Physicians’ Burnout (and That of Psychologists, Nurses, Magistrates, Researchers, and Professors) For a Control Program*

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Abstract
Just as with burnout in other social sectors, burnout among physicians is acquiring epidemic proportions. After describing the pathology, this article covers the multidisciplinary aspects of its clinical management. As for prevention, the article describes the importance of the socially motivated, professionally oriented management of health care services, courts, universities, and schools for preventing burnout and contrasts such features with the characteristics of their industrial and commercial management.

Keywords
burnout syndrome, epidemiology, prevention, clinical management, mobbing

Introduction
The suicide rate of physicians is the highest of all occupations in the United States. It is higher than the suicide rate in the military and is approaching twice the national average.1 To develop suitable prevention, we must understand why this rate is much higher than in Europe and why its main cause, burnout, is growing rapidly.

Burnout in doctors is at the origin of medical errors. It deteriorates therapeutic communication and teamwork. It communicates anxiety to the patient and undermines the practitioner’s reflexivity. In short, the authorities should address burnout at least out of public health concerns, if not for the sake of the professionals themselves. Unfortunately, it seems that authorities are preoccupied mainly with the growing worker absenteeism, and the temptation is great to control it without acting on its causes.

Belgium’s Higher Health Council (HHC) sets the health system guidelines for the country in terms of burnout at work.2 Its 2017 report explains the spread of the epidemic by societal factors (increased time pressure, reinforcement of individualism, digitization, and pressure to perform) and others related to work (mutations in interpersonal relationships, tasks, career profiles, and organization).

This article sets some health service rules for managing and preventing burnout. They are formulated to inspire the design of local and regional programs for controlling burnout – the creation of which is justified here – and to guide the work of professional organizations and unions. These recommendations were formulated based on clinical and public health considerations and a reinterpretation of the context of the contemporary organization of work in sectors with a social mission, i.e., health, education, and justice.

This article could have been called “professional burnout, mobbing, and industrialization” because (1) it uses the burnout of doctors as a paradigm of burnout in other social sectors.
health, education, justice, public purpose research, and social services; and (2) it examines how moral harassment is linked to industrial management. But this title would have ignored the author’s central concern in writing this article, which is to give practical guidance to readers who share his ethical positions.

**Epidemiology of Distress**

Burnout is a pathological condition linked to emotional exhaustion, depersonalization, and reduced personal fulfillment.³ I would add that it is also linked to a loss of will and “power,” in the Spinozian sense of the word.

While the etiological, clinical, and nosological characteristics of burnout are similar to those of depression, burnout comes from a growing powerlessness experienced at work, where this impotence can be socialized and ritualized for production and power purposes (see the section “Burnout, Industrial Management and De – professionalization, below). In this vein, we shall thus see how bullying is a common cause of burnout.

The prognosis is serious: transition to chronicity of psychosomatic pathologies, loss of employment, lasting loss of self-esteem, alcoholism, divorce, and suicide. If working conditions allow it, the victim comes out of it like a snake shedding its skin, by a cognitive reappraisal; by a development of the perception, the love, and the poetic emotions; and by an adjustment of her or his social relations, while at the same time restoring a little “power” to her or his environment.

The financial stakes of burnout are enormous because, in addition to the indirect costs of absenteeism, its prevalence has been growing rapidly over the past 10 years and treatment is expensive. Perhaps this is why burnout is still not included in the DSM-5 or, as a pathological disorder, in ICD-10, although the term was used in 1961 by Graham Greene and has been used (by Harold B. Bradley) in the scientific world since 1969. (Graham Greene made it the title of his novel, *A Burnt-out Case,* which recounted the epic of Dr. Lechat, Catholic University of Louvain, who was then working in the Congo.)

