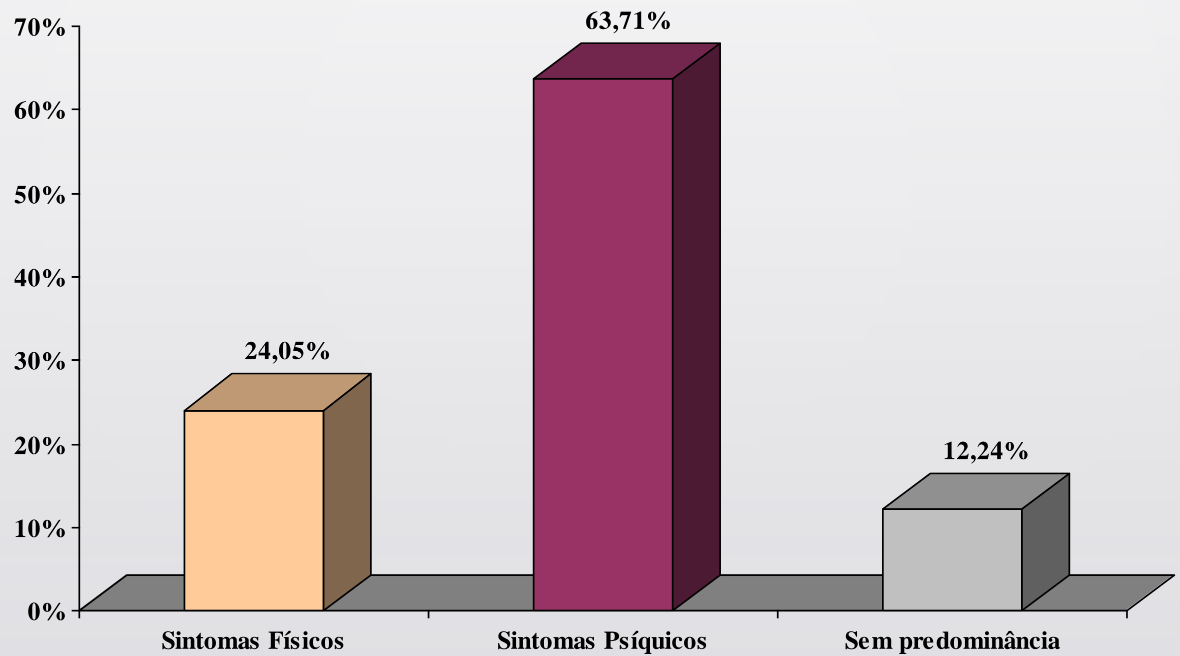


Gráfico 9 – Predominância dos sintomas entre os estudantes de medicina da FAMEMA com estresse, segundo ISSL, em 2003.



PRIVAÇÃO DO SONO

- teste de atenção sustentada - 14 R1
  - detecção de arritmias em ECG
- resultados:
  - aumento do número de erros
  - 7,3 minutos a mais para leitura adequada do ECG
- efeitos da privação do sono:
  - dificuldade de concentração
  - irritabilidade
  - sentimentos de auto-referência
  - inadequação afetiva associada a humor negro
  - depressão

(Friedman e cols, 1971; 1973)

PRIVAÇÃO DO SONO E FADIGA

- Plantão noturno pode reduzir o período de latência do sono a níveis patológicos.

(Mathias e cols, 2004)

