Commentary on: Burnout in the Plastic Surgeon: Implications and Interventions

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In their exhaustive review of the literature, the authors correctly point out the increasing attention devoted to physician burnout, as manifested by emotional exhaustion, depersonalization, and reduced personal accomplishment. Although their focus has been on the medical scientific literature, the lay press has also expressed interest about the topic. In his 2016 Presidential Address to the American Association of Plastic Surgeons, Dr Michael L. Bentz highlighted a feature in the Time Magazine September 2015 issue entitled Life/Support: Inside the Movement to Save the Mental Health of America’s Doctors that pointed out physician burnout compromises patient care and outcomes of physicians, leads to more medical errors, a decrease in the quality of practice, and loss of professionalism.

 Appropriately, this demonstrates that even our patients are reading that plastic surgeons may be suffering the same burnout symptoms they may have from their lives and jobs. This public exposure may be a “two-edged sword.” On the one hand, our patients may experience empathy for the “humanness” of their doctor. On the other, a loss of confidence could be the result.

 Why are those with income levels considered by our patients to be in the “one percent” and with a high standard of living view themselves as having a quality of life only three quarters as satisfying as their non-physician high school classmates? Why are suicide rates among male physicians 40%, and female physicians 130% higher than general population cohorts? Unfortunately, many of us have had plastic surgeon friends and colleagues who have taken their own lives. The many articles quoted by the authors provide insight into the answers to these questions, with experiences differing from medical students, residents, early career, middle career, and late career physicians.

 It is difficult to ignore the early classroom and clinics where our medical students are first exposed to the stresses of training and to the practice of medicine. In their article about the effect of depersonalization generated by residents using humor and slang (ie, “gomer,” “train wreck,” “brick”) in reference to patients, medical students were interviewed by Parsons et al in two groups: those beginning clinical exposure, and a second group completing their first year on the wards and clinics. The students provided responses that placed them into one of two groups – “outsider” or “insider.” The former were critical of the residents’ behavior, with empathy for the patient’s position. But gradually students become “insiders,” understanding the humor as a defense mechanism, a way of protecting their already stressful emotional lives from deterioration.

 As physicians move on in their careers, Dyrbye et al reported that early career physicians have the highest rates of depersonalization, lowest satisfaction of career choice, and highest work/home conflicts. Middle career doctors are more likely to leave the practice of medicine for reasons other than retirement. Late career physicians cite

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Disclaimer: Dr Genevieve N. Parsons, lead author of Reference #3, is Dr Noone’s daughter.
higher career satisfaction and best home/work environments. The latter group lists retirement decisions as providing the most stress, related to increasing malpractice costs and other overhead issues. Paradoxically, one of the factors contributing to stability and success in practice—a long-serving experienced office staff—impacts late career surgeons because they receive regular salary increases in an environment of decreasing reimbursements. Increasing regulations, ineffective electronic medical records, and other practice stressors have an affect on practice exit strategies. Leaving a profession you love that has provided self-satisfaction from serving others and from a positive identity in the community at large was difficult for me.

The all-important evaluation of declining technical and/or cognitive skills is a major factor for those in late career. A study by the American College of Surgeons Board of Governors showed that we surgeons may not be able to evaluate these declining skills. In my case, I asked medical colleagues, anesthesiologists, office staff, operating room nurses, and physician assistants to report any concerns they had about me or my function. Understandably, no one would step forward and all were reassuring and not critical. So, left to my own devices, I decided to leave the operating room before anyone would have reason to tell me.

Plastic surgeons fall somewhere near the middle on the burnout scale of surgeons, with trauma surgeons and those in critical care specialties ranking highest in the burnout category. In the 2015 study by Balch et al of members of the American College of Surgeons, those in academic medicine are less likely to suffer burnout and depression and have higher career satisfaction than private practitioners. For the latter group of surgeons in general, trauma care, nights on call, number of work hours, and perhaps the lack of resident support may have impact. Balch et al noted plastic surgeons in the middle of the pack, with a 37% burnout rate.

The authors quote the classic paper by Qureshi et al that reports on a survey of 1691 ABPS board certified plastic surgeons, discovering that almost 30% of plastic surgeons had validated symptoms of burnout and 25% reported a quality of life norm less that that of the general population. Of particular interest is the comment in this article that plastic surgeon burnout is higher in the subspecialties of microsurgery and aesthetic surgery.7

The average non-surgeon physician could easily understand the dilemma in the subspecialty of microsurgery, arguably more of a demanding exact science than the art of aesthetic surgery, with longer work hours in a specific case, less reimbursement, higher use of hospital resources, and a complication rate that may be higher than other subspecialties of plastic surgery.

But why does aesthetic surgery have an equally high burnout rate? The authors mention two factors that are difficult to rebut—the growing demands of the marketplace, and a definite increase in patient expectations of results from aesthetic surgery. However, they fail to elaborate on the root causes of these elements, or the proposed solutions.

No doubt there is increasing stress in managing the private practice of aesthetic surgery to face the competition from fellow plastic surgeons, dermatologists, otorhynologists, opthalmologists, oral surgeons, and other “cosmetic” surgeons. Increased overhead from marketing, advertising, office operating facilities, and other office accouterments can contribute to aesthetic surgeon burnout. But, satisfaction and positive feedback from our aesthetic patients should increase the well-being of the aesthetic surgeon, not cause more stress. If so, then why the burnout?

Reviewing my 43-year practice career focused largely on aesthetic surgery or the aesthetic results of reconstructive surgery, my unscientific opinion is that our specialty has raised patient expectations to the level of greater dissatisfaction with results. Plastic surgeons displaying only their best results on websites and other marketing entities set a bar which is difficult not only for them, but for all of us, to emulate on a consistent basis. Advertising programs highlighting the wonders of aesthetic surgery cannot help but lead to higher patient expectations. Higher expectations lead to more dissatisfaction with a less than ideal result. More patient dissatisfaction leads to a reduced feeling of professional accomplishment for the aesthetic surgeon and emotional exhaustion, both hallmarks of burnout.

The authors recommend that aesthetic surgeons who have an awareness of burnout symptoms can participate in hospital-based wellness programs. This is an admirable suggestion, but may not be applicable to the majority of aesthetic surgeons who do not practice in a hospital setting.

Burnout is documented to be more common in private practice than in academic surgery. Fortunately, I practiced in what has been viewed as “the best of both worlds” with one foot in the academy and the other in private practice. I was taught by my mentors to provide realistic and sincere consultations, showing photos of average results, telling patients all possible complications, and telling them that aesthetic surgery is not an exact science. Fortunately, I did not need to advertise, and the patients came for the “old-fashioned reasons”–patient and physician recommendations and confidence that I would practice within their expectations. This provided a comfortable living and a relatively stress-free, very satisfying practice. I did not experience the burnout symptoms shown in early career or mid-career surgeons, my stress was delayed until retirement was close to reality.
I was distressed to read in the Balch report, not included in this article’s bibliography, that 31% of plastic surgeons would not again select our specialty for a career; and 46% would not recommend medicine as a career for their children.

I was fortunate to practice in “the best of times,” but never gave advice on career direction to my children unless they asked. However, all five selected careers of service to patients – general/colorectal surgeon, school psychologist, pediatrician, medical aesthetician, and nurse midwife.

At the risk of sounding even more “old fashioned,” may I suggest that medical students considering a career in plastic surgery, and residents in training, approach our specialty with an attitude of serving others rather than starting a business. That attitude may change future statistics about burnout.

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