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Original Article

Prevalence and Pattern of Burnout Syndrome amongst Doctors Working in a Nigerian Tertiary Hospital

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Abstract

Background: Burnout Syndrome (BOS) is a psychological condition increasingly recognised in occupational health, especially within the healthcare sector. It significantly affects doctors' efficiency, job satisfaction, and well-being. Despite its global importance, there remains a lack of empirical studies exploring the prevalence and determinants of burnout among doctors in Nigeria. This study aimed to evaluate the prevalence, patterns, and predictors of Burnout Syndrome among medical doctors at the Federal Medical Centre, Abeokuta, Ogun State, Nigeria.

Methodology: A descriptive cross-sectional study was conducted among 211 doctors between January and December 2020. A semi-structured, self-administered questionnaire was used, incorporating the Minnesota Job Satisfaction Questionnaire and the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) for Medical Personnel. Burnout was defined as a high emotional exhaustion score, a high depersonalisation score, and a low personal accomplishment score. Data were analysed using SPSS version 25, with statistical significance set at $p < 0.05$. Multivariate logistic regression was utilised to identify independent predictors of burnout.

Results: The overall prevalence of burnout was 54.5%. High levels of emotional exhaustion, depersonalisation, and low personal achievement were observed in 59.7%, 85.8%, and 96.2% of respondents, respectively. Younger age (31–40 years), absence of children, being a house officer, lack of additional qualifications, and ≤10 years of post-registration experience were significantly associated with increased burnout. In logistic regression analysis, younger age and fewer years of post-registration practice remained significant predictors.

Conclusion: Burnout is highly prevalent among doctors in the study location, with younger practitioners and those in early career stages particularly vulnerable. Institutional interventions focusing on wellness promotion, professional development, work-life balance, and institutional support are crucial in reducing the risk of burnout.

Keywords: Burnout Syndrome, Emotional Exhaustion, Depersonalisation, Personal Accomplishment, Doctors, Nigeria, Occupational Health, Mental Health

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Introduction

In recent decades, Burnout Syndrome (BOS) has emerged as a significant occupational health concern, particularly among healthcare professionals. First described in 1974 by Freudenberger, burnout was characterised as a state of emotional and physical depletion resulting from prolonged occupational stress, especially in professions requiring emotional labour.[1]. Burnout is a multidimensional construct comprising three domains: emotional exhaustion (EE), depersonalisation (DP), and reduced personal accomplishment (PA)[2].

Burnout is defined as a psychological syndrome resulting from chronic interpersonal stressors on the job, manifesting primarily as emotional fatigue, cynicism or detachment from work, and a diminished sense of professional efficacy.[3]Emotional exhaustion refers to a state of overwhelming fatigue and depletion of emotional resources, while a callous or detached attitude towards service recipients marks depersonalisation. Reduced personal accomplishment reflects a decline in feelings of competence and achievement in one's work. These three dimensions are interrelated and collectively diminish job performance, professional satisfaction, and overall well-being.

Empirical research has shown that burnout is notably more prevalent among medical professionals compared to other occupational groups, even after adjusting for variables such as age, gender, education level, and weekly working hours.[4] In the United States, for example, approximately 54% of physicians have reported experiencing at least one symptom of burnout.[5].In Eastern Nigeria, a prevalence of burnout of 31.64% - Personal Accomplishment subscale, 25.47% - Emotional Exhaustion subscale and 9.87% - Depersonalisation subscale was reported[6].The mental health ofNigerian healthcare workers is of growing concern. Obi et al. found that nearly 15% of health workers in Southeast Nigeria were at risk of depression.[7] Furthermore, burnout is associated with significant clinical implications, including increased risk of medical errors, reduced quality of patient care, substance misuse, professional attrition, and even suicidal ideation.[8]

The Nigerian healthcare system is currently experiencing substantial human resource challenges, including the mass emigration of medical professionals in pursuit of better employment conditions abroad. A study conducted in Jos University Teaching Hospital reported widespread dissatisfaction among doctors concerning remuneration, workload, research opportunities, and allowances for professional development.[9] Such structural deficiencies exacerbate workplace stress, strain existing personnel, and create fertile ground for burnout, particularly among junior doctors who often bear the brunt of systemic inefficiencies.

Despite the global recognition of burnout among medical professionals, there remains a dearth of context-specific data regarding its prevalence and risk factors within Nigerian health institutions. Most available studies are either limited by scope or utilise varied assessment tools, making national comparisons difficult. Consequently, targeted interventions remain underdeveloped.

This study, therefore, seeks to address this gap by investigating the prevalence and pattern of Burnout Syndrome among doctors at the Federal Medical Centre (FMC), Abeokuta, Ogun State, Nigeria. Specifically, it aims to identify sociodemographic and professional predictors of burnout and assess the level of job satisfaction among the study population. The findings are expected to inform institutional policies aimed at improving physicians' welfare, enhancing productivity, and safeguarding mental health within the hospital setting and beyond.

Materials And Methods

Study Design and Setting

This study employed a descriptive cross-sectional design to examine the prevalence and factors associated with Burnout Syndrome among doctors at Federal Medical Centre (FMC), Abeokuta, a 320-bedded tertiary public healthcare institution located in Ogun State, South-West Nigeria. The centre serves as a referral hospital for surrounding primary and secondary health facilities and provides a broad range of medical services.

Study Population

The target population consisted of medical doctors who had been in continuous employment at FMC Abeokuta for a minimum period of six months as at the commencement of data collection (January 4, 2020,to December 4, 2020). Doctors previously diagnosed with, or currently being treated for, psychiatric disorders were excluded from participation to minimise confounding related to pre-existing mental health conditions.

Sample Size and Sampling Technique

The sample was recruited through census sampling, whereby all eligible doctors were invited to participate. Of the original respondents, twelve declined participation, nine were excluded due to prior psychiatric history, and nine were removed due to incomplete data. Thus, the responses of 211 were analysed in this study.

Data Collection Instrument

A structured, self-administered questionnaire was utilised to obtain data. The instrument comprised three sections:

(i) Socio-demographic and professional characteristics of respondents, including age, gender, marital status, number of children, income level, cadre, years of post-registration practice, speciality, call schedule, and working hours.

(ii) The Minnesota Job Satisfaction Questionnaire (MSQ) – a validated tool for assessing perceived job satisfaction across multiple dimensions of occupational fulfilment.

(iii) The Maslach Burnout Inventory-Human Services Survey (MBI-HSS) for Medical Personnel – a widely adopted instrument for measuring burnout across the three domains of emotional exhaustion (EE), depersonalisation (DP), and personal accomplishment (PA).

Burnout was operationally defined as the presence of at least one of the following: a high score (≥27) in emotional exhaustion, a high score (≥13) in depersonalisation, or a low score (≤31) in personal accomplishment[10].

Ethical Considerations

Ethical approval for this study was obtained from the Health Research Ethics Committee (HREC) of the Federal Medical Centre, Abeokuta. All respondents provided written informed consent before participation. The study adhered strictly to the ethical principles outlined in the Declaration of Helsinki on research involving human subjects.

Data Analysis

Data were coded and entered into the Statistical Package for the Social Sciences (SPSS), version 25. Descriptive statistics were used to summarise demographic variables and burnout patterns. Inferential statistics, including Chi-square tests and Fisher's exact tests (for expected frequencies less than five), were used to explore associations between categorical variables. Z-tests were conducted to compare means. Logistic regression analysis was performed to identify independent predictors of burnout among socio-demographic and professional variables. A p-value of less than 0.05 was considered statistically significant.

Results

The study commenced on January 4, 2020, and was concluded on December 4, 2020. Out of 240 eligible doctors, a total of 211 completed responses were analysed, resulting in a response rate of 87.9%. Twelve individuals declined participation, nine had a history of psychiatric illness, and another nine submitted incomplete questionnaires.

Table 1 illustrates the sociodemographic characteristics of the respondents. The mean age was 34.32±8.05 with a modal age of 30 and a median of 31 (Min – 21yrs and Max. – 67yrs).

Table 1: Socio-demographic Characteristics of respondents

CHARACTERISTIC		FREQUENCY (n)	PERCENTAGE (%)
Age Group (years)	21 – 30	81	38.4
	31 – 40	96	45.5
	41 – 50	26	12.3
	>50	8	3.8
Sex	Male	128	60.7
	Female	83	39.3
Marital Status	Married	134	63.5
	Single	73	34.6
	Cohabiting	4	1.9
Ethnic Group	Yoruba	175	82.9
	Igbo	25	11.9
	Hausa	1	0.5
	Others	10	4.7
Income per month	100,000 – <200,000	75	35.6
	200,000 – <300,000	57	27.0
	300,000 – <400,000	14	6.6
	≥400,000	65	30.8

Number of Spouses	0	76	36.0
	1	134	63.5
	2	1	0.5
Number of children	0	96	45.5
	1 – 2	67	31.8
	3 – 4	40	18.9
	> 4	8	3.8

The professional characteristics of respondents, as illustrated in Table 2, revealed that 35.5% of respondents were residents. The majority (77.4%) of respondents didn't have additional qualifications beyond their MBBS/MBChB, with the most common additional qualification being Fellowship (13.7%).

Table 2: Professional Characteristics of respondents.

CHARACTERISTICS		FREQUENCY (n)	PERCENTAGE (%)
Cadre	House Officer	68	32.2
	Medical Officer	37	15.5
	Resident	75	35.5
	Consultant	31	14.7
Specialty	Surgical	104	49.3
	Medical	100	47.4
	Dental	7	3.3
Additional Qualification to MBBS/MBChB	Nil	130	77.4
	Dip/BSc/MSc	18	10.7
	Fellowship	23	13.7
Years of Practice Post full Registration	≤10	92	38.7
	11 – 20	36	14.3
	>20	15	11.9
Years on current Job	≤10	201	95.3
	>10	10	4.7

Average working hours per week	≤80	161	76.3
	>80	50	23.7
Mode of Calls	Consecutive	43	20.4
	Staggered	168	79.6
Average No of Calls per Month	1 – 10	175	82.9
	11 – 20	34	16.1
	>20	2	1.0

The mean Job satisfaction score was 63.93±11.15 with the mode being 54.00 (Min. – 20.00; Max – 86.00). This revealed a fair level of job satisfaction amongst respondents.

Prevalence and Patterns of Burnout among Respondents

The prevalence of Burnout (which was defined as a high emotional exhaustion score, a high depersonalisation score and a low personal accomplishment score) in this study was 54.5% with the most common subset of burnout amongst respondents being Personal Accomplishment. The distribution of the levels of the domains of burnout is as illustrated in Figures 1, 2 and 3.

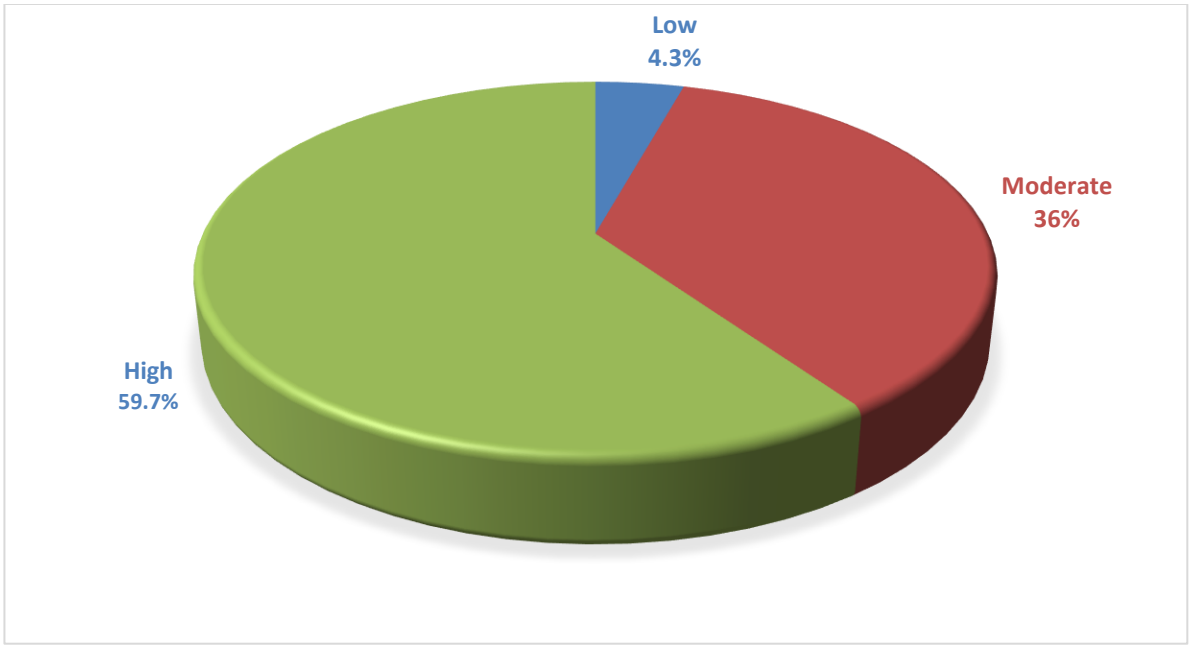

Figure 1: Levels of Emotional Exhaustion.

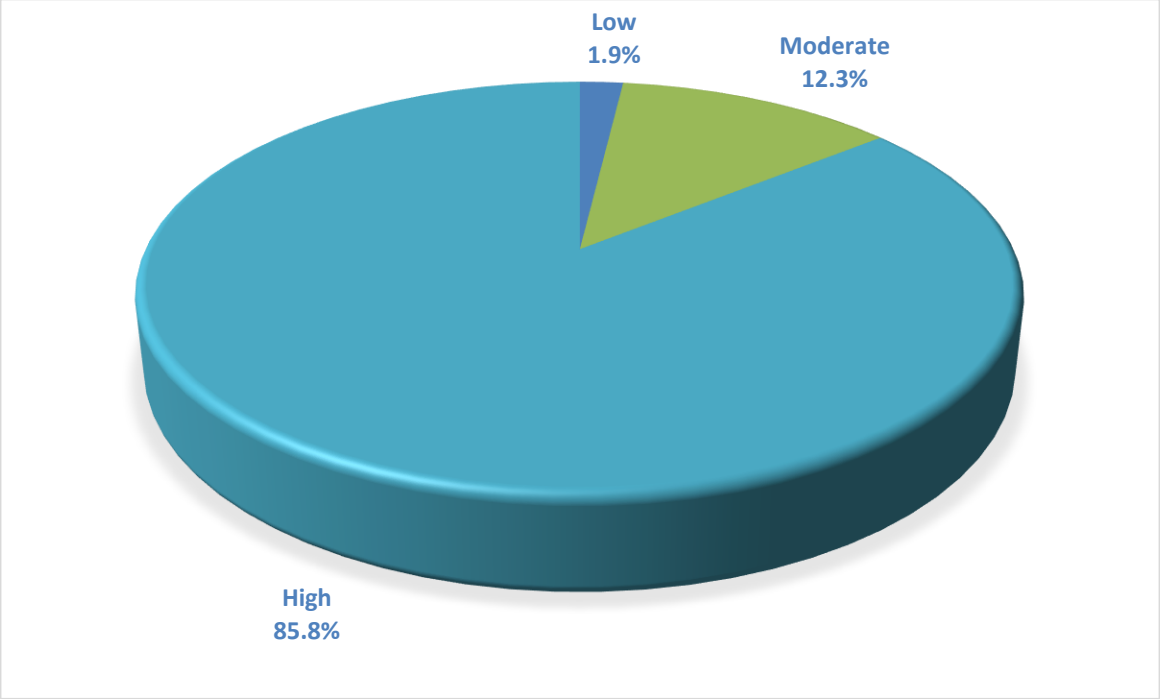

Figure 2: Levels of Depersonalisation

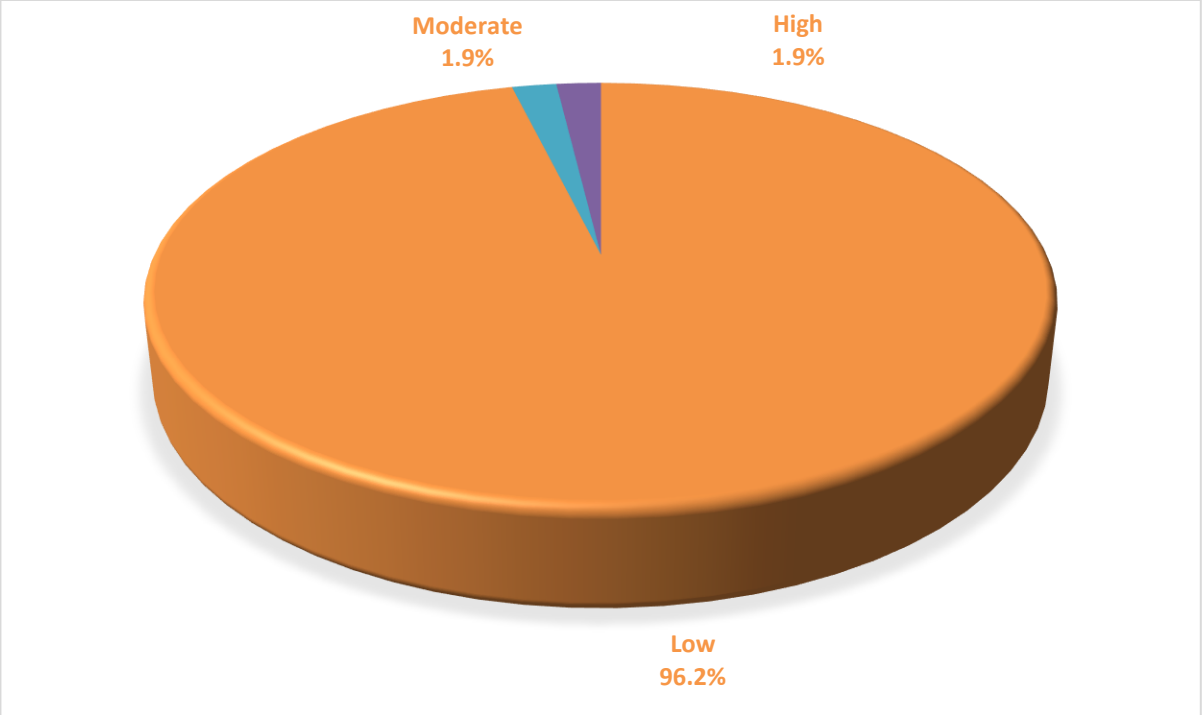

Figure 3: Levels of Personal Accomplishment

Association between burnout and Sociodemographic characteristics of respondents

Table 3 illustrates the association of burnout with the socio-demographic characteristics of the respondents. There was a statistically significant increase in burnout among those between the ages of 31 and 40, and this association was statistically significant (p = 0.008). There was a statistically significant reduction in burnout with increasing number of children, and those with no children had the highest prevalence of burnout (p = 0.002).

Table 3: Association between Burnout and Sociodemographic Characteristics

CHARACTERISTICS		Burnout		χ^2	P
		No	**Yes**	Total	
		n (%)	**n (%)**	**n (%)**	
Age group (years)	21 – 30	31 (32.3)	50 (43.5)	81 (38.4)	
	31 – 40	41 (42.7)	55 (47.8)	96 (45.5)	
	41 – 50	24 (25.0)	10 (8.7)	34 (16.1)	11.845 **0.008***
Sex	Female	37 (38.5)	46 (40.0)	83 (39.3)	
	Male	59 (61.5)	69 (60.0)	128 (60.7)	0.047 0.829
Marital status	Cohabiting	1 (1.0)	3 (2.6)	4 (1.9)	
	Married	67 (69.8)	67 (58.3)	134 (63.5)	
	Single	28 (29.2)	45 (39.1)	73 (34.6)	3.275 0.195*
Ethnic group	Yoruba	82 (85.4)	93 (80.9)	175 (82.9)	
	Igbo	8 (8.3)	17 (14.8)	25 (11.9)	
	Hausa	0 (0.0)	1 (0.9)	1 (0.5)	
	Others	6 (6.3)	4 (3.4)	10 (4.7)	3.650 0.302*
Income per month	100,000 – 200,000	30 (31.3)	45 (39.1)	75 (35.5)	
	>200,000 – 300,000	23 (24.0)	34 (29.6)	57 (27.0)	
	>300,000 – 400,000	8 (8.3)	6 (5.2)	14 (6.6)	
	>400,000	35 (36.4)	30 (26.1)	65 (30.9)	4.116 0.249
Number of Spouses	0	29 (30.2)	47 (40.9)	76 (36.0)	
	1	66 (68.8)	68 (59.1)	134 (63.5)	
	2	1(1.0)	0 (0.0)	1 (0.5)	3.611 0.164*
Number of children	0	32 (33.3)	64 (55.7)	96(45.5)	
	1 – 2	32 (33.3)	35 (30.4)	67 (31.8)	

3 – 4	26 (27.1)	14 (12.2)	40 (19.0)		
> 4	6 (6.3)	2 (1.7)	8 (3.8)	14.810	**0.002***

* Fisher's exact test

Logistic Regression analysis of Socio-demographic factors and Burnout

In Table 4, a logistic regression model including age, sex, marital status, ethnic group, monthly income, number of spouses, and number of children was statistically significant, $\chi^2(14) = 26.195$, $p < 0.05$. The model explained 15.6% (Nagelkerke R^2) of the variance in burnout and correctly classified 64.5% of cases. The Hosmer-Lemeshow goodness-of-fit test showed adequate fit ($\chi^2(8) = 10.943$, $p = 0.205$).

Age remained a significant predictor. For each additional year in age, the odds of experiencing burnout decreased by 7% (B = -0.076, p = 0.017, OR = 0.93, 95% CI ≈ 0.87 – 0.98).

Other variables, including sex, marital status, ethnicity, income, and number of children, were not statistically significant in the multivariate model.

Thus, age is aprotective factor against burnout, independent of other socio-demographic characteristics.

Table 4: Logistic Regression analysis of Socio-demographic factors and Burnout

	B	SE	Wald	df	Sig	Exp(B)
Age	-.076	.032	5.663	1	**.017**	.927
Sex (1)	.123	.306	.162	1	.688	1.131
Marital Status			.655	2	.721	
Marital Status (1)	1.075	1.338	.646	1	.421	2.931
Marital Status (2)	.186	1.028	.033	1	.856	1.205
Ethnic Group			1.994	3	.574	
Ethnic Group (1)	21.153	40192.970	.000	1	1.000	1.537E9
Ethnic Group (2)	.508	.474	1.150	1	.284	1.662
Ethnic Group (3)	-.699	.809	.748	1	.387	.497
Income per Month			2.736	3	.434	
Income per Month (1)	.173	.657	.070	1	.792	1.189
Income per Month (2)	-.782	.806	.940	1	.332	.458
Income per Month (3)	-.120	.703	.029	1	.864	.887
Number of Spouses			.179	2	.914	
Number of Spouses (1)	19.622	40195.242	.000	1	1.000	3.323E8
Number of Spouses (2)	20.068	40195.242	.000	1	1.000	5.194E8
Number of Children			4.477	2	.107	

Number of Children (1)	1.400	1.031	1.846	1	.174	4.057
Number of Children (2)	.299	.911	.107	1	.743	1.348
Constant	-17.874	40195.242	.000	1	1.000	.000

a. Variable(s) entered on step 1: Age, Sex, Marital Status, Ethnic Group, Income per Month, Number of Spouses, Number of Children
Model X^2 (14) = 26.195, Sig. = 0.024 Nagelkerke R Square = 0.156
Overall percentage (Accuracy) = 64.5%, Hosmer and Lemeshow TestX^2 (8)=10.943,Sig. = 0.205

Association between burnout and professional characteristics of respondents

Table 5 below describes the association between burnout and the Professional characteristics of the respondents. The statistically significant associated factors include being a house officer (p = 0.006), having no additional qualification (p = 0.010), and less than 10 years of practice post-full registration (p = 0.001).

