Reducing Burnout among Hospital Professionals

EAPs can help identify and alleviate the factors that cause burnout and improve the health and performance of hospital staff.

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The provision of health care services is demanding work, both physically and psychologically. The around-the-clock responsibilities, the life-or-death nature of the services, and the lack of tolerance for error can exert intense psychological and physical pressures. In these conditions, health care professionals face a heightened risk for a serious clinical condition called burnout syndrome (Ilhan et al. 2005; Özyurt et al. 2006; Kaçmaz 2005).

The concept of burnout, first introduced by Freudenberger, has been defined as "the detachment of a professional person from the essence and purpose of his/her profession, not being interested in the people that he/she provides a service to anymore" (Kaçmaz 2005). Burnout can lead to social and medical problems, including frustration, disappointment, anxiety, apathy, psychological fatigue, headaches, sleep disorders, and a desire to quit a job (Kaçmaz 2005; Wu et al. 2007).

Burnout is a serious problem that affects both employees and their workplaces. It presents with symptoms both somatic and psychological and is related to the deterioration of relationships between health care professionals and their patients, co-workers, and family members and of their social environments. Additionally, burnout has been closely related to both absenteeism from work and abandonment of professional responsibilities.

Among the many factors contributing to burnout are the following:

- Too much time spent caring for patients;
- Too much contact with patients who have a poor prognosis;
- Too much contact with patients who have significant emotional demands;
- Heavy workload;
- Ambiguity and role conflict;
- Lack of support from supervisors and colleagues;
- High levels of job-related stress;
- Lack of job satisfaction;
- Fear of death;
- Lack of control over outcomes because of limited decision-making authority and insufficient organizational support;
- Inadequate coping mechanisms for stress and grief exposures; and
- Emotional exhaustion.

This article will present the results of burnout research conducted in Turkey and discuss some of the personal and institutional factors causing burnout and methods for preventing or reducing it.

RESEARCH POPULATION AND METHODS

The research was undertaken at the Baskent University Ankara Hospital and its affiliated health care institutions (Ayas Physical Therapy and Rehabilitation Center, Yapracik Psycho-Social and Rehabilitation Center, and Maltepe Woman and Child Health Center). The total number of staff working at these hospitals in June 2006 was 2,162.

An analysis determined that a sample of 385 ± 10 percent of staff would represent the entire population (Lwanga and Tye 1996). A survey was administered to 379 staff members for the year 2004, 415 for the year 2005, and 391 for the year 2006. Stratification was carried out in two steps: the first step was carried out between the Central Hospital and Ayas, Maltepe, and Yapracik Centers, while the second step was performed according to staff profession.

Survey forms, consisting of 63 questions, were distributed to employees by department managers and collected after one week. The GHQ-12 and MBI-GS scales were used in the survey forms together with questions about sociodemographic characteristics, professional status, health status, and personal habits.

The GHQ-12 (General Health Questionnaire-12) is a set of 12 questions used to determine the general psychopathological status of a respondent and to identify psychiatric cases during population screenings. Each question asks about symptoms appearing within the last few weeks and offers four possible answers ("more than usual," "same as usual," "worse than usual," and "much worse than usual"). A bi-modal scoring system was used, assigning zero points for "more than usual" and "same as usual" answers and one point for "worse than usual" and "much worse than usual" answers. Using this scoring procedure, two points and under are considered normal while three points and over are considered risky in terms of psycho-

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logical disease (Kiliç 1996).

The MBI-GS (Maslach Burnout Inventory-General Survey) is a scale consisting of 22 questions. The scale evaluates burnout along three dimensions: emotional burnout, personal success, and apathy (Wu et al. 2007; Ilhan et al. 2005; Ünal et al. 2001; Kaçmaz 2005). The emotional burnout (EE) subscale evaluates the status of a person in terms of being exhausted and overloaded by his/her profession or job. The apathy (AP) subscale assesses whether a person lacks feeling for the people s/he is helping and pays no attention to their individual identities. The personal success (PS) subscale determines the extent to which a person feels capable of handling problems that arise when working face to face with people.