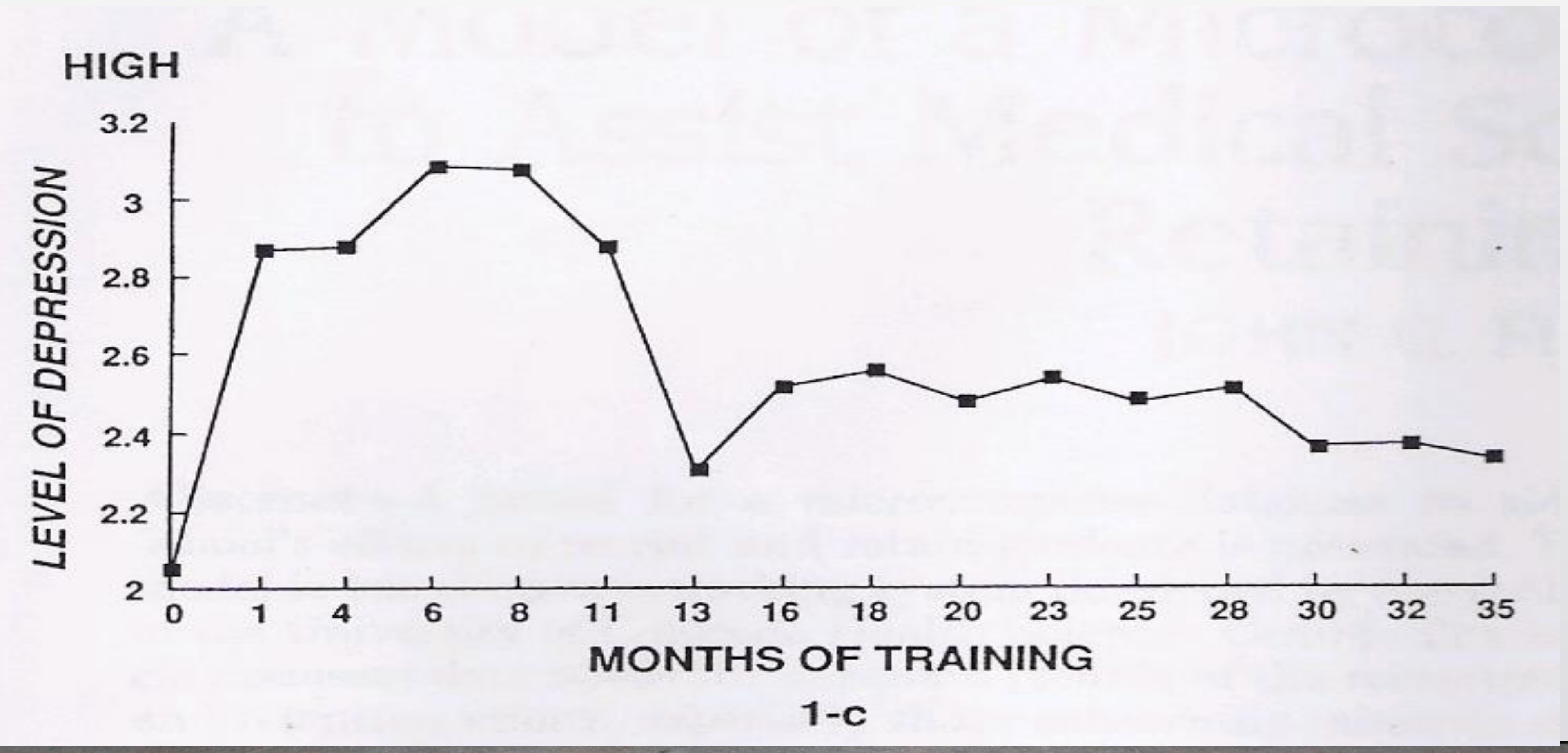
- Redução da carga horária de trabalho foi acompanhada por redução do número de erros médicos em UTI.

(Landrigan e cols, 2004)

SINTOMAS DEPRESSIVOS EM R1

Prevalência	Autores
38%	Reuben, 1985
31%	Hsu e Marshall, 1987
15%	Kirsling e Kochar, 1989
28%	Firth-Cozens, 1990
19%	Obara, 2000
33%	Peterlini, 2000
35%	Collier, 2002
30%	Rosen e cols, 2006
22%	Demir e cols, 2007
29%	Sakata e cols, 2009
28,8%	Mata e cols, 2015

DEPRESSÃO AO LONGO DE 36 MESES DE RESIDÊNCIA



(Girard e cols, 1991)

QUALIDADE DE VIDA

Associação entre pior qualidade de vida e:

- ser residente de primeiro ano,
- com mais de 30h semanais de atendimento a pacientes críticos e
- trabalhar em plantões fora da RM

(Macedo, 2004)

Carga horária > 60 horas/semana associada com comprometimento da qualidade de vida

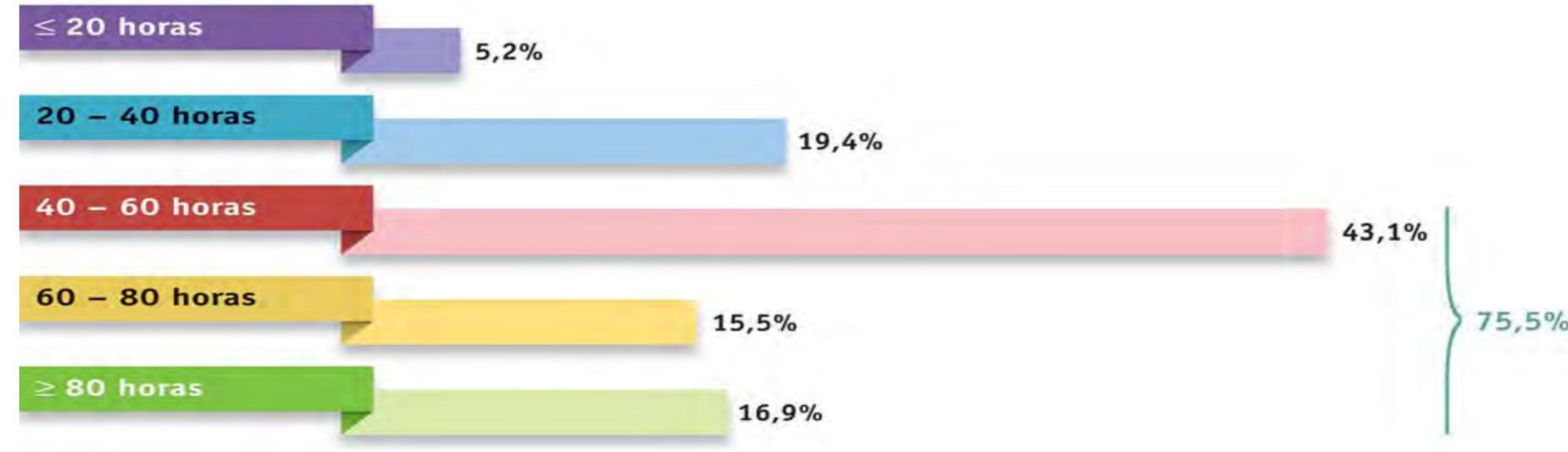
(Oliveira Filho e cols, 2005)

PRIVAÇÃO CRÔNICA DO SONO, DEPRESSÃO E BURNOUT

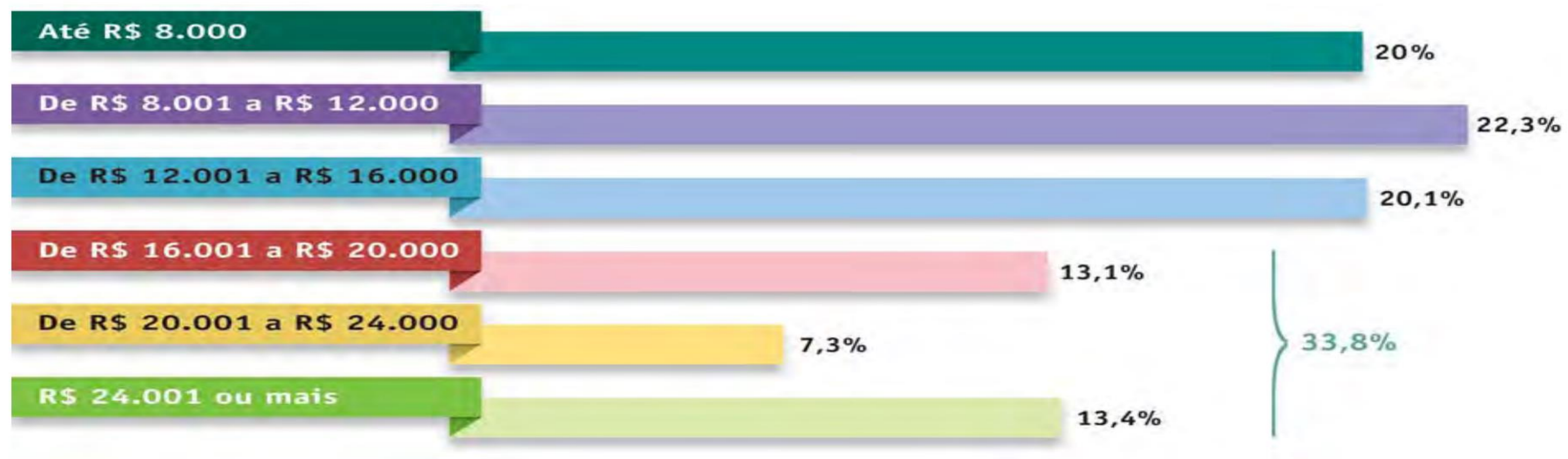
	Privação do sono	Depressão	Burnout
Início do R1	9%	4,3%	4,3%
Final do R1	43%	29,8%	55,3%

