Emotional Intelligence: One Cure for Physician Burnout

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Abstract

Less is known about physician's physical illnesses than about physician's mental health. Physician's rate of suicide is greater than that of the general population and greater than that of other professionals. Currently, psychiatric illness such as depression, anxiety disorders and stress related conditions is the most important cause of physician's burnout. Burnout is a state of persistent exhaustion, which is work-related and characterized by emotional exhaustion, cynicism or depersonalisation and reduced competence. This article reviews the sources, impacts and solutions of burnout among physicians and how emotional intelligence can help them better react to situations by enhancing their own emotional self-awareness, potentially reducing professional burnout.

Key words: emotional intelligence, burnout, stress, emotional exhaustion

Introduction

Burnout is a familiar term for today's health care professionals. Fruedenberger (1980) proposed burnout as a concept defining it as "emotional, psychological, physical, social and spiritual characteristics experienced by helping professionals in varying levels of intensity". Maslach (1982) defined burnout as "when a person has reached a state of mental and physical exhaustion combined with a sense of frustration and personal failure". Maslach and Leiter (1997) defined the key dimensions of burnout as overwhelming exhaustion, feelings of cynicism and detachment from the job, a sense of ineffectiveness and lack of accomplishment.

It reveals that work-related stress leads to job dissatisfaction, low organizational commitment, absenteeism, and high turnover; it affects the interpersonal functioning of teams and colleagues with increased conflict, substandard patient care, attrition, problems at home, and physical and mental health problems (Bailey, 1990a, 1990b; Balogun, Titiloye, Oyeyemi & Katz, 2002; Brown & Pranger, 1992; Davis & Bordieri, 1988; Laminman, 2007; Moore et al, 2006a, 2006b; Painter et al, 2003; Rees & Smith, 1991; Rogers & Dodson, 1988).

Today physician practice in an ever-changing landscape. A harsh cutback in public health spending is resulting into hospital closures and transfer of services into other professions. Many physicians embrace new role including becoming consultants or case managers and explored private practice opportunities. Health system reforms are primarily directed towards cutting costs, gaining efficiencies, integrating new technologies and meeting the needs of a more informed health consumer. As hospitals are under increasing pressure to balance their budgets, senior positions are lost within health profession departments and therefore mentorship roles are lost for new graduates who join the department.

Research in the field of burnout started as an attempt to make sense of what physicians were experiencing at work. Along with it grew a body of research and literature on how to remodel the stress placed on physicians. This led to proliferation of strategies such as emotional intelligence and research on its efficacy. Schonfield and Farrell (2009) expressed for using qualitative and quantitative methods in the research of occupational stress to help

work towards the common goal of understanding, and doing something about, stressors affecting workers.

Understanding Burnout

Burnout is characterized by exhaustion, cynicism and feelings of reduced competence. It is a state of persistent exhaustion, which is work-related and characterized by emotional exhaustion (a feeling of being 'empty' or 'worn out'), cynicism or depersonalisation and reduced competence. These symptoms result from prolonged periods of high workload or persistent or recurrent stress without sufficient recovery.

Work-stress is a state of incapability of the employee to meet the demands of the work environment. There are several theoretical models on work-stress, which predict a negative health effect. The best known are the demand-control (support) model of Karasek (1979), and the effort-reward imbalance model (ERI-model) of Siegrist & Weber (1986) (De Jonge, Le Blanc et al. 2003). The first model predicts that high workload, lack of control and insufficient social support can lead to an elevated stress level. The second model predicts stress responses when there is an imbalance of high effort combined with low reward. It is predicted in the ERI-model that persons who show over-commitment towards work are especially at risk (De Jonge, Le Blanc et al. 2003).

Burnout shows overlap in symptoms with other stress-related health outcomes like depression (major depression disorder; MDD), fatigue (Chronic fatigue syndrome; CFS, vital exhaustion), anxiety (posttraumatic stress disorder; PTSD), and sleep disorders. Other unexplained chronic psychosomatic syndromes are mentioned in relation to burnout as well; whiplash, repetitive strain injury (RSI), irritable bowel syndrome (IBS), multiple chemical sensitivity, and fibromyalgia (Ursin and Eriksen 2001). Despite the overlap in symptoms, the work-related character distinguishes burnout from syndromes with a resembling appearance (Schaufeli and Enzmann 1998; Shirom 2005).

