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ORIGINAL RESEARCH

The Stigma of Burnout Impeding Formal Help: A Qualitative Study Exploring Residents' Experiences During Training

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Purpose: Burnout is an occupational stress syndrome that gives rise to emotional exhaustion (EE) depersonalization (DP) and reduced personal accomplishment (PA). Increasing rates of burnout among health care professionals has been reported globally. Saudi Arabia appears to be among the highest in prevalence with reports of higher than 70%. Medical residents in training are the highest group at risk. The literature has repeatedly linked burnout among residents with poor academic performance on training exams, impaired quality of life, career choice regret and intentions to abandon medicine. In this study, we explore the factors that contribute to resident burnout, their experiences with burnout and how they choose to mitigate it.

Methods: A qualitative design was used to conduct this study in the city of Riyadh, Saudi Arabia. A total of 14 residents from surgical and non-surgical programs were interviewed through in-depth interviews. Interpretive thematic analysis was used in coding and generated coding templates. Categories were repetitively reviewed and revised, expanding to include new data as it emerged and collapsing to remove redundant codes. Categories were organized into the final themes and sub-themes.

Results: All participants demonstrated a shared thread of shame in reaching the level of burnout. Three main interlinked themes were identified: Burnout stigma cycle, amalgamated causes of burnout and self-coping with burnout. One of the concerning findings in our study is the participants' pursuit of self-coping strategies and the avoidance of formal help, creating a cycle of suffering in silence.

Conclusion: The literature has repeatedly reported high levels of burnout among residents in training. This study has added another dimension to those findings through the exploration of residents actual accounts and appears to link burnout with suboptimal training and working conditions. We have highlighted the pivotal role stigma and shame play in completely preventing residents from seeking professional help.

Keywords: resident training, burnout, stigma, self-coping

Introduction

Burnout is an occupational stress syndrome that gives rise to emotional exhaustion (EE) depersonalization (DP) and reduced personal accomplishment (PA).[1] The literature has repeatedly shown increasing rates of burnout among health care professionals with negative impacts on the individual and the health care system.[2] For example, burnout among physicians has been linked to suboptimal patient care, medical errors, low physician professionalism and low patient satisfaction as well as poor function and reduced sustainability of healthcare organizations.[2] A systematic review from 45 countries reported variable prevalence rates of burnout among physicians with the highest reports reaching 80.5%.[3] The rate of burnout among health care professionals in Arab and Middle Eastern countries appears to resemble results in the global literature.[4,5] However, Saudi Arabia seems to be on the upper end of the spectrum with reports of prevalence higher than 70%.[5]

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Many studies have suggested medical trainees and especially residents to be at a higher risk for burnout.[6,7] Middle Eastern and African residents report the highest levels of burnout globally (67.4–69.5%) in comparison to North America (51.2%), Asia (48.8%) and Europe (30.8%).[7] Saudi studies comparing residents to consultants, as well as studies comparing residents to students demonstrated that residents were at the highest risk for burnout in both groups, with rates as high as 81.22%.[5,8,9]

Multiple studies have explored the different factors that may increase a resident's risk for burnout including individual predictors such as age, gender, medical specialty, family support and resilience, as well as, environmental factors involving work hours, number of call shifts, job satisfaction and suboptimal working conditions.[7,10,11] There appears to be a consensus that burnout is predominantly related to heightened stress levels and poor working environments rather than personal factors.[7,10,11]

Teunissen et al suggested that the problem may be related to the nature of residency training and the transition from undergraduate to postgraduate educational structures.[12] Residents were under greater stress caused by interacting with patients and medical staff, learning new material in a more self-directed manner, bearing many responsibilities that accompany the delivery of patient care and the need to take on increasingly more tasks independently.[12] Residents demonstrated mental fatigue and restrained emotions during this phase.[12] In Saudi Arabia, the prevalence of severe stress was found to be higher among residents in training (46.6% −59.4%) when compared to undergraduate students (12.6–35.8%), suggesting that residents in training may be experiencing greater levels of stress.[5] In addition, multiple Saudi and global papers have linked resident burnout with poor academic performance on training exams, lower social skills, alcohol abuse, substance abuse and self-medication, impaired quality of life, suicide and/or suicidal ideation.[4,5,13]

In general, reluctance in seeking professional care for serious emotional concerns is common among residents.[14] However, burnout was found to be independently associated with an increase in that reluctance (OR 1.65; 95% CI 1.17, 2.34; P = 0.004).[14] Ten years of literature involving multiple countries has repeatedly linked burnout among residents with career and specialty choice regret as well as intentions to change specialties or abandon medicine.[15] A Saudi study in Makkah similarly reported an association between burnout and the physicians' intent to continue or change specialties.[16] In addition to the obvious effects on physicians' lives and health, these practice changes may reduce patient access to physician care and further strain healthcare systems already struggling to meet the needs of the populations they serve.[15]

Although the literature in Saudi Arabia reports high levels of burnout among residents, there is little published information on the factors that contribute to this or how residents chose to manage it and seek support.[5,8,9] Furthermore, there are no studies to our knowledge that have explored residents' personal experiences with burnout. Thus, in this qualitative study, an in-depth exploration of the factors that contribute to resident burnout, their experiences with burnout and how they choose to mitigate it will be an initial step in addressing this gap.

Methodology

Study Design, Setting and Participants

This qualitative study was conducted using one-on-one interviews at King Khalid University Hospital, part of King Saud University and Medical City in Riyadh, Saudi Arabia. This center has multiple Saudi Board residency programs in both surgical and non-surgical fields of medicine, with programs ranging between 3 and 5 years.[17] Residents at different stages of training (R1-R5) were invited to participate through emails, posters and colleague recommendations (Snowball effect).

Prior to commencing recruitment, ethical approval was obtained by the Institutional Review Board (IRB) number (KSU-IRB017E) which abides by the Declaration of Helsinki.[18] Participants provided written informed consent to participate, including audio recording and publication of anonymized responses. They were assured of the voluntary nature of the participation and of the confidentiality of their information. Each interview lasted between 60 and 90 minutes in person or by phone. Interviews were conducted between November 2019 and November 2020 by 4 researchers (MA, LS, NF, RA) trained in qualitative interviews.

Data Collection

In-depth interviews using a semi-structured interview guide (Appendix I) and additional probes were used to explore the following domains: understanding of burnout, experience, impact, relieving and aggravating factors, aids and barriers to support. The guide was continuously adapted to reflect adjustments from concurrent interviews. Interviews continued until adequate thematic saturation was achieved in analysis (ie, when no new themes emerged with further interviews) by

the 14th interview.[19] All interviews were conducted in English, were recorded, and transcribed verbatim after removal of all identifiers. Data collection ended with a total of 14 participants.

Qualitative Analysis

Interpretive thematic analysis was used in this study. This approach was chosen as it provides a deeper exploration of residents' experiences with burnout; especially, when trying to uncover risk factors and help-seeking behavior. The principle of this design is to reduce individual experiences to a description of the universal essence of the experience while unveiling otherwise hidden meanings in the experience.[20,21] The sequential process of analysis, started with six researchers being divided into groups of two (RA, NF), (MA, LS), (NM, RM) each group worked on 4–5 transcripts. Initially, each researcher independently coded the data and then each group of 2 coders compared, clarified and agreed on the coding. Next, the entire team which included the 6 researchers and 1 qualitative research expert (LW) met to compare, corroborate and group codes into categories within a coding template according to similarities. Subsequently, all categories were repetitively reviewed and revised, expanding to include new data as it emerged and collapsing to remove redundant codes. Finally, categories were organized into the concluding set of overarching themes and sub-themes.

Results

A total of 14 residents were interviewed in this study with ages ranging between (26–35), from both surgical and non-surgical residency training programs (See Table 1 for demographic details).

All participants demonstrated a shared thread of shame in reaching the "level of burnout" and were compelled to continue suffering in silence. Three main interlinked themes were identified during the interviews. Burnout stigma cycle, amalgamated causes of burnout and self-coping with Burnout.

Burnout Stigma Cycle

Unanimously all participants described burnout as a form of mental "breakdown" and "depression". The participants mostly equated the symptoms to psychiatric diagnoses and physical exhaustion.

Table 1 Demographic Details

Gender	Age	Marital Status	Number of Children	Nationality	Specialty	Level Of Training
F	29	Married	2	Saudi	Psychiatr	R4
F	28	Unmarried	0	Saudi	Psychiatry	R4
F	26	Unmarried	0	Saudi	Internal Medicine	R1
F	26	Married	0	Saudi	Pediatrics	R1
M	26	Unmarried	0	Saudi	Emergency Medicine	R2
M	28	Unmarried	0	Saudi	Family Medicine	R3
M	29	Unmarried	0	Saudi	Internal Medicine	R3
F	29	Married	0	Saudi	Internal Medicine	R3
F	35	Married	1	Egyptian	Internal Medicine	R4
F	26	Married	0	Saudi	Pediatrics	R1
M	29	Unmarried	0	Saudi	General Surgery	R5
M	32	Married	2	Sudanese	Family Medicine	R3
F	26	Unmarried	0	Saudi	Orthopedics	R1
M	27	Unmarried	0	Saudi	General Surgery	R2

> Burnout in terms of he lost interest socially, social withdrawn from life! … you don't show interest either in the training itself, in residency or over all in social life … basically for me burnout is equal to depression. (P11)

> Burnout is basically the end stage of stress and anxiety. (P7)

> A person reaches a level of exhaustion, that he can't be productive like he used to. He feels tired from the simplest things. (P6)

> A common sense among us [Residents] is when you feel tired even at rest we would call that burnout. (P8)

Interestingly all participants, except for one, described burnout through witnessing or hearing stories of colleagues going through burnout, but rejecting any personal burnout experiences. There was a shared undercurrent of denial among participants in experiencing burnout and shame in reaching that stage.

> I believe everyone as medical doctor has experienced burnout! …to be honest for me I did have it like two or three months it wasn't that significant in my personal perspective, but to some other people it was significant, for me it wasn't that bad to be honest. I didn't seek help! I can tolerate it. (P3)

> For me I know this [burnout] is a normal part of the job and I know that when I signed up for medicine I knew this was part of it so I'm paying the consequences right now but I mean I know because I have a good coping mechanism that's why I until now I'm surviving. (P5)

> They don't want to seem weak in front of their colleagues, like ooh he couldn't handle the stress of residency or he couldn't handle the stress of [name of specialty] so everyone wanna act tough! (P13)

The shame in reaching the stage of burnout was further perpetuated by embarrassment in pursuing avenues of professional help or feeling that help was useless; creating a stigma cycle of denial, shame, avoiding help and burnout. Figure 1

> The stigma I don't want people to say I saw a psychiatrist! I'm afraid to have the reputation of someone that needs psychiatric help. (P4)

