Education for Primary Care (2009) **20**: 353–9 © 2009 Radcliffe Publishing Limited

Preventing burnout among general practitioners: is there a possible route?

Helena Galina Nielsen MD
Specialist in Family Medicine, The Research Unit for General Practice, University of Copenhagen, Denmark

Charlotte Tulinius MD PhD MHPE
Senior Researcher, The Research Unit for General Practice, University of Copenhagen, Denmark and The Centre for Education and Development, University of Cambridge, UK

WHAT IS ALREADY KNOWN IN THIS AREA
- A substantial proportion of GPs show signs of burnout; there is some evidence of beneficial interventions.

WHAT THIS WORK ADDS
- This study presents the first empirical findings on how prevention of burnout can be specifically incorporated in supervision groups.

SUGGESTIONS FOR FUTURE RESEARCH
- Longitudinal prospective studies about how supervision groups may contribute to the prevention of burnout should be conducted.

Keywords: Balint group, burnout, compassion fatigue, general practitioner, therapeutic supervision

SUMMARY

Stress and burnout among general practitioners (GPs) is a serious problem. Some authors suggest supervision groups or Balint groups as a means of preventing burnout and others address how to treat the condition. This paper reports a case study of a supervision group for Danish GPs which, as well as training reflective practice, focuses specifically on the prevention of burnout. The concept of compassion fatigue is extended to cover the circumstances reported by some practitioners in supervision.

INTRODUCTION

Burnout among doctors is a serious problem that affects patient care.[1–3] Recent years have seen a growing focus on burnout among general practitioners (GPs). Goehring *et al* reported that one third of GPs in Switzerland showed sign of burnout,[4] and in a recent European survey, Soler *et al* found that a substantial number of GPs in Europe revealed signs of burnout that seemed to be associated with a heavy workload.[5] In his book *Le Burn-out du Soignant,* Delbrouck argues that doctors are especially exposed to and at risk of burnout because of excessive work and difficult encounters with patients.[6] Benson and Magraith, both GPs from Australia, claim that GPs are at risk because they are often the 'first port of call' for patients with a range of mental health problems, many of whom have a history of trauma or loss. Exposure to emotionally difficult situations puts them at risk of burnout and compassion fatigue.[7]

In a recent questionnaire study in Aarhus County, Denmark, Brondt demonstrated that not being a member of either a continuing medical education (CME) group or a supervision group was statistically significantly associated with likelihood of burnout twice as high as that found among members of such groups.[8] This would seem to indicate that membership of a group has a positive impact on job satisfaction and counteracts burnout.

Several authors suggest participation in supervision groups or Balint groups, along with other professional and personal activities, to prevent compassion fatigue and burnout.[6,7,9,10]

In Denmark, GP 'supervision groups' have

existed for more than 30 years. The groups are generally seen as an opportunity for the GP to train in talk therapy and communication skills.[11–13] Since the mid 1990s the number of groups has increased as the result of an agreement about incentive payments in the contract between the Danish National Health System (NHS) and the GPs to strengthen talk therapy. In 2003 about one third of Danish GPs participated in a supervision group.[14]

According to two Danish regional progress reports, GPs participating in a supervision group reported that their participation had improved their communication skills, had helped them develop personally and professionally, had led to higher job satisfaction and had a preventive effect on burnout.[11,15] No follow-up of these reports has yet been undertaken and the issue of how supervision groups are being used in Danish general practice has not previously been researched.

A larger study of GPs' use of supervision groups in Denmark aimed to study the meaning and significance of different kinds of group supervision from the perspective of the experienced GPs. One of the study groups specifically addressed the potential of supervision to prevent burnout among GPs. This group addressed all aspects of professional life and was headed by a supervisor who, besides training the GPs in reflective practice, was also focusing on how to prevent burnout. The aim of the present paper is to offer an empirical description in the form of a case study of the methods used to prevent burnout among GPs.

METHODS

The supervision process used for case study

The group

The group started as a supervision group in 2000 with nine GP members. Most had been practising as GPs for at least two years at that time and had all been members of the same self-directed learning group since they started practising. The supervision group consisted of seven members; during the observation period, all seven members were only all present at a single session; all but one participated in the group interview. The group met once a month 10 times a year.

The supervisor

The supervisor had worked with GPs for almost 20 years. Some of her groups had existed for more than 17 years. Primarily trained within a psychoanalytical frame of reference, her frame of reference may now be called eclectic and she uses a developmental process-orientated supervision model. The overall aim of the supervisor was to nurture a personal developmental process[16] in which the GPs became more aware, mindful and reflective practitioners, even if this were a long process. The supervisor realised that her personal style would not appeal to all GPs and acknowledged that the demands of daily life meant that GPs had to be good problem solvers as well.

The most essential objectives of her interventions were 1) to train GPs' reflective practices, 2) to boost their awareness of their occupational conditions, and 3) to train them in coping with compassion fatigue.[17]

The supervision methods used

The sessions were held at the supervisor's house in a light, friendly room equipped specifically for supervision and therapy. Each three-hour session was scheduled from 3 pm to 6 pm with a short break for coffee or tea. The session began with a round where feedback from the last session was given and the cases for the day would be chosen on a needs basis. Presentations lasted from 30 to 90 minutes, depending on the problem presented and the work to be done.

The main supervision model used was the reflecting team model[18] in which the supervisor would act as a team member, possibly providing teaching material in the last part of the session. The presenter would choose one of the group members to be the interviewer. Other methods used were role playing, presenting the case openly to the whole group, or the supervisor might interview the case presenter. The supervision could focus on all problems of the professional life, but would most often address the doctor–patient relationship, starting with the doctor's description of a troublesome patient encounter. The supervision could also target the GP's role as an administrator or an educator, or aspects of collaboration with staff, colleagues and other healthcare professionals. Complaints against doctors had priority. Issues such as how daily practice was organised were also raised if it was recognised that this would be helpful for the presenting doctor. For a short description of the main method, please see Box 1.

Case study research

Data collection

Data were collected using qualitative research methods in the form of interviews and participant observation during the supervision sessions.[19–24] The supervision group was followed in three sessions over a five-month period. Immediately after the sessions, five case presenters were briefly interviewed about the current supervision session. An in-depth interview *ad modum* Spradley[22] of the same doctors was carried out after one to

Box 1 A brief version of a supervision session, from the first participant observation by the first author

- After the group has assembled the supervisor reports apologies from two doctors. She recalls the last supervision session and gives feedback from one of the absent doctors.
- She then invites the group to inwardly concentrate to examine what their needs are for the day.
- After some minutes of silent concentration each doctor in turn is asked to contribute feedback from the last session. The supervisor explores and asks questions regarding problems from earlier supervisions.
- The supervisor names her concerns about some of the supervisees' modes of speech and affect (e.g. C's expression of anger, A's short breath).
- The GP in most apparent need of help is selected to have her case presented first. This GP chooses her interviewer. The supervisor decides which model to use in a dialogue with the presenter. The reflecting team is chosen.
- After the interview the supervisor gives instruction to an empathising exercise ('tuning in') first for the presenting doctor then for the patient.
- The team discusses and reflects without addressing either the presenter or the interviewer who are sitting apart from the group. After a round with tuning in to the presenting doctor, the presenter is invited to make comments; after that another round is made in the team with tuning in to the patient. Finally the presenter summarises which reflections the session has brought to her mind.
- After a short coffee break another case is addressed.
- After the second case the supervisor teaches body–mind relations and signs and treatment of traumatic stress.
- Every supervision session ends by assessing/evaluating: How was it for the presenter, for the interviewer and for the group?
- On that day three cases were addressed: 1 hour, 45 minutes, and 30 minutes, respectively.

two weeks. This interview departed from the observed supervision, but also included narratives that belonged to the interviewee's previous and present professional life. The supervisor was interviewed immediately after the first session and had an in-depth interview after the last participant observation of the group. At the end of the study period the entire group was interviewed (Figure 1). The interviews were audio recorded and transcribed verbatim by the first author.

Analysis

The analysis followed the phenomenological-hermeneutic tradition inspired by Giorgi and modified by Malterud.[23] This method was chosen to obtain a descriptive analysis of the lived experiences of the informants.[19–24] The software NVivo was used to handle the transcribed texts.

The interviews were analysed sequentially: first the interviews with the GPs, then the interview with the supervisor. Researcher triangulation was done as the second author also listened to all interviews, read the transcripts, and made themes and categories and performed the coding (see overall themes in Box 2). Finally, the themes of the doctors' experiences were analysed within the supervisor's frame of reference.[16] The quotations used in this article are only illustrations of the themes, extracted from the pool of interviews.

RESULTS

Perceived benefit from the supervision

All GPs reported having benefited from the supervision, using expressions such as it was like 'a scratch in the varnish' to having a feeling of 'moderating and changing over time'. Many reported that they had changed the organisation of their daily work. They expressed that now they felt differently about their patients, and encounters which were previously perceived as tiresome were more often now perceived as challenging. During the years in the supervision group, two of the doctors had considered a change of job because of the strenuous nature of their working

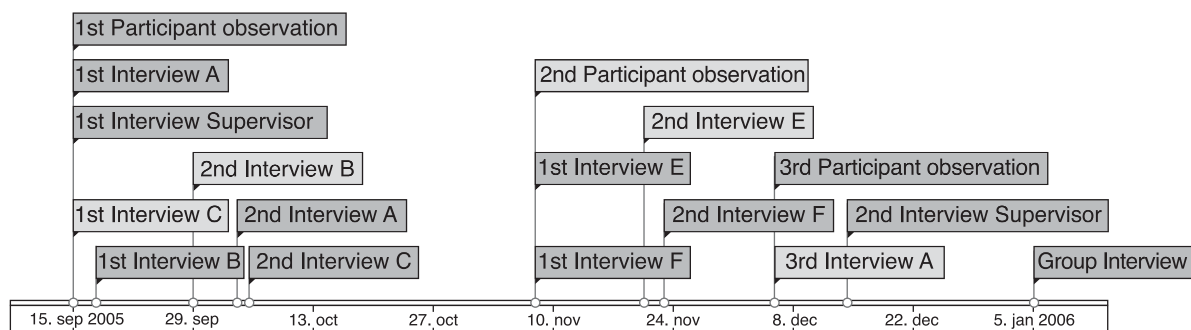

Figure 1 First supervision group September 2005–January 2006.

Box 2 Themes from coding

- **Profession** (vocational training, continuing medical education, self-directed learning group, identity)
- **Relations** (supervisor, group, self, interviewer)
- **The supervision** (the session, content and tasks, process)
- **Benefit from supervision** (advice, insight, tools, personal and professional development, bodily changes)
- **Practice life** (organisation, daily work, a typical day in the surgery, collaboration)
- **Private life** (family life, family history)
- **Self-care** (coping with stress, physical activity, medication, alcohol)

conditions. They both attributed their ability to remain GPs to the support received in the supervision group.

In the following analysis of emergent themes we report firstly the GPs' experience and then the supervisor's view.

From constant troubleshooting to continuous 'being'

The GPs described how they had earlier been focusing mostly on acute problem solving, trying to solve the problems for the patients. They believed that it was what was learned during hospital training where they had been treating diseases rather than human beings. They recognised that this strategy did not work in many of the encounters in general practice, and actually felt that it had been a futile workload, adding stress to their lives and aggressive feelings towards their patients. They found that their changed ways of handling the encounters made it easier for them and provided better outcomes for the patients as well.

> '. . . and I know for certain that I have changed my way of speaking with the patients . . . earlier on, I felt I had to solve the problem for them . . . and really, really used a lot of effort feeling that I must solve the problem or [I had a feeling of] an enormous responsibility for understanding or solving it. Now I am better at leaning back in my chair, emanate more calmness and let the patient tell his story without me posing questions all the time . . .' (GP-A)

In the supervisor's experience the GPs had a tendency to be constantly troubleshooting as opposed to health visitors and social workers who were much more prone to 'being and sitting together' with their clients without having to solve their problem right away. During the supervision her aim would be to get the doctors to work on how to slow down, sit back and take the opportunity to reflect on these situations.

Occupational overview of the working conditions

Several of the GPs had suffered serious stress-related conditions because of a heavy workload and overwhelming stress during their working life.

Working as self-employed practitioners running their own practices, these doctors regretted that little – if any – of their specialist training had addressed how to organise a practice or their working days. This was remedied by the supervision.

> 'I had a stressful period some years ago. My mother was dying and the workload was high I think. We had tried to reduce it by increasing the number of appointments and reconsidering the importance of the lunch by going to the 1st floor, so that we could be eating in peace and quiet for one hour instead of half an hour. But it did not help me; I got more and more stressed. At that time I used the group a lot to find out how to progress . . . I reached the point where I was ready to sell my practice. But during that period I got the right model [in the group] and I came back and made a structure and time schedule like B. Now, I am happy and have a good working day. But I still have it in the back of my head; the stress level increases very easily and I have to remind myself of how it was and then I use all the tools I learned in the supervision group for myself also so that I do not become too stressed during the encounters with the patients and so that it becomes possible for me to have a working day I can endure.' (GP-D)

'Compassion fatigue'

The GPs did not use the expression 'compassion fatigue'; however, they described the preconditions for the feeling which was referred to by the supervisor.

> 'There are special needs for GPs; they have so many contacts with people, and sometimes you have known somebody for a long time . . . and if something goes wrong, you may think that it is your fault, because you did not realise or discover the problem, or you feel sorrow because your relation has been so close. If you have longstanding continuous contacts with seriously ill patients, you ought to go to supervision. We do see horrible things sometimes. Of course you learn to cope after some years, but you are very hardcore if you are not touched by some of the cases . . . and you have to confront the family afterwards.' (GP-D)

The expression 'compassion fatigue' means 'being exhausted emotionally' and is defined in the first place in the domain of secondary or

vicarious traumatising.[25] The supervisor in this case study, however, uses the expression in a broader sense, talking about how doctors develop stress-related conditions because of multiple and often difficult encounters with patients who may or may not be traumatised: as mentioned by Figley, 'the costs of caring, empathy, and emotional investment in helping the suffering'.[17]

The supervisor reported hearing doctors report concerns that they are becoming demented, or that they have trouble concentrating and they do not feel up to listening to their children in the evenings. She describes the condition to the interviewer as follows:

> '... the tiredness of meeting people. ... to feel full to the brim, which you would typically recognise when you cannot stand that the nurse has a problem to share with you as well. ... or the children when you come home. You really ought to recognise it before then ... [recognise] now, I cannot stand more eye contact. Now, I need to keep my body for myself and keep my antennas and sensations for myself. ... to feel it and to create that little space for myself. What is needed is some tools ... Tools need to be built into your schedule in a way that is just right for you.'

The tools she is referring to are, among others, to map one's working week and to organise the daily schedule according to the doctor's emotional energy flow (see Appendix online at www.radcliffe-oxford.com/journals/J02_Education_for_Primary_Care/supplementary_papers.htm).

DISCUSSION

Most research on supervision has targeted education and health professions other than GPs, or has focused on one-to-one supervision.[16,26–28] Overall, research in group supervision remains rather sparse.[16,26,27] The use of Balint groups is an exception. Such groups have been extensively studied all over the world.[29–35] Thus, Kjeldmand shows that doctors participating in Balint groups become more patient centred and feel more in control of their working life and that they become more satisfied with their jobs.[30] Balint groups are practised differently in different countries, their purpose originally being to train psychological awareness by focusing on the doctor–patient relationship. However, Salinsky *et al* showed that experienced Balint groups may be able to address the doctors' personal feelings in the doctor–patient relationship with a view to avoiding defensive behaviour in consultations.[31]

In the present research project, the study group consisted of experienced GPs who had all participated in the supervision group for more than five years. Besides training in communication skills, the supervision addressed all aspects of professional life as a GP and two of the doctors attributed their decision not to cease being GPs to the help offered by the supervision group

Methodological considerations and limitations

The present project used qualitative methods to describe how the GPs experienced their participation in a supervision group. The description builds on the GPs' self-reported changes in their working lives. Research involving direct observation of practice in the GPs' surgeries might have revealed changes in their behaviour which were not captured by the chosen research methods. However, the triangulation of methods for data collection and the use of researcher triangulation enabled us to obtain more nuanced description than would otherwise have been possible.

This paper builds on the experience of one group of highly motivated doctors who had practised as GPs for about two years when the group started. It might be that some of the benefit applied to the supervision group would have occurred by ordinary experience and CME in a self-directed learning group in a supportive group of colleagues. These GPs who were interviewed in-depth, however, explained how learning in supervision was so much deeper because the supervisory process based cases on the personal dilemmas encountered in their professional lives.

Reflective practice

Supervision is commonly defined as a 'room of reflection'. Reflection may be seen as one important element in becoming a competent GP.[36,37] However, the ability to reflect needs to be developed. In nurse supervision, Fowler questions if training reflective practice should always be part of clinical supervision as not everybody is prepared to be aware of the self, which is part of being reflective.[38] However, the GPs in this group acknowledged and appreciated the opportunity to develop a more reflective position.

Working conditions

Dealing with the work context seems to have been very important and lay at the heart of two doctors' decision not to give up being a GP. It is not known how often supervision groups address these issues. In the present group, most doctors reported a change in their daily working routine as a result of the supervision. A change to a less stressful professional life may also pave the way for profiting from other issues of the supervision.

Compassion fatigue

The present study deploys the concept of compassion fatigue in a novel context that has little to do with its traditional therapeutic use in contexts

characterised by traumatic stress and victimisation.[17,25] In the present study, the concept is used to describe the feelings doctors who lack adequate tools may develop in response to an excessive workload with frequent, often difficult patient encounters, some of which demand much attention and empathic listening. The energy required and the emotional cost of such encounters[28] rise with their frequency and severity, and the gravity of this issue and the toll it takes on GPs seem too underestimated. The present study as well as studies on other professions and nurses have shown how group supervision may prevent stress and burnout[39,40] and it may be considered an expedient preventive measure of particular pertinence especially during the early professional life of GPs.

Longitudinal prospective studies on how supervision groups may contribute to the prevention of burnout deserve to be further researched.

Acknowledgements

Thanks to the participating GPs and their supervisor for the confidence they have shown me to give me admittance to this part of their professional lives. The project was supported by the Committee of Multipractice Studies in General Practice, the research fund of Danish Regions and PLU.

Ethical approval

There was no need for approval of the ethical committee. (According to Danish law ethics approval is not needed for this sort of research.)

Conflicts of interest

Charlotte Tulinius has been supervisor for Helena Nielsen on this part of the research project. The project is part of a larger PhD study. There were no personal relationships between any of the authors to either the group of GPs or to the supervisor.

References

1 Firth-Cozens J (2001) Interventions to improve physicians' well-being and patient care. *Social Science and Medicine* **52**: 215–22.

2 Bruce SM, Conaglen HM and Conaglen JV (2005) Burnout in physicians: a case for peer support. *Internal Medicine Journal* **35**: 272–8.

3 Isaksson Rø K, Gude T, Tyssen R and Aasland OG (2008) Counselling for burnout in Norwegian doctors: one year cohort study. *BMJ* **337**: a2004.

4 Goehring C, Bouvier-Gallacchib M, Künzic B and Bovierd P (2005) Psychosocial and professional characteristics of burnout in Swiss primary care practitioners. *Swiss Medicine Weekly* **135**: 101–8.

5 Soler JK, Yaman H, Esteva M and Dobbs F (2008) Burnout in European family doctors: the EGPRN study. *Family Practice* **25 (4)**: 245–65.

6 Delbrouck M (2003) *Le Burn-out du Soignant*. De Boeck & Larcier: Brussels.

7 Benson J and Magraith K (2005) Compassion fatigue and burnout. The role of Balint groups. *Australian Family Physician* **34(6)**: 497–8.

8 Brøndt A, Sokolowski I, Olesen F and Vedsted P (2008) Continuing medical education and burnout among Danish GPs. *British Journal of General Practice* **58 (546)**: 15–19.

9 Burton J and Launer J (2003) *Supervision and Support in Primary Care*. Radcliffe Publishing: Oxford.

10 Lambie GW (2006) Burnout prevention: a humanistic perspective and structured group supervision activity. *Journal of Humanistic Counseling, Education and Development* **45**: 32–44.

11 Rasmussen PB and Bentzen K (1997) *Supervision of Talking Treatment in General Practice – the perspectives of doctors and supervisors*. Danish Medical Association: Copenhagen.

12 Nielsen HG (2007) Supervision for GPs in Denmark. *Maanedsskr Prakt Laegegern* **11**: 1215–24.

13 Nielsen HG (2008) Supervision in the county of Copenhagen. *Maanedsskr Prakt Laegegern* **86**: 673–82.

14 DSAM and DPS (2004) *Bedre patientforløb for patienter med psykisk lidelse af ikke-psykotisk karakter [Better Treatment Courses for Mentally Disordered Non-psychotic Patients*]. Danish College of General Practitioners and Danish Psychiatric Society: Copenhagen.

15 Krøll V and Folmer E (2002) *Supervision for General Practitioners – impact and outcome*. Progress report. The County of Ringkjoebing. Available by contacting Central Denmark Region kontakt@regionmidtjylland.dk

16 Bernard JM and Goodyear RK (2003) *Fundamentals of Clinical Supervision* (3e). Allyn & Bacon Merrill: Boston.

17 Figley RC (2002) Compassion fatigue: psychotherapists' chronic lack of self care. *Psychotherapy in Practice* **58 (11)**: 1433–41.

18 Andersen T (2007) *Reflekterende processer. Samtaler og samtaler om samtalerne*. [*The Reflecting Team: dialogues and dialogues about the dialogues* (3e).] Dansk Psykologisk Forlag: Copenhagen.

19 Crabtree BF and Miller WL (1999) *Doing Qualitative Research* (2e). Sage Publications: London.

20 Giorgi A (ed) (1985) *Phenomenology and Psychological Research*. Duquesne University Press: Pittsburgh, PA.

21 Jorgensen DJ (1989) *Participant Observation: a methodology for human studies*. Sage: London.

22 Spradley JP (1979) *The Ethnographic Interview*. Wadsworth Group/Thomson Learning: Belmont, USA.

23 Malterud K (2003) *Kvalitative Metoder I Medisinsk Forskning – en innfoering* [*Qualitative Methods in Medical Research – an introduction*]. Universitetsforlaget: Oslo.

24 Kvale S (2004) *Interviews – learning the craft of qualitative research interviewing*. Hans Reitzel's Publishers: Copenhagen.

25 Figley RC (1995) *Compassion Fatigue: coping with secondary traumatic stress disorders in those who treat the traumatized*. Brunner-Routledge: New York.

26 Kilminster S and Jolly BC (2000) Effective supervision in clinical practice settings: a literature review. *Medical Education* **34 (10)**: 827–40.

27 Wheeler S and Richards K (2007) The impact of clinical supervision on counsellors and therapists, their practice and their clients: a systematic review of the literature.

Lutterworth: BACP.
28 Rose ML and Best DL (2005) *Transforming Practice Through Clinical Education, Professional Supervision and Mentoring.* Elsevier: London.
29 Balint M (2000) *The Doctor, His Patient and The Illness*. (Millenium reprint of second edition.) Churchill Livingstone: London.
30 Kjeldmand D (2006) *The Doctor, the Task and the Group: Balint groups as a means of developing new understanding in the physician–patient relationship*. PhD Thesis, Uppsala University.
31 Salinsky J and Sackin P (2000) *What Are You Feeling Doctor: identifying and avoiding defensive patterns in the consultation.* Radcliffe Publishing: Oxford.
32 Kutter P (2002) From Balint method to profession-related supervision. *American Journal of Psychoanalysis* **62 (4)**: 313–25.
33 Johnson AH (2001) The Balint movement in America. *Family Medicine* **33 (3)**: 174–7.
34 Salinsky J (2002) The Balint movement worldwide: present state and future outlook: a brief history of Balint around the world. *American Journal of Psychoanalysis* **62 (4)**: 327–35.
35 Kaltoft S and Thorgaard L (eds) (2005) The Doctor as Drug – about the doctor–patient relationship. *Maanedsskr Prakt Laegegern.*
36 Epstein RM (1999) Mindful practice. *JAMA* **282**: 833–9.
37 Schön D (1987) *Educating the Reflective Practitioner*. Jossey-Bass: San Francisco.
38 Fowler J (1998) Evaluating the efficacy of reflective practice within the context of clinical supervision. *Journal of Advanced Nursing* **27**: 379–82.
39 Williamson GR and Dodds S (1999) The effectiveness of a group approach to clinical supervision in reducing stress: a review of the literature. *Journal of Clinical Nursing* **8**: 338–44.
40 Hyrkäs K (2005) Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in Finland. *Issues in Mental Health Nursing* **26**: 531–56.

Correspondence to: Helena Galina Nielsen, The Research Unit for General Practice, Center for Sundhed og Samfund, 5, Øster Farimagsgade, P.O. Box 2099, DK-1014 Copenhagen K, Denmark. Email: Helena.g.nielsen@gpract.ku.dk

Accepted June 2009

Supplementary material for this paper is available at www.radcliffe-oxford.com/journals/J02_Education_for_Primary_Care/supplementary_papers.htm

Copyright of Education for Primary Care is the property of Radcliffe Publishing and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.