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Burnout between intensive care physicians or the Burnout society

Burnout entre médicos intensivistas ou Sociedade do burnout

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Abstract

Physicians who work in critical care units are prone to emotional exhaustion, manifestations of depersonalization, and professional dissatisfaction. These three manifestations make up what has been identified as burnout, and are a cause for growing concern. In this article, the authors review the available literature on burnout among intensive care physicians, but discuss it from a perspective that includes burnout as a broader manifestation, related to the exaltation of performance and the subsumption of life to capital, understanding this phenomenon as related to the society of burnout. The authors also discuss initiatives to combat burnout from the perspective of an expanded view of the concept of biopolitics, especially psychopolitics.

Keywords: Burnout; Intensive Care; Biopolitics.

Resumo

Os médicos que atuam em unidades críticas são propensos a exaustão emocional, manifestações de despersonalização e insatisfação profissional. Essas três manifestações compõem o que foi identificado como *burnout* e são motivo de crescente preocupação. Neste artigo, os autores revisam a literatura disponível sobre o *burnout* entre os médicos intensivistas, mas discutem-no sob uma ótica que inclui o problema em uma manifestação mais ampla, relacionada ao culto do desempenho e à subsunção da vida ao capital, entendendo esse fenômeno como relacionado com a sociedade do *burnout*. Também se discutem iniciativas para combater esse quadro na perspectiva de uma visão ampliada do conceito de biopolítica, especialmente a psicopolítica.

Palavras-chave: *Burnout*; Terapia Intensiva; Biopolítica.

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Introduction

In recent years, there has been a great interest in the specialized literature of the phenomenon known as “burnout,” which affects professionals who work in intensive care medicine. In our article, we review the available literature on the prevalence of the burnout syndrome between intensive care physicians, but we do it so based on the study of the German-Korean philosopher, who lives in Berlin, Byung-Chul Han (2015, 2017). Some of Han’s ideas had already been considered by Foucault (2008) in his critique of Gary Becker’s human capital theory and the debate between the author and two Foucault’s pupils in 2012. We argue that there is no independent phenomenon of burnout among workers in critical areas, especially intensive care physicians. The explanation proposed for the presence of this pattern is related to broader issues of our society. In Portuguese, there is no word capable of properly grasping the meaning of such syndrome, in such a way that we chose to use the English word “burnout” even in the original version of the study. Accordingly, we also criticize measures adopted to prevent and to manage this syndrome, identifying them as a manifestation of psychopolitics.

Burnout in general medicine and in intensive care medicine

Burnout is a psychological concept for the chronic feeling of exhaustion and lack of interest, often manifested by cynicism, generally occurring in the workplace. Burnout syndrome was described in the early 1970s (Freudenberger, 1974) and is common among healthcare workers (Maslach et al., 2001). Burnout syndrome has been considered an inability to cope with emotional stress in the workplace (Pines; Maslach, 1978) or as an excessive expenditure of energy leading to the feeling of exhaustion (Freudenberger, 1975). Its symptoms are nonspecific and grouped into three dimensions: emotional exhaustion, depersonalization (negative or cynical attitudes in relation to patients), and sense of professional dissatisfaction (Embriaco et al., 2007a). Prolonged exposure to stress is generally considered to be the main cause of

emotional exhaustion and is manifested through the loss of enthusiasm for the work, feeling of helplessness, and defeatism. Depersonalization occurs when physicians treat patients with indifference, objectifying them, and developing a negative attitude towards their colleagues and profession. The lack of personal achievement is characterized because professionals delegate their responsibility and feel detached from their work (Romani; Ashkar, 2014).

Great variations in the prevalence of Burnout syndrome have been reported between physicians (Ramirez et al., 1996) and nurses (Lu et al., 2005) as well as between different medical specialties (Embriaco et al., 2007b). The Maslach Burnout Inventory (MBI) is the quantitative instrument used the most to identify the presence of burnout. Variations reported on the prevalence can be related to the lack of a consensus in the literature for the interpretation of the Maslach Questionnaire. We may define Burnout syndrome considering the high score in the three evaluated dimensions or the high score in only one dimension, regardless of which (Tucunduva et al., 2006). For emotional exhaustion, scores higher than or equal to 27 are considered high; from 17 to 26, moderate; and lower than 16, low. For depersonalization, scores equal to or higher than 13 are considered high; from 7 to 12, moderate; and lower than 6, low. Scores concerning professional dissatisfaction goes in the opposite direction, since scores from 0 to 31 indicate high dissatisfaction; from 32 to 38, moderate dissatisfaction; and higher than or equal to 39, low dissatisfaction (Tucunduva et al., 2006).

High rates of severe Burnout syndrome have been reported among intensive care nurses since 1987 (Soupios; Lawry, 1987) and, subsequently, among intensive care physicians (Guntupalli; Fromm Junior, 1996). Several aspects of the professional practice have been changing for doctors and nurses and comprise loss of autonomy, reduction of resources, and need for high levels of competence (Donchin; Seagull, 2002). Workload, stressful work environments – such as intensive care units (ICU) –, and conflicts with other professionals, patients, and family members are considered risk factors for Burnout syndrome (Embriaco et al., 2007b).

Several studies indicate a high prevalence of burnout among specialized doctors, and one-third of these professionals experience this clinical pattern at some moment throughout their careers (Shanafelt et al., 2012). Burnout syndrome starts during college, continues throughout residency, and matures in the daily activity of doctors working after completing the residency. In a recent study in the United States of America, 45.8% of doctors presented at least one symptom of burnout (Shanafelt et al., 2012). Likewise, the “European general practice research network burnout study group” study, which included relatives of 1,400 doctors from 12 European countries, showed that 43% of individuals featured a high score regarding emotional exhaustion, 35% for depersonalization, and 32% for professional dissatisfaction, whereas 12% of the participants suffered from burnout in all three dimensions (Soler et al., 2008). Another study that included more than 500 doctors in the United Kingdom demonstrated that at least a third of these showed burnout symptoms (Sharma et al., 2008).

The first study that evaluated the incidence of Burnout syndrome among intensive care physicians reported high rates of emotional exhaustion and depersonalization, in addition to reduced professional satisfaction (Guntupalli; Fromm Junior, 1996). A study in France has confirmed high rate of Burnout syndrome and showed that being a woman was an independent risk factor for the issue (Embriaco et al., 2007b). Burnout syndrome has been associated with poor performance, low professional satisfaction, and reduced commitment to the work or organizations (Maslach et al., 2001).

Van Mol et al. (2015) published a meta-analysis on the prevalence of burnout and loss of compassion between intensive care workers. Loss of compassion is a state of physical and emotional stress in caregivers, and it was first described in the early 1990s as a result of repeated exposure to suffering at work (Joinson, 1992). Later, it was recognized as a manifestation of post-traumatic stress (Figley, 1995). Although Burnout syndrome is closely related to the loss of compassion, the underlying mechanism is probably different. This syndrome is believed to be related to occupational factors, such as workload, autonomy, and bonuses, and not to interpersonal

relations (Whitebird et al., 2013). Otherwise, the inability to start or engage in a care relationship is considered the core for loss of compassion (Sabo, 2011). Van Mol et al. (2015) included 28 studies in which the prevalence of burnout was specifically evaluated, which ranged from 0 to 70.1%.

Recently, Chuang et al. (2016) published a meta-analysis on the prevalence of burnout in professionals working in intensive care medicine and associated factors. Among the 25 studies included in the final analysis, the prevalence varied from 6% to 47%. The following factors were associated with higher prevalence of Burnout syndrome: age (younger individuals), sex (although the factor is controversial and identified in four studies only; interestingly, in one of these men had higher score for depersonalization and women had higher score for emotional exhaustion), marital status (more common among single people and those with no children), personality traits, less experience in working in ICU, workload, workload with short breaks for resting, ethical issues, and decisions related to terminal illnesses (Chuang et al., 2016).

The prevalence of burnout has also been studied among Brazilian doctors, especially residents. National studies indicate a prevalence between 20% and 50%, according to the MBI instrument. Half the residents of internal medicine at a philanthropic hospital in São Paulo/SP, Brazil met the criteria for burnout in 2012 (Fabichak et al., 2014). In a 2004 study, the prevalence was 20.8% among residents of several specialties (Lima et al., 2007), similar to the results of 2009 in Goiás, Brazil, which accounted for 18% (Soares et al., 2012). A study on Oncology resident physicians of several centers of Brazil identified a prevalence of 36% (Cubero et al., 2016). Gouveia et al. (2017) assessed burnout levels according to the MBI instrument among 129 residents. The prevalence was 27.9% and the rate of low professional satisfaction was 94.6% (Gouveia et al., 2017).

Paiva et al. (2017) evaluated professional satisfaction and burnout levels with the MBI instrument on 436 healthcare professionals, 81 of whom were physicians. Depersonalization was higher in doctors with several jobs. Low professional satisfaction was found in doctors without graduate degree, whereas higher levels of professional

achievement were associated with those with graduate degree (Paiva et al., 2017). Novais et al. (2016) assessed levels of burnout with the MBI in 43 trauma surgeons working as duty doctors. The prevalence of Burnout syndrome among duty surgeons in a reference hospital was 46.5%. In this sample there was correlation between weekly workload and Burnout syndrome (Novais et al., 2016). Silva et al. (2015) evaluated the prevalence of this syndrome and associated factors in highly-qualified professionals linked to the Primary Healthcare Network in the municipality of Aracaju, Sergipe state, Brazil. These professionals responded a demographic questionnaire and the MBI. Most were nurses and the prevalence was from 6.7% to 10.8%. The associated factors were younger age and excessive workload. There were no differences between the occupational categories evaluated (Silva et al., 2015).

Studies involving intensive care physicians have also been carried out in our field. Barros et al. (2008) assessed the burnout levels with the MBI instrument among 297 intensive care residents. High levels of emotional exhaustion, depersonalization, and lower personal satisfaction were found, respectively, accounting for 47.5%, 24.6%, and 28.3%. The prevalence of Burnout syndrome, regarded as a high score in at least one dimension, was 63.3%. This number was statistically lower for physicians specialized in intensive care, for those with more than nine years working after graduation, and among those who intend to continue working in intensive care units for more than 10 years. The prevalence was higher between physicians with more than 24 hours of uninterrupted workload per week (Barros et al., 2008). The same authors published a new analysis of the same data, in which they reported a prevalence of 7.4% considering the criterion of high scores in the three dimensions (Tironi et al., 2009). In this new analysis, the prevalence of Burnout syndrome varied according to the demand-control model. The situation of high demand (high demand and low control) showed the highest prevalence of burnout (13.3%). On the other hand, the situation of low demand (low demand and high control) presented the lowest prevalence (1.3%). The active work (high demand and high control) the and passive work (low

demand and low control) featured intermediate prevalence of 6.5% and 8.8%, respectively. Results showed that physicians with high work demands showed burnout 10.2 times more than those with low work demand (Tironi et al., 2009).

Barbosa et al. (2012) assessed burnout levels with the MBI instrument among 67 intensive care physicians. The frequency of high scores in at least one of the three dimensions of the MBI was 70.14%. Garcia et al. (2014) assessed burnout levels with the MBI instrument among 70 pediatricians, divided between 35 intensive care physicians and 35 general practitioners. Burnout was more frequent in intensive care physicians (71% versus 29%) (Garcia et al., 2014). Recently, Tironi et al. (2016) published an epidemiological study on 180 intensive care physicians in five Brazilian cities representing the several geographical regions of the country: Porto Alegre/RS, São Paulo/SP, Salvador/BA, Goiania/GO, and Belém/PA. A self-applicable questionnaire analyzing demographic data was used as well as the MBI for measuring burnout levels. The prevalence was 61.7%, considering a high score in at least one dimension, and 5% considering the need for high scores simultaneously in three dimensions (Tironi et al., 2016).

High frequency of burnout in studies conducted worldwide has led to consider the management of this syndrome as a priority (Embriaco et al., 2007b). Stress-reduction programs, focusing on cognitive-behavioral therapies, have been described as beneficial in the prevention and treatment of this problem among healthcare professionals. Results of systematic reviews in which were evaluated the management of stress among general practitioners reported that relaxation and cognitive-behavioral tools were useful. However, group methods were more effective-costly and more beneficial than individual counselling (Sims, 1997). Gardiner et al. (2004) evaluated the effect of 15 hours of stress management with training programs on 85 Australian general practitioners. The programs were focused on the fields of stress reaction, psychoeducation, relaxation techniques, and cognitive interventions. Work-related stress levels were significantly reduced, and the feeling of well-being and quality of life improved in the

12-week period following the intervention (Gardiner et al., 2004).

Mindfulness is defined as a self-applicable practice for body and mind relaxation by using techniques to focus on the present moment. Mindful meditation is a complementary therapy that has been shown to be promising in reducing stress and the influence of external factors that lead to burnout. Many studies have assessed these mindfulness techniques and showed that they can potentially play a role in the reduction of stress and burnout.

Krasner et al. (2009) evaluated the effects of an intensive educational program applied to primary care physicians, which included mindful meditation, self-awareness exercises, narratives about clinical experiences, and appreciative interviews. Participants benefited from mindfulness, which was correlated with improved mood, reduced emotional exhaustion, and improved professional satisfaction during the intervention with effects maintained for up to 15 months (Krasner et al., 2009). Goodman and Schorling (2012) evaluated four types of mindfulness practices. MBI scores have significantly improved after the program, both for physicians and other healthcare professionals, concerning the dimensions of emotional exhaustion, depersonalization, and professional satisfaction. There was also greater mental well-being, but there were no significant changes in scores of physical health (Goodman; Schorling, 2012). Shapiro et al. (2005) and Martín-Asuero and García-Banda (2010) reported that mindfulness-based interventions for stress reduction decreased the psychological stress and encouraged empathy, in addition to significantly increasing physicians' quality of life. Rø et al. (2004) observed that even short-term counseling sessions - whether individually, for just one day, or as groups, lasting a week - significantly reduced the emotional exhaustion among Norwegian doctors.

However, Marine et al. (2006), in a *Cochrane* review, concluded that the available data are insufficient to corroborate the hypothesis that these programs, for healthcare professionals, reduce work-related stress in addition to the period of the intervention itself. Furthermore, there is little evidence concerning long-term interventions with reactivation periods (Marine et al., 2006). One of

the hypotheses for the limited success of many interventions is the possibility that individuals in late stages of burnout show physiological changes that cannot be easily reversed (Danhof-Pont et al., 2011). Recently, Moss et al. (2016) published an official document of the intensive care medical societies with the subtitle "A call to action," reviewing criteria, diagnosis, prevalence, causal factors, and consequences of Burnout syndrome as well as potential interventions for prevention and treatment (Moss et al., 2016).

Discussion

The available literature suggests a high prevalence of burnout among physicians, with probable harmful consequences for professionals and potentially for the individuals they take care of. Intensive care professionals seem to be especially prone to the development of this syndrome. The prevalence seems higher in women, in those without graduate degree, and subjected to excessive workloads, especially when uninterrupted. However, the variability for defining the diagnosis of Burnout syndrome, sometimes valuing the highest score of one of the three dimensions of the MBI instrument, sometimes valuing high scores within the three dimensions, limits the prevalence findings.

Among Brazilian intensive care physicians, the findings of Barros et al. (2008) concerning a lower prevalence of Burnout syndrome in physicians specialized in intensive therapy, those with more than nine years of graduation, and among those who intend to continue working in intensive care units for more than 10 years are noteworthy, probably reflecting that the vocational aspect has a protective effect for developing Burnout syndrome. The finding of higher prevalence between physicians with more than 24 hours of uninterrupted workload per week is intuitive (Barros et al., 2008). Risk factors identified for Burnout syndrome among intensive care physicians, participants of studies conducted abroad, can be similar to those found in the intensive care medicine of Brazil: higher prevalence in younger individuals, women, single or with no children, with less work experience in ICU, subjected to excessive workload and/or workload with short breaks for

resting, and facing ethical issues and decisions related to terminal illnesses (Chuang et al., 2016). However, a specific analysis of these risk factors between intensive care physicians is not yet available in our field. In addition, characteristics inherent to intensive care in Brazil, such as a many jobs and professional insecurity concerning the work stability and need for supplementary pensions, should also be considered in further studies. Findings of Paiva et al. (2017) on 436 healthcare professionals, 81 of whom were physicians, not specifically intensive care ones, are noteworthy for showing higher depersonalization in doctors with several jobs and low professional satisfaction in physicians with no graduate degree, whereas the highest levels of professional satisfaction were associated with those who hold a graduate degree.

Nevertheless, do we actually have a specific burnout phenomenon affecting intensive-care health professionals, or are we all part of a broader context, defined by Byung-Chul Han (2015) as the burnout society, in which intensive care medicine is only a microcosm more intensively distinctive?

When Marx (2014) formulated his theories about the world divided into classes, this was the reality of the historical moment in which he lived. He was in the middle of the Industrial Revolution, when there was the capitalist and the proletariat. Nowadays, the concept of classes has lost much of its explanatory force. According to Han (2015), under certain aspect, we currently are entrepreneurs of our careers. Thus, although apparently free, we are, in fact, slaves. This slavery, however, is induced by ourselves, because we are also the “feudal lords.” The system in which we take part of does not seek to make us do anything, but to convinces us to optimize ourselves professionally so that we can meet the needs towards the efficiency of processes and results (Han, 2015). We have to worship our leadership skills and be constantly informed, even if superficially, about what happens around us.

Subjects of the postmodern performance are no longer subjects, since this concept is characterized by submission. Hence, they freed themselves to become a project; however, this did not suppress coercion. Instead of external coercion, self-coercion emerged, which presents itself as freedom. The

fall of the former dominant instance did not bring the promised freedom. On the contrary, it made freedom and coercion to be related. This paradoxical freedom turns into violence, and psychic symptoms of the performance society are its pathological manifestations (Han, 2017). Due to a certain need for productivity, self-exploration becomes more efficient, because it combines with the feeling of freedom. Thus, the performance society is a self-exploration society. The I goes to a war with themselves, in which there can be no winner, because victory ends with the death of the individual. Performance subjects destroy themselves with the victory (Han, 2017).

This modification of the postmodern performance subject proposed by Han (2017) can be previously identified in the criticism of Foucault, in 1979, against the Human Capital Theory formulated by a group from the University of Chicago coordinated by Theodore Schultz, with Gary Becker and Jacob Mincer (Foucault, 2008). The theory incorporates a quantitative analysis of human capital and, at the same time, it measures the impact of education about productivity. Human capital analysis assumes that individuals decide on their education, training, medical care, and other issues, weighing the costs and benefits (Becker, 1993; Sousa, 2009). Understanding Foucault’s critique (2008) depends on the connection between knowledge, power, and subject structured by the author. Knowledge refers to the several ways societies organize their own practical problems. Thus, it is directly related to the practices of power within the society, and knowledge itself is a kind of power. This set of knowledge and power leads to a particular conception of what subjects are, people who practice or suffer from a certain power, and what is their relationship with such knowledge. Foucault understands liberalism as a governing art. The principle of this art, this governmentality, works as a limitation to the *raison d’état*, since it determines how far the State may or may not act within its legitimacy. The philosopher interprets the birth of Political Economy as having occurred in the 18th century.

Quesnay and Adam Smith were exponents of the liberal thinking of the period, in France and in Scotland, and the natural order that these thinkers

found within economy was precisely this object that should be removed from the State responsibility to work on its own, a knowledge that imposed a limit to the very power of the State. According to Foucault, the classical political economy and much of the economic thought prior to Schultz and Gary Becker considered economy especially as variations between land, labor, and capital. However, labor within the production process was not analyzed with due attention. According to the author, the human capital theory considered the worker as the active being in the productive process when focusing on their ability to decide how to invest in their own human capital. Thus, subjects are no longer just workers, but they become a kind of entrepreneur themselves, as also corroborated by Han (2015). This would be the progressive thought of the theory. However, Foucault already warned about the issues that could arise to a society aiming at the expansion of its human capital. This would create the possibility of new social-control techniques, which Han also considers in psychopolitics. In the debate between Becker and two pupils of Foucault (Ewald and Harcourt) in Chicago, in 2012, these addressed the danger of the human capital theory being combined with discourses of eugenics, bioengineering, or behaviorism, if the society considered as beneficial the unlimited magnification of its human capital. They also questioned that the theory points to a change in the way of thinking of the State and public policies, with an increasing control over the environment in which individuals are inserted, working by persuasion and not direct coercion, but with the possibility of being even more controlling than the latter forms (Becker; Ewald; Harcourt, 2012).

Another way to interpret the present moment is through the concepts of Marx's subsumption of work to capital, as proposed by Fumagalli (2016). Marx described the capitalist exploitation through two different subsumption forms: the formal and the real (Marx, 2014). The historical period of formal subsumption corresponds to the period of the preindustrial capitalism, which leads to the edge of the Industrial Revolution and the first small-scale capitalism, but which faced an insurmountable boundary, the 24 hours of the day. With the transition to the real subsumption, the

exploitation process moves from extensification to intensification of the work process. This transition occurs by a series of three different models of organization. The simple beginning cooperation, typical of the first stage of pre-capitalist formal subsumption, gives rise to the so-called manufacturing system of the late 18th century, according to which work still has a formal self-organization and employees use their own tools. This simple cooperation stage changes and turns into division of labor. Afterwards, the third organizational model emerges, in which there is no longer specialization and workers perform monotonous operations throughout the work day. It is in this transformation that the transition to the real subsumption from labor to capital occurs. Nowadays, we live in the bio-cognitive capitalism, in which the real subsumption and the formal subsumption work together, creating a form of subsumption defined by Fumagalli (2016) as life subsumption. When life becomes workforce, the working time is not measured in hours or days and we are in the presence of formal subsumption. When life becomes workforce, because the brain becomes a fixed capital and a variable capital at the same time, the intensification of the work performance reaches its peak: we are, therefore, also in the presence of the real subsumption (Fumagalli, 2016).

Foucault (2008) coined the term "biopolitics" to refer to the domestication of bodies, in order to increase their efficiency for the industrial activity. The middle class in the late 19th century and the early 20th century, especially the portion accounting for liberal professionals, was still a quantitatively little important phenomenon. However, currently, the traditional concept of domestication of bodies of Foucault's biopolitics does not seem to have enough explanatory power. This phenomenon can be best explained by the concept of psychopolitics by Byung-Chul Han (2015), according to which minds are convinced, and the body is not domesticated. On the other hand, we can interpret the Foucauldian biopolitics concept more broadly, in which the production of subjectivity is also present (Chignola, 2015).

In order for us to be fully informed, we need to be constantly connected to social networks and

WhatsApp groups. Nothing can be left too late. More important than being in all possible events is to share that we were there, looking through the lens of devices such as smartphones and tablets. Professionals who work in intensive care medicine are often connected, both in their leisure time and in hours in which they are working. Overstimulation radically modifies the attention structure, fragmenting it and destroying it (Han, 2017). Instead of a focused professional, we currently value the multitasking worker, although performing various tasks does not mean a civilization advancement, but a step backwards. The attention without a single focus is characteristic of wild animals, since it represents the possibility of surviving or dying. On the other hand, cultural activities of mankind depend on full attention (Han, 2017). In addition to losing it, we live in a low tolerance for silence and boredom, which is crucial to the creative process (Han, 2017). As intuited by Nietzsche in 1878, “for lack of resting, our civilization is heading towards a new barbarism. In no other time active people, that is, uneasy people, worthed that much” (Nietzsche, 2005, p. 117, free translation).