Table 5: Association between Burnout and Professional Characteristics

CHARACTERISTICS					χ^2	**p**
		No	**Yes**	**Total**		
		n (%)	**n (%)**	**n (%)**		
Cadre	Resident Doctor	31 (32.3)	44 (38.3)	75 (35.6)		
	House Officer	23 (24.0)	45 (39.1)	68 (32.2)		
	Medical Officer	21 (21.9)	16 (13.9)	37 (17.5)		
	Consultant	21 (21.9)	10 (8.7)	31 (14.7)	12.339	**0.006**
Specialty	Surgical	49 (51.0)	55 (47.8)	104 (49.3)		
	Medical	44 (45.8)	56 (48.7)	100 (47.4)		
	Dental	3 (3.1)	4 (3.5)	7 (3.3)	0.220	0.896*
Additional Qualification to MBBS/MBChB	Nil	63 (65.6)	93 (80.9)	156 (73.9)		
	Dip/BSc/MSc	12 (12.5)	12 (10.4)	24 (11.4)		
	Fellowship	21 (21.9)	10 (8.7)	31 (14.7)	8.027	**0.018**
Years of Practice Post full Registration	≤10	39 (53.4)	53 (75.7)	92 (64.3)		
	11 – 20	21 (28.8)	15 (21.4)	36 (25.2)		

	>20	13 (17.8)	2 (2.9)	15 (10.5)	11.139	**0.004***
Years on current Job	≤10	91 (94.8)	111 (96.5)	202 (95.7)		
	>10	5 (5.2)	4 (3.5)	9 (4.3)	0.0769	0.735*
Average working hours per week	≤80	79 (82.3)	82 (71.3)	161 (76.3)		
	>80	17 (17.7)	33 (28.7)	50 (23.7)	3.493	0.062
Mode of Calls	Consecutive	22 (22.9)	21 (18.3)	43 (20.4)		
	Staggered	74 (77.1)	94 (81.7)	168 (79.6)	0.699	0.403
Average No. of Calls per Month	1 – 10	80 (83.3)	95 (82.6)	175 (83.0)		
	11 – 20	15 (15.7)	19 (16.5)	34 (16.1)		
	>20	1 (1.0)	1 (0.9)	2 (0.9)	0.046	0.977*

* Fisher's exact test

Logistic Regression analysis of professional characteristics on Burnout.

In Table 6, a second regression model incorporating professional factors — cadre, speciality, additional qualification, years of practice, years on the current job, weekly working hours, number of calls per month, and call schedule — was also statistically significant, $\chi^2(13) = 27.544$, $p = 0.010$. This model accounted for 23.4% of the variance in burnout and accurately classified 66.4% of the sample. Model fit was good ($p = 0.723$).

Key findings include:

(i)Years of Post-registration Practice: This was a strong independent predictor. Those with more than 20 years of practice were 98% less likely to experience burnout compared to those with ≤10 years (B = -3.750, p = 0.004, OR = 0.024, 95%CI≈ 0.002 – 0.27). This indicates that long-term experience is a strong protective factor against burnout,

(ii)Years on Current Job: Showed a marginally significant association with burnout (B = 1.356, p = 0.053, OR = 3.880,95% CI ≈ 0.99 – 15.2).Respondents who had spent more than 10 years in the same job role had almost 4 times higher odds of experiencing burnout. Although p = 0.053 is slightly above the conventional cut-off, it suggests a potentially important trend: long tenure in the same position may increase burnout risk.

(iii)Other professional factors, including cadre, speciality, additional qualifications, working hours, number of calls, and mode of calls, showed no significant association with burnout after adjusting for other variables.

Table 6: Multivariate analysis of professional characteristics on Burnout.