If work-stress can lead to burnout, the question arises what the mediating mechanisms might be. For understanding this issue, it is crucial to study the physiological stress response as a potential mediator. Under stressful conditions, the body becomes activated to meet the increased demands of the environment. During acute stress the 'fight-flight response' is turned on. The sympathetic (activating) pathways of the body elevate heart rate, blood pressure, respiration, and glucose synthesis. Simultaneously the parasympathetic pathways (rest & recover) involved in feeding, sleep, and sexual drive are decreased. This whole system can be activated by external and internal cues, and since organisms learn from their experiences, can become sensitized for cues related to a potential stressor (Ursin and Eriksen 2001).

In the long run, the inability to properly terminate a stress response, or chronic exposure to stress can lead to pathological changes. In the 1930's Hans Selye described this process as the 'General Adaptation Syndrome', which consists of three stages – the alarm reaction, the stage of resistance, and the stage of exhaustion. More recently the term allostatis or 'stability through change' was introduced by Sterling & Eyer (1988). Allostatis is the adaptation of a set point (homeostasis) to meet the changing demands of the environment. The set point for room temperature needs to be adjusted to be able to maintain a constant temperature under these different conditions. In the long run the 'allostatic load', or the price that is paid for the change in set point, can lead to wear and tear (McEwen 1998). The equivalent in burnout, the recurrent activation of the stress response system, leads to an allostatic change in the set point.

This could initially result in a state of hyperarousal, in which the system becomes activated too soon.

Emotions at work

Every organization aims to reach at the level of optimum productivity. Certainly, skillful and competent human force is one of the most important elements that help organization to achieve their goals, because human force plays a noteworthy role in changing the level of productivity. Abraham (1999) claimed that emotionally intelligent individuals are more skilled to cope with life activities and they have productive thinking which often includes affective awareness. Emotion work is defined as emotional job demands and psychological strategies necessary to regulate these demands. Emotional job demands can be summarized into five requirements and one stressor. These five job requirements are the display of positive emotions, negative emotions, neutrality, sensitivity, and sympathy. The job stressor, emotional dissonance, is demanded when these emotional job requirements are not actually felt. This definition allows for a broad, inclusive understanding of emotion work from an organizational perspective, extending beyond efforts and labor limited to the worker.

Emotional Intelligence

Emotional Intelligence has been a much debatable topic during the last decade. It has seen some serious contributions from researchers like Goleman, D. Meyer, J. and Salovey, P. Daniel Goleman being a staunch supporter of emotional intelligence presented a mixed model for emotional intelligence. His counterparts are of a different view in this regard. Meyer et al. (2004) discussed the ability based model of emotional intelligence. They argued that even though there have been some severe controversies on emotional intelligence being a form of intelligence but immense evidences have been found out in the recent years and we can now say with all our audacity that emotional intelligence fills all the criteria of being a form of intelligence. They also throw some light on the validity of emotional intelligence tests. Huy (1999) has linked the emotional intelligence with emotional capability. He proposed that emotional intelligence is solely based on individual's capacity to adapt to dynamic environment and change while emotional capability is more of an organizational factor which enhances the chances that organization will adopt to change. He also introduced emotional dynamics like receptivity, mobilization and learning in the organizational context. Oatley (2004) viewed emotional intelligence as a source of understanding. In this regards he also discussed the Renaissance idea of emotions and intelligence which acted as the building blocks for today's concept of emotional intelligence.

Mandelle and Pherwani (2003) discussed the relationship of emotional intelligence with the transformational leadership style. They explained that both these constructs have a significant relation with each other emphasizing the fact that emotional intelligence has huge implications for the leaders. They supported the fact that both these variables have a lot in common between them. It was also found out that in general women score more in emotional intelligence tests than males do. This supports Salovey, Meyer's (1996) concept and contradicts Goleman's (1998) view. Fox and Spector (2000) identified that emotional intelligence is a very good predictor for the job selection and interviewing process. They proposed that factors on the part of individuals like empathy, self presentation and regulation of mood contribute a lot for one to be successful in an interview. They also concluded that managers should evaluate their employees on the basis of emotional intelligence rather than their academic capacity. Rode, J. C. et al (2007) explained that emotional intelligence has an indirect impact on individual's performance. It is not just about the presence of emotional intelligence it is also about the motivation to use it. They discussed the direct and moderated

impact of emotional intelligence on business undergraduates. Boylr Jr et al (2010) investigated that all three streams of emotional intelligence which are based on Meyer and Salovey's ability model, the self report measure, and the mixed model are correlated with the job performance. They can be seen as good predictors of job performance.

Sources of Stress

The sources of stress in physicians vary with the type of medical practice and specialty. There are many potential sources of stress that relate to the job, the organisation, the physician himself/herself, work-life balance and relationships with other people. A number of these factors are present in an individual physician and therefore the difficulties faced by the physician are compounded and complicated. In addition, there is an apparent difference between what physicians are trained for and what they are required to do. For example, in the medical curriculum, there is much focus on patho-physiology, diagnosis and treatment. There is now increasing emphasis on communication skills, law and ethics in medical education. However, other key aspects of a physician's job like administrative and financial management are poorly addressed and these often cause stress amongst physicians.
Following are some of the major sources of stress among physicians:

a) **The job**
    Workload
    Time pressure
    Administrative duties
    Sleep deprivation
    No regular meals
    Threat of malpractice suits

b) **The organisation**
    Career structure
    Career uncertainties
    Inadequacy of resources and staff
    Lack of senior support
    Culture and climate of the organisation

c) **The physician**

    Personality (e.g. perfectionist, Type A)
    High demands on self and others
    Dealing with death and dying
    Confrontation with emotional and physical suffering

d) **Relationships with other people**

    Staff conflicts
    Bullying
    Professional isolation
    Patient's expectations and demands
    Level of support from friends and family

e) **Work-life balance**
    Stress over-spill from work to home and vice versa
    Lack of exercise and other leisure activities
    Lack of free time
    Home demands
    Disruptions to social life

The views on Emotional Intelligence

Although there are different views regarding the concept of emotional intelligence, it can be said that all the critics have presented their own views about emotional intelligence. Some have said that emotional intelligence cannot be regarded as a real intelligence while others think the opposite and connect emotional intelligence with common human intelligence. There are still a lot of different dimensions to be seen and a lot of different psychological facts to be uncovered before anyone can come up with a proper interpretation of emotional intelligence.

Professional organizations, such as the American Dietetic Association and the State Board of Higher Education of the University of Illinois, established guidelines and edicts for the paradigm shift in the educational institutions. These organizations prompted the implementation of several emotional intelligence-based programs ranging from small-scale projects, such as developing interview skills in residents, to large-scale endeavors, such as creating an emotional intelligence-based curriculum for first-year psychiatry residents, or a baccalaureate program for physical therapy students. The American Board of Pediatrics published one of the first comprehensive documents on this subject, entitled Foundations for Evaluating the Emotional intelligence of Pediatricians.

A Physician-to-Physician Satisfaction study was conducted by The Center for Health Futures at Florida Hospital in Orlando, Florida, in collaboration with the hospital's Physician Support Services and research partners at the University of Central Florida attempted to find out physician satisfaction. The doctors were asked to rate their satisfaction in 17 different areas of their lives as physicians. Of the 17, 10 items were rated below average or less satisfying than the average rating for all 17 items. The hospital cost containment efforts topped the list as the source of least satisfaction. The other factors were, including the amount and quality of physicians' personal time as well as opportunities for research and training were statistically significant and should also be considered as opportunities for improving physicians' lives. In addition to understanding the factors that lead to physician satisfaction and dissatisfaction, it is important to examine the pivotal role that stress plays in physicians daily lives. The Center for Health Futures study measured stress with one self-report item, "How would you rate your overall stress level?" The responses ranged from 1 to 9, with 1 being "very low." The average score was 6.0.

Selection Tool

Medical education is considered as a complex, demanding and stressful program, on successful completion of which an undergraduate student is required to attain unique and diverse competencies. An ideal academic environment may be defined as one that best prepares students for their future professional life and contributes towards their personal and psychosomatic development along with social well-being as well. The environment of the Medical College should be one which encourages academic excellence and psychosocial well being through motivation and positive inputs rather than stress generation so as to make the learning experience more enriching and fulfilling for the undergraduate student.

