Articles

The Burnout in Health Professionals in Guayaquil

El burnout en profesionales de la salud de la ciudad de Guayaquil

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ABSTRACT

This article addresses the phenomenon of burnout in the healthcare sector in the city of Guayaquil, Ecuador, exploring the complex interactions between work challenges and the socio-economic environment. From the local context to specific manifestations and underlying causes, this analysis seeks to provide an understanding of a critical problem affecting healthcare professionals, demanding innovative strategies for prevention and mitigation. The methodology employed is quantitative in nature, utilizing an instrument based primarily on the Maslach Burnout Inventory, comprising three dimensions: emotional exhaustion, depersonalization, and personal accomplishment. Three groups were defined for analysis: no burnout, mild/moderate burnout, and severe burnout. 33.65% of healthcare professionals do not exhibit high values in burnout dimensions, while 13.94% exhibit severe burnout. Statistically significant relationships are found between the presence of the syndrome and most demographic variables. It is concluded that there is an impact on the quality of life of healthcare professionals, which affects patient care in both public and private institutions. Implementation of intervention programs is recommended to mitigate the effects of burnout on the physical and mental well-being of healthcare professionals.

Keywords: Burnout, productivity, quality of life, teaching

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RESUMEN
El presente artículo aborda el fenómeno del burnout en el sector de la salud de la ciudad de Guayaquil, Ecuador, explorando las complejas interacciones entre los desafíos laborales y el entorno socioeconómico. Desde el contexto local hasta las manifestaciones específicas y las causas subyacentes, este análisis busca proporcionar una comprensión de un problema crítico que afecta a los profesionales de la salud y que demanda estrategias innovadoras para su prevención y mitigación. La metodología utilizada es de carácter cuantitativo, empleando un instrumento, cuya base principal es el inventario de burnout de "Maslach", que consta de tres dimensiones: cansancio emocional, despersonalización y realización personal. Para el análisis se definieron tres grupos: sin burnout, burnout leve/moderado y burnout grave. El 33.65% de los profesionales de la salud no presentan valores altos en las dimensiones del burnout, el 13.94% presentan un burnout grave. Se encuentran relaciones estadísticamente significativas entre la presencia del síndrome y la mayoría de las variables demográficas. Se concluye que existe una afectación en la calidad de vida de los profesionales de la salud, lo cual repercute en la atención a los pacientes de instituciones tanto públicas como privadas. Se recomienda la implementación de programas de intervención para mitigar los efectos del burnout en el bienestar físico y mental de los profesionales de la salud.
Palabras clave: Burnout, profesional, salud, Maslach, factores

INTRODUCTION

Stress is so much a part of our daily lives that it can be considered a plague on our civilization, as it affects personal health and well-being, as well as work and collective satisfaction. In the context of occupational health, a new process has emerged: burnout syndrome. It is a chronic adaptive disorder associated with inadequate coping with the psychological demands of work that alters the patient's quality of life and negatively affects the quality of health care delivery. (Polacov, et al., 2021)

"Burnout is a response to persistent job stress, shaped by negative attitudes and feelings toward the people you work with, and toward your own professional role," according to American psychologist Christina Maslach and her colleague Susan Jackson, who have been researching this topic since the mid-1970s. The "Maslach Burnout Inventory" was developed by Dr. Christine Maslach and Susan Jackson and uses a seven-level frequency scale to assess the three symptoms of professional burnout: depersonalization, emotional exhaustion and low personal fulfillment at work. (Olivares Faúndez, 2017)

The healthcare field has been highlighted as an environment particularly prone to the presence of physical and emotional burnout symptoms due to the nature of the activity and the frequent imbalance between external demands, social pressure, patient expectations, self-demand and the actual capacity of medicine and the resources available to efficiently meet these objectives (Koppmann, Cantillano, & Alessandri, 2021).

The health emergency that began in 2019 due to Sars-CoV-2 infection has saturated health systems, worsening the physical and mental health of health workers, generating an increased workload, concern about exposure to risks and hazards, lack of support in institutions, perception of organizational injustice and lack of protective equipment. The current situation has highlighted the need for health professionals to optimize resources, take self-care measures and learn to adapt to changes. (Torres, et al., 2021).

Professional burnout, combined with other factors such as long working hours, night shifts, stress and anxiety, has a negative impact on physical and mental well-being and decreases the quality of care and increases the likelihood of medical errors. Depressed residents present six times more errors than non-depressed residents, he assures (Toala, 2019).