It’s not going out on a limb to say that today nearly 1% of the Belgian working population is in burnout; the figure was 0.8% in 2010.⁴ The latest Belgian report on burnout in hospitals dates from 2012 (published in 2013).⁵ At the time, 6.6% of the staff suffered from burnout, and 13.5% belonged to the group at risk. In 2012, Aiken and colleagues⁶ calculated that 25% of Belgian doctors and nurses achieved a high score of emotional exhaustion, and the prevalence has very likely increased since, for the 2017 HHC report stated a 25% increase in disability in Belgium between 2010 and 2015, including one-third related to mental disorders. It is likely that, as in the United States, keeping everything in proportion, doctors and health professionals are the ones who pay the highest price.

This article makes some recommendations to take care of and prevent the burnout of professionals. To do this, by examining the peculiarities of the causal epidemiology of the burnout of physicians, it extends its conclusions to professionals in health, education, and justice, that is, sectors with a public welfare or social mission. Whenever the term “professional” is used below, it refers to them.

**A 21st Century Epidemic? The Industrial Management of Medicine, Education, Research, and Justice**

The scientific literature acknowledges that the overall characteristics of the work environment determine the risk of burnout more than individual features.² It recognizes chronic work stress, especially overwork, as the main cause of burnout. In the workplace, speeding up the pace (of production) is often incriminated, but we should not forget the socioeconomic downscaling, income insecurity, and worsening of the employee and self-employed statuses.

However, the workload-based analysis model feeds the conviction in health service management circles that burnout is like a machine that fails due to exhaustion, and thus needs time and antidepressants to be put back to work. This model leads the manager or department head to focus on the increased pace of work a particular person is subjected to. This attitude is all the more understandable as the time of contact between the professional and the patient, litigant, or student continues to shrink.

Without questioning the importance of this factor, the causal epidemiology of burnout in the workplace reveals the simplicity of this way of seeing and acting.

One factor can be ruled out right off the bat. Caregivers are known to suffer acute stress similar to post-traumatic stress disorder (PTSD) linked to the empathetic listening of the traumatic tale of a primary victim. This stress is known as vicarious or secondary trauma. Since this mechanism has always existed in the health care and justice sectors, we must look elsewhere to understand the rapid spread of the burnout endemic-epidemic, that is, in the changing organization of labor.

We can of course attribute part of the epidemic dynamics of burnout to better diagnosis and the socialization of the concept. But this does not explain why the prevalence of medical burnout is 50% in the United States⁷ compared with 6% in Belgium in 2010⁸ or why doctors have the highest suicide rate of all professions in the United States.

It is probable, as C. Dejours points out, that “the irreducible gap between the prescribed organization of
work and the actual organization of work” is a source of suffering. This co-factor is especially plausible when bureaucratization proliferates in both the private and public sector, which seems to be the case. Thus, the increase in reimbursement procedures and deepening of accreditation processes are putting doctors under more bureaucratic control and practices.

This article discusses the hypothesis that the rapid growth in the prevalence of burnout among doctors (nurses, psychologists, teachers, and magistrates) in Belgium and Europe is due to

- the underfunding that precedes the activity’s privatization
- and the industrialization of care production, i.e., the general application of management techniques for commercial and industrial purposes to health care (education and justice)

Burnout, Industrial Management, and De-Professionalization

Developed in 1979 to inform the organization of work and reduce the employee’s mental load, R. Karasek’s influential model analyzes the relationship between the demands of production and freedom of decision. To understand burnout, it focuses on the loss of professional autonomy.

To maximize employee productivity, professional autonomy is precisely what industrial management must shatter to be able to use the industrial management tools that came out of the manufacturing industry, to wit:

- delegation of tasks to unskilled technicians or algorithms
- rationalization based solely on efficiency gains
- hyper-standardization of tasks
- strict regulation and productivity control procedures
- the limitation of evaluations to quantitative probabilistic domains – interpretative qualitative assessments are neglected, whereas they are essential to the quality of care, education, and judgments
- competition (encouraged by competitive assessments) over cooperation
- faster pace, at the expense of quality of work
- the development of employee assertiveness
- the promotion of the identity of belonging and the scotomization of the role identity
- the highly material motivation of “human resources,” for example, with “pay-for-performance” schemes

These techniques degrade physicians’ problem-solving abilities by reducing their therapeutic freedom excessively, although they need such freedom to

- integrate the biological, social, and psychological dimensions of care
- mobilize and develop their manual, communication, and behavioral skills
- be reflective (i.e., to improve their problem-solving skills by analyzing their own and their teams’ mistakes)
- negotiate the therapeutic strategy with their patient
- make their professional ethics operational

It might be added in passing that by undermining the medical professionalism, Europe is burying 2,500 years of Hippocratic ethics.