It seems prudent to ensure that all physicians possess some degree of emotional intelligence. Exactly where in the medical education process assessment of emotional intelligence should be undertaken, however, depends largely on how mutable emotional intelligence is. Unfortunately, questions regarding the stability of emotional intelligence remain empirically unresolved, but proponents of neither model suggest that emotional

intelligence is necessarily immutable to training or intervention. If emotional intelligence can be instilled, nurtured or even taught during medical training either via mindfulness exercises, mentoring or modeling then screening for these aptitudes among medical school applicants may not be as important. If, on the other hand, emotional intelligence is akin to cognitive intelligence (e.g., trait-like, developmental, etc.), assessment during the admissions process may make sense.

Even if the use of emotional intelligence to select applicants at admission is not yet empirically justified, Carruthers, Gregory and Gallagher (2000) have demonstrated that, logistically, emotional intelligence can be assessed during the admissions process by having interviewers rate the extent to which applicants possess specific abilities. Other programs, in an effort to improve selection tools are developing objective standardized clinical exam (OSCE)-type exercises in which applicants are required to demonstrate certain skills. Perhaps the use of performance-based emotional intelligence measures like the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) could be correlated with applicants' actual behaviors as demonstrated in an admissions-based OSCE.

Measurement concerns that once plagued emotional intelligence related research have become far less intimidating and empirical evidence now shows encouraging signs of incremental and construct validity. A far greater limitation to using emotional intelligence as a screening criterion for medical school admission is a relative lack of companion research establishing emotional intelligence as a predictor of desirable clinical outcomes. Stratton, Elam, Murphy, Spencer and Quinlivan (2005) found an unassuming but significant positive relationship between students' emotional intelligence and communication skills as measured across a series of OSCE scenarios. These same data also revealed emotional intelligence to be significantly negatively correlated with students' performances on physical exam-related components.

Dundee Ready Education Environment Measure (DREEM) has been widely used as a tool to gather information about the educational environment in many institutions worldwide. A study was conducted using DREEM in an educational environment at a new medical college, in New Delhi, India to determine quality of educational environment in preclinical years as perceived by the students so that appropriate remedial measures could be taken to enhance the students' learning experience. The students felt more encouraged to participate in teaching sessions but a formal or informal support system must be developed so as to make them more positive and more in control of their education which would help alleviate their stress. The students felt intimidated to ask the questions they wanted and found the overall medical college experience disappointing. They felt that the curriculum was overcrowded, inflexible and promoted memorization of factual knowledge over development of critical thinking skills and reasoning. This forced them to adjust to convenient strategies of passive learning which got them discouraged from critical thinking with the result that students felt stressed due to the fact that the focus of the curriculum was on performance rather than on learning.

Understanding the gravity of emotional intelligence, Medical Council of India in its Vision 2015 has recommended major change in the existing curriculum for integrating ethics, attitude and professionalism in all phases of learning. Even the society demands Medical Institutes to teach, would be doctors emotional, psychological and spiritual wellbeing along with clinical competencies.

Use of Medical Education in practice

Emotions should be coupled to teaching since emotions strongly influence behaviors. Instead of attending lectures as a passive audience, the student must discover knowledge through a deeper dimension as he recognizes the value of the lecturer's messages. Didactic instruction which activates emotions and feelings inclines students to learn and improves their performance. Integrating emotional intelligence training into graduate medical education may accordingly improve young physicians' interpersonal and communication skills while create a caring environment for patients.

Having set the stage for the context in which emotional intelligence-based education is to be developed, a stepwise approach to curricular design can be applied. The four steps are (1) emotional intelligence identification, (2) determination of emotional intelligence components and performance levels, (3) emotional intelligence evaluation, and (4) overall assessment of the process. The second step involves determining emotional intelligence components and performance levels. The former includes tasks that, either sequentially or in sum, make up the emotional intelligence. These tasks are often referred to as benchmarks or performance indicators. They must be measurable and in the aggregate determine achievement of the specific emotional intelligence. Performance criteria set the threshold for demonstrating emotional competence. The expected performance level for each benchmark must be clearly defined to determine whether competence has been achieved. The educator must then determine the methods by which the emotional intelligence might be attended, such as through didactic learning, small-group discussions, or on-site experiences, or via information technology. The third step determines how the attainment of emotional competence will be assessed. The challenge in medical education is to understand and identifies those emotional factors that help promote the development of effective skills, thereby allowing for the development of more effective curricula. Recently there have been demands to include training in emotional intelligence in healthcare workers to improve leadership qualities, communication skills and prevent burnout, and stress. The emotional intelligence abilities are building blocks that may allow students and residents to develop competence. The first step in applying an emotional intelligence framework in medicine is successfully measuring emotional intelligence in individuals.