Another important contradiction to healthcare workers is the fact that all ethical discourse regarding the professional practice is dominated by duty, by the Kantian obedience. However, subjects of the contemporary performance do not subject themselves to compulsory work. Their maxims are not obedience and fulfilling duties, but liberty and the pursuit of pleasure. This establishes a freedom in relation to the other, but, instead of leading to emancipation, it causes a crisis of bonuses. Bonuses depend on the other. In their absence, the coercion of the performance forces individuals to produce more and more, hence, they never reach a point of rest that allows bonuses, thus leading to exhaustion and burnout (Han, 2017).

It is hard not to understand that this whole process generates anxiety and incompleteness levels of difficult resolution, in which the work environment can only be part of a broader context, the burnout society. What makes individuals sick in this society is not the excessive responsibility and initiative, but the obligation of performance (Han, 2017). The performance obligation is the very

subsumption of labor to capital and the engine of a diffuse burnout. Thus, it is not surprising that the very system that favors the disease offers a cure. The growing interest in meditation and the initial favorable results with mindfulness in the management of Burnout syndrome in intensive care medicine follow the psychopolitics logic, that is, increasing the efficiency of professionals involved in the care of critical patients. It is worth resuming Foucault, who already defined the liberal governmentality as a consumption of freedom, since in order for it to be accomplished freedom must exist (Foucault, 2008).

Success, even if partial, of initiatives such as mindfulness can be due to the development of the negative power. Positive power is doing something, and when isolated, it generates hyperactivity, not allowing reflection. Negative power is the ability not to do something, which is different from impotence, which is the inability to do something. The negative power is paramount for contemplation and is an important tool for meditation processes (Han, 2017). It is not surprising, when adopting a more broad point of view, that the success of the initiatives to reduce burnout has been limited, including mindfulness, to the period of their use.

One of the dimensions of the burnout syndrome between intensive care physicians is professional dissatisfaction. However, would the professional frustration have deeper roots? Historically, medicine has a strong liberal discourse. To this discourse, the growing worship of performance is added. The French sociologist Alain Ehrenberg (2010) argues that the stimulus of the neoliberal discourse to entrepreneurship, that is, to take risks and be obstinate, is linked to the convergence between sports, business, and consumption discourses. All this liberal and pro-entrepreneurship trend has taken place in a context of progressive establishment of wages for physicians, directly and indirectly. Hence, physicians feel like their autonomy is being deprived from them, since it is not enough to be autonomous, it is necessary for autonomy to be recognized in a world in which it no longer occupies a significant position, in which the disseminated freedom may not be a real freedom.

In the intensive care environment, physical work, number of admissions, number of procedures

performed, medical records, etc. are valued. Is this not a cause for burnout due to the fetish for legwork? The fetish for work is a Marxist heritage previous to the work towards the capital and which proclaimed that the future would hold the freedom from capital. But the Marxist position never defended freedom from work, since work and capital are two sides of the same coin (Grupo Krisis, 2003).

Thus, paraphrasing Han (2017, p. 29, free translation), the dissatisfaction of the critical areas professional, who believe that “nothing is possible, is only possible in a society that believes that nothing is impossible.”

Final considerations

Certainly, burnout is a real issue among healthcare professionals and, in our review, particularly among physicians. Some areas, such as intensive care medicine, seem to be more prone to developing symptoms of such a syndrome. However, a compartmentalized vision of this process may not have the explanatory force that the burnout society concept has. This society, in its turn, may have its roots in the subsumption of life to capital. Initiatives aimed at the prevention and management of Burnout syndrome, even though potentially beneficial, bears the mark of biopolitics, interpreted more broadly to physically and intellectually adapt the individual to the market, or more specifically of psychopolitics, a new form of power without external coercion, but which equally aims to suit the individuals to the society in which we live.

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Authors' contribution

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