Burnout as a clinical entity — its importance in health care workers

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Burnout, viewed as the exhaustion of physical or emotional strength as a result of prolonged stress or frustration, was added to the mental health lexicon in the 1970s, and has been detected in a wide variety of health care providers. A study of 600 American workers indicated that burnout resulted in lowered production, and increases in absenteeism, health care costs, and personnel turnover. Many employees are vulnerable, particularly as the American job scene changes through industrial downsizing, corporate buyouts and mergers, and lengthened work time. Burnout produces both physical and behavioural changes, in some instances leading to chemical abuse. The health professionals at risk include physicians, nurses, social workers, dentists, care providers in oncology and AIDS-patient care personnel, emergency service staff members, mental health workers, and speech and language pathologists, among others. Early identification of this emotional slippage is needed to prevent the depersonalization of the provider–patient relationship. Prevention and treatment are essentially parallel efforts, including greater job control by the individual worker, group meetings, better up-and-down communication, more recognition of individual worth, job redesign, flexible work hours, full orientation to job requirements, available employee assistance programmes, and adjuvant activity. Burnout is a health care professional's occupational disease which must be recognized early and treated.

Key words: Burnout; health care workers; health professionals; stress; stress management.

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INTRODUCTION

It was only 20-odd years ago that a behavioural entity was added to the medical lexicon — 'Burnout', as a clinical complex, was given recognition in the psycho-social literature. The term was originally applied around 1940 to the cessation of operation of a jet or rocket engine. The designation was adapted to humans in the mid-1970s by Freudenberger,[1,2] replacing in part such loosely-applied terms as 'depression' and 'nervous breakdown'.

While occupational medicine (OM) is concerned primarily with the prevention of work-related disease in the physical sense, no illness can present without emotional concomitants. Observers and planners in human services, particularly at the federal level, have given emphasis in their health promotional efforts to psychological disorders. In a 1985 conference sponsored by the National Institute for Occupational Safety

and Health (NIOSH) and the Association of Schools of Public Health (ASPH), strategies for 10 leading work-related diseases and injuries were developed and published in 1988, including a *Proposed National Strategy for the Prevention of Psychological Disorders.* Included among 'Disorders of Current Interest' were affective disturbances such as anxiety, depression, and *job dissatisfaction* [emphasis added]. A recommendation was made to integrate mental health services into the overall occupational health (OH) care programme, whether on-site or external to the organization.[3]

With century's end as a road mark for improvement in all human endeavours, the Public Health Service aligned the thoughts of some 10,000 knowledgeable individuals in an agenda for the year 2000. In the document produced, mental health was considered as referring 'to an individual's ability to negotiate the daily challenges and social interactions of life, without experiencing undue emotional or behavioural incapacity'.[4] The stated objective in this area was to reduce the adverse effects of stress to less than 35% of people, an 18% decrease. Specifically stated was the need for

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employers to give more attention to services related to managing employee stress.[4] As burnout is the end point of stress in certain work settings, its nature, development, and prevention should be clarified.

DEFINITIONS

Attempts have been made to define the term that moved from rocketry to psychiatry. A contemporary dictionary views burnout as 'exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration'.[5] Some have written that staff burnout among professionals and parapro-fessionals in the human services is much easier to observe and to describe than it is to define — 'it is many things and many people . . . '[6] During the same period, a decade-and-a-half ago, strict defining of the term was skirted — 'What do we mean by the term, "burnout"? The current popularity of the concept is a major barrier to defining it, for it has become an appealing label for many different phenomena. It has come to mean different things to different people. Until this confusion over definitions is dispelled, little progress can be made in identifying causes and cures'.[7] In another observation, the writer indicates that the term is used so frequently that much of its original meaning has been lost. As employed early on, 'burnout' meant a mild degree of stress-induced unhappiness. Ultimately, though, the term was used to describe many distressing situations, coursing from fatigue to an epi-sode of major depression. As used by that particular author, burnout is equated with adjustment disorder with depressed mood.[8]

In essence, burnout is either physical or emotional exhaustion, usually caused by stress at work, the affected workers being found most frequently among human services professionals. As a further result of occupational stress — initially described in the 1950s by Hans Selye as 'the nonspecific response of the body to any demand made upon it'[9] — is discouragement in the work setting. It is viewed also as a complex of psychological responses (strain) to the particular stress of constant interaction with people who are in need. Differing from other interactional symptoms related to job stress is the effect on others seen as a depersonalization of clients.

Some further defining is in order, for burnout may be used erroneously when stress is implied. A stressor is the stimulus that causes stress, and the latter is the bodily or mental tension resulting from factors that tend to alter an existing equilibrium or, in other phrasing, the sum of the biological reactions to any adverse stimulus, physical, emotional or mental, inter-nal or external, that tends to disturb the organism's homeostasis.

Significant study of burnout

The most relevant survey conducted in recent years was that undertaken by Northwestern National Life of Minneapolis.[10] Telephone interviews were held with 600 American workers. It was the experience of the respondents that they were highly stressed, had mani-fested burnout, and had noted an increase in physical ailments. It was the experience of the employers that there was a decrease in productivity, a rise in absen-teeism, higher health care costs because of stress, and a greater personnel turnover. In the findings among 600 workers nation-wide, it was learned that one-third thought seriously in 1990 about quitting work because of stress; one-third expected to burn out in the near future; 14% quit employment or changed jobs in the past two years because of job stress; stress levels were extremely or very high for nearly one-half of the interviewees and one-third reported job stress as the greatest stress in their lives.[10]

Significant burnout occurred when employee benefits were cut; when corporate ownership changed; when frequent overtime was required; or when the work force was reduced'.[10] That these aetiologic factors have increased in years subsequent to the survey is given testimony in the continuing mergers or takeovers of large organizations, the downsizing of corporations, the move from permanent employees to part-time workers *sans* benefits, the increased work level follow-ing company shrinkage, and in the endless bankruptcies reported each month.