Emotional intelligence training could lead to better work/life balance and doctor-patient relations. Emotional intelligent physician builds resilience and copes with stressful periods, as well as experiences better physical and psychological health. Therefore, physicians care for themselves through self-awareness and reflection, which appears to be one of the most important things to provide good care to others. Being more sensitive to their own and their patients' feelings and emotions, emotional intelligent physicians use supportive behavior and provide psychological benefits.

Emotional intelligence skills are mainly developed trough life's experience. Students and physicians should use introspection. Introspection is a goal for professional and private life success. One should analyses and learns from its own gestures, speech and behaviors. Medical associations as the Canadian Medical Association (CMA) offer non-clinical professional development to medical students, fellows and physicians. A program, titled Scholarly Excellence, Leadership Experiences, and Collaborative Training (SELECT), is a joint effort between the University of South Florida College of Medicine (USF) in Tampa and Lehigh Valley Health Network in Pennsylvania. At the start of medical school, students begin the longitudinal leadership curriculum with an intensive 5-day immersion course that introduces emotional intelligence concepts and competencies through small-group experiential learning activities, debriefing, journaling, and peer coaching. In year 2 there is

added emphasis on high-functioning interprofessional teams, a peer coaching practicum, and a health care leader interview and shadowing experience. The curriculum expands to include change management, quality improvement, and project management in years 3 and 4. Early in the first year, and again at the end of the second year, students complete the Emotional and Social Competency Inventory (ESCI) administered by certified coaches. Students receive feedback on how their peers, faculty, and administrative team members perceive their application of EI competencies. Other assessment strategies for leadership and emotional intelligence training include project presentations, reflective writing, measurement of achievement of professional and personal development benchmarks and milestones, and performance on simulated and small-group exercises.

Emotional intelligence skills training helps address some of the biggest complaints about medical practice, such as poor bedside manner and physician burnout.

Emotional Intelligence and Physicians Burnout

During the past few decades, the quality of work life has moved from the periphery to the mainstream of Psychology research. Burnout and emotional intelligence have been key concepts guiding numerous research studies concerned with aspects of physician's health and wellbeing.

Burnout is regarded as a form of impairment and type of work stress related to not only care giving or the helping professions, but employees in almost any occupation can develop burnout (Schaufeli & Enzmann, 1998). Emotional exhaustion is reached when employee's emotional resources become depleted, and they no longer feel able to give of themselves at a psychological level (Maslach, 1982). Emotional exhaustion may be conceptualized as the first stage of burnout and therefore, provides a critical point for intervention.

Schaufeli (2003) regards employee burnout as a potentially economic loss for organizations. For this reason the prevention of burnout becomes a focus point for organizational consultants and researchers for alerting management and pointing out the necessity to prevent burnout. They believe that preventing burnout increases employer and employee well-being and profitability. Bar-On (2003) agrees that educating people to be socially and emotionally intelligent are regarded as a valuable commodity in the corporate world that will not only increase individual performance but also overall organizational productivity. These constructs, emotional intelligence and burnout, both represent elements of human interaction. Elements such as emotional intelligence may represent competencies that can protect the individual (employee) from the negative effects of workplace stressors Gulle et. al., (1998), which may decrease the likelihood that the individual would suffer burnout.

Burnout, an insidious process that can take years to develop fully, is well under way. The years of toiling under conditions of great and constant stress is taking their toll. Working harder doesn't work anymore and productivity declines. Compassion fatigue has set in and physicians are seeking relief by looking for new places to work that aren't so stressful. Some who can't bear the idea of continuing any kind of medical practice seek new careers in other professions. Sometimes, advanced burnout results in depression, substance dependence or even suicide.

