Burnout or mismatch between expectations and reality?

The debate on physician burnout, published in the July issue,[1,2] underscores how we often argue about issues, yet miss the point! *Burnout* is an umbrella term that means different things to different people in different circumstances—when someone takes leave from work for stress, there could be myriad underlying factors or diagnoses. Dr Trollope-Kumar[1] identifies several conditions that might contribute to burnout, each of which requires proper assessment and treatment, rather than a decision on whether burnout is mild, moderate, or severe.

I agree with Dr Kay[2] that neither the workload nor the type of work necessarily cause burnout. It is caused by how we approach the work. A stressful situation for one person is "grist for the mill" for another. Resilience means being able to deal effectively with stressors, which requires a careful evaluation and acceptance of one's strengths and vulnerabilities, in terms of capacity and coping abilities.

Dr Trollope-Kumar shares her personal issues from medical school, which underscore the real problem—the mismatch between the perception of what is expected and the reality of what is possible. She rightly identifies palliative care physicians as suffering less burnout. Her suggestion to use physician health programs for proper assessment and treatment is a very important message that can never be overemphasized. Physicians generally wait too long to seek help, often because of the "medical deity syndrome." We are all vulnerable to and powerless over a lot of people, places, and things, both professionally and personally. We need to embrace the serenity prayer at all times: "God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference." Palliative care physicians providing end-of-life care are familiar with the concepts of surrender and acceptance. So are physicians, such as myself, who have long been involved in developing and supporting physician health programs, in addition to providing assessment and proper treatment for physicians.

Burnout is not a diagnosis, so let us not waste time and effort debating this term. Promotion of resilience, together with prevention and early intervention for mental health and addiction-related problems, is what is needed. We need to move forward with reducing the stigma associated with seeking help and make it easier for those who need help to get it before they experience burnout.

—Raju Hajela MD MPH CCSAM FCFP
Calgary, Alta

Competing interests
None declared

References
1. Trollope-Kumar K. Do we overdramatize family physician burnout? No [Debates]. *Can Fam Physician* 2012;58:731,733 (Eng); 735,737 (Fr).
2. Kay E. Do we overdramatize family physician burnout? Yes [Debates]. *Can Fam Physician* 2012;58:730,732 (Eng); 734,736 (Fr).

Response

Dr Hajela's comment that burnout is not a diagnosis is a point well taken. Physicians in distress need a clear diagnostic assessment and an appropriate treatment approach.[1] For this to happen, we need to combat the stigma regarding mental health issues so that physicians in distress willingly seek help when needed. Promotion of physician resilience is also an important goal, as Dr Hajela highlighted in his response.

—Karen Trollope-Kumar MD PhD
Hamilton, Ont

Competing interests
None declared

Reference
1. Trollope-Kumar K. Do we overdramatize family physician burnout? No [Debates]. *Can Fam Physician* 2012;58:731,733 (Eng); 735,737 (Fr).

Encouraging successful weight management

In reading the discussion of obesity in the May issue of *Canadian Family Physician,*[1,2] we were astonished and disappointed, both as clinicians and researchers, to discover strong attitudes suggesting that obesity should not be treated. We found it particularly alarming that doctors should feel so hopeless; they are no doubt transmitting this frustration to their patients. Thus, we are concerned that numerous obese individuals will be discouraged from taking better care of themselves. This letter examines the basis for hopefulness in obesity treatment research, considering the results of our own research program.

In thinking about whether obesity should be treated, we considered the effect of the well-documented negative bias among health professionals—physicians, nurses, psychologists, dietitians, and others—against obese people and the negative attitudes toward the subject of weight management. The obese individual is blamed for the problem and is thought to be perhaps less deserving of care. Such biases, implicit and explicit, have been shown time and again.[3]