	B	SE	Wald	df	Sig	Exp(B)
Cadre			5.259	2	.072	
Cadre (1)	-.082	1.138	.005	1	.943	.922
Cadre (2)	-1.167	1.143	1.043	1	.307	.311
Specialty			.210	2	.901	
Speciality (1)	-.044	.408	.012	1	.914	.957
Speciality (2)	.421	.967	.189	1	.664	1.523
Additional Qualification to MBBS/MBChB			4.975	2	.083	
Additional Qualification to MBBS/MBChB (1)	.313	1.072	.085	1	.771	1.367
Additional Qualification to MBBS/MBChB (2)	-1.101	1.146	.922	1	.337	.333
Years of Practice Post full Registration			8.797	2	**.012**	
Years of Practice Post full Registration (1)	-1.040	.553	3.531	1	.060	.354
Years of Practice Post full Registration (2)	-3.750	1.300	8.315	1	.004	.024
Years on current Job	1.356	.700	3.751	1	.053	3.880
Average working hours per week (1)	.219	.640	.117	1	.733	1.244
Average No of Calls per Month			1.149	2	.563	
Average No of Calls per Month (1)	.631	.588	1.149	1	.284	1.879
Average No of Calls per Month (2)	-20.821	40192.970	.000	1	1.000	.000
Mode of calls (1)	-.143	.538	.071	1	.790	.867
Constant	-.108	.900	.014	1	.905	.898

A Variable(s) entered on step 1: Cadre, Speciality, Additional Qualification, Years of Practice Post full Registration, Years on current Job, Average working hours per week, Average No of Calls per Month, Mode of calls.

Model X^2 (13) = 27.544, Sig. = 0.010Nagelkerke R Square = 0.234
Overall percentage (Accuracy) = 66.4%, Hosmer and Lemeshow TestX^2 (8)=5.315,Sig. = 0.723

Table 7revealed an association between job satisfaction score and risk of burnout syndrome. Although respondents with burnout had slightly lower mean job satisfaction scores (62.57 ± 10.61)

compared to those without burnout (65.55 ± 11.61), the difference was not statistically significant (p = 0.053). However, the trend suggests a possible negative association between job satisfaction and burnout severity.

Table 7: Association between Job Satisfaction Score and Burnout

	Burnout		**Z**	**p**
	No	Yes		
Job Satisfaction Score Mean ±SD	65.55±11.61	62.57±10.61	1.945	0.053

Discussion

This study assessed the prevalence, pattern, and predictors of Burnout Syndrome (BOS) among doctors in a Nigerian tertiary hospital. The findings revealed that more than half (54.5%) of the respondents experienced burnout, with significant proportions exhibiting high emotional exhaustion (59.7%), high depersonalisation (85.8%), and low personal accomplishment (96.2%). These figures suggest that burnout is a critical concern among Nigerian doctors, warranting urgent institutional and policy responses.

The prevalence observed in this study aligns closely with that of Oluwadiya et al., who reported a comparable burnout rate among academic physicians in Nigeria.[11]. It also mirrors the findings of Grover et al. in India, where systemic stressors in tertiary institutions were highlighted as central to burnout.[12] However, it is notably lower than rates reported by Aldrees et al. in Saudi Arabia (70%) and by Nwosu et al. (75.5%) and Gadzama et al. (85%) in Nigeria.[13–15]. These discrepancies can be partially attributed to variations in burnout measurement tools. Whereas this study employed the Maslach Burnout Inventory (MBI-HSS), others used instruments such as the Oldenburg Burnout Inventory or the Burnout Clinical Subtypes Questionnaire (BCSQ-12), which assess different dimensions and thresholds of burnout.

The high proportion of doctors with low personal accomplishment (96.2%) is particularly concerning. This figure exceeds those reported by Hasan et al. (51.8%) and Ogundipe et al. (61.8%)[16,17]. A plausible explanation is the deteriorating socio-economic and institutional conditions in Nigerian health institutions, where career advancement opportunities, infrastructure, and recognition mechanisms are severely limited. Moreover, increased societal expectations and professional isolation may further erode doctors' sense of purpose and achievement.

The association between burnout and age was statistically significant, with younger doctors (aged 31–40 years) more likely to experience burnout. This is consistent with the findings of Aldrees et al.13, Hasan et al.17, and Visser et al.20) and may reflect the pressures faced by junior medical personnel in resource-constrained settings.[13,16,18]. Early-career doctors often lack job autonomy, receive limited mentorship, and shoulder extensive clinical responsibilities, all of which contribute to stress and emotional exhaustion.

Interestingly, while bivariate analysis suggested an association between marital status and burnout, this relationship did not hold in the multivariate model. However, the number of children emerged as a protective factor in the bivariate analysis, corroborating findings by Toyry et al.and Aldrees et al.[13,19]. Interaction with children may serve as an emotional buffer, offering doctors a sense of fulfilment and balance outside work. Conversely, the absence of such support may intensify professional dissatisfaction and emotional fatigue.