The concept of emotional intelligence as a component of total intelligence and personal coping can protect one from the deleterious effects of a relentlessly toxic work environment. It has been identified as a moderator that could possibly buffer against the effects of burnout. Ciarrochi et. al. (2002) contends that emotionally perceptive people appear to be less

impacted by burnout, expressing low levels of burnout that are accompanied by high levels of emotional intelligence. Ciarrochi et. al., also reported that emotionally perceptive people are more impacted by stress than compared to others. Thus, they are more likely to suffer from burnout.

The reason was that emotional intelligence is an important resource that supports employees in their efforts to cope with emotional and time demands of their service work as well as with states of emotional dissonance (Giardini & Frese, 2006). High emotional intelligence would be regarded as a resistance to burnout (Farmer, 2004). Conceptual linkages that supported this conclusion include:
a) Individuals with high emotional intelligence should be capable of managing emotional stressors and as a result are more likely to experience less burnout.
b) Emotional intelligence competencies may also represent competencies that can protect the individual from the negative effects of workplace stressors, which may decrease the likelihood that the individual would suffer burnout.

Research has shown that physicians, like the rest of us, are not great at accurately assessing their own levels of stress. And the more stressed you become, the less adept you are at making judgments about your level of fatigue and your ability to function. Emotionally intelligent physicians will be better equipped to derive meaning, interpret and act appropriately in dealing with their emotions and that of others when being faced with emotionally charged situations.

It can be assumed that physicians look up to their supervisors as role models for the way in which stressful work situations should be managed and controlled. It could also be further assumed that physicians exhibiting high levels of emotional intelligence indicate a capacity to:
a) Appraise one's own emotions and effectively express those emotions to others;
b) Recognise emotional responses in others, empathetically gauge the appropriate affective response, and choose the most socially adaptive behaviour in response;
c) Regulate and enhance one's own mood and the mood of others thereby motivating others towards the accomplishment of a particular goal; and
d) Solve problems by integrating emotional considerations when choosing alternatives to a particular problem or issue (Salovey & Mayer, 1990).

Emotionally intelligent physicians would thus be capable of resisting the pressures and burden of burnout. As a result they are more likely to enjoy their jobs and feel a sense of self-actualisation in their career.

Physicians are considered to be at high risk for burnout due to the nature of work. Though medical training might imply otherwise, physicians must heed the fundamentals of physical health like everyone else. The first fundamental is nutrition. A healthy diet is a conscious, deliberate thing. Balanced food choices taken in the right amounts, and at the right times, energize and heal.

The skills that a physicians needs to demonstrate includes the ability to decide quickly and accurately, the ability to favourably interact and to observe, retain and recall critical information. However, these skills are affected when the physicians experiences feelings of stress and burnout (Goodman, 1990).

One variable that might help physicians with these skills is emotional intelligence (Levert, et. al., 2000; Mayer & Salovey, 1997). Farmer (2004) suggests if emotional intelligence has a negative relationship with burnout, it is essential for individuals to develop

or enhance their emotional intelligence, as high emotional intelligence would be regarded as a resistance to burnout. This would also mean that individuals with high emotional intelligence, having the ability to perceive, use, understand and manage emotions would be less likely to experience burnout. Individuals with high emotional intelligence will perceive work experiences as less stressful, have health consequences and thus will possess the ability to effectively cope with environmental demands (Bar-On, 1997a).

Coping with Stress and Burnout

Strategies for preventing and remediating burnout are numerous and have been reported in a variety of sources. Remedies include strategies at the intrapersonal, interpersonal, and organizational levels.

Strategies at the intrapersonal level focus on methods which physicians can use which do not involve others. Various strategies have been delineated such as relaxation, time management, recreational activities, and realistic goal setting and whatever strategy is applied must be tailored to the unique situation of the system involved.

Given the diversity among organisational settings, there is unlikely to be one common coping strategy which will be effective across all organisational settings. Nonetheless, all successful intervention techniques do rest upon one essential pre-requisite activity i.e. self-assessment. The most crucial component of a burnout coping technique begins at the individual level who are aware of and sensitive to their own antecedents and manifestations of burnout. Prior to taking steps to overcome or prevent the occurrence of burnout, physicians must be able to recognize their own unique reactions which signal the onset of the burnout process. Thus, they need to be able to accurately identify their own "burnout states" and the associated conditions which have given rise to the reaction.