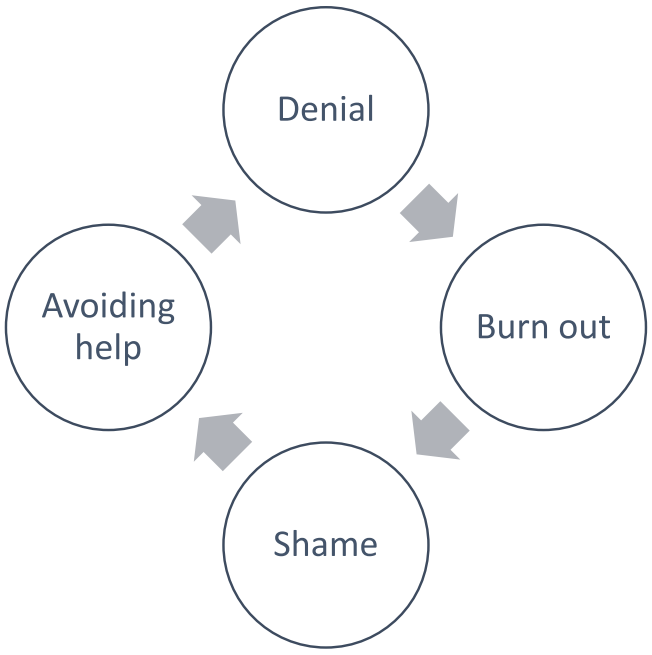

Figure 1 Stigma Cycle of Burnout.

I wasn't denying the burnout but I thought that nothing will be added from psychiatry or psychologist, I thought whatever they are going to provide I can provide it myself. I'm afraid I don't want anything to be documented that I went for a psych help, I don't want people to know or say that I'm taking SSRI, I feel like it's a weak point. (p9)

I always advocate for patients seeking psych help even with my own family members but when it came to me I don't know I feel ashamed I think it's us in the medical field we don't anything documented. (P14)

Amalgamated Causes of Burnout

Participants related the cause of burnout to a variety of aspects of being a physician. Two distinct sub-themes emerged that reciprocally cause burnout: Intimidating Environment and a Demanding Occupation. See Table 2 and Table 3 for description and quotes.

Table 2 Intimidating Environment Quotes

Description	Quotes
Lack of Support	• *Residents who had burnout, was because the general environment is unsupportive and unappreciative*. (p1) • *The environment! Difficult, not flexible, not cooperative environment, no one encourages you to be better or give more*. (p8) • *Overall the mental health of residents is not being protected by anyone, no one cares, as long as the workflow is moving, no one cares how stressful it is for you. Literally in front line we had to do everything by ourselves, no one supporting, they just expect a lot*. (p9)
Not Being Taken Seriously	• *Work environment is unhealthy, like I can talk to the consultant … but they will not take it seriously*. (p6) • *When you ask for a post call they will laugh at your face, the consultants, they say 'we don't have such a thing' [post call time off]*. (p5) • All you hear from consultants "we don't want anyone who keeps complaining". (p11) • *One consultant as an R1, he told me "you shouldn't be in [specialty name] You don't have the gut to be in it"*. (p14)
Not Trusting the Team	• *Burnout can happen with lack of skills and new job, or when there are grudges or people who hate you, when people don't want to see you succeed that causes a lot of burnout!* (p4) • *One time as R2 we had one patient who had complications and it was a mortality case and the consultant started blaming me for no reason although I'm a junior resident*. (p11) • *Honestly I feel like the whole system is toxic … either you have to lie to be one of them or you just have to act all alone and most likely you will lose your opportunity in the future, for me I'm 100% sure I lost my opportunity all because I said the truth*. (p9) • *Sometimes the work environment is hostile, for example ist's competitive, yah that would give me burnout*. (p3)

Table 3 Demanding Occupation

Description	Quotes
Heavy Workload	• *The load of the patient I mean having like 40 patient in a ward …. even if not having a burnout it's not going to be an easy thing*. (P3) • *Burnout from the clinics. I can see in some clinics between 25–30 in one shift from 8 to 12 this is from the things that gives me stress*. (P4) • *Well, residents are the backbone of any hospital. There is no such a thing called home on-calls for residents… We are usually the first liners. I mean every complaint from a patient we have to attend to, paperwork and discussing is all stressful in addition to having to pursue academics*. (P5) • *Let's imagine how you feel when you go back home and you have responsibilities and you're already burned out from the new tasks, and tasks over your ability and you just pass your responsibilities to another resident who will be overwhelmed and burned out too, I think it is cycling between us*. (P7)

(*Continued*)

Table 3 (Continued).