While the original MBI-GS scale uses a seven-point scoring system, its Turkish adaptation uses a five-point system, as follows: "never" = 0, "rarely" = 1, "sometimes" = 2, "usually" = 3, and "always" = 4 (Wu et al. 2007; Ilhan et al. 2005; Ünal et al. 2001; Kaçmaz 2005). A high score on the EE and AP subscales and a low score on the PS subscale are considered evidence of burnout.

Data from the survey were analyzed using the SPSS 11.0 program. A chi-square test and Pearson correlation analysis of the difference between the two average scores were used to determine the difference regarding burnout status and age, gender, professional group, marital status, and working duration in the institution. A p value of <0.05 was used for statistical significance.

Approximately three-fifths of the survey participants were female, and 61.3 percent were married. The average age of the participants was 29.9 ± 5.7, and the average daily working hours was 8.9 ± 1.9 hours.

Figure 1: **Mean Burnout Subscale and Health Scores by Year**

	GHQ-12	*Personal Accomplishment*	*Apathy*	*Emotional Burnout*
	Mean±SD	*Mean±SD*	*Mean±SD*	*Mean±SD*
2004	1.8±2.6	30.7±4.6	8.8±3.3	20.4±6.8
2005	1.7±2.5	31.0±4.4	8.9±3.2	20.3±6.8
2006	2.0±2.7	30.3±5.6	9.1±3.5	21.2±7.8
	p > 0.05	p > 0.05	p > 0.05	p > 0,05

SD = Standard Deviation P = One-Way Anova

Figure 2: **Mean Burnout Subscale and Health Scores by Demographic Characteristics**

	GHQ-12	*Personal Accomplishment*	*Apathy*	*Emotional Burnout*
	Mean±SD	*Mean±SD*	*Mean±SD*	*Mean±SD*
Male	1.4±2.3	31.2±5.3	8.4±3.1	17.9±6.5
Female	2.2±2.7	30.3±4.4	9.3±3.4	22.6±6.9
p*	0.0001	0.004	0.0001	0.0001
Married	1.5±2.3	30.9±5.1	8.5±3.1	19.0±6.9
Single	2.5±2.9	30.2±4.3	9.6±3.5	22.6±7.1
Widowed/ Divorced	0.9±1.9	32.1±6.7	7.8±2.3	18.4±6.4
p**	0.0001	0.02	0.0001	0.0001
Physician	2.0±2.8	30.9±3.6	9.2±3.0	22.3±6.8
Nurse	2.6±2.8	30.1±3.9	9.7±3.6	23.8±6.8
Administrative Personnel	1.9±2.5	30.2±5.9	9.5±3.6	20.6±7.1
Technical and Support Services	1.3±2.2	31.0±5.3	8.2±3.0	18.4±6.7
p**	0.0001	0.065	0.0001	0.0001

p* = Independent Sample T test (Student T Test) p** = One-Way Anova

SURVEY RESULTS

Figure 1 shows there was no significant difference between burnout indices and the general health status of the staff.

When the relationships between the independent variables and general health and burnout status were analyzed, it was found that general health scores were higher (worse) among women. When analyzed in terms of marital status, the burnout scores of singles were found to be higher (worse) than those of married people (see Figure 2). This finding was statistically significant.

Another interesting finding was that burnout scores were higher among nurses and physicians compared to other hospital employees. Except for the personal success dimension, the burnout scores and the GHQ-12 scores were higher among nurses, and this finding was statistically significant.

When the relationships between the GHQ-12 score and the burnout score, working time, experience, and monthly income were evaluated, a weak positive correlation was found to exist between working time and the GHQ-12 and personal success scores, while a weak negative correlation was identified with the emotional burnout score. A weak positive correlation was determined between daily working time and monthly income and the GHQ-12, apathy, and emotional burnout scores.

ANALYSIS OF SURVEY RESULTS

This study found that the burnout scores of women generally were higher (worse) than those of men. In a study by the Turkish Medical Association (TMA), male physicians showed more signs of burnout in the apathy context, while female doctors were more burned out in the personal success context (TMA 2005). It is thought that the higher burnout scores of women are related to their higher GHQ-12 scores. While a

poor psychological status can cause burnout, the reverse is also true—burnout can cause psychological problems.

Burnout is common in jobs involving close contact with people, and nurses fit this criterion. Nurses in this survey reported high levels of anxiety, sleep disorders, and difficulty in handling personnel problems. In addition, nurses have more restricted social lives due to Turkish traditions, and this further increased their stress.

The scores obtained from all dimensions of the burnout syndrome were higher among single members of the hospital staff. The social support unit in which an individual is most likely to find shelter from the conflicts and difficulties of daily life is the family. Therefore, it was expected that married individuals would report lower levels of burnout syndrome than singles.

This study also found a higher rate of burnout syndrome in the physician and nursing groups. The riskiest services provided in hospitals are those delivered by physicians to patients, so a substantial amount of stress is shouldered by doctors. This can lead to the development of burnout syndrome signs and a deterioration in general health status.

Although contradictory data exist in the literature, this study found a weak positive correlation between work experience and the personal success score and a weak negative correlation between work experience and the emotional burnout score. This may suggest that inexperienced staff members are more inclined to exhibit symptoms of burnout than their older, wiser colleagues. Further research on this subject is needed.

An unexpected finding was the weak positive correlation between monthly income and emotional burnout and apathy. The physician and nurse groups exhibited the highest burnout scores, yet have the highest incomes among hospital workers.

A weak positive correlation also was identified between the number of daily working hours and emotional burnout and apathy. In the study carried out by Ilhan et al. (2005), no difference was detected between those working 40 hours per week or more and those working less. However, the study by the Turkish Medical Association (2005) found that emotional burnout and apathy increased as working hours increased. The findings obtained in this study are considered an expected result.

POTENTIAL INTERVENTIONS

The results of this study confirm the need for health care institutions to conduct burnout surveys at regular intervals for screening purposes. EAPs, with their mission of helping improve workforce performance and their commitment to confidentiality, are a logical choice to lead this process.

Organizations should provide individual and group therapies for staff found to be at risk of burnout and/or general health complications. In addition, health care institutions should identify the factors influencing burnout and take these into consideration when selecting staff, developing training programs, and improving working conditions. Personal, institutional, and system-related problems must be evaluated as a whole among the causes of burnout syndrome. While gender, marital status, profession, and length of job tenure are the most prominent personal factors, monthly income and daily working time are key institutional influences.

Organizational interventions such as decreasing long working hours, rotating duties between units, conducting team-building exercises, offering stress management training, and teaching health care staff how to relax can help reduce burnout. An often-overlooked strategy that EAPs can promote is to improve social environments within health care institutions and encourage informal interactions among colleagues. Many health care professionals, especially high performers, have an overly developed capacity for tolerating stress and physiological strain, causing them to work long hours and spend less time with friends and family. Providing more opportunities for these professionals to socialize with colleagues can help reduce stress and strain and, thus, the risk of burnout.

Employees also have responsibilities to help prevent burnout. For example, they should try to improve their social relationships, both within their families and their network of friends. Avoiding family and friends promotes exhaustion and cynicism and impedes professional efficacy; seeking emotional support, conversely, counteracts exhaustion and cynicism and promotes professional efficacy. These considerations can direct specific strategies that promote performance and prevent burnout.

Best practices for addressing burnout syndrome require a multifaceted approach to supporting employee performance. The solutions must be evaluated at the macro level, since the roots of the problem are both personal and institutional in nature. ■

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