This loss obviously hurts the patient, but the doctor as well. As C. Dejours says, the defensive strategies necessary to protect mental health from the deleterious effects of suffering “sometimes make ethical, and no longer just psychic, distress tolerable, if we mean by that the distress that results not from harm sustained by the subject, but the distress that s/he may feel by committing, by reason of her/his work, acts that s/he condemns morally.”

Because it reduces the clinical and social utility of the doctor’s, judge’s, researcher’s, and teacher’s knowledge and ethics, industrial management undermines their professional identities. We shall see the psychological consequences of this further in this article.

But there is more. In the United States, hospital managers, including the managers of more than 4,000 community hospitals, are required to follow a commercial rationale, that of the insurance companies that invest in the health care sector, because these companies bargain their clients’ hospital affiliations in exchange for the imposition of standardized clinical procedures (their guidelines).

In turn, the managements of the hospitals, under the insurance companies’ sway, control the doctors in ways that devalue them:

- Information technology makes the rationales behind health care deliberately incomprehensible.
- The manager creates a threatening atmosphere regarding the physicians’ job stability and earnings.
- Industrial management transforms doctors into executors of clinical decisions made by artificial intelligence and guidelines.
- Industrial management undermines the doctors’ authority (e.g., with patient satisfaction scores influenced by factors over which physicians have little control, such as references to high-complexity medicine).
The management introduces all kinds of obstacles between physicians and their patients.

What do burnt-out professionals experience? Distress, of course, but also a loss of “power” because they can no longer use their experience, knowledge, and ethics to make clinical (educational, legal) decisions and solve problems (of care, creation, research, development, production, evaluation, teaching, and judgment) personally.

To understand how this hurts, we can use the concept of “anomie,” “a condition of instability resulting from the breakdown of standards and values or from a lack of purpose or ideals,” which Durkheim linked to acculturation in the beginning of the 20th century. (Encyclopaedia Britannica https://www.britannica.com/topic/anomie consulted on May 9, 2019.) Deprofessionalization causes distress by provoking anomie and the resulting loss of self-esteem and disarticulation of human relations.

This leads to emotional exhaustion, depersonalization, and a reduction in personal fulfillment, namely the Maslach’s burnout criteria. And, the deprofessionalization that takes the return arm of the feedback loop reduces the doctor’s benevolence and empathy for patients and their relatives.

**Job and His Job**

*All my inward friends abhorred me:*
*and they whom I loved are turned against me*
(Book of Job, 19:19)

*All I have of oppressors*
*Made me a scandal:*
*For my neighbors I am only disgust*
*A fright for my friends*
(Book of Job, 31:12-14)

Behind burnout lies a collective process. It often takes the form of moral harassment, which causes post-traumatic stress disorder (PTSD).

The English language uses 3 terms to describe moral harassment. “Harassment,” Marie-France Hirigoyen writes, refers to “repeated and persistent attacks by one person on another, to torment, undermine, frustrate and provoke.” The term “bullying,” she says, consists of “intimidation, bullying and any abusive conduct by tyrannical superiors who attack the weakest” at work. Finally, Leymann introduced in Sweden the concept of “mobbing,” translated as psycho-terreur in French, in the 1980s. It consists of hostile behavior expressed or manifested by colleagues and the hierarchy for a minimum of 6 months and repeated at least once a week. It is considered a group phenomenon, that is, a coalition of colleagues or superiors against a person until the person leaves the job, becomes sick, or even commits suicide.