Description	Quotes
Shifting Between Specialties	• *As a resident during my training I go through a lot of specialties, surgery, medicine, ER …. I feel all these rotations cause pressure because they expect us to function and have the knowledge of every type of resident, surgical resident or medical resident, not just a rotating resident.* (P5) • *I go through many different specialties in my program… and there's pressure because they treat me as if I am a resident of theirs, not a rotator.* (P4) • *When our patients are cancer patients… you need skills to calm the patients and their relatives… in the same time you are planning the treatment.* (P7)
Disorganization	• *Unplanned tasks, unplanned duties during the day. If you have the plan you'll have breaks and avoid burnout. Unplanned tasks equal burnout.* (p7) • *People cannot manage their time; the opposite of time management, it creates stress… he will be misorganized because he doesn't know what is going on. Even if it's all on his head, before he is* in *the stage of burnout, if he just manage his time he can manage all of it.* (P2) • I *mean definitely I think when you begin as R1 because it's a new environment for you so that would be a surprise … you have to cope with new system and the unorganized way of working and as you go on through the years it become easier and much acceptable.* (P1)
Unrealistic Expectations	• *The resident has the pressure that he needs to know everything about their patients … sometimes they have irrational or above expectation hours of working, so whenever there is increase working hours for physician there is less time for him to see friends and family and enjoy his time so there are people more vulnerable to burnout and those factors will push it.* (P4) • *It's both a combination of hard work during working hours and getting back home and again hard work in order to study, no rest! Fellows suffer from the same thing but I don't believe consultants do as much as residents.* (P5) • *Our expectations about ourselves and our efforts must be real, when they are real I think we can overcome this [Burnout].* (P7)
COVID- 19 was Challenging	• *Especially during the last period of the COVID pandemic, … some people would work for two weeks straight without any weekends, and that definitely plays a major role.* (P5) • *One of my friends… it was tough and complicated, we faced the same heavy cases and practices affected by COVID situation… but eventually she dropped out of the program.* (P8) • *At the beginning of covid for the first 2–4 months…we had zero protection, we didn't have N95 no gowns, nothing …everyone is worried about covid no one wants to come in.* (P9)

Self-Coping with Burnout

When participants were asked directly about how they would handle burnout, consistently they all enumerated different formal avenues of seeking help including "professional psychiatric assessment", "available hospital services" and "approaching the program director". However, none of the participants witnessed or actively pursued any of those avenues. Alternatively, they talked about personal self-coping approaches and silently managing on their own. See Table 4 for mentioned coping strategies and related quotes.

All the themes seem to interplay into a story of suffering in silence. The stigma attached to the strong feelings of "shame" and "weakness" coupled with fear and lack of trust in help and support, resulted in silent suffering and private self-directed coping approaches. Figure 2

Discussion

In this study, we explored the factors that contributed to occupational burnout affecting residents in training, their approach to managing through burnout and how they sought out support. This is one of the first qualitative studies on the topic in Saudi Arabia. One of the interesting findings of this study was that residents described burnout as psychological stress, anxiety and exhaustion and linked it with shame and a stigma towards being burned-out, which led to avoidance of formal avenues of help and isolated self-coping strategies. In the literature, there appears to be a general trend by the medical culture to strongly stigmatize burnout.[22–25] Physicians tend to view their state of health, especially mental health, as an indicator of their medical competence.[25] Physicians suffering from burnout may be seen by colleagues and