According to several studies conducted in the last five years in Latin America and Peru, Burnout syndrome is increasing among health professionals, as these workers experience different levels, even from their undergraduate training. Therefore, the risk of contracting this syndrome or worsening this condition increases during the economic exercise.(Yslado, Norabuena, Sanchez, & Norabuena, 2020).

In medicine, especially in situations of severity of illness, physicians may be in contact with patients and sometimes become involved with their patients' pain or indifferent to them, so they must behave appropriately. Hence the ability to know how to manage "emotionally" in both cases. This competence will improve interaction with patients and peers.

Health personnel is one of the most vulnerable groups for Burnout. Some stressors that create a high environment of toxicity have been described and can be identified in the life of medical students and later in their career: excessive competitiveness, even in entrance exams, leaving home to study or work, increased autonomy, frustration at the beginning of the career due to not being performed in contact with the patient, related to the workload, work hours and responsibility for the patient's health, frustration with the health system and poor working conditions, excessive tasks on the medical staff and little economic compensation (Alcaraz, et al., 2023).

It is said that incorporating emotional intelligence in academic training is to acquire a key social competence that allows physicians to relate to themselves and to others. In daily praxis, an intelligent performance consists of knowing how to identify well the origin and nature of emotions in ourselves in order to be able to control them in a flexible way, establishing appropriate relationships between thoughts, emotions, behavior and behavior (Hernandez & Dickinson, 2014).
Some of the strategies to decrease Burnout syndrome applied in health institutions in Colombia are the following:

- Actively listen to the person without offering advice or judging their actions.
- Provide technical support through the validation of an expert colleague to confirm that the health activities are being carried out adequately.
- Encourage the worker's need and curiosity to be creative and engage with colleagues who are experts in their field.
- Emotional support involves offering unconditional support, something that all people need; if it is not possible to obtain in the work environment, it should be found in the personal sphere.
- Offer challenging emotional support that prompts reflection on whether all possible solutions have been explored and promotes a reconsideration of responsibilities for work outcomes, avoiding blaming colleagues or superiors for professional failures.
- Engage in the social reality of the person, either confirming or questioning their beliefs about themselves, such as their self-concept, self-efficacy and self-esteem.(Durán, García, Parra, García, & Hernández, 2018).

It is feasible to reduce Burnout through individual (rational approach to problems), social (social support, multidisciplinary work) and labor or organizational measures (reduction of quotas, reduction of the bureaucratic burden, promotion of autonomy and participation in decision-making, optimization of communication between care levels) (García, et al., 2022).

MATERIALS AND METHODS

The approach of this research is quantitative, with a descriptive methodology. A structured survey was used for data collection. The first part of the questionnaire is a battery of 22 questions with a time frequency scale, developed from Maslach's burnout inventory, which consists of three dimensions, which can be visualized in Table 1.

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Table 1. *Dimensions of the Maslach Burnout Inventory, associated with the questions of the instrument*

Dimension	Questions involved
Emotional fatigue	1–2–3–6–8–13–14–16–20
Depersonalization	5–10–11–15–22
Personal relationship	4–7–9–12–17–18–19–21

Source: (Maslach, Jackson, & Leiter, 1996)
Each question of the Maslach Burnout Inventory is evaluated according to a frequency scale:
0 = Never.
1 = A few times a year.
2 = Once a month or less.
3 = A few times a month.
4 = Once a week.
5 = A few times a week.
6 = Every day.

The second part of the questionnaire included demographic variables: sex, age group, marital status, religion, number of children, level of education, work seniority and family income. In addition, health and behavioral variables were included: hours of sleep, self-rated mental health, self-rated physical health, tobacco consumption and physical activity.
An electronic survey using the QuestionPro platform was used to collect the information. The instrument was a structured questionnaire.
The population considered for this study consisted of health personnel in the city of Guayaquil, including physicians, psychologists, dentists, obstetricians, nurses and nursing assistants. According to INEC, this population represents a rate of 53.94 per 10,000 inhabitants. Considering that the population of the city of Guayaquil, after the last population and housing census was 2746403 inhabitants, the population of health personnel would be approximately 14814 individuals.
In order to obtain the sample size, a pilot sample of 50 people was considered in which an estimate of the adjusted population proportion of 0.85 was obtained. The sample was calculated considering a confidence level of 95% and a maximum admissible error of 5%.
$n=(Z_{(\alpha/2)}^2 PQN)/(e^2 (N-1)+Z_{(\alpha/2)}^2 PQ)$
$n=((1.96)^2 (0.85)(0.15)(14814))/(〖(0.05)〗^2 (14814-1)+(1.96)^2 (0.85)(0.15))$
$n\cong 194$