Professional factors also played a significant role in predicting burnout. House officers and residents were disproportionately affected, consistent with studies by Al-Dubai et al and Aguwa et al.[20,21]. These cadres often experience uncertainty regarding career progression, endure longer call hours, and lack institutional recognition. Moreover, doctors with no additional qualifications were more susceptible to burnout. This finding supports Aguwa's position that higher education may empower doctors with coping strategies and open avenues for professional development.[20]

Years of post-registration practice remained a strong predictor of burnout in the multivariate model. Doctors with more than 20 years of experience were significantly less likely to report burnout. This trend may reflect increased resilience, greater career stability, and enhanced autonomy among senior practitioners. However, the marginal significance of years on the current job points to the potential for job stagnation and fatigue when doctors remain in unchanging roles for extended periods.

Although job satisfaction scores were slightly lower among those experiencing burnout, the difference was not statistically significant. Nonetheless, this trend aligns with literature linking workplace dissatisfaction to burnout. Shanafelt et al. and Ozumba et al. have demonstrated that poor workplace community, inadequate recognition, and misalignment between individual and institutional values contribute to professional disenchantment and psychological distress.[5,22].

Overall, the findings of this study offer a critical snapshot of the burnout crisis among Nigerian physicians. They also echo broader global trends, indicating that younger, less experienced doctors operating in under-resourced systems are especially vulnerable. In the Nigerian context, this vulnerability is exacerbated by institutional inefficiencies, poor remuneration, and inadequate support systems.

Strengths and Limitations

This study has several strengths. The use of validated and widely adopted instruments—the Maslach Burnout Inventory-Human Services Survey and the Minnesota Job Satisfaction Questionnaire—enhances the reliability and comparability of the findings. The census approach improved representativeness and reduced selection bias. Additionally, the inclusion of both sociodemographic and professional variables, along with multivariate regression analysis, provided a comprehensive assessment of predictors of burnout within the study population.

However, certain limitations should be noted. The cross-sectional design restricts causal inference, and the single-centre setting may limit generalisability to other institutions or regions. Self-administered questionnaires are subject to social desirability and recall bias. Exclusion of doctors with prior psychiatric diagnoses may have led to underestimation of burnout prevalence. Furthermore, the study did not incorporate qualitative data or assess organisational-level factors, which may have provided deeper contextual insight into the drivers of burnout.

Conclusion and Recommendations

Conclusion

This study has revealed a high prevalence of Burnout Syndrome among doctors working at the Federal Medical Centre, Abeokuta, with over half of the respondents affected. Alarmingly, the majority exhibited high levels of depersonalisation and emotional exhaustion, while nearly all reported low personal accomplishment. These findings reinforce the view that burnout constitutes a significant occupational health challenge in the Nigerian healthcare system.

Age and professional experience emerged as the most salient predictors of burnout. Younger doctors, particularly those in the 31–40 age group and within ten years of full registration, were disproportionately affected. The findings further highlight the vulnerability of house officers and doctors without additional qualifications—groups typically characterised by limited job autonomy, increased workloads, and institutional invisibility.

Although job satisfaction did not emerge as a statistically significant determinant in the multivariate model, its inverse trend with burnout signals the importance of work-related contentment in mitigating emotional fatigue. Taken together, the study underscores the urgent need for structured interventions targeting early-career doctors and systemic reform in workplace environments.

Recommendations

In light of the findings, the following recommendations are proposed to reduce the incidence and impact of burnout among Nigerian doctors:

Creation of Supportive Work Environments: Health institutions should foster environments that are conducive to well-being by promoting teamwork, psychological safety, and open communication. Recognition of professional efforts and constructive feedback should be institutionalised.

Promotion of Professional Development: Opportunities for post-registration qualifications, continuing medical education, and mentorship should be prioritised. Encouraging doctors to pursue fellowships or specialised training may enhance their sense of professional accomplishment and control.

Reinforcement of Work-Life Balance: Flexible scheduling, job rotation, and leave policies should be introduced or strengthened to reduce the burden on junior doctors. Family-friendly policies and childcare support may further insulate doctors from emotional depletion.

Implementation of Mental Health Services: Exclusive in-house mental health support units should be established within hospitals to offer counselling, psychotherapy, and burnout screening. Access to confidential and stigma-free care is essential.

Provision of Recreational Facilities: Recreational and wellness programmes—such as gym facilities, group outings, or stress-relief workshops—should be integrated into institutional life to promote emotional resilience.

Policy Development and Advocacy: National and hospital-based health policy should incorporate burnout prevention frameworks. Regular audits and inclusion of burnout metrics in employee health assessments can serve as a basis for data-driven planning.

Further Research: Longitudinal and multi-centre studies are needed to track burnout trends, explore causal mechanisms, and evaluate the impact of interventions in diverse healthcare settings across Nigeria.

By addressing the root causes and perpetuating conditions of burnout, stakeholders in the Nigerian healthcare sector can ensure a more sustainable, motivated, and mentally resilient workforce. The protection of doctors' mental health is not merely a matter of occupational ethics but a fundamental prerequisite for effective healthcare delivery and national development.

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