Interestingly, 82% of the respondents in the North-western survey believed that those persons manifesting burnout deserved disability pay. When those employees file claims for stress-related disorders under the workers' compensation authority, the employer or insurer sets aside reserves of $73,270, 36 times the average cost of rehabilitation of $1,925. It was found that companies had half the burnout rate if supportive work and family policies were in place; if their health insurance provided coverage for mental illness and chemical dependency treatment; if effective commu-nication was practised throughout the organization; and if flexible work hours were allowed.[10]

Symptoms or components of burnout

Employees are vulnerable if they have little say about how to do a job, every specific of work execution being dictated or laid-out in lengthy job descriptions. Only recently has employee input been seen in some organizations through the mechanism of 'quality circles'. Burnout can be expected if the employee is never caught up with work demands.

The vulnerability is there if a worker frequently is ill or would like to quit the job but fears doing so, or if there are major changes in a workplace. If there is acquisition of the company, as indicated earlier, even high-level managers can be affected by the increased stress, for no executive knows which managers will be retained following a merger. A marked contributor to increased job stress is a crucial departmental reorgani-zation or change.

Feelings

When people are saying that they are burning out, they are indicating that work has lost its meaning for them, that they feel disillusioned, or that they are being 'stretched too thin'. They are beginning to believe that their investment may not be making a 'difference' in their approach to lifelong goals.

Other feelings of burnout are expressed as being 'run down', or affected individuals find that they make more mistakes and that they cannot concentrate.

Physical manifestations

In the survey cited earlier,[10] there were many respondents reporting 'often' the presence, or experience, of having physical stress-related illnesses. Exhaustion was noted by 62%, 62% were angry; and muscle pain was expressed by 60%. Headache was indicated by 45%, and insomnia by the same percentage. Respiratory illnesses had been mentioned by 40% and gastrointestinal disorders by 38%. Some 33% described depression, and hypertension had been recorded in 9%. Without hypertension — which was not felt, but objectively measured — nearly one-half had physical responses as part of the burnout pattern. Directly connecting ambulatory blood pressure (Am BP) and 'job strain' is a study by Schnall and associates[11,12] in which their definition of 'job strain' implies high psychological demands and low decision latitude on the job. They found that job strain had significant effects on Am BP at home and during sleep as well as on left ventricular mass index. They believe that the large body of previous research that suggests that job strain is a risk factor for the development of coronary heart disease may now be partially explained as the consequence of elevation of blood pressure and structural changes in the heart. The blood pressure recorded during working hours was highest among healthy working men. The research group indicated that women and large numbers of minority workers need to be studied as well.

Occupations at risk

Certain occupations are at a distinct risk for the development of burnout — those individuals who work with the public or special populations such as those persons with disabilities, the severely ill, children, prisoners, or the impoverished. Similarly, work involving extreme responsibility, such as hazardous work, precision work, work that may involve severe consequences, shift work, or work in which the entailed responsibilities are not liked, may be productive of burnout.

Specific occupations at risk

As connoted by the title, certain specific occupations are at risk for the evolution of burnout, particularly those positions in the human services, especially in health care. Many of these careers have been studied and while a few are not involved in the provision of care, they do concern a close working relationship with one or more human beings.

Physicians

In these days of faltering systems of medical care that are being subjected to a multiplicity of new designs, physicians are finding their chosen occupations being attacked from many fronts, causing the practitioners to question their choice of careers. That criticism of physicians is not new is illustrated by Smith[13] in his review of the aspersions cast upon such great healers as Avicenna and Chaucer's Doctour of Physik, and in the writings of Smollet, Hawthorne, Trollope, Eliot, and Proust, among others. Smith cites John of Salisbury, a contemporary of Chaucer's who states, in part, that '[Physicians] have only two maxims which they never violate: Never mind the poor; never refuse money from the rich'.[13] Closer to home are the fellow practitioners of Bernadino Ramazzini, one of whom '[C]irculated in manuscript an attack on Ramazzini's attitude to the case and to himself. This censura (criticism), with his own response, was published by Ramazzini'.[14]

Medicine attracts idealists who want to help others, but as professional demands increasingly impose on their available time and energy, more is crowded into the limited work day. The support which has been granted physicians in the past is not at hand in modern America, for many of the practitioners are far from their families and hometowns, a great number settling in the area of their education and training. Their interactions are with patients who are in pain, sick, or frightened.

Rarely is a thank-you proffered from a patient, practice is competitive, and the emphasis is on achievement, and the threat of a malpractice suit, often suggested by a too-eager attorney, constantly hovers over the physician, particularly one whose speciality is surgery or obstetrics. Premiums for such protective insurance are extraordinarily high. After a suit, be it won or lost, the defendant is depressed, frustrated, less satisfied with the practice, and subsequently many consider early retirement.

A group of physicians in a rural southern state were studied regarding the psychologic sequelae of malpractice litigation.[15] Factor analysis showed clusters of symptoms, including psychologic trauma, job strain, shame/doubt and active coping. Stress decreased with time, not returning to baseline until two years with winning a case and with increased age. Multiple suits or pending cases heightened the stress. Female physicians in a high-risk speciality experienced greater job strain and active coping, irrespective of the litigation outcome. Further light is shed by a review of obstetricians' malpractice experience.[16] In that study it was found that physicians who have been sued frequently

are more often the object of complaints about the interpersonal care they provide, even by their patients who do not sue.

Threats of suits lead to changes in practice, including more accurate records, a greater number of tests, a negative attitude toward patients, and a defensive mode of practice which tends to narrow the physician–patient relationship.

There is great pressure on physicians, particularly in light of today's pace in technologic developments, to 'keep up'. This effort has to be balanced against family life.

Further, there is genuine fatigue as a by-product of a busy practice; most practitioners share 'on-call' duty — which means contact with patients whose progress or treatment plan is unknown; work loads are heavy; there is a daily dealing with life and death situations; decisions concerning the maintenance of impaired living vs. 'do-not-resuscitate' orders are difficult to make; and, lastly, there are the constant interruptions at the office, the hospital, and the home.

The opinion of today's healers is in descendancy. A letter from a reader, cited in a lay magazine, reads as follows: 'The medical profession in America has become a new aristocracy that, like its predecessors in Europe, has arranged a transfer of wealth from the poor and middle class to its bulging coffers. We must put a cap on the greed and power of this burgeoning "First Estate".'[17] Alternative healing — frequently termed complementary medicine — has increased in both practice and publicity. In a city of 56,000 persons, there were 500 full-time and 1,500 part-time alternative practitioners, a ratio of one per 27 residents, in comparison with physicians at a ratio of one MD per 200 citizens.[18]

An Idaho physician worded the fall in this manner: 'Physicians are denigrated with the same zeal that our predecessors were apotheosized. Amid this cacophony, it becomes ever more difficult to attend to our societal and personal sworn duty of caring for the ill and tending to the infirm. The routine intrusion of the non-physician on our educated decisions and the implications of dishonesty regarding our provision of care by the bureaucracy erodes our professional confidence and effaces the ancient numinosity [spirituality] of the physician–patient relationship'.[19] The letter ends pessimistically with, 'The decline of the professional class precedes the decay of the culture'.

Physicians continue to bemoan the changes taking place in their positions in the professional hierarchy. One practitioner in family practice cites the disparity in income between specialists and generalists: '[A]s a family physician I am near the bottom of the medical caste system. What manner of dizzying mental gymnastics must be required to justify the incomes of those perched on the Olympian heights of our profession?'[20] Another points to the professional desperation of today's physicians when he writes, 'Medical care today is a battleground. Physicians are caught in the middle,

presumed by all sides to be the enemy. We have become targets of all who would criticize, victims of needing to follow a course through a mine field of risks. We constantly dodge assaults. We bleed from many wounds of constant skirmishes with insurance companies. We cower in the trenches, stirring to fight disease, but struggling more to stay alive in the battle zone. How can we be asked for compassion, sympathy, empathy?'[21]

While physicians may still hold authority positions in medical schools, in the wider society and within the non-medical school portion of the health sector, they occupy a smaller proportion of positions of authority.[22] Finally, the words of the recent president of the American Medical Association, Dr Lonnie Bristow, echo the same refrain: 'Sure, physicians are frustrated, confused, even angry about the reform movement. One reason for their edgy mood is the implication by reformers that doctors are somehow dishonourable, or, at the very least, profligate and wasteful. And they are receiving no credit for the good results they produce. . . . They feel misunderstood, and you know how physicians hate to have to deal with all the bureaucratic details — getting on the phone and asking permission from a "coordinator" to provide the care they know the patient needs'.[23]

Despite a positive answer to a study entitled, 'Is Being a Doctor Still Fun?',[24] the dissatisfaction felt by some physicians — a precursor of burnout — was given headlines in the lay press when the author indicated that 'I am tired, physically and emotionally. I wonder about moving and changing professions. Maybe I could find a job where people would respect me and appreciate what I do for them . . .',[25] and in another column, the headline reads, 'Specialist physicians fleeing county — Anger over health care's new order'.[26] A recent advertisement by a countrywide executive search firm in the *JAMA* was headed, 'Physicians Get Sick and Tired', in which the company offered to relocate physicians who were 'unhappy with their practice situation'.[27]

Most telling of the road to burnout is the expressed opinion of 30–50% of physicians that they would not go to medical school if they were to begin a career anew[28] and that they would encourage their offspring to follow other occupational ladders.[29] Many have retired, finding that, '[T]here is life after medicine!',[30] one leaving medicine because of '[T]he devastation of a noble profession into a meretricious business'.[31]

With these many views, there may continue to be an increase in burnout among successful practitioners, until the new model of health care delivery is finalized. That there has been concern is given a base in two conferences held in California in 1993 and 1994 entitled, 'Physician Heal Thyself'. The programmes included such topics as 'Physician Burn Out', 'How to Live Between Office Visits', 'Is There Life After Medical School?', 'Physicians and Their Families: Balancing Commitments to Family and Profession', and 'Pathways to Self Discovery and Renewal'.

Nurses

Nurses, in a manner similar to physicians, undergo repetitive and continuing exposure to the ill, the dying, and death. Whereas physicians' contacts are intermittent and shorter in duration, nurses are in attendance of their assigned patients throughout eight-hour and, frequently, twelve-hour shifts. There has always been work overload in this profession and, in many hospitals in isolated areas, overloading has increased in the form of double shifts. The popularity of extended shift hours has been increasing despite indications that most 12-hour nurses report fatigue.[32]

Patients can be demanding and often communication with caring nurses is dulled or negligible because of overriding medication, precluding any feeling of gratification derivable from an ailing person. If the clinical disorder is not amenable to therapy — metastatic carcinoma, acquired immunodeficiency syndrome (AIDS), as examples — there may be a perception of personal failure and a sense of futility for the nurse has not been able to eradicate the disease process. With the frequent calling in of nurses from centralized registers, the registered nurses (RN) or licensed vocational nurses (LVN) may find themselves working with different teams from day to day following transfer from one hospital service to another or one hospital to another, where communication with the newcomer may break down in the harried provision of care, or where they may be no support of the newly-come professional.

Further, there are area hazards in nursing care. Back problems have been reported by many writers[33-35] and the mixing and administration of antineoplastic drugs carry the potential of mutagenesis, teratogenesis, and carcinogenesis in the handlers, and give other evidence of embryo-foetal toxicity.[36]

Nurses have been subject to violence while on duty. From 1987 to 1989 in Ontario, Canada, some 100 workers' compensation claims among nurses were allowed, the annual rates higher among males at 13.9 per 1,000 than among females at 1.4 per 1,000.[37] Student nurses, likewise, have been subject to attack, the severity of the assault being greater in the general hospital than in the psychiatric facility.[38] Because of the escalating problem in health care settings, the State of California published safety guidelines particularized for health care and community service workers.[39] There is a constant fear of error in the giving of medications, and always there is the pressure of time in trying to fit the care of many patients into the work shift. Numerous are the times when nurses from succeeding shifts overlap in their completion of records, updating of the oncoming team, and the like. Many believe that there is a lack of respect from the public which may have entered into the replacement of traditional uniforms by street clothing.

