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]

It is our opinion that those offering far-reaching conclusions about whether obesity "should" be treated[1,2] need to recognize the possibility of their own negative biases toward the obese patient and the weight management process. Negative attitudes in practitioners might be linked to their feeling ill-equipped to conduct this type of counseling.[4] It is unknown to what extent practitioners are conscious of such feelings of low self-efficacy.

Doctors very frequently prescribe healthy behaviour like better eating, exercise, and stress reduction.[5,6] In fact, these are the fundamentals of weight management. Are doctors more effective at influencing health behaviour than they are at influencing weight management? There is a paradox in which doctors recognize and support the practice of healthy behaviour (in regard to eating, exercise, substance use, stress, mood, and sleep), but dismiss the likelihood of successful weight management. If an obese person improves on these health behaviour dimensions, isn't it a virtual certainty that he or she will lose weight?

Developing a better theory

Most of the available obesity treatment research has looked at outcomes primarily in terms of weight change, with insufficient attention to concurrent changes in behaviour, attitudes, and emotions, and there is almost no consideration of the treatment process. A theory-based account of how processes lead to weight control outcomes over time is needed. If we observe a negative outcome, there is no way to engineer better treatments without a strong theory. Our research is an example of a more theory-based approach—an analysis of process and outcome in weight management based on a reliable set of measures of psychological variables and the therapeutic alliance, as well as body mass index and other physiologic variables.

If the outcome of obesity treatment is very poor, as some believe, then we must try harder to understand why results are so poor and develop a better theory that will predict more successful outcomes. This is not the time for hopelessness. To develop and test such a theory, we need studies with multiple observations over time and under different conditions. This type of research design is a perfect fit for obesity treatment, which involves ongoing treatment visits and assessments over a long period. In recent years we have used this type of repeated-measures design with a multilevel modeling analysis to show the following.

- Early (approximately 1 month) improvements in both weight and eating habits (less uncontrolled eating) predict better later weight changes (at up to 9 months).[7] This indicates that we must pay very close attention to early treatment results.
- Changes in "negative" weight control motivation (feelings of resentment, regret, doubt, and effort) are related to changes in weight and improvements in eating behaviour and mood. "Positive" weight control motivation (beliefs that weight is causing physical or emotional suffering, and expectations that better weight control will have physical or emotional benefits) is not associated with weight or psychological changes.[8] It is clear that the negative motivation dimension must be a focus of treatment research.
- Improvements in psychological variables (eating, depression, stress, perfectionism, negative motivation) are related to improvements in the therapeutic alliance between clinician and patient; the alliance is related to weight loss outcomes, but this effect is fully mediated by changes in psychological variables. Thus, the alliance directly influences the patient's mood and behaviour, which are directly related to weight change (C. Larocque et al, unpublished data).

Commitment and optimism

Our combined body of research leads us to conclude that the outcomes of weight control treatment are more predictable than previously believed.[9] This research brings needed optimism for practitioners deciding to venture into the field of helping people with their weight. Patients often feel hopeless about weight control and seek support from their doctors and therapists. We must practice hope, as we continue to conduct theory-driven research to try to better understand the processes of weight control failure and success. We were motivated to write this response to counter what we saw as a particularly negative viewpoint that some, but not all,[10] professionals seem to have about obesity treatment. We believe it is important to promote a stronger commitment to treating this problem.

Our research shows that some of the causes of success and failure are controllable, such as helping patients to address their negative attitudes about the weight control process and establishing a good working alliance. Our research shows it is not the initial levels of psychological variables (eg, depressed mood, emotional eating) or the alliance that predict outcome, but changes in these variables. Patients improve (and backslide) in all of these dimensions simultaneously, which shows that practitioners must be sensitive to such changes. If we accept the premise that lifestyle change is possible—although a difficult, variable, and long-term process—we are likely to achieve better outcomes. Surely we must not stop trying to better understand weight control, as we work to develop better ways to help individuals improve their health behaviour.

—Stephen Stotland PhD
—Maurice Larocque MD
Montreal, Que

Competing interests
None declared

References

1. Ladouceur R. Should we stop telling obese patients to lose weight? *Can Fam Physician* 2012;58:499 (Eng), 500 (Fr).
2. Havrankova J. Is the treatment of obesity futile? Yes [Debates]. *Can Fam Physician* 2012;58:508,510 (Eng); 512,514 (Fr).
3. Puhl RM, Heuer CA. The stigma of obesity: a review and update. *Obesity* (Silver Spring) 2009;17(5):941-64. Epub 2009 Jan 22.
4. Greenwood JL. The complexity of weight loss counseling. *J Am Board Fam Med* 2009;22(2):113-4.
5. Foster GD, Wadden TA, Makris AP, Davidson D, Sanderson RS, Allison D, et al. Primary care physicians' attitudes about obesity and its treatment. *Obes Res* 2003;11(10):1168-77.
6. Phelan S, Nallari M, Darroch FE, Wing RR. What do physicians recommend to their overweight and obese patients? *J Am Board Fam Med* 2009;22(2):115-22.
7. Stotland S, Larocque M. Early treatment response as a predictor of ongoing weight loss in obesity treatment. *Br J Health Psych* 2005;10(Pt 4):601-14.
8. Stotland S, Larocque M, Sadikaj G. Positive and negative dimensions of weight control motivation. *Eat Behav* 2012;13(1):20-6. Epub 2011 Oct 20.
9. Stubbs J, Whybrow S, Teixeira P, Blundell J, Lawton C, Westenhoefer J, et al. Problems in identifying predictors and correlates of weight loss and maintenance: implications for weight control therapies based on behaviour change. *Obes Rev* 2011;12(9):688-708. Epub 2011 Apr 27.
10. Moyer VA; US Preventive Services Task Force. Screening for and management of obesity in adults: US Preventive Services Task Force recommendation statement. *Ann Int Med* 2012 Jun 26. Epub ahead of print.

Make your views known!

To comment on a particular article, open the article at **www.cfp.ca** and click on the **Rapid Responses** link on the right-hand side of the page. Rapid Responses are usually published online within 1 to 3 days and might be selected for publication in the next print edition of the journal. To submit a letter not related to a specific article published in the journal, please e-mail **letters.editor@cfpc.ca**.

Faites-vous entendre!

Pour exprimer vos commentaires sur un article en particulier, ouvrez l'article à **www.cfp.ca** et cliquez sur le lien **Rapid Responses** à droite de la page. Les réponses rapides sont habituellement publiées en ligne dans un délai de 1 à 3 jours et elles peuvent être choisies pour publication dans le prochain numéro imprimé de la revue. Si vous souhaitez donner une opinion qui ne concerne pas spécifiquement un article de la revue, veuillez envoyer un courriel à **letters.editor@cfpc.ca**.