RESULTS

Table 2 shows the frequencies of the demographic variables. Of the respondents, 71.15% were female. Regarding the age group, 28.85% were under 25 years of age,

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46.15% were between 25 and 34 years of age, 9.62% were between 35 and 44 years of age and the rest were 45 years of age and older. Regarding marital status, 64.90% were married, 23.56% were single and the rest were divorced or unmarried. Regarding the number of children, 69.23% said they had no children, 28.84% said they had between one and three children and the other 1.92% said they had three or more children. The predominant religion was Catholic with 66.83%, followed by evangelical with 8.65%; there were 3.37% atheists and 15.38% with no religion. Regarding educational level, 19.23% had secondary education, 58.66% had higher education and 22.11% had a master's degree or doctorate.

Table 2. *Demographic variables*

Variable	Categoría	Porcentaje
Sexo	Masculino	28,85%
	Femenino	71,15%
Grupo etario	< 25	28,85%
	25 - 34	46,15%
	35 - 44	9,62%
	45 - 54	13,94%
	55 +	1,44%
Estado civil	Solter@	23,56%
	Casad@	64,90%
	Divorciad@	2,88%
	Viud@	0,00%
	Unid@	8,65%
Religión	Católica	66,83%
	Evangélica	8,65%
	Otra religión	5,77%
	Sin religión	15,38%
	Ateo	3,37%
Nivel educativo	Educación secundaria	19,23%
	Tecnología	1,44%
	Formación técnica super	16,35%
	Licenciatura/Ingeniería	40,87%
	Maestría	19,23%
	Doctorado	2,88%
Número de hijos	Ninguno	69,23%
	1	8,17%
	2	11,54%
	3	9,13%
	Más de 3	1,92%
Ingreso familiar	$500 o menos	27,40%
	$501 a $1000	44,71%
	$1001 a $1500	8,65%
	$1501 a $2000	4,81%
	$2001 a $3000	4,81%
	Más de $3000	9,62%

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Table 3 shows the percentages of the health and behavioral variables. Regarding mental health, 18.27% rated it negatively, 59% rated it positively, the rest rated it neutrally; regarding physical health, 24.52% rated it negatively, 48.55% rated it positively, and 26.92% rated it neutrally. A total of 81.25% indicated that they do not smoke. Finally, with regard to sports activity, 37.50% stated that they had none, 37.98% indicated between 30 and 69 minutes per week and the rest were mainly distributed between 70 and 300 minutes per week.

Table 3. *Health variables and composition*

Variable	Categoría	Porcentaje
Horas de sueño por día (horas)	4 o menos	3,37%
	Entre 5 y 6	60,10%
	Entre 7 y 9	36,54%
	Más de 9	0,00%
Autocalificación salud mental	Muy mala	5,77%
	Mala	12,50%
	NI buena, ni mala	31,73%
	Buena	35,10%
	Muy buena	14,90%
Autocalificación salud física	Muy mala	4,33%
	Mala	20,19%
	NI buena, ni mala	26,92%
	Buena	39,42%
	Muy buena	9,13%
Fuma	Si	18,75%
	No	81,25%
Actividad deportiva (minutos por semana)	Ninguna	37,50%
	Entre 30 y 69	37,98%
	Entre 70 y 149	13,46%
	Entre 150 y 300	9,62%
	Más de 300	1,44%

Table 4 shows the percentages of the work variables that were also included in the present investigation. In the case of the type of institution, 53.97% of the respondents were from public institutions and the rest from private institutions. As for the work climate rating, 65.22% rated the work climate of their company with a score of 7 or higher.

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Table 4. *Labor Variables*

Variable	Categoría	Porcentaje
Tipo institución	Pública	53,97%
	Privada	46,03%
Clima laboral	1	3,37%
	2	5,77%
	3	3,37%
	4	0,00%
	5	10,10%
	6	8,65%
	7	13,46%
	8	35,10%
	9	13,46%
	10	3,20%

The results of the application of the battery of questions of the Maslach burnout inventory are shown in Table 5.