For Leymann, a person is mobbed or harassed when colleagues and superiors

- prevent the person from self-expression (by not speaking to the person, cutting her or him off, criticizing without listening, refusing to explain oneself, ignoring her or his presence, acting as if he or she were not there, or transmitting paradoxical messages)
- isolate the person (by reducing the person’s communications with others, entrusting files that cut him or her off from others, or forgetting to invite the person to meetings)
- ridicule the person (by launching rumors about her or his private life or morals; imitating her or his way of walking; giving degrading nicknames; judging the person’s origins, beliefs, sexual orientation, gender, or political convictions; advising the person to go get treatment)
- discredit the person’s work and professional reputation (asking the impossible, taking credit for the person’s work, spying to point out the slightest mistake, giving unnecessary tasks, questioning her or his competence, creating a black book of alleged mistakes to justify a layoff)
- compromise the person’s health (assigning risky tasks, physically assaulting the person, threatening and intimidating, causing costs and doing damage to her or his workstation)
- finally, one could add, remove the person’s tools or instruments

Industrial management precipitates moral harassment by its permanent incentive to competitiveness, its aggressive model of behavior at work, and its recourse to the identity of belonging, which dehumanizes because it ignores the role identity. As for underfunding, it contributes to mobbing by reducing workstations and making employment contracts precarious.

Management literature attributes to the toxic manager the use of “divide and conquer” tactics, discrimination, a highly competitive attitude, and procedural inflexibility (contrary, among other things, to the needs of research). This literature tells us how but not why a manager instigates moral harassment.

Girard offers a timeless reading of Job’s tragedy to understand why violence falls on a victim of harassment and how this violence becomes communal or institutional, thereby gaining sacredness. The Book of Job is the story of a fall, that of a notable who is ostracized by society for the crime of perversion, of deviance designated by power and religion. The cause, says Girard, is a sacred mystery whose conclusion is the most appreciated part. The sacredness of the
discourse transcends the violence and makes it acceptable to all the players, except, of course, to the victim.

The socialization of violence ensures its permanence and effectiveness: The unanimity of the condemnation erases the victim’s innocence. In a modern organization, designating a scapegoat diverts the violence of power from other potential victims. Everyone serves their own interests best by pledging allegiance.

There remains the question of why harassment is instigated.

“Royalty,” says Girard,

by definition, is not shared. Job cannot succeed as he does without provoking in his own milieu a tremendous jealousy . . . By the very fact that it (the admiration) rests on the mimetic desire, the fascination exerted by the too-happy rival already tends to boomerang as implacable hatred, the captivation is always already mingled with this hatred. The kind of hateful fascination that shows through in almost all the utterances of ‘friends’ blossoms between people who are socially close. (op. cit.)

As for the myth that justifies and transcends violence, it is neither fiction nor religious truth but the narrative of a social reality that is gradually acquiring the status of political truth.

**Burnout and Political Economy of Care**

The experience of European doctors is that of all their colleagues working in the social sectors, because industrial management reduces professional autonomy similarly in the name of quantitative probabilistic sciences in all these sectors.

Other professionals went through the painful experience before them. Industrialization began at the dawn of the 18th century, and it will be remembered that it provoked the revolt of the Canuts (silk workers) in Lyon. Over the past 2 centuries, craftsmanship, agriculture, and all areas of human activity tipped into industrialized production. Now it’s the turn of health care, public services, education, and justice.

Not a doctor, teacher, or magistrate is unaware of the fact that their own risks of burnout are linked to state underfunding of their departments. What they do not, but should, know is that the underfunding of health care is linked to an economic crisis only because it serves as a pretext and electric shock, for such underfinancing has always preceded partial or total privatization of their sector.

Thus, health expenditures in Switzerland (before and after 1996), in the Netherlands (around 2006), and in Colombia (around 1993) yield a “V-plot.” Before privatizing health insurance, the respective governments applied rigid austerity policies to health services so that professionals would not oppose or, even better, would clamor for change. Then, once health insurance was privatized, there were no longer any limits to public health spending – something that inter-branch tradeoffs in the government’s budget make possible.

With the industrial management of public welfare services, which is promoted in the name of efficiency, and their underfunding, health services function like cages with sliding walls that are moving closer and closer. Like trapped rats, the caregivers suffer from a loss of ethics and self-esteem, anxiety, aggression, inability to work in teams, anomie, and then depression.

This type of scenario is in no patient’s interest, but the occupational burnout epidemic follows the meanders of the privatization/commercialization of care (education and justice). In the particular case of public universities, this privatization is functional but not statutory: it concerns the production of knowledge but not the property of the institution.15

In the days of the Canuts, the de-professionalization of textile workers was settled or put down in the street. Today, health professionals, teachers, researchers, and judges suffer as they lose all power over their own work. But if suffering is no longer expressed collectively, as Foucault said, it always leaves its imprint on the body. So it is that the burnout and moral harassment epidemic spreads, apace with budget cuts, the maturing of the health care market (and of justice, teaching, or research), and the generalization of industrial management.

**Therapeutic Management of Burnout and Rehabilitation/Tertiary Prevention**

The aims of burnout management are to reduce suffering while rehabilitating the “Spinozian power” of the burnout patient in family, social, and work environments. With nearly 1% of the Belgian population in burnout, such care could easily exceed the possibilities of the country’s health care systems. According to a survey by the European Occupational Safety and Health Agency (EU-OSHA), work-related stress costs Europe €25.4 billion a year,16 hence the importance of effective, efficient care.

Experience has shown that at least 1 general practitioner (GP), a psychologist, and a social worker should be involved and work together. The GP should take charge of the overall biopsychosocial synthesis and prevention. This team must then be able to call on reference specialists (psychiatrist, gastroenterologist, neurologist, etc.), as needed.

Here are some quality standards for burnout clinical management. These are criteria not only for health professionals but also health network managers, policy...
makers, and executives of a hypothetical local or regional program to combat this scourge:

a. The complex determinism of burnout calls for biopsychosocial care, i.e., professional practice that connects the 3 components to which it refers, namely, the management of suffering with its psychic, ethical, and somatic expressions; deterioration of social link and socioeconomic status; and the weakening of the ego. It should be noted that the need for such interconnection has many implications for the epistemology of GPs’ and psychologists’ knowledge and for clinical coordination.

b. Management must be patient-centered so that the biopsychosocial synthesis, which governs the choice of any therapeutic strategy, is negotiated with the patient. In fact, if we want the patient to comply with the treatment, even the etiology of burnout must be negotiated: the patient and the doctor must agree on how to weight the causes of the suffering, and in this the doctor must show empathy. The etiology, whether that of burnout or any other disease, cannot be decreed.

c. Caregivers must guide burnt-out patients through the labyrinth of occupational medicine, courts, unions, and hierarchy. Continuing medical education should therefore provide generalists and psychologists with skills in the social care of their burnout patients, not only for the purpose of prevention and early diagnosis but also to ensure the efficient use of existing social safety nets.

d. Finally, psychological care must be a source of readability and communication in the multidisciplinary team. Because systemic therapy mobilizes the resources of the patient’s family environment reliably, disseminating its foundations to general practitioners is highly worthwhile. By contrast, brief stress management does not seem to yield convincing results in the case of burnout.

**Primary Prevention**

*Management for Social and Professional Goals or Industrial Management of Hospitals, Schools, Universities, and Courts?*

Primary prevention embraces the interventions that prevent the development of burnout. Because burnout is epidemic, we are entitled to think that prevention, such as it is organized by the Belgian government today (to take that particular case), is ineffectual. It can be argued that this is because burnout victims and those at risk are excluded from the implementation of these preventive measures.

When it comes to burnout in doctors, psychologists, teachers, and magistrates, the most effective primary prevention would undoubtedly be to enable these groups to play an active role in prevention, the role of actors in managing their units or departments and the technostructures thereof.

For this, health professionals should be able to replace the industrial management of hospitals (and health services in general) with management guided by social and professional rationales and to use indicators of quality and access to care democratically. This would kill 2 birds with 1 stone by protecting both the caregivers’ professionalism and the patients’ right to quality care.

Ultimately, if people want to have a chance to defend themselves against burnout and mobbing and act effectively against the alienating facets of their work, professionals must learn (1) to recognize industrial management; (2) to know and actively disseminate its alternatives; and (3) to recognize, denounce, and combat toxic management and moral harassment.

However, in Belgian hospitals, schools, universities, and courts, professionals know above all that

- the employer is the one who pays for occupational health, which prevents the employer from effectively protecting the employee from the risks of burnout and moral harassment. The crisis of occupational medicine in this country might well be structural.
- to play a significant role in mobbing and burnout prevention, the human resources department in a public service and the like should be sufficiently independent from the top management. This unfortunately assumes that the board of directors is aware of this need and can act with sufficient independence to correct any anomalies.
- every burnout case should be seen as a critical incident. In reality, employers should also publish statistics, although political parties and unions do not seem to be in a hurry to ask for that. The fact that Belgian law recognizes burnout as a form of occupational stress is a concession to employees. Still, the employees’ professional organizations and trade unions may not always take sufficient advantage of this, whether out of reluctance to analyze subjectivity (C. Dejours, op. cit.) or for lack of managerial and political prospects.
- finally, the use of an ombudsman is often ineffectual due to the latter’s loyalty to authority.

If they want to weigh upon their work environments individually and collectively and act to democratize hospitals (schools, universities, and courts), doctors, psychologists, teachers, and magistrates need to learn the
alternatives they can propose to industrial care management and top-down planning.

The social and professional management of health services differs from their industrial and commercial management by its priorities.20:

- **The quality of care (education, rulings) over their quantity.** The publicly minded manager guarantees the quality of care in a territory.
- **The fairness and accessibility of care.** The publicly minded manager aims to ensure access to quality health care in a defined area. Public hospitals and health centers, and the doctors and paramedics who are interested in them, are responsible for improving access to care for their patients and their families and persons at health risk based, among other things, on geographical criteria that ensure maximal social heterogeneity in the patient mix. To organize the health services, they take account of all the dimensions of accessibility, i.e., geographical, psychological, financial, bureaucratic, technical, and so on. Finally, they avoid allowing the patient’s solvency to influence the nature of treatments and care.
- **Professionalism.** The publicly minded manager treats professionals as the main actors in the health care production chain. She or he promotes the professionals’ personal development through an individualized plan of continuing medical education, for example. The manager promotes the immaterial motivation and personal development of staff by treating dialogue, teamwork, and knowledge management as priorities; through self-evaluation and reflexivity; and through professional education and ethics. For this type of management, the physicians’ empathy and commitment are more important than resolving the tension between the effectiveness and efficiency of clinical decisions.20 (Effectiveness measures the degree to which a goal is achieved in operational conditions and efficiency, the effectiveness of the use of resources to achieve it.)
- **The democratic functioning of health services.** Management that has the public’s welfare in mind involves doctors and paramedics in the organization of services and organizes community participation.
- **Public health.** The publicly minded manager weighs the consequences of health care management for community health.

The structure of the hospital or academic department also affects the professional’s effectiveness and development. The most favorable structure allows the organization of independent teams in which mutual adjustment is a central concern. Mintzberg has dubbed this type of organization “divisionalized adhocracy.”21 Its characteristics favor creativity, cooperation, the circulation of knowledge, and mutual psychological support.22

Organizations that employ professionals should therefore promote teamwork because it fosters not only the flow of knowledge, exchange of experience, and internal evaluations (of quality of care and legal decisions alike) but also psychological support between colleagues.

Managers in hospitals, schools, courts and universities should not be appointed for their technical skills alone but also for their abilities to continue educating professionals and to energize a team. And over the course of their career, they should learn how to clear crisis in teams and prevent harassment.

The professional and union organizations, for their part, would attract the political benevolence of patients, parents, and litigants if they set themselves the objectives of measuring and defending the working time devoted to each patient, student, and litigant and actively defended priority funding for the nonclinical or “auxiliary” activities of physicians (teachers, judges, etc.), i.e., those related to knowledge, communication, evaluation, and professional development.