Physicians and other medical professions frequently are not getting enough sleep. They are under educated in recognizing the symptoms of sleep deprivation and sleep disorders in their patients and themselves. Depending on what specialty a physician pursues, on-call hours and rotating shift work can vary tremendously. The work lives of an obstetrician, a cardiologist, and an ophthalmologist will look very different from one another. So will their sleep habits and the challenges they face in getting adequate rest. The consequences of sleep deprivation among physicians are real and serious like surgical complications increase when attending physicians had less than a six-hour window for sleep between their final evening procedure and their first procedure the following day. Further, extended duration shifts are associated with significantly increased risk of errors that can result in fatalities.

Rather than denying the problem of sleep deprivation, physicians can take this genetic predisposition into consideration when creating their schedules or structuring shifts. Only then can they expect to develop appropriate and effective interventions to alleviate their stress. It should be noted that physicians who have had personal therapy experiences may be at an advantage as a result of increased levels of self-awareness and self-acceptance.

In addition to intrapersonal strategies, interpersonal and organizational strategies are often necessary depending upon the specific incidence factors in any given case. Perhaps the most useful recommendation at the interpersonal level involves the creation of support groups for physicians. As noted previously, support from others at various levels of the organization is critical in coping with burnout. One strategy, which is often recommended to increase resources in organizational settings, but which can also serve as a buffer against burnout, is networking. It can provide a valuable source of support among related professionals who share similar interests.

The physicians can initiate a peer support network which can aim or give specific services such as counselling to physicians who are at risk or in need for emotional problems, relationship issues, anxiety disorders, substance abuse.

Organizational strategies are also often needed. Watzlawick, Weakland, and Fisch (1974) cautioned that interventions at the intrapersonal and interpersonal levels only produce first order changes (i.e., changes in a physicians perceptions and/or feelings), while many circumstances require second order change (i.e., actual systems operation changes). What is perhaps important to emphasize here is that physicians should consider organizational factors when assessing the antecedents of their burnout. They should not be quick to assume that their problems are solely a result of personal "defects" or incompetence. Rather, they should consider the impact of organizational variables as well. As stressed above numerous conditions exist in many organizational settings which can create or intensify problems of burnout among competent physician. Following the assessment of organizational factors, physicians would be well-advised to engage in systematic problem-solving activities in an effort to increase the likelihood of successful intervention. As is the case with all interventions, the development of carefully planned and monitored strategies is essential to production and maintenance of change effects.

The healthcare industry is constantly changing and is looking for new ways to increase revenue, boost productivity, save money, streamline communication and improve accuracy. Medical organizations have been thrown on the defensive, struggling to preserve the professional autonomy of physicians. This has created a tremendous pressure on physicians for tighter controls of medical costs. The industry should consider spending cuts based on the relative value approach e.g. the medicare fees would be raised for certain services, including office visits, but would be lowered for some surgical procedures.

Coping Strategies

It is well-known that being a physician is stressful. From the myriad stresses associated with getting into and graduating medical school, to clinical training in a hospital, to dealing with the emotions inherent in doctor-patient relationships, to guarding against wrongful malpractice suits, to unreasonable workloads, to the pursuit of financial freedom, stress can closely follow and eventually catch up with some physicians. Firth-Cozens (2003) summarized that the proportion of doctors showing above threshold levels of stress is around 28%, in cross-sectional and longitudinal studies, compared to around 18% in the general working population. There is also evidence to show an increased rate of psychological morbidity, for example, depression, anxiety and substance abuse amongst physicians. Unfortunately, coping strategies employed by physicians are often not the most advantageous for dealing with stress and maintaining a sound work-life balance. Research proves that physicians are reluctant to seek help from others, employ denial and avoidance as coping strategies, and disregard symptoms of burnout. Physicians ignore their own health, delay their own medical treatment, and avoid problems that may negatively impact their ability to care for patients. Instead, physicians often adhere to the unspoken values and norms of their specialty culture, thereby consciously or subconsciously accepting stigma they associate with seeking help.

The most frequent coping strategies are active coping, planning, restraint, and acceptance. A study by Lemaire and Wallace (2010) explored the prevalence and consequences of burnout among 1,178 physicians and surgeons in western Canada. For surgeons in the group, the three most commonly employed coping strategies to combat workplace stress i.e. keeping stress to oneself, concentrating on what to do next, and going on as if nothing happened which positively correlated with feeling emotionally exhausted. These

strategies reflect maladaptive denial responses to stress. Few participants used adaptive coping strategies i.e. taking a time out or talking with colleagues to alleviate stress at work. According to study results, physicians and surgeons adopted beneficial strategies to cope with stress after leaving work by setting aside quiet time, exercising, and spending time with family. These coping strategies to equal workplace stress negatively correlated with feeling emotionally exhausted.