Nurses, like physicians, have experienced feelings of disillusionment with the health care system and the metamorphoses it is currently undergoing, with the final template as yet-to-be designed. All health professionals are feeling the demands for cost-containment and fear the absenting of appropriate patient care as the bottom line is being given greater emphasis by the care conglomerates that have emerged. Also, there has been dislike of the traditional domination of physicians in the health care system, the nurses constantly striving to move from 'helper' to independent provider as seen in the creation of nurse practitioners and administrators, and the delegation of the once exclusive tasks of nurses to LVNs and nurses' aides. Patients hospitalized today rarely see RNs except during their hurried checking of room occupants at shift's end.

Maslach, who has written early on burnout and its measurement through the use of the Maslach Burnout Inventory[40] has epitomized unmediated job stress as emotional exhaustion, depersonalization, and reduced personal accomplishment, all applicable to the nurse in this discussion. She has written:

Perhaps the most visible impact of burnout is the change in people's work performance. Motivation is down, frustration is up, and an unsympathetic, don't-give-a-damn attitude predominates. They don't take care in making their judgements, and they don't care as much about the outcome. They 'go by the book' and are stale rather than fresh. They give the bare minimum rather than giving their all, and sometimes give nothing at all. As one long time schoolteacher said, 'My motto is, "The more they ask, the less I do".' (C. Maslach, cited in Crawford[41]).

Probably a most devastating statement relating to some of the effect of burnout is the fact that workers in American health care services are twice as likely to commit suicide as controls, a possible result of their close involvement with disease and death.[42]

The modes of prevention and reversal of burnout will be discussed later.

Social workers

Burnout, as manifested among social workers, has been seen in their move from official agencies to private practice. It might be that these practitioners prefer to work with different patrons, the so-called YAVIS clients (young, attractive, verbal, intelligent, and successful).[43] Workers in hospital settings had the greatest level of stress-related symptoms, and child welfare workers were reported as having a significantly more stressful work environment with associated symptoms than colleagues in community mental health or family service agencies. Private practitioners had fewer such symptoms than workers in mental health or counselling settings, with fewer feelings of psychological distress, fewer somatic complaints, greater levels of personal accomplishment, and greater life satisfaction. The differences in strain level were not explained by differences in year of receipt of the Master of Social Work degree (MSW), age, gender, income, or marital status. The clients in private practice were more middle

class, presenting problems more characteristic of the so-called worried well, and were less likely to be poor, unemployed, old, and uneducated.[43] Bureaucratization, controls introduced by funding sources, and limits on autonomy have become characteristic of the social services workplace. Social workers, rather than believing themselves members of a status profession, have undergone a proletarianization process and have turned to unions. In one study, 31% of respondents were union affiliates.[44] The pressure is often on social workers to accomplish more with less, and to 'process' the maximum number of people in the shortest possible time.[45] These professionals, in settings where the constraints and limitations are oppressive, where resources are limited, and where there is a sharp curtailment of autonomy, 'do not have an opportunity to be effective, to be a cause, to make things happen'.[45]

Many of the services provided through social casework are not reimbursable, and an agency might be functioning under multiple sponsorship, support coming from federal, state, or local governments, or insurance underwriters or investors. As determined by current legislation, financial benefaction can vary with the political tenor of the day.

Social workers like other health care providers, can experience the same signs of burnout: A broad range of physical symptoms, a lowering of self-esteem, withdrawal from both occupational and extracurricular activities, and some tendency to blame clients for their personal problems. In addition, they have been subjected to acts of violence similar to those perpetrated against other care givers.[46]

Most significant in the behavioural change in social workers is the depersonalization of clients, the deprivation of their clients' sense of personal identity. Social work has been defined as any of various professional activities or methods concretely concerned with the provision of social services, particularly involved with the investigation, treatment, and material aid of the economically underprivileged and socially maladjusted.[47] Social workers just out of graduate school are enthusiastic and anticipate their role as mental health professionals. When the reality of their work situation becomes clear, they find that caseloads are great and that the demands and goals of the institution employing them are not in parallel with their perceived objectives. For example, discharge planning in a hospital usually precludes the kind of counsel needed by the patient and the family, and is carried out in keeping with a hurried timetable. The directions given at the time of departure are rote regarding diet and appointments and, as noted by Weiner,[48] 'The social worker may feel helpless and unappreciated by [the] patient for the efforts exerted in trying to help the patient and may begin to question his or her own competence and reason for being in the field'. Disillusionment sets in, and distances the social worker further from the ideals given in the lexical description, and burnout is not far off, with callousness or even hostility entering into the depersonalized relationship.[49]

Dentists

Dentists, also, have experienced stress and burnout in a somewhat different milieu. Whereas patients develop affection for most therapists, many fear and dislike dental practitioners, the fear often dating to early contacts in childhood.

Dental anxiety centred on the equipment (drills, needles), a distrust of dentists and dental assistants, worries about embarrassing reactions during treatment (fainting, throwing up), and an overall, generalized anxiety prevail. As much of the oral work accomplished is neither seen nor appreciated by onlookers, there is no one able to praise the care given, unless a positive comment is made by a new dentist reviewing the work of a previous practitioner. These care providers have as great a need for approval, appreciation, and respect as do others in human services. Does one ever hear a patient exclaim, 'Boy, that was a great filling!'?

The work is difficult and is conducted in an uncomfortable position at chairside. Freese[51] has observed that dentistry is certainly one of the most stressful of all occupations. If a complex prothesis turns out all wrong, the dentist is informed immediately by the wearer.

A study conducted in Finland[52] queried 232 dentists under age 62. Most dentists, of both genders, worked in group practice and 88% employed an assistant. Professional problems were generally solved through consultation with colleagues. Half of the respondents indicated satisfaction in their relationship to other dental staff, but all but 9% of dentists experienced problems in their physical working environments and 22% felt that their uncomfortable working posture interfered significantly with job satisfaction. Women reported chronic work-related conditions, physician-diagnosed, more often than men, and at the time of the study most dentists were experiencing pain in connection with work on patients, and 41% of women and 59% of men were undergoing occupational stress. Most encountered at least temporary psychological fatigue as a result of their work and almost half were exhausted at the end of each day. The three aspects of burnout that emerged were psychological fatigue, loss of enjoyment of work, and hardening. One-third experienced the last, and 'ceased to care greatly what happened to some of their patients'. Unsatisfactory relationships with patients, problems involving the physical environment, and poor working posture significantly increased burnout. It was concluded that burnout can be regarded as posing a significant threat to good dental care.

Investigators in South Africa pursued the issue of stress in dentists via questionnaires.[53] In their review, several sources of stress were identified: Problems of patients' compliance; interpersonal relations; economic pressures; working conditions; business management; pressure to earn more money; and idealism and perfectionism. The sources were wide, stemming largely from the mode of practice, and appeared to include subjective perceptions as well as objective conditions.

Significant in the findings were the role of the dentist in society and the need to be useful in the community; primary in the prediction of stress was the quality of working life. The authors concluded that, 'The results suggest[ed] that the communality of work characteristics [led] to significant stress patterns among dentists which need to be considered in [the] future if dentistry is to maintain its prestige as a profession.'[53]

Certain work hazards have been noted in dental offices. Dental hygienists have experienced musculoskeletal problems in general, and carpal tunnel syndrome in particular. Attention should be directed to work station design, posture, treating patients with heavy calculus, and the scheduling of rest periods.[54] Numerous hazards were found in an OSHA survey of a dental office wherein it was noted that there was a lack of compliance with the hazard communication standard, OSHA's current requirements for preventing occupational exposure to the hepatitis B virus (HBV) and the human immune deficiency virus (HIV).[55] Further, it is currently believed that there is an airborne route for HBV infections reported for dental professionals, as seen when powered instruments are applied to whole-blood in a typodont field of operations. The passage of 15–83% of aerosolized plasma particles, through nine different makes of surgical masks used for infection control, offers a mechanism for part of the reported failure of universal-precautions masks to protect oral surgeons against occupationally caused HBV infection. The use of engineering controls can prevent the spread of bacterial aerosols throughout the dental suite.[56] The requirements of the Federal OSHA's standard for occupational Exposure to Bloodborne Pathogens (6 December 1991) and information for dental health care employers and employees concerning the risks of occupational exposure to bloodborne pathogens and the reduction of these risks have been published.[57] These concerns and the perceived opportunity to conduct office intervention against the use of smokeless tobacco[58] add to further predictors of burnout in this profession.

Health care providers in oncology

Among the difficult work areas in health care is that of oncology, where despite maximal therapy, patients keep on dying. For the idealistic professional such a situation allows little in the area of gratification. The patients are depressed, knowing the diagnosis and prognosis, and they are not in any emotional state to be considerate, responsive, or grateful for the care received. The providers, particularly nurses who are in fairly constant contact with cancer patients, give much of themselves, but because of the patient's dismal outlook on the future, get little in return. For the health care professionals who want to see their patients get better, the milieu is laden with despondency, and when metastatic disease is noted, it becomes extraordinarily difficult to maintain a sense of hope. Particular difficulty is seen among medical and nursing specialists who are providing care to children with malignant disease. Even the most optimistic provider soon experiences burnout.

Health care providers and patients with AIDS

Possibly the most difficult professional challenge to care givers is in those situations where patients with AIDS, or those who are seropositive, are receiving daily attention. Much has been written about sustained care among these patients since the AIDS epidemic struck in the beginning of the 1980s. Maj[59] reviewed the literature and found that there was a wide range of emotional reactions, ranging from rejection and refusal to provide care, to immersion in the infected person's needs and burnout. There has been fear of contagion, avoidance of infected patients or distancing, unprofessional removal of patients from lists of dentists or general practitioners, and identification to the point of believing that they, the providers, believe themselves to be affected by the disease. Nurses have resigned from positions with contact, and pathologists have refused to process specimens from infected persons.[59] Non-medical support staff have refused to enter AIDS patients' rooms, and some in attendance have used excessive and inappropriate isolation measures. In the case of some nurses, their mates have questioned intimacy and possible transmission of infection. Further, friends of some of the nurses have stopped calling because of unbiased fears. The stress related to AIDS is increased by homophobic attitudes.[59]

The telling reality that affects an attending staff is ·the death of young persons — frequently extremely talented in the arts — despite continuous, intensive care. Futility was deeply sensed by all of the care personnel as well as frustration. Many were fatigued, some somatized their anxiety, and many withdrew. The pattern of burnout was similar to staff members caring for cancer patients on paediatrics services or persons with extensive burns.[59,60]

One other element may enter into the AIDS patient-nurse relationship. Because of the iatrogenic nature of HIV infection among persons with haemophilia, many staff members feel guilty, even though they acted in good faith at the time of administration of contaminated blood products.[61] Because of the co-morbidity of tuberculosis and AIDS, concerns are added to those felt by nurse professionals who now must work with public health officials, in addition to the many other specialists included in the AIDS treatment teams.[62]

Emergency service personnel

Whether the workers in emergency services are physicians, paramedics, emergency medical technicians (EMT), or specially trained firefighters, they are subject to being called to physical catastrophes presenting emotionally taught, high-risk situations. All are expected to be able to respond quickly and appropriately in life-and-death circumstances.[62]

The stress encountered among emergency service personnel has been documented. In one study, it was shown that job stress manifested itself as work dissatisfaction, organizational stress, and negative patient attitudes. The absence of fatigue, sickness, and other psychophysiologic markers of stress might mislead supervisors into believing paramedics are not stressed. In this population, stress was seen in what the individual said about the organization, co-workers, and patients.[64]

In an effort to understand the dynamics underlying a high turnover rate, over 100 EMT union members were studied. The samples had high stress, strain, and burnout scores, but normal coping skills. These various elements were related significantly to job satisfaction, worry about infectious diseases, and perceptions of being poorly treated by emergency room personnel and firefighters. In addition these responses were related to being upset by 'runs' related to injuries from violence, drug overdoses, and exposure.[65]

To counteract the effects of dealing with stressful situations, emergency personnel resort to humour with its 'often sick and morbid content'.[63] There is a humour subculture and trainees in emergency services become involved in it through the process of socialization, acquiring the use of humour informally from their more experienced associates. Sharing this humour with family or friends was not possible, for it would not be understood and would be considered highly inappropriate. Experienced paramedics identified the humour that was used to cope with stress as unique, spontaneously produced, and experiential, and its effects included increased objectivity, improved perspective, and higher morale.[63] Of particular worth was its use to combat emotional depletion brought on by the demoralizing and dehumanizing events to which the workers were witness. In essence, its use was an outlet for the bombardment of the illness, trauma, death, and social maladies that were encountered almost daily.

A group of firefighters and paramedics was studied[66] and the signs and symptoms of burnout were listed as follows: Physical and emotional fatigue, apathy, and feelings of hopelessness, helplessness, guilt, inadequacy, failure, incompetence, cynicism, disillusionment, suspicion, resignation, and indifference. Despite these negative feelings, such personnel do undertake extremely hazardous tasks, many of which are heroic and noted by public awards.

Mental health workers

Many of the elements of burnout have been reported among mental health professionals, who seem particularly vulnerable to severe emotional exhaustion and psychological tension.[67] Among 234 state psychiatry facility professionals, the primary coping strategy of escape/avoidance related to three symptoms of burnout — emotional exhaustion, depersonalization, and lack of personal accomplishment.[68] Employing the Holmes and Rahe method of scaling stress,[69] a study of

psychiatrists at a large public mental hospital showed that most of the events rated as highly stressful fell into the category of administrative and organizational shortcomings.[70]

Fully agreeing that nursing is a stressful occupation, Sullivan[71] studied the specialized area of nursing practice that involves daily dealing with the psychological distress and suffering of the mentally disordered. He steers away from the profession's belief that stress is an individual problem, claiming that both the individual and the organization must accept some responsibility regarding the control and management of stress. chiding executives for their style of management, he asks that the difficulties of nursing be recognized, the climate be geared to minimizing individual stress, and individual performance be maximized. To be fully effective, he concludes, the providers of care must be valued.

More recently, concern has been expressed regarding violence against the staff in psychiatric hospitals. In an effort to minimize assaultive behaviour on the part of patients, an attempt was made to identify the antecedent events leading to violence. Three broad classifications could categorize the preceding circumstances: agitated or disturbed patient; clinical and legal restrictions (hospital regime); and provocation by other patients, relatives, or visitors. Some eight per cent of the patients contributed to over 40% of reported incidents.[72] A complete volume has been devoted to aggressive behaviour in psychiatric patients.[73]

In an assault-based study in a large Australian psychiatric hospital, it was learned that student nurses were assaulted most frequently.[74] The other side of the coin was seen in sexual abuse of patients by psychiatric hospital staff members.[75] The incidents alleged included voyeurism, harassment, fondling, and rape. These negative environments are mentioned because they add to the factors present in work practice that lead to professional burnout. Not only can one's emotional store be drained, but depersonalization can be a logical end result where one must be on guard not only against the repetitive emotional insults of the work itself but against perpetrators of physical harm. To remain professionally astute and caring, and still offer quality care with such a volatile population, requires the maximum in understanding, tolerance and academic and practical preparation.

Speech–language pathologists

While not in exactly the same clinical settings as most of the specialists cited, emotional fatigue can affect speech–language pathologists (SLP). Such professionals have experienced the same tension, stress and negative attitudes others have encountered in the workplace.[76] Caseloads are large at 52 clients (range of 5–152), and 25% of SLPs report programme budgets under $100. The factors that lead to burnout include (a) bureaucratic restrictions (limit growth and effectiveness; little emotional and intellectual stimulation

on the job); (b) emotional-fatigue manifestations (procrastination, call in sick, think of other things during conversations); (c) time and workload management (little time for preparation and personal priorities, over-commitment, excessive paperwork); (d) instructional limitations (students poorly motivated, do not improve and present discipline problems; inflexible scheduling); (e) biobehavioural manifestations (respiratory, cardiac, and gastrointestinal problems; use of drugs and alcohol) and (f) lack of professional supports (lack of recognition, alienated from school staff, misunderstood by public, lack of consultation opportunities).

Other professionals

Burnout has been experienced by health care workers in other speciality areas. Nurses employed in relatively small nursing homes, where there is a high probability of the residents' deaths, are under stress.[77] Job stress has been described, as has burnout, among rehabilitation practitioners,[78-80] and also among nurses in critical care.[81] Workers in the neonatal intensive care unit have experienced burnout,[82] for 15–20% of admitted infants die, and nurses in a sense become surrogate parents, taking care of high-risk babies from high-risk families. Occupational therapists have had comparable brushes with burnout.[83]

Identification

In the analysis of any troubling situation, it is important that the problem be identified, and as early as possible, to facilitate its ultimate resolution. Familiarity with the signs and symptoms of burnout among health care workers should be one of the lead bodies of knowledge among supervisors. Group directors should be able to detect the effects of stress not only through observation of work performance but through the accumulation of information gathered from other workers and from patients, many of whom are highly verbal in their reaction to impaired handling.

A worker's behaviour can change markedly when under continued pressure, and these changes must carry meaning to the supervisor. Not all signs are verbal signals., for much of the evidence of burnout in professionals is to be seen in the quality of care provided and, if possible, in a review of therapeutic outcomes. Hardening toward clients or patients must be identified not only to effect a reversal of behaviour but for the ultimate good of the organization.

Employees' records should be reviewed periodically to determine any excessive absenteeism, tardiness, or inordinate use of sick leave, or other evidence of a wish to leave the job, as seen also in unnecessary wandering from the customary work station. An unwillingness to work with a staff member who is undergoing burnout may be expressed by fellow employees in whom dedication to the mission is still paramount. While such feelings may not emerge through direct verbalization, tendencies toward non-

co-operation can be detected by a sensitive supervisor. While a manager is usually inclined to defend a staff person when attention is directed to a work error, patients or clients should be heard to the fullest if a complaint has been raised. Not all recipients of care are to be dismissed as unknowing of, or insensitive to, inadequate treatment or harried inattention. Every grievance must be given a hearing, for behind some of the dissatisfaction felt may be a worker in the process of undergoing emotional loss or behavioural flattening, and no longer able to provide effective care.

Prevention and treatment

It is difficult to distinguish readily between measures preventive of burnout and efforts taken to treat the disorder. If preventive measures are in place, burnout will not occur; if the behavioural disorder is already in place, the same preventive moves may be used therapeutically.

Group or staff discussion meetings are essential to increase communication among members of a work unit, be it a small group or a division. The unit chief should serve as chair, discussion leader, or facilitator, but he or she must be able to allow free interchange of ideas and be tolerant of expressed negative feelings concerning his or her style of management.

In a similar vein, the initiation of critical incident stress debriefing (CISD) in law enforcement, essentially a discussion allowing the free flow of feelings after a traumatic event — a chase, a shooting, a death — will allow a return to work without the accompaniment of lingering reactions of guilt, inadequacy or inefficiency. The debriefing after negative outcomes permits the communication needed for resumption of duties after an extremely stressful experience. These staff meetings must be characterized by an air permissive of the expression of ideas, complaints, suggestions or questions, without the fear of retribution, punishment, delayed promotion, or any negative action by the supervisor. Also, the meetings should be held expressly for exchange and not merely for the supervisor to announce predetermined decisions concerning significant issues. Further, if ideas are offered that could prove remedial of current problems, action should be taken by the immediate manager, so that participants in these sessions will know there is follow-up to proffered points of view.

Apart from maximizing communication through group sessions, feelings of managers can be extended to workers so that they become cognisant of the value or worth of what they are doing.

Probably of greatest importance in the prevention of burnout among valued professionals is the increased control of individual jobs, or the granting of greater autonomy in what one does daily. As expressed by writers cited earlier,[67] one must 'redesign jobs to enrich the work and to rejuvenate [the] staff'. Efforts in this area have been seen in the creation of work circles where employees have a greater saying how their jobs

are to be performed. The worth lies in there being teams rather than groups; the workplace team may not be recognized formally, and its members may change from week to week, but if the group is organized to achieve a common goal, then it is a team[84] and the team can reconfigure jobs, for its members are those persons closest to, and most knowledgeable of the work practice components. The increased control of a job by its incumbent adds purpose to the conduct of the job and new value is seen in what had previously been a ritualistic execution of functions.

Jobs can be redesigned, even in health care, so that new duties may be assigned, functions may be rotated, and responsibilities increased or diminished, thus freshening the daily set of tasks.

While recognition is accorded work teams, individuals can receive approbation in a more subtle way and be given the realization that their participation in the organization is of special meaning. Visitors to health care facilities — who are members of the medical community from this country or abroad — usually wish to see an installation and the manager of the unit being visited ordinarily serves as the guide. Most often the various activities are pointed out and the functions are explained. More to the point of worker significance is the manager who, when a section is reached, will introduce the supervisor, say, of a clinical laboratory, and then will ask, 'Miss Smith, would you please tell Dr Jones what your group does?' rather than relating the unit's function with the supervisor standing there as though he or she were a person of no importance in the overall therapeutic thrust.

A counter measure to burnout in areas where such a change would be feasible is the introduction of flexible work hours, particularly in our contemporary society where so many women lead double careers and there is need for time available to family members who are on immutable work or school schedules. With the increase of telecommuters, some work days may be spent at home, but such a change would be applicable solely to those staff members not engaged in patient care.

Decision making as a process can be formalized so that employees are aware of the modus operandi in place regarding suggestions or choices among variables. It was Lt General Brehon Somervell's personal philosophy, as chief of the American Services of Supply in World War II, that one *must make* a managerial decision with the knowledge that the exact decision frequently is unimportant. But the declaration of a point of view or an opinion will give the requester security and he or she will then be able to proceed. 'Should I use blue or black for this background?' 'Use blue'. End of session, and the inquirer goes off, secure in the idea that what will be done is in keeping with managerial policy and that there will be no reversal of thought on completion of the project.

Members of the health care team must undergo both personal and professional growth, often the two types of maturation being interchangeable end points. While

directing the Residency Program in Occupational Medicine at a large university, the writer encouraged the graduate students to enrol in on-campus Sensitivity Training, in addition to the technical master's degree requirements, so that personality aberrations could undergo straightening and interactions with future employees and patients would be productive and burnout would be averted. A difference in the lives of those undertaking the additional experience was seen as the years progressed. In keeping with this sense of growth is the role of managers in encouraging teaching, writing, and research by staff members. Offers to teach should be made to institutions of higher learning and the preparation of articles for the appropriate professional literature should be fostered. While the appearance of a piece in a journal by a seasoned medical scribe may not be too personally exciting, it can be an unbelievable joy to a staff member who has never attempted such publication.

New members of a health service staff should be oriented fully as to duties and expectations. While one does learn on the job, some formal direction is needed in acquainting a new employee with the goals of the institution, its role in the community, the functions of the assigned service, and even with some of the negative aspects of the position now being filled. Knowing what is expected of an incumbent can allay many apprehensions attendant upon assuming a new position.

Because all workplaces generate stress for some individuals, and as urban health centres are the recipients of victims of violence, there is definite stress for emergency service and physician and nurse staff members. As unresolved personal problems are brought to work to be added to the job site stressors, provision must be made for an Employee Assistance Program (EAP). As Freehill[85] has observed, 'Emergency personnel are notorious for delaying visits to medical doctors when they develop physical problems. They are far worse when it comes to emotional needs. Staff will often say they don't need to talk when they do. Routinely scheduled group meetings help caregivers deal with the stress of traumatic situations'.

Initially, EAPs were developed to combat the problem of alcoholism among employees, most of the counsellors being recovered alcoholics 'who had been there' and who could detect verbal fabrication on the part of referred workers. In the mid-1970s, the occupational alcoholism programmes were replaced by EAPs for the problem base broadened and a referral source was needed for workers with psychological, marital, family, or legal difficulties'.[86] The EAPs soon began to be staffed by psychologists so that broader counselling could be offered.

The programme could be available as a unit within the OHS, or could be a distinct function in the overall organization, or could be a separate agency in the community, under contract to several companies. At the first sign of burnout — as experienced by the worker or as viewed by an astute supervisor — a referral can be made, or requested, to the EAP, where

skilled counselling can be obtained. Irrespective of the source of the referral, either the supervisor or the OHS, there must be an explanation for the recommendation — impaired work performance, disinterest in patients, repeated negative outcomes — and some clarification of the counselling process, so that the affected employee will be prepared for the aid to be offered by the EAP. A 'cold' referral without some introductory discussion may deepen the burnout, for the employee may feel that he or she is a true 'mental case', stigmatized and beyond rehabilitation.

This mode of providing professional help is one method of managing stress, but if the emotional flattening is extant among many workers, then a group may be formed for Stress Management sessions conducted by an outside firm. One such group, known as the Balint group method,[87] provides health professionals with a sympathetic and accepting forum in which to present instances of the client–professional relationship and to focus on issues troubling the members at a given moment. The group avoids examination of physicians' deep emotional states, for example, except insofar as they affect professional relationships with patients. Offered is a supportive atmosphere for increasing personal awareness and recognizing and modifying defensive reactions. With the use of this method, burnout is reduced through an increase in psychosocial self-efficacy.[87]

There can be changes made in the work environment so that the area where health care is offered can be 'salutogenic'.[88] A few decades ago corporate industry in America began to add art to its premises, possibly in an effort to soften its image. Large sculptures were commissioned for placement adjacent to building entrances and framed art began to line waiting areas and corridors in the headquarters buildings. In one instance, an entire collection of murals was saved, restored, and moved to the primary urban building of a large insurance company.[89] Physicians' offices now display attractive current works. Factors in the physical environment that can prove stressful are lack of control over the environment, distractions from co-workers, a lack of privacy, noisy crowding, and environmental deprivations such as a lack of windows and aesthetic impoverishment.[88] The creation of 'salutogenic' environments involves not only the elimination of the indicated negative factors, but such enhancements as increased personal control (mentioned earlier), contact with nature and daylight, aesthetically pleasing spaces, and areas for relaxation alone or with others. One of the major concerns in creating a positive work environment is employee well-being and, thus, the opposite of burnout.

Other elements in burnout prevention or counteracting therapy can include such offerings as health insurance coverage for mental health and chemical dependency care; life style management/change through 'wellness' or physical fitness programmes; orientation programmes for new employees so they truly understand the corporate philosophy and the

institutional goals and can begin work free of any feelings of role ambiguity; the development of family policies and certain leave procedures so that conflicts between home and work can be resolved; informal staff and family events such as picnics, retreats, or potluck suppers; and, probably most important, the encouragement of some kind of activity between work and home, be it exercise, walking, swimming or other sports participation. Many companies now have workout facilities, gymnasia, or paths or roof-top tracks for walking or jogging. There can be other activities, as determined by an individual's interest, such as music or even meditation. The alternative to work can be anything else: the study of Sanskrit, a plan for permanent peace in Bosnia, or the collection of old buttonhooks — anything that demands an attention other than that devoted to work requirements.

Conferences of the type indicated earlier ('Physician Heal Thyself') can be suggested activities of various professional health care societies, or burnout content can be included in the regularly scheduled annual meetings. Recently, the subject of burnout was touched on under a page-wide newspaper headline reading, 'Managed care forcing demoralized physicians to quit' and with a sub-heading restating the issue, 'Loss of control, red tape take toll'.[90] A meeting sponsored by the American and Canadian Medical Associations will include a Harvard psychiatrist who will lead a panel on physician burnout. In response to these new pressures some physicians have closed their practices, some have turned to drugs or alcohol, some have sought counselling, and some have filed disability claims.[90] More such meetings should be held to reverse the trend of emotional destruction among caretakers.

That the need for such conferences has increased is seen in the restrictions placed on medical practice within health-maintenance organizations (HMOs), where the issue of cost has supplanted the indications for extensive care.

For those who have undergone burnout, multidisciplinary rehabilitation may be needed beyond counselling, as determined by the extent of the effect of the occupational stressors. How burnout relates to 'stress' as the basis of a workers' compensation claim can not be estimated at present for, most likely, 'stress' is the rubric under which most claims are currently being filed. It may be that only through specialized examinations conducted in order to resolve legally the asserted harm, that burnout as an entity will be distinguished from other states of stress. In keeping with resulting decisions coming from workers' compensation hearings, care will have to be exercised in the return-to-work placement. Recrudescence of the emotional trauma must be avoided or the initial disorder will be intensified.

THE FUTURE

One of the preventive measures to be utilized in the aborting of burnout among health care workers, or

any workers, is the institution of much more careful, earlier vocational counselling. Such counselling in today's schools is minimal, at best. It is needed for such reasons as matching the physical and emotional capacities of a potential caretaker with the demands of the position sought, and detecting early career choices that are parent-driven and not candidate-selected.

Even though the Act for Disabled Americans (ADA) has brought many limited or impaired persons into the work force, there still are great numbers of physically and emotionally demanding jobs in health care, so that careful placement is mandatory.

One additional view of the future must be considered. Life is more than an eight-hour workday, and at some time in the future, one must return to living without the exercise of the vocational skills acquired in school and honed at the workplace. Much of today's preparation of health care personnel is via training and not through education. One is broadened by a learning programme that touches on the arts, on different cultures, on the world's history, and the like. There must be a fuller life to which one can turn when the repetitive cycle of work days has slowed. Many individuals — in health care - look forward to post-retirement leisure, only to learn that they are ill-prepared to extract from the time remaining, the emotional, mental, and spiritual joys they had anticipated. Were there an *educational* preparation beyond the *technical* honing, life would be fuller for those who have given much of themselves to a career, always with the potential of a terminal burnout.

SUMMARY

Burnout is a professional occupational disease manifest in the many specialities of health care and will be a disorder as long as human values and worth are disregarded by inept policy makers and managers of human resources. In the ultimate, the elimination of burnout will mean better care for clients and patients.

Herbert Freudenberger who brought the concept of burnout to professional and public awareness in 1973, cautioned a few years ago that, 'We also need to incorporate a sense of spirituality in our work. I do not mean institutionalized religion, rather a sense of morality, ethics, shared values and beliefs. Values should help to promote the human good, and help us face frustration, sadness, stress and ultimately death. We need to develop ways and means, like a good relay team, to pass our knowledge of how to prevent burnout on to the next team, so that they will benefit from our errors and not become enmeshed in the same difficulties.'[91]

Will the 21st century see a lessening or an increase in burnout among health care workers? Only when the method of providing care moves from dissolution to resolution will the answer become available.

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