Table 5. *Responses to the Maslach Burnout Inventory questions*

Cat.	Id.	Statement	Nunca	Pocas veces al año	Una vez al mes o menos	Unas pocas veces al mes	Una vez a la semana	Unas pocas veces a la semana	Todos los días
Cansancio emocional	1	Me siento emocionalmente agotado/a por mi trabajo.	12,02%	8,65%	13,46%	17,31%	19,71%	20,67%	8,17%
	2	Me siento cansado al final de la jornada de trabajo.	4,33%	12,02%	5,77%	23,56%	8,65%	29,33%	16,35%
	3	Cuando me levanto por la mañana y me enfrento a otra jornada de trabajo me siento fatigado.	14,42%	19,71%	12,02%	18,27%	11,54%	9,13%	14,90%
	6	Siento que trabajar todo el día con personas supone un gran esfuerzo y me cansa.	24,52%	16,35%	9,62%	10,58%	11,54%	13,46%	13,94%
	8	Siento que mi trabajo me está desgastando/Me siento quemado por mi trabajo.	19,23%	15,38%	10,58%	16,83%	4,33%	19,71%	13,94%
	13	Me siento frustrado/a en mi trabajo.	28,37%	14,42%	14,42%	12,02%	13,94%	11,06%	5,77%
	14	Siento que estoy demasiado tiempo en mi trabajo.	12,98%	17,79%	11,54%	10,10%	13,46%	13,46%	20,67%
	16	Trabajar directamente con la gente me produce estrés.	23,08%	19,23%	12,50%	10,10%	7,21%	12,98%	14,90%
	20	Me siento acabado en mi trabajo, al límite de mis posibilidades.	36,54%	9,13%	13,46%	18,27%	13,46%	1,44%	7,69%
Despersonalización	5	Creo que estoy tratando a algunas personas como si fueran objetos impersonales.	70,67%	10,10%	10,10%	1,44%	4,33%	1,44%	1,92%
	10	Me he vuelto más insensible con la gente.	46,15%	18,75%	3,37%	12,50%	7,21%	5,77%	6,25%
	11	Pienso que este trabajo me está endureciendo emocionalmente.	27,88%	19,23%	1,92%	9,13%	10,58%	11,54%	19,71%
	15	No me preocupa realmente lo que les ocurra a algunas de las personas a las que debo atender profesionalmente.	50,48%	17,79%	4,81%	4,33%	12,02%	4,33%	6,25%
	22	Creo que las personas a las que atiendo me culpan de algunos de sus problemas.	44,23%	19,23%	5,77%	10,10%	1,44%	5,77%	13,46%
Realización personal	4	Tengo facilidad para comprender como se sienten las personas a las que tengo que atender	4,33%	4,33%	7,69%	1,44%	2,88%	12,98%	66,35%
	7	Creo que trato con mucha eficacia los problemas de las personas que atiendo	0,00%	2,88%	2,88%	2,88%	6,25%	15,87%	69,23%
	9	Creo que con mi trabajo estoy influyendo positivamente en la vida de otras personas.	1,44%	5,77%	6,25%	8,17%	4,33%	9,62%	64,42%
	12	Me siento con mucha energía en mi trabajo.	3,37%	6,25%	5,77%	9,13%	9,62%	25,48%	40,38%
	17	Siento que puedo crear con facilidad un clima agradable en mi trabajo	1,44%	10,58%	1,44%	10,10%	2,88%	16,83%	56,73%
	18	Me siento motivado después de trabajar en contacto con las personas que atiendo.	5,77%	10,58%	4,33%	13,94%	3,37%	29,33%	32,69%
	19	Creo que consigo muchas cosas valiosas en este trabajo.	2,88%	12,50%	4,33%	5,77%	13,46%	21,15%	39,90%
	21	En mi trabajo trato los problemas emocionales con mucha calma.	0,00%	5,77%	6,25%	10,58%	6,25%	19,23%	51,92%

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Considering what is indicated in Table 1, we proceeded to generate the three main categories into which the MBI is divided and to make the corresponding descriptive statistics. Each dimension is evaluated according to the ranges shown in Table 6.

