THE LANCET

Volume 344, Number 8937

EDITORIAL

See next page

Burnished or burnt out: the delights and dangers of working in health

Health workers run risks to their health as a consequence of their work. In the UK, for example, suicide rates in veterinary surgeons are 3·5 times the national average, and doctors, pharmacists, dentists, and other therapists (apart from physiotherapists, who have had no suicides reported for many years) are twice as likely as others to commit suicide.[1] The morbidity of health workers is also high, with particular risks of drug and alcohol abuse.[2] Lately there has been concern about the frequency of stress-related illness in health professionals exposed to the upheavals of health service reforms.[3,4] Nevertheless, we still do not know whether health workers are more vulnerable to work-related stress than are other employees. Rees and Cooper,[5] in a study of over 1000 National Health Service employees, found that those workers reported significantly greater pressure of work but fewer symptoms of poor mental health than non-health white collar workers; levels of job satisfaction were similar. Studies of mental health service staff in the USA[6] have likewise found high job satisfaction and personal accomplishment existing alongside high emotional exhaustion. Patient contact seems to offer a buffer against the worst effects of stress and is a valuable source of reward among staff.[7]

These findings disguise considerable variation between groups. Some people ostensibly thrive under pressure; they learn new skills, develop greater commitment, and shine through all adversity. They are burnished by exposure to stress and come out looking brighter than ever. Others become dull and ineffective through a combination of emotional exhaustion, a sense of occupational uselessness, and indifference to the needs of those they care for. This is often described as "burn-out", which in the zeal for identification of new syndromes in psychiatry may well become a formal diagnosis in future versions of the DSM classification of psychiatric disorders.

Factors predisposing to burn-out include uncertainty over one's role (role ambiguity) and loss of control over the achievement of effectiveness.[7] Both separate the burnished from the burnt out. To be effective, practitioners need the skills and resources to do their work well. People use resources best when they are clear about their roles, and when they are responsible only for events within their powers. For example, making a doctor responsible for the work of another professional's practice, or a psychiatrist responsible for a disturbed itinerant patient placed on a supervision register, is

not stress-reducing and will create conditions that are ripe for burn-out.

Time is a key resource. Staff need to feel they have some control over their workload, and can organise this to maintain an acceptable and recognised quality of care. Traditional gender roles mean that women are often especially vulnerable to burn-out and low job satisfaction because family commitments reduce the flexibility of their working hours and impair their career prospects.[8] Women doctors die on average 10 years earlier than their male counterparts, the opposite of what happens in the general population. One factor here is the suicide rate among female physicians, which is significantly higher than among male doctors and four times higher than that in the age-matched female population.[2]

Effective control over one's work includes involvement in controlling it. In this way workers take pride both in their personal contribution and in the work of the organisation as a whole. Thus the highest levels of satisfaction reported among general practitioners were associated with the amount of responsibility given, the freedom to choose working methods, and the amount of variety in the job.[9] If the locus of control is shifted away from the worker, this pride will be lost. Where performance is judged against standards that have not been established with the involvement of the worker, and where the achievement of these standards goes beyond the worker's control, the result will be poor morale and a shattering of organisational commitment. There are clear lessons here for the introduction of performance-related pay. Staff must be involved in setting standards of obvious relevance to patient care.

It is difficult now to maintain pride, commitment, and resolve in health workers exposed to a plethora of health service reforms which they have in no way initiated. Those who are burnished and invigorated by such changes identify with them and with colleagues who are promoting them. In management-speak they have "corporate identity", an elusive quality that is embodied in the mission statements and business plans of every NHS trust across Britain (and many other businesses too). Most employees are indifferent to such proselytising; their loyalties are to their individual professions and their work-mates rather than to the employing authority. Why should they, as believers in NHS principles, feel any corporate loyalty towards a commercial enterprise based on market forces? The effect on staff morale has been well illustrated by Collee:[10] "In the past there was a sort of Dunkirk spirit in the NHS, with the Treasury as the common enemy. Now a struggle for survival is being conducted between professional colleagues and morale is suffering as a result. . . And morale is crucially important. Contrary to Conservative doctrine, people don't work simply for money. If they did they would not be in the public health service. . . A sense of solidarity within the NHS is one of the things that keeps people working there. If that goes, they might go too".

Many trusts are introducing punitive approaches to the taking of sick leave, making staff feel like anonymous units of production. Concern over job security is increasing and more and more nurses want to leave the profession.[11] The goodwill that for so long formed the backbone of the NHS may soon be broken irreparably. Previously there was a much greater degree of clinical autonomy; practitioners could decide on both the nature and volume of their work with a relatively free hand. When pressure increased, the solutions were generally found by other clinicians who understood the skills required and the nature of pressures at work. Now, with much greater emphasis on the needs of populations and the introduction of commercial pressures into the health workplace, decisions about the nature and volume of work are increasingly determined by managers. Do managers recognise that, by taking on this role and removing responsibility from health professionals, they are creating the potential for resentment and burn-out?

The mental health of those working in the health professions is a high priority in public health and deserves to be. The likelihood is that we will be seeing more of burn-out than of burnishment in the immediate future. But this need not be the case if we can match the skills and talents of the staff and if we can persuade management to be concerned about promoting staff effectiveness. What price "investing in people" if managers refuse to listen?

The Lancet

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