by Norman Sartorius



An Epidemic Is Threatening Health Care Worldwide

Most diseases can be successfully treated. Some cannot: in those instances we can provide care and support hoping that, in the future, effective treatments for these diseases will be developed. New diseases may appear – AIDS is an example of a new disease that is ravaging the world – while some of those that plagued mankind for untold millennia will be eradicated as was smallpox and, in the near future, we hope, poliomyelitis.

Yet, while diseases come and go, sometimes killing millions and often evading control for a while, an underlying pandemic is growing worldwide, largely unrecognized or ignored. This pandemic, looming large and threatening health care as a whole, is the burn-out syndrome striking those providing care for people with chronic illness and those suffering from it. The burn-out syndrome was first described in staff working in medical wards hosting people with lethal cancers and in wards where people with major burns suffered and died in large numbers. Staff reported to be exhausted, not only by hours of work, but also by the fact that they had used up their emotional resources in empathy with so many severely sick and suffering people, of whom many died despite all their efforts. In other wards, some of the patients survived and some died; some had a longlasting disease, others were well soon after treatment. But, this was not so in the wards in which the burn-out syndrome was first described: there, hopes were doused and the perspective was that staff would have to continue providing care for many more people who would suffer and very probably die, or remain severely disabled, no matter how much care they recieved. Staff who developed the burn-out syndrome lost interest in almost everything and were not motivated to partake in

any venture. Somatic symptoms, such as a deregulation of sleep and of appetite, fatigue and fatigability, irritability, deteriorating relations with other people, and a decreased resistance to physical illness, were also described as parts of the syndrome.

Soon after the first reports of burn-out syndrome appeared, there were many others informing about the presence of the syndrome in other parts of the health services – from emergency services to wards of surgery or infectious diseases. It was not only the type of patients who were a risk factor for the appearance of the syndrome. Other risk factors were described, such as the lack of incentives, poor career prospects, lack of recognition of merit, harassment, unclear sense of mission, the increasing emphasis on economic rather than on human gains from health care, as well as the probability that one will stay forever in a peripheral part of the health system.

People working in peripheral parts of the health system are leaving it in increasing numbers and enter into other professions or occupations, thus obscuring the magnitude of the problem. Managerial positions, teaching institutions in the larger cities, and private practice of different descriptions are usual avenues of change: and where this is not easily possible driving a taxi or opening a boutique seems also more attractive than working in health services engendering the burn-out syndrome.

What is making matters worse is that those who cannot stand it any longer are often staff members of excellent quality: their departure leaves the services deprived of many potential leaders and models. Disgruntled and de-motivated

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staff do not perform as well as they could. This opens the door to corruption by family members and others who are bribing the employees, hoping that this will help to ensure that their relatives are treated well. Corruption soon becomes widely known, thus decreasing the reputation of the institution, which in turn makes it even more difficult for all those who are employed in it – corrupted or not – to feel proud of their work and of their institution.

Unfortunately, the appearance of increasing numbers of people with the burn-out syndrome are also reported from other social services, again particularly from those at the periphery. The poorly paid teachers whose motivation was previously to a large extent dependent on their reputation of being learned people performing a vitally important function in the community are now no longer feeling this way. The importance of economic success for social recognition in today's societies and the multitude of sources of learning (including the Internet) are decreasing the exclusivity of teachers as a source of knowledge and diminish the teachers' motivation to continue working in schools which nowadays, even in rich countries, find it more and more difficult to get funds for the repair of their buildings, for the purchase of teaching tools and for the creation of incentives for their staff.

Other professions, institutions, and population groups share the fate of the health and teaching systems. These include general administrative staff, particularly those poorly paid, staff working in nursing homes, in homes for the elderly, and in orphanages as well as an increasing number of people who are responsible for the care of disabled people at home. These carers have until now born the lion's share of the burden of looking after chronic illness: the promotion and implementation of community care usually means an increase of the burden for an ever larger number of members of the community without substantive help from those who promote the discharge of patients – even those with serious and lasting impairment – into family and other forms of community care. With the excessive burden and continuing lack of recognition and support - material and

moral – the members of the family of chronically ill people and other carers are also becoming victims of the burn-out syndrome. The syndrome is often made more severe by a feeling of guilt for not doing more implied by what health care staff and the government say about modern community care and family duties.

There are many effective measures and interventions that could be used to prevent burnout or reduce it. Some of them are difficult to implement because they would require a substantive reform of the health or other system as a whole. Others, however, are easily applicable and depend on individual action. In institutions, it is often possible to introduce a systematic recognition of merit for staff, without a large investment of funds. An improvement of the managerial control with an equitable mixture of rewards and punishments often depends only on the will of the (enlightened) manager. A rational distribution of tasks, holidays and short-term exchanges of work in similar posts elsewhere is often easy to arrange. Training in practical skills enhances the sense of mastery and allows at least a brief respite. There are numerous publications and guidelines for interventions which can reduce or prevent burn-out: why not devote a special time slot to examine them and see what suggestions about doable interventions they contain? One could think of devoting a session or two of professional meetings or congresses to the problem of burn-out. Instead of yet another epidemiological study of the prevalence of some disorder it might be useful to carry out a survey of the prevalence of burn-out and of the reasons for it in different settings. In daily practice all of us could do something about it - by praising families who are providing care for chronic patients, instead of taking their care for granted, for example, or by making sure that we have listened to the complaints of staff with the empathy and seriousness that they deserve.

It is urgent to deal with the pandemic of burn-out syndromes before it infects us all and before it ruins social services as well as progress towards a civic society that will always depend on the motivation and value systems of its members.