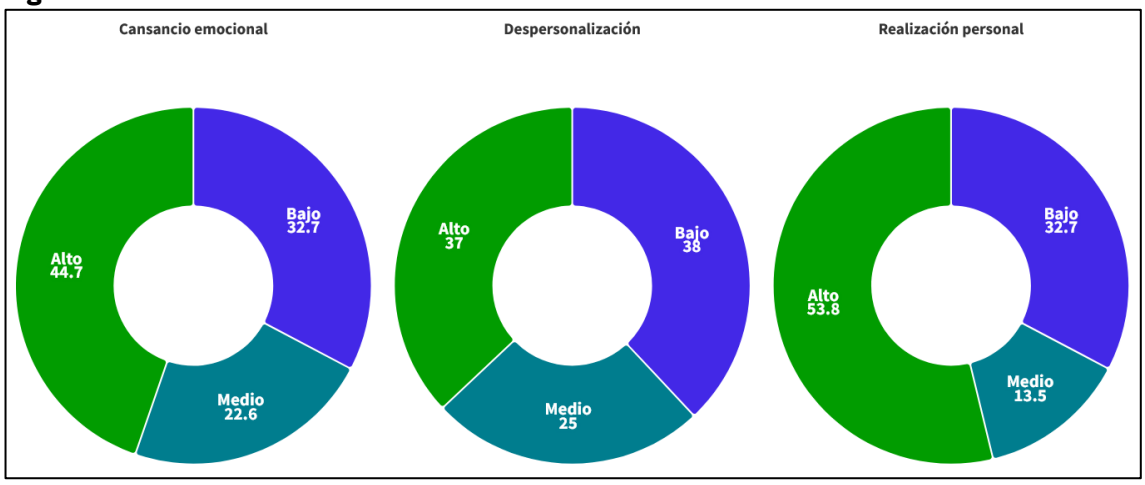
Table 6. *Reference for the interpretation of the results obtained in each of the dimensions of the Maslach burnout inventory.*

Dimensión	Puntuación baja	Puntuación media	Puntuación alta
Cansancio emocional	≤ 18	19 - 26	≥ 27
Despersonalización	≤ 5	6 -9	≥ 10
Relación personal	≥ 40	34 - 39	≤ 34

Source: (Maslach, Jackson, & Leiter, 1996).

Figure 1 shows the different levels in the three dimensions of burnout. The emotional exhaustion dimension presents a low level in 32.70% of the cases, a medium level in 22.60% of the cases and 44.70% of the cases have a high level. In the depersonalization dimension, 38.00% have a low level, 25.00% have a medium level and 37% have a high level. Finally, in the personal fulfillment dimension, 32.70% have a low indicator, 13.50% have a medium indicator and 53.80% have a high indicator.

Figure 1. Levels of the Burnout dimensions.



As mentioned, each burnout dimension has three levels (low, medium and high), but there is no certainty among the authors to consider the existence of burnout syndrome according to the levels in each dimension. What is clear is that a high level in one or more dimensions is evidence of the presence of the syndrome in the person.

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Figure 2 shows the frequency of obtaining high scores in 1 or more of the burnout dimensions. Of the respondents, 33.65% do not have high scores in any of the dimensions (no burnout), 32.21% have high scores in one of the dimensions (mild burnout), 20.19% have high scores in two dimensions (moderate burnout) and 13.94% have high scores in all three dimensions (severe burnout).

Figure 2. Number of dimensions with high scores

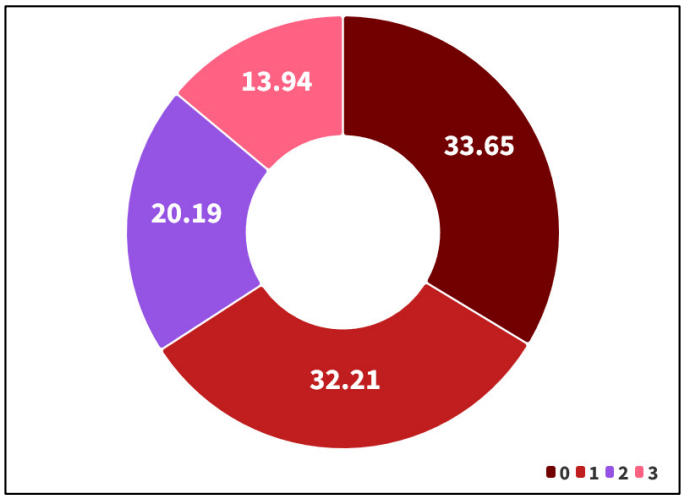

Table 7 shows the percentages of burnout according to the different demographic variables.

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Table 7. *Percentage of burnout according to demographic variables. A level of statistical significance is considered if p < 0.05.*

Variable	Categoría	Sin Burnout	Burnout leve/moderado	Burnout grave	Valor p
Sexo	Masculino	16,70%	73,30%	10,00%	0,000
	Femenino	40,50%	43,90%	15,50%	
Grupo etario	< 25	26,70%	58,30%	15,00%	0,000
	25 - 34	22,90%	63,50%	13,50%	
	35 - 44	65,00%	35,00%	-	
	45 - 54	65,50%	10,30%	24,10%	
	55 +	-	100,00%	-	
Estado civil	Casad@	46,90%	26,50%	26,50%	0,000
	Solter@	23,70%	64,40%	11,90%	
	Otros	62,50%	37,50%	-	
Religión	Católica	35,30%	48,20%	16,50%	0,000
	Evangélica	16,70%	50,00%	33,30%	
	Otras	35,29%	64,71%	-	
Nivel educativo	Educación secundaria	45,00%	47,50%	7,50%	0,005
	Educación superior	31,15%	55,74%	13,11%	
	Maestría/Doctorado	30,43%	47,83%	21,74%	
Número de hijos	Ninguno	26,40%	58,30%	15,30%	0,000
	1	64,70%	35,30%	-	
	2	50,00%	50,00%	-	
	3 o más	39,13%	30,43%	30,43%	
Ingreso familiar	$500 o menos	15,80%	56,10%	28,10%	0,000
	$501 a $1000	44,10%	49,50%	6,50%	
	$1001 a $1500	33,30%	66,70%	-	
	$1501 a $2000	70,00%	30,00%	-	
	$2001 a $3000	-	60,00%	40,00%	
	Más de $3000	35,00%	50,00%	15,00%	

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A higher percentage of severe burnout is evidenced in men. The same occurs in the group of people between 45 and 54 years of age. Married people have a higher level of severe burnout. With regard to religion, a higher level of severe burnout is found among evangelicals. Severe burnout is higher in those with three children; there is a higher incidence of severe burnout in people with a master's degree or doctorate. Finally, a greater presence of severe burnout is evidenced in those with family incomes of $2001 to $3000.

A statistically significant association was found between burnout and all demographic variables (sex, age group, marital status, religion, educational level, number of children and family income). Table 8 shows the percentages of burnout according to health, behavioral and occupational variables.

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Table 8. *Percentage of burnout according to health, behavioral and occupational variables. A level of statistical significance is considered if p < 0.05.*

Variable	Categorías	Sin Burnout	Burnout leve/moderado	Burnout grave	Valor p
Horas de sueño por día (horas)	4 o menos	42,90%	57,10%	0,00%	0,749
	Entre 5 y 6	31,20%	53,60%	15,20%	
	Entre 7 y 9	36,8	50,00%	13,20%	
Autocalificación salud mental	Muy mala	-	75,00%	25,00%	0,000
	Mala	23,10%	76,90%	-	
	NI buena, ni mala	21,20%	56,10%	22,70%	
	Buena	38,40%	46,60%	15,10%	
	Muy buena	71,00%	29,00%	-	
Autocalificación salud física	Muy mala	-	66,70%	33,30%	0,000
	Mala	7,10%	61,90%	31,00%	
	NI buena, ni mala	30,40%	58,90%	10,70%	
	Buena	41,50%	50,00%	8,50%	
	Muy buena	84,20%	15,80%	-	
Fuma	Si	10,30%	71,80%	17,90%	0,003
	No	39,10%	47,90%	13,00%	
Actividad deportiva (minutos por semana)	Ninguna	16,70%	62,80%	20,50%	0,001
	Entre 30 y 69	43,00%	44,30%	12,70%	
	Entre 70 y 149	42,90%	57,10%	-	
	Entre 150 y 300	55,00%	30,00%	15,00%	
	Más de 300	-	100,00%	-	
Típo institución	Pública	39,70%	49,20%	11,10%	0,433
	Privada	31,00%	53,80%	15,20%	

A higher percentage of severe burnout is evidenced in those with between 5 and 6 hours of sleep. Likewise, a higher level of burnout was found in smokers and in those with no sporting activity. Similarly, severe levels of burnout are found in people with a poor or very poor self-rating in both physical and mental health. Finally, a higher level of burnout is shown in those belonging to private institutions.