Table 4 Self-Coping Strategies and Quotes

Self-Coping Approach	Frequency Reported	Quotes
Distraction/Detachment	12	• *If I was under stress I would add a new activity that takes me out of routine, new hobby or anything new, the gym or traveling. It's not always guaranteed that's why I add new things every 6 months in case I feel under pressure I have something to fall back on.* (P1) • *What I do is you know detach, complete detachment from the job, enjoy yourself, spend time with family and friends, socially maybe going out.* (P5) • *Find a way to defer! For me the Gym, honestly I get rid of a lot of energy, I spend two hours on daily basis, even the days I'm on call.* (P9) • *Every two months I have to take a week off, a reality escape. Most of my friends are outside the medical field, because I don't want a social life with anyone in the medical field because I feel they bring stress to me.* (P11) • *I had to do more to distress! I added travel. I started to take short trips every month, I had to travel every month. That's what helped me survive R2.* (P13)
Normalizing/ Suppressing Feelings	9	• *I would tell myself it will get better, you will start to get used to it.* (P3) • *It's ok at the end of anxiety you will end up with burning out which is something normal, sometimes it happens to residents.* (P2) • *Knowing that it's part of life, it's normal to have stress, it's normal for residents to have burnout.* (P6) • *I didn't ask for help because I just had 1 or 2 years left and I was counting the remaining days and when I get tired and want to give up I am reassured of my exam results.* (P1) • *I was telling myself I can deal with this. I didn't need any help and I knew it was burnout.* (P9)
Surrender/ Left Profession / Change Specialty	4	• *One of my friends… it was tough and complicated, we faced the same heavy cases and practices affected by COVID situation, but eventually she dropped. She surrendered basically. I was shocked. I didn't think this can impact us to this degree.* (P8) • *3 years we have been noticing residents dropping from the residency program. 2 years ago one resident changed his training to ENT. Last year one resident changed the program to Family medicine. I have now two junior residents thinking about changing centers.* (P9) • *I know one junior resident who had a bad experience in [specialty] and is already burned out and thinking about changing the program.* (P14) • *It was a big thing for me stopping my residency program. I believe it was burnout. I switched from [specialty] to [specialty].* (P3)
Escape / Substance Use	2	• *Some people will go to substance abuse to help them cope with the stress.* (P5) • *Some people use drugs to relieve the anxiety and there are different kinds of drugs they may use. I mean sometimes they may use drug, abuse it, illegal drugs! Sometimes they seek medical help and they get some antidepressant or whatever.* (P5) • *I know a bunch of residents on drugs or alcohol abuse all because of the stress. My colleague I have heard him say it* "I'm leaving the hospital to use some weed" *I have heard this multiple times they are burnt-out, they seek any reality escape.* (P11)

themselves as weak and incompetent.[22,25] Our results are consistent with many studies around the world with regard to stigma and shame being factors that hinder seeking help. Dyrbye et al found that medical students with burnout had higher perceived stigma scores and a higher fear of discrimination and breach of confidentiality than students without burnout.[22] Burnout stigma has been linked to negative influences on medical trainees' help seeking behavior and increases in their hesitancy to peruse support, with reports of only a third of trainees with burnout seeking formal help.[14,22] Similarly, Weiss et al concluded that burned-out trainees were significantly more likely to perceive stigma than their peers regarding seeking help to deal with psychological problems.[23] Studies have found correlations between the level of burnout and the level of stigma, and in turn the level of help avoidance, ie the higher the burnout the higher the stigma.[22,24–26]