Lastly, in some manufacturing sectors, co-management structures (as in Germany) make it possible to control certain perverse effects of industrial management and to contribute to the prevention of burnout.

### Secondary Prevention

**Continuing Medical Education and Clinical Coordination**

General practitioners and psychologists know from experience the frequency of stress at work, both from their own experiences and that of their patients. However, they generally treat it as an environmental condition invulnerable to the physician’s intervention and warranting sick leave, if nothing else. If they knew the possibilities of acting on the organization of labor to reduce stress, they likely would detect people at risk of burnout and cases of harassment better and faster.

If these themes were included as a subject of continuing medical education, GPs and psychologists could reflect with their patients on ways to cleanse pathogenic workplaces. They would also be encouraged to take the time to share their analyses with occupational physicians and trade unions. In practice, for lack of knowledge and time, they rarely push the anamnesis in this direction and the information is hermetically compartmentalized. It would be less so if social security reimbursed doctors and psychologists’ nonclinical activities.

Finally, to facilitate access to secondary prevention, the full reimbursement of care for people at risk of burnout is certainly a step in the right direction.
Conclusions

Burnout is an extreme form of distress at work and is even more so when it is caused by moral harassment. Its prevalence probably exceeds 1% of the Belgian population, and this is probably only the tip of the iceberg, because it takes many unrecognized forms. In addition, burnout is underdeclared to occupational medicine departments because the patients are afraid of losing their jobs.

By contributing to exhaustion, de-professionalization, and anomie, the underfunding of services with a social mission, their industrial management, and the moral harassment associated with this industrial approach are the first causes of burnout in doctors, psychologists, teachers, and magistrates. The toxic leader is only the potentiator of the psychopathological effect of industrial management, which is called “scientific,” and harassment is only an immoral form of it. The prevention of burnout in Belgium would entail radical changes in the status of occupational health structures, in the type of management imposed on hospitals, schools, universities, and courts, and in the management of their human resources departments.

While the human and material cost of burnout is high, so is its immaterial importance, in connection to the respect of universal human rights:

- Industrial management is responsible for burnout in doctors, psychologists, teachers, and magistrates because it de-professionalizes them.
- However, safety, health, and education are each the subject of a universal human right, and each of these rights requires doctors, psychologists, teachers, and magistrates to their jobs professionally.
- Industrial management thus undermines the exercise of the universal rights to justice, education, and health care by de-professionalizing these sectors.

As hospitals, schools, universities, and courts in sub-Saharan Africa and Central America have experienced this de-professionalization for a long time, often at the instigation of cooperation agencies, we see its security and migratory consequences in all its cruelty.

It derives from the exercise of these human rights that health care, education, and the justice system must be managed for social and professional ends. Backed up by decent funding of the sectors, no other measure would have a greater impact on the prevalence of burnout in the professionals who carry out such services. In addition, this must be the subject of a local and regional control program that matches up the players with available resources. Its existence could be promoted in the industrialized countries by the political weight of nearly 25% of the population of working age, that is, professionals and workers who are employed in the sectors of justice, health, education, research, social services, and overseas development;

- and by social dialogue structures, which are an old Belgian tradition

The outputs of hospitals, schools, universities, and courts are immaterial. To prevent burnout in their professionals, management with a social and professional purpose makes use of tools such as continuing medical education; coaching and technical supervision; the tools of professional reflexivity (team audit, qualitative assessment, career plan, etc.); the symbolic, immaterial motivation of doctors, psychologists, teachers, and judges; and teamwork and the “adhocratic” and participatory organization of services.

If professional organizations and unions want to give doctors, psychologists, teachers, and judges tools to defend themselves, they will have to explain the mechanics of de-professionalization through appropriate outreach and to encourage the socially minded, professional management of care, education and training, and justice. They will do so only if they take stock of the existential threat posed by industrial management to professionalism of and access to health care (education and justice).

To prevent burnout effectively, these organizations will have to promote co-management in public services. Co-management makes sense only if the professionals working in the sector are able to devise strategies to improve the quality and accessibility of care, and similarly, education, research in the public interest, and justice.

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References

1. Anderson P. Physicians experience highest suicide rate of any profession. Medscape. https://www.medscape.com/viewarticle/896257?src=soc_fb_180507_mscpedt_news_mdscep_suicide&faf=1. Published May 7, 2018. Accessed May 9, 2018.

2. Conseil Supérieur de la Santé. Burnout et travail. Brussels, Belgium: CSS; 2017. Avis n° 9339.

3. Maslach C, Jackson SE. The measurement of experienced burnout. J Occup Behav. 1981;2:99–113.

4. http://www.emploi.belgique.be/moduleDefault.aspx?id=33630. Accessed October 8, 2019.

5. Vandenbroeck S, Vanbelle E, De Witte H, et al. Burnout chez les médecins et les infirmiers. Rapport de synthèse, Une étude sur le burn-out et l’enthousiasme chez le personnel médical et infirmier dans les établissements hospitaliers de Belgique. Brussels, Belgium: Service Public Fédéral Santé (Federal Ministry of Health); 2012.

6. Aiken LH, Sermeus W, Van den Heede K, et al. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. BMJ. 2012;344:e1717.

7. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc. 2015;90:1600–1613.

8. Kumar S. Burnout and doctors: prevalence, prevention and intervention. Healthcare (Basel). 2016;4(3):37.

9. Dejours C. Souffrance en France. La banalisation de l’injustice sociale. Paris, France: Editions du Seuil; 1998.

10. Karasek RA. Job demands, job decision latitude, and mental strain: implications for job redesign. Admin Sci Q. 1979;24(2):285–308.

11. Gunderman R. How hospitals discourage doctors: a step by step guide. Medpage Today. https://www.kevinmd.com/blog/2014/09/hospitals-discourage-doctors-step-step-guide.html. Published September 26, 2014. Accessed October 8, 2019.

12. Hirigoyen M-F. Le harcèlement moral dans la vie professionnelle. Paris, France: Editions La découverte et Syros; 2001.

13. Leymann H. The content and development of mobbing at work. Eur J Work Org Psych. 1996;5(2):165–184.

14. Girard R. La route antique des hommes pervers. Paris, France: Grasset; 1985.

15. Unger J-P, De Paepe P, Van Dessel P, Stolkiner A. The production of critical theories in Health Systems Research and Education. An epistemological approach to emancipating public research and education from private interests. Health Cult Soc. 2011;1(1):1–28. doi:10.5195/hcs.2011.50

16. European Occupational Safety and Health Agency. Calculating the Cost of Work-related Stress and Psychosocial Risks. Bilbao, Spain: EU-OSHA; 2014.

17. Unger J-P, Shelmerdine S, Van der Veer C, Roland M. How can GPs best handle social determinants in practice? Application in the Brussels environment. J Fam Med Dis Prev. 2016;2(1):25.

18. Quinet A, Shelmerdine S, Van Dessel P, Unger J-P. Family therapy in developing countries primary care. J Fam Med Dis Prev. 2016;1:6.

19. Van Wyk BE, Pillay-Van Wyk V. Preventive staff-support interventions for health workers. Cochrane Database Syst Rev. 2010;3:CD003541.

20. Unger J-P, Marchal B, Green A. Quality standards for health care delivery and management in publicly-oriented health services. Int J Health Plan Manag. 2003;18:S79–S88.

21. Mintzberg H. Structure in Fives. Designing Effective Organizations. London, England: Paperback, Pearson Ed; 1992.

22. Unger J-P, Macq J, Bredeo F, Boelaert M. Through Mintzberg’s glasses: a fresh look at the organization of ministries of health. Bull WHO. 2000;78(8):1005–1014.

23. Unger J-P, De Paepe P, Sen K, Soors W. International Health and Aid Policies. The Need for Alternatives. New York, NY: Cambridge University Press; 2010:275.

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