A statistically significant association was found between burnout and the variables: sports activity (p=0.001), smoking (p=0.003), self-rated mental health (0.000) and self-rated physical health (0.000).

Some previous studies highlight a particular prevalence among certain types of professionals, specifically those who have direct contact with clients or users (Arayago, González, Limongi, & Guevara, 2016), such as social workers, nurses, doctors, teachers, public servants, among others (Schaufeli & Enzmann, 2020).

The present study conducted among health care workers of public and private institutions (doctors, dentists, psychologists, nurses and nursing assistants) in the city of Guayaquil. The study revealed the absence of burnout in 33.65% of the health professionals, as well as 52.40% of individuals with mild to moderate levels of burnout

(high scores in one or two dimensions evaluated). A total of 66.35% of the respondents presented high values in at least one of the three dimensions of burnout and 13.94% of the health professionals were found to have a severe level of burnout (high scores in all three dimensions).

The indicated results do not differ from those obtained by (Hidalgo, Genaro, & Moro, 2023), who report that 71.2% of the participants present high scores in at least one of the MBI subscales. (Chiriboga & Chiriboga, 2020) evidenced a joint percentage of moderate and severe burnout of 37.5%; similarly (Tacle & Gárate, 2023). The prevalence shown by health personnel in Guayaquil is very similar to that found in nurses by (Woo, Ho, Tang, & Tam, 2020), who determine a combined prevalence of burnout symptoms worldwide of 11.23%; finally (Medina, Medina, Gauna, Molfino, & Merino, 2017) evidence a 4% prevalence in health personnel in Ecuador.

Other studies, however, report lower levels in terms of the prevalence of burnout syndrome, For example (Poveda, et al., 2023) report that in the León Becerra Hospital in Guayaquil there is no evidence of the presence of burnout syndrome; (Ambousi, Chalco, & Endara, 2023) found a prevalence of 3.6% in pediatric and neonatology staff of the General Hospital San Francisco de Quito; (Ramírez, 2017) also reports a prevalence 4.2% among medical and nursing staff.

In the dimensions of burnout, the highest prevalence was obtained in personal accomplishment with high levels in 53.80% of cases, versus 44.70% in emotional exhaustion and 37% in depersonalization. These results show similarity to the findings of (Lauracio & Lauracio, 2020), in which 78.6% of health personnel have low personal fulfillment, likewise (Cerón, 2020) who found the highest prevalence in personal fulfillment in nurses in public and private hospitals in Guayaquil. Also, (Vafaee-Najar, Delshad, Pourhaji, Tabesh, & Pourhaji, 2023)

A statistically significant association was evidenced between burnout and all demographic variables (sex, age group, marital status, religion, educational level, number of children and family income). These results can be compared with (Castillo, Rosas, Cajías, & Escobar, 2019) who found a level of association with the variable sex; (Lugo, 2019) found a relationship with the variable age group; (Vinueza, et al., Burnout syndrome among Ecuadorian medical doctors and nurses during COVID-19 pandemic, 2020) evidenced a statistically significant relationship between burnout levels and the variables sex and age. On the contrary, research was found in which there was no significant relationship between demographic variables and burnout syndrome, for example (Orosco & Romero, 2023), similarly (Cañadas, et al., 2018) do not find significant relationships with demographic variables, but rather with personality factors.

Statistically significant relationships have been determined between burnout and the variables: sports activity, smoking, self-rated mental health and self-rated physical health.

In this regard (Lucero, Noroña, & Vega, 2022) found a strong correlation between the presence of burnout and depression; (Ciprián, Adame, & Juárez, 2023) found a relationship between the syndrome and aspects of quality of life, such as hours of sleep.

CONCLUSIONS

Burnout among health professionals in Guayaquil is a growing concern that requires immediate attention and preventive measures by health institutions and relevant authorities.

It is important to find the relationship between burnout and different demographic and behavioral variables, because contractual processes can be directed towards people whose characteristics make them less prone to the presence of burnout syndrome.

It is crucial to implement intervention programs and self-care strategies aimed specifically at health professionals in Guayaquil to mitigate the effects of burnout and promote their physical and emotional well-being.

Addressing burnout not only benefits individual health professionals, but also has a positive impact on the quality of health care provided to the community in Guayaquil, promoting a healthier and more satisfying work environment for all involved.

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