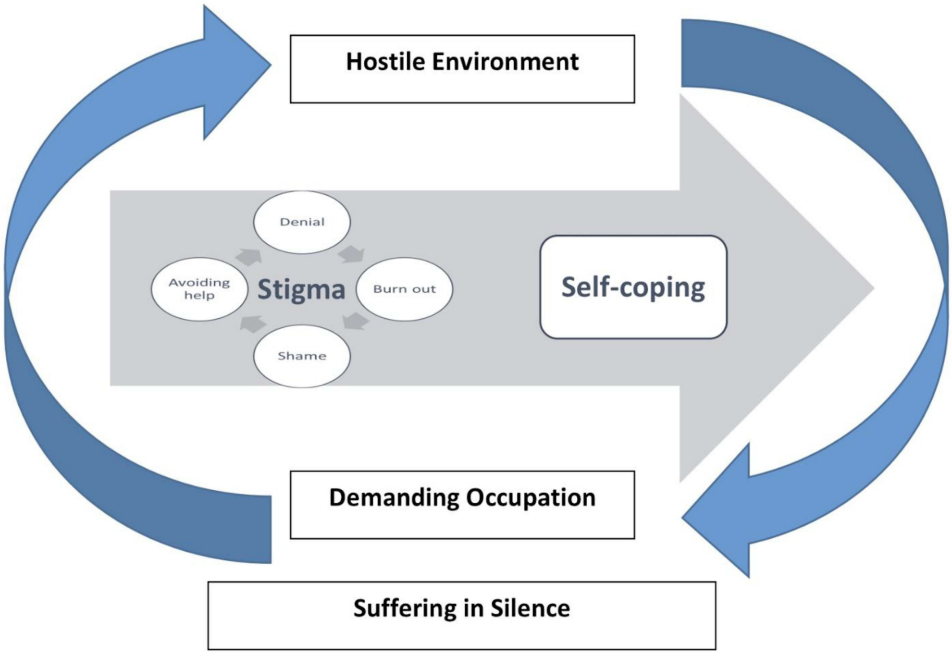

Figure 2 The Story of Suffering.

One of the concerning findings in our study is the participants' pursuit of self-coping strategies and the complete avoidance of formal help, creating a cycle of suffering in silence. This is probably directly related to the idea of stigma and shame they have attached to having burnout and needing professional help. Distraction and detachment were the most described coping strategies used by participants in our study. The second most frequently described strategy was normalizing and suppressing feelings. Using self- distraction as a coping mechanism has been reported as one of the most used coping strategies among medical residents globally and is considered a maladaptive approach.[27,28] Studies have also suggested that residency training is a time of heightened vulnerability associated with mental exhaustion and suppressed emotions.[12] A study looking at the impact of emotional regulation on burnout reported that emotional suppression was associated with higher burnout and depersonalization and was also considered maladaptive.[29] Alternatively, the presence of compassionate supervisors mitigated residents' emotional stress and aided their support.[29]

The literature has repeatedly supported the protective role a good working environment has against resident burnout.[7,10,11,29] With poor working conditions and heavy workloads cited as risk factors that outweigh individual predictors.[7,10,11] Our participants described two main sources of burnout both of which were predominantly environmental in nature, an intimidating environment and a demanding occupation. Many studies have shown that the primary predictors of physicians' well-being and drivers of burnout are workplace conditions, rather than individual characteristics.[6,15] International and Saudi studies have suggested that residents' burnout is associated with excessive workload, stressful relationships with supervisors and colleagues, and a perception that personal needs are inconsequential.[6,9,15] All findings that are similar to our participants' accounts.

In spite of the alarmingly high prevalence of resident burnout both internationally and in Saudi Arabia, and the many initiatives to promote medical trainee wellbeing, yet the prevalence has remained unchanged over the last two decades.[5,7,10,13,15,29] This suggests that merely offering physiological support services may not be sufficient to assist burned-out residents in need.

Conclusions

This study has added another dimension to our understanding of resident burnout. We have highlighted the pivotal and direct role stigma and shame around being burned-out contribute to residents' complete avoidance of formal support services, and their choice to self-cope and suffer in silence. Although our study was limited to a university training

setting, we believe this area of medical training would benefit from further research especially focusing on prevention, early identification and strategies to overcome the barrier of stigma. In addition, our findings could persuade training centers and programs to support and fund trainee wellbeing curricula that center on early identification of struggling residents with proactive professional interventions.

Ethics Approval and Informed Consent

Ethical approval was obtained through the King Saud University Institutional Review Board (IRB) number (KSU-IRB017E). Study participants have given written consent to participate in this study as well as publish data prior to the commencement of the interviews. All identifiers from quotes have been removed to maintain participant confidentiality.

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