O3_A2_A_Scientific Evidence

PROFESSIONAL BURNOUT SYNDROME

Q1	**Are community/work organization interventions to prevent professional burnout (e.g. deterioration of relationship, professional ineffectiveness, disillusion…) effective and should be generally implemented?**
Patients	Healthcare Nurses Medical doctors
Intervention	Assessment and evaluation scale
Comparator	Any intervention
Outcome	Efficacy measured in reduction of stressors, increased job satisfaction, improved psychological outcomes
Methodology	Systematic reviews Randomized controlled trials
Extra	None

References

Studies:
Three systematic reviews have been included.

1. Niall D. Galbraith & Katherine E. Brown, Assessing intervention effectiveness for reducing stress in student nurses: quantitative systematic review, Journal of Advanced Nursing 67(4), 709–721
2. Rebecca C Hill1, Martin Dempster1, Michael Donnelly1 and Noleen K McCorry1,2 Improving the wellbeing of staff who work in palliative care settings: A systematic review of psychosocial interventions, Palliative Medicine 2016:1– 9
3. Colin P West, Liselotte N Dyrbye, Patricia J Erwin, Tait D Shanafelt Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis, www.thelancet.com Published online September 28, 2016
4. Dio Kavalieratos, Jennifer Corbelli, Di Zhang, J. Nicholas Dionne-Odom, Natalie C. Ernecoff, Janel Hanmer, Zachariah P. Hoydich, Dara Z. Ikejiani; Michele Klein-Fedyshin, Camilla Zimmermann, Sally C. Morton, Robert M. Arnold, Lucas Heller, Yael Schenker, Association Between Palliative Care and Patient and Caregiver Outcomes A Systematic Review and Meta-analysis, 2016 American Medical Association
5. Salzano AT, Lindemann E and Tronsky LN. The effectiveness of a collaborative art-making task on reducing stress in hospice caregivers. Art Psychother 2013; 40: 45–52.

Basar U, Basim N. A cross-sectional survey on consequences of nurses' burnout: moderating role of organizational politics. J Adv Nurs. 2016 Aug;72(8):1838-50. doi: 10.1111/jan.12958.

Labrague LJ, McEnroe-Petitte DM, Gloe D, Tsaras K, Arteche DL, Maldia F.
Organizational politics, nurses' stress, burnout levels, turnover intention and job satisfaction. Int Nurs Rev. 2017 Mar;64(1):109-116. doi: 10.1111/inr.12347.

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Ufuk Basar & Nejat Basim, A cross-sectional survey on consequences of nurses' burnout: moderating role of organizational politics, . J Adv Nurs. 2016 Aug;72(8):1838-50

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Indications:

Health professionals (doctors, nurses, caregivers etc.) with a high burnout score according to questionnaires or other quantitative methods.

Discussions

There is an increasing incidence of burnout among health professionals (1), associated to decreased performances, decreased quality of care for patients and increased risk of emotional exhaustion and depersonalization among caregivers.

For the 12 randomised controlled trials and 28 cohort studies reporting differences in emotional exhaustion score as a continuous variable, the pooled mean difference estimate was a significant 2 · 65 point reduction (95% CI 1 · 67–3 · 64; p<0 · 0001; I2=82%) in emotional exhaustion domain score from 23 · 82 points to 21 · 17 points (fi gure 3). Results did not differ for randomised controlled trials versus observational studies (p=0 · 55; I2=0%), residents versus practising physicians (p>0 · 99; I2=0%), or structural or organisational versus individual-focused interventions (p=0 · 69; I2=0%; appendix) (3).

In one international study, which included the United Kingdom (UK), 40% of hospital nurses were found to have levels of burnout that were higher than the norms for healthcare staff and in the US, job dissatisfaction in nurses was four times higher than that of the average worker. Stress within the trained nursing workforce can also lead to patient dissatisfaction and reduced quality of care (1).

Various interventions have been described in order to reduce professional burnout, such as: alterations to clinical work process shorten shifts, stress management techniques, self-care training, communication skill training, reduced academic demands, belonging intervention, music therapy etc (1).

For palliative care staff, little evidence was found of adequate quality to evaluate the success of interventions, as research in this area encounters methodological difficulties. However, art therapy and music therapy have demonstrated a moderate improvement in psychological outcomes. (2).

Various individual-focused interventions, structural intervention within the work environment and belonging interventions improve the overall burnout (RR=0.82, p< .0001), emotional exhaustion score (RR=0.70, p<.0001), depersonalization score (RR=0.88, p=.01) in healthcare professionals. (3).

Conclusion:

Professional burnout is a current important issue with a negative impact upon healthcare providers, patients and family. There are various interventions that have proven beneficial in reducing burnout scores, but more evidence on which interventions or combination of interventions might be more effective are needed. Moreover, optimal approaches to develop and implement these interventions in work structures with a high risk of professional burnout need to be developed.

However, burnout should be screened for and dealt with in health care units, using individual or work-related interventions.