(Rosen e cols, 2006)

Mercado de trabalho(CFM,2015)



Mercado de trabalho (CFM,2015)



Burnout

Esgotamento emocional

Despersonalização

Baixa realização

Burnout

- Fadiga
- Cansaço
- Alterações de humor
- Desinteresse
- Frieza,distanciamento
- Sensação de ineficácia profissional

Beyond Burnout — Redesigning Care to Restore Meaning and Sanity for Physicians

Alexi A. Wright, M.D., M.P.H., and Ingrid T. Katz, M.D., M.H.S.

In late 2016, a primary care physician with a

“work after work” — at night, on

To Care Is Human — Collectively Confronting the Clinician-Burnout Crisis

Victor J. Dzau, M.D., Darrell G. Kirch, M.D., and Thomas J. Nasca, M.D.

The ethical principles that guide clinical care — a commitment to benefiting the patient, avoiding harm, respecting patient autonomy, and striving for justice in health care — affirm the moral foundation and deep meaning underlying many clinicians' view of their profession as a worthy and gratifying calling. It is clear, however, that owing to the growing demands, burdensome tasks, and increasing stress experienced by many clinicians, alarmingly high rates of burnout, depression, and suicide threaten their well-being. More than half of U.S.

quences in terms of both human cost and system inefficiency.[1] Nothing puts these consequences into starker relief than the devastating rates of suicide among physicians. As many as 400 U.S. physicians die by suicide every year.[2] Nearly every clinician has been touched at some point by such a tragedy.

Not only are clinicians' lives at risk, so is patient safety. Some studies have revealed links between clinician burnout and increased rates of medical errors, malpractice suits, and health care–associated infections. In ad-

ing programs, professional societies, and specialties to confront the crisis. But no single organization can address all the issues that will need to be explored and resolved. There is no mechanism for systematically and collectively gathering data on, analyzing, and mitigating the causes of burnout. The problem is not lack of concern, disagreement about the severity or urgency of the crisis, or absence of will to act. Rather, there is a need to coordinate and synthesize the many ongoing efforts within the health care community and to generate mo-

symptom of burnout: emotional exhaustion, depersonalization, or a diminished sense of personal accomplishment due to work-related stressors. Those in "front-line" specialties, including general internal medicine, family medicine, emergency medicine, and neurology, are at the highest risk.[2]

"There was this assumption that doctors could take on extra work seamlessly, but now it is crowding out our true work as healers," notes Sinsky. "Physicians are at the sharp end of the stick for accountability, regulatory issues, and now even data acquisition and entry — it's too much."

Shanafelt and others argue that burnout can undermine a physician's sense of purpose and altruism and lead to higher rates of substance use, depression, and suicidality. Physicians with symptoms of burnout are more likely to report having made a major medical error in the past 3 months and to receive lower patient-satisfaction scores.[3]

Female physicians may be at highest risk, particularly those with heavy clinical loads. A survey of Stanford School of Medicine faculty found that few female faculty members reported "feeling supported" in their career development. The survey prompted the administration to

Physicians with symptoms of burnout are more likely to report having made a major medical error in the past 3 months and to receive lower patient-satisfaction scores.

ported" had nearly doubled by the end of the pilot program.

Increasingly, other medical organizations are starting to tackle the challenge of burnout. In 2016, chief executives from 10 major health care organizations gathered at a summit to share strategies for combating physician burnout. The group committed to 11 actions, including measuring physician well-being, supporting team-based models of care that allow physicians to operate at the top of their license, and proactively monitoring and addressing the increasing regulatory burden imposed on physicians.[4]

Measuring rates of physician burnout is the first step toward addressing this national epidemic. "Fundamentally, you manage what you measure," argues Mayo Clinic President and Chief Executive Officer John Noseworthy. "CEO performance scorecards always include financial and quality measures, but mine also has staff engagement, satisfaction, and

Are EMRs to Blame for Physician Burnout?

Interview · October 24, 2016

Thomas H. Lee, MD, MSc & Steven Strongwater, MD

Press Ganey Associates, Atrius Health

Physician burnout is a hot topic these days — for good reason. As Steve Strongwater, President and Chief Executive Officer for Atrius Health, notes in his discussion with Tom Lee, 54% of U.S. physicians are experiencing physician burnout. Are electronic medical records worsening the problem? In short, yes. Find out why, and how we can address this to improve not only the quality of care for patients, but also the quality of life for physicians.

Listen to audio interview.

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- Resiliência
- Exercício físico
- Sono
- Lazer
- Família

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- Núcleos de atenção ao aluno
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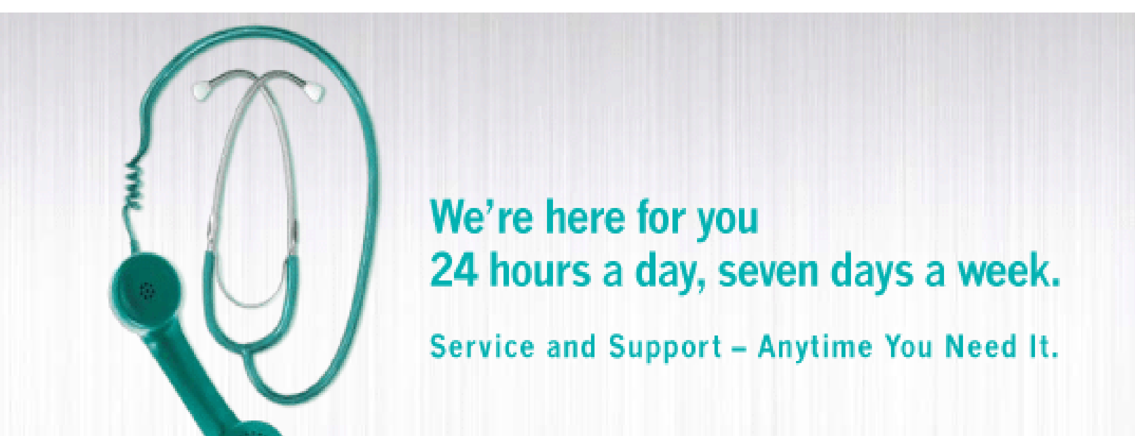
We're evolving to serve you better

Over the past year, the Physician Health Program has reflected on how best to realize our vision of a healthy, connected and resilient physician community in BC, both now and in the future. Our Steering Committee has approved a new organizational structure that makes more time available for physicians doing intake and assessment, improves responsiveness, flexibility and continuity, and maintains the quality of services provided. We are excited about what the future holds, and look forward to serving physicians better, through our improved structure.

As we make these changes, we will maintain our core services to BC physicians and trainees and their families with unwavering commitment to quality, confidentiality and integrity.

If you have any questions about our evolution, please contact us.



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