Steps in Hospital Government overall Health of Population

Today every health care system is struggling with rising costs and uneven quality despite the hard work of well-intentioned, well-trained physicians. Health care leaders and policy makers have tried countless incremental fixes like reducing physicians stress, enforcing practice guidelines, making patients better consumers, but none have had much impact.

Most of the hospitals or clinics are moving away from a supply driven health care system organized around what physicians do and toward a patient-centered system organized around what patients need. They are shifting the focus from the volume and profitability of services provided physician visits, hospitalizations, procedures, and tests to the patient outcomes achieved. Making this transformation is not a single step but an overarching strategy. The transformation to value-based health care is well under way. Some organizations are still at the stage of pilots and initiatives in individual practice areas. Other organizations, such as the Cleveland Clinic (USA) and Schön Klinik (Germany), have undertaken large scale changes involving multiple components of the value agenda. The result has been striking improvements in outcomes and efficiency, and growth in market share.

There is no longer any doubt about how to increase the value of care. United States is an over arching concern about the significant dollars being spent on health care i.e. over 15% of the GNP and the less than optimal outcomes achieved (not in the top 20) compared to other nations providing better outcomes at lower costs. The question is, which hospital or health clinic will lead the way and how quickly can others will follow. The challenge of becoming a value based organization should not be underestimated, given the entrenched interests and practices of many decades. This transformation must come from within. Only physicians and provider organizations can put in place the set of interdependent steps needed to improve value, because ultimately value is determined by how medicine is practiced. Yet every other stakeholder in the health care system has a role to play. Patients, health plans, employers, and suppliers can hasten the transformation and all will benefit greatly from doing so.

The first step in solving any problem is to define the proper goal. Efforts to reform health care have been staggered by lack of clarity about the goal, or even by the pursuit of the wrong goal. Narrow goals such as improving access to care, containing costs, and boosting profits have been a distraction. Access to poor care is not the purpose, nor is reducing cost at the expense of quality. Increasing profits is today skewed with the interests of patients, because profits depend on increasing the volume of services, not delivering good results. In health care, the overarching goal for providers, as well as for every other stakeholder, must be improving value for patients, where value is defined as the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes. Improving value requires either improving one or more outcomes without raising costs or lowering costs without compromising outcomes, or both.

In today's complex medical environment, hospitals as well as physicians need to work together in order to provide best patient outcomes of care. Hospitals should recognize physicians as being a precious resource and try to gain a better understanding of their issues

relating to stress, burnout, and compassion fatigue. Continued emphasis on the importance of maintaining a positive lifestyle and work life balance should also be stressed and the hospitals should provide services and logistical support by addressing physician access and convenience and encouraging physicians to make this a priority.

Conclusion

Pressured by the rigours of daily medical practice, the doctor can lose perspective. It's tempting to lament that there isn't time to do so but this impression is an illusion. Becoming less empathic is frequently a protective phenomenon. Contemporary physicians face incredible pressures in terms of the number of patients they are expected to see and the documentation requirements for each of those patients. It can be difficult for physicians to respond to those pressures while maintaining their empathy and compassion. It's a matter of precedence because if a physician has to take care of anyone else in an effective and sustained way, he or she must not risk burnout and illness.

Obviously, regarding the association between emotional exhaustion and personal accomplishment with emotional intelligence, and considering that emotional intelligence is attainable and acquisitive feature, it is recommended that emotional intelligence training be implemented in hospitals to augment efficiency and quality of health care services in addition to diminish physicians occupational burnout. It sounds that training the ability of identifying self and others' emotions, appropriate expression ways, and emotional management to physicians can be highly useful.

Of course, patients themselves benefit by having empathetic caregivers whom they can trust to listen to their concerns. This trust encourages patients to give physicians all the information they need to make an accurate diagnosis, and it fosters a relationship where patients are more likely to comply with recommended treatment plans. This, in turn, will lead to the better long-term health outcomes that all interest groups wish to achieve.

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