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Q2	**Which are the scientific tools in order to identify the burnout Syndrome? Is LBQ (link Burnout Questionnaire) an efficacy tool for evaluating the burnout level?**
Patients	Healthcare Nurses Medical doctor
Intervention	Other questionnaires
Comparator	LBQ
Outcome	Efficacy endpoints
Methodology	Systematic reviews Meta-analysis Randomized controlled trials Cohort studies

Studies:

- meta-analysis
- Descriptive study
- Survey

Indications:

- Health professionals with high risk of burnout

Discussions:

Regarding assessing burnout in health professionals, various tools are currently used, such as Link Burnout Questionnaire (LBQ – add reference), Maslach Burnout Inventory (1, 4), Granada Burnout Questionnaires and the Shirom-Melamed Burnout Questionnaire (3).

The MBI is currently the widest used and researched, although there is no "golden standard" or current guidelines on burnout survey. The MBI is the widest used as a diagnostic tool for burnout and it was the widest researched. Two meta-analysis show that MBI is a validated tool with an alpha-coefficient between 0.7-0.8. (5), the data being supported by another prospective study (7).

The Granada Burnout Questionnaire is another validated tool, assessed in a prospective study (N=1177), being able to cover all three aspects of burnout. (6).
Other tools are currently used (LBQ and Shiron Melamed Burnout Questionnaire), according to local preferences. However, there is no direct comparison between the burnout scales in terms of validity or efficacy (9).

Conclusions:

Current data show that any validated tools can be used, as there are no recommendations or standardized scales to evaluate burnout. We consider that the choice can be made locally.

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Q3	**As a prevention approach the weekly supervisor for healthcarers can be an efficacy way? If yes, which are the elements to be support this and which not?**
Patients	Healthcarers Nurses Medical doctors
Intervention	Supervisor for healthcarers factors contribute the most to the prediction of burnout job
Comparator	Standard intervention
Outcome	Efficacy Side effects to therapy Tolerability Quality of life.
Methodology	Systematic reviews Randomized controlled trials Qualitative study

References

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Conclusion

Maslach et al. (2001), three of the most prominent researchers on burnout and contributors to the most widely used measure of burnout – the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986; Maslach, Jackson, & Leiter, 1996), describe job burnout as consisting of three dimensions; (1) overwhelming exhaustion where one feels overextended and depleted of their emotional and physical resources (EE – emotional exhaustion); (2) cynicism or depersonalisation (Dp) where one displays a detached, negative and callous response to aspects of their work; and, (3) lack of accomplishment where one feels a sense of lack of achievement and productivity, and incompetence (PA – personal accomplishment). Previous research has found low to moderate levels of the three burnout symptoms are prevalent in the DSW population (e.g., Aitken & Schloss, 1994; Alexander & Hegarty, 2000; Boumans & van den Berg, 2000; Chung & Corbett, 1998; Chung, Corbett, & Cumella, 1995; Edwards & Miltenberger, 1991; Lawson & O'Brien, 1994; Mitchell & Hastings, 2001; van Dierendonck, Schaufeli, & Buunk, 1996) (3).
The students stated that supervision was helpful overall, implying that clinical supervision is culturally appropriate for clinical psychology students in Uganda. Suggestions for future supervision were given. In order to decrease high levels of staff burn out in the mental health systems in Uganda, supervisory structures with an emphasis on self care need to be established. (1)
Out of 206 psychiatrists, 154 (74.8%) responded to the survey. The respondents' mean (SD) age was 34.3 (5.2) years. The estimated prevalence of significant depressive symptoms was 34.4% (n = 53), and the experienced frequent violence was 14.9% (n = 23). The level of depressive symptoms was inversely correlated with the level of occupational satisfaction. In respondents who reported a moderate level of occupational stress, having fewer depressive symptoms was associated with higher occupational satisfaction, but this association was not significant in those who reported a high level of stress. In addition, high occupational satisfaction was associated with interest towards work content, ability to work at one's discretion, opportunities for growth and career development, and ease of communication with supervisors and colleagues.(2)
We surveyed 206 psychiatrists and 74.8% responded (n = 154). The majority of respondents were male (n = 111, 72.1%) and the mean (SD) age of participants was 34.3 (5.2) years. Of the total respondents, the mean (SD) period of post-graduate (PGY) training was 5.5 (4.0) years. Additionally, 41.6% (n = 64) of the sample were licensed psychiatrists.
More than half of the respondents were working at psychiatric hospitals (n = 92, 59.7%), followed by university hospitals (n = 35, 22.7%), general hospitals (n = 21, 13.6%), and community psychiatric clinics (n = 6, 3.9%). The mean (SD) working hours per day were 8.3 (1.9) hours and the mean (SD) number of outpatients seen per day was 26.0 (10.7). For respondents who have been working at a hospital, the mean (SD) number of inpatients in their care was 15.7 (12.8). Approximately 14.9% (n = 23) of the psychiatrists had experienced frequent violence during patient care. There was no significant association between the level of depressive symptoms with gender, age, or the type of hospital, the number of outpatients seen per day. Further, there was no significant association between the levels of occupational stress and satisfaction (measured by VAS) with these factors (data available upon request) (2).

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