Journal of Intercultural Management and Ethics

JIME

ISSN 2601 - 5749, ISSN-L 2601 - 5749

published by

Center for Socio-Economic Studies and Multiculturalism
Iasi, Romania
www.csesm.warter.ro

Special Editors

Drs. Huib Wursten,
Author and Consultant, Netherlands
E-mail: huibwursten@gmail.com

Beatrice Gabriela Ioan
"Grigore T Popa" University of Medicine and Pharmacy, Iaşi, Romania
Dept. of Forensic Medicine
E-mail: ioanbml@yahoo.com

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BURNOUT SYNDROME IN PALLIATIVE CARE

Ana-Roxana Gănceanu-Rusu
”Grigore T. Popa“ University of Medicine and Pharmacy, Iasi, Romania
”Sf. Spiridon“ Emergency County Clinical Hospital, 3rd Medical Clinic, Iasi, Romania
E-mail: roxanarusu12@yahoo.com

Elena Rezuș
”Grigore T. Popa“ University of Medicine and Pharmacy, Iasi, Romania
Clinical Rehabilitation Hospital, 1st Rheumatology Clinic, Iasi, Romania
E-mail: elena_rezus@yahoo.com

Nicoleta Dima
”Grigore T. Popa“ University of Medicine and Pharmacy, Iasi, Romania
”Sf. Spiridon“ Emergency County Clinical Hospital, 3rd Medical Clinic, Iasi, Romania
E-mail: nicoleta2006r@yahoo.com

Codruța Bădescu
”Grigore T. Popa“ University of Medicine and Pharmacy, Iasi, Romania
”Sf. Spiridon“ Emergency County Clinical Hospital, 3rd Medical Clinic, Iasi, Romania
E-mail: codruta.badescu@gmail.com

Daniela Tănase
”Grigore T. Popa“ University of Medicine and Pharmacy, Iasi, Romania
”Sf. Spiridon“ Emergency County Clinical Hospital, 3rd Medical Clinic, Iasi, Romania
E-mail: tanasedm@gmail.com

Anca Ouatu
”Grigore T. Popa“ University of Medicine and Pharmacy, Iasi, Romania
”Sf. Spiridon“ Emergency County Clinical Hospital, 3rd Medical Clinic, Iasi, Romania
E-mail: ank_mihailescu@yahoo.com

Andreea Clim
”Grigore T. Popa“ University of Medicine and Pharmacy, Iasi, Romania
”Sf. Spiridon“ Emergency County Clinical Hospital, 3rd Medical Clinic, Iasi, Romania
E-mail: andreea.clim13@yahoo.com

Ana-Maria Pop
Clinical Rehabilitation Hospital, 1st Rheumatology Clinic, Iasi, Romania
E-mail: ana.strainu.16@gmail.com

Minela Aida Mărănducă
”Grigore T. Popa“ University of Medicine and Pharmacy, Iasi, Romania
”Sf. Spiridon“ Emergency County Clinical Hospital, 3rd Medical Clinic, Iasi, Romania
E-mail: sminelaaida@yahoo.com

Ciprian Rezuș
”Grigore T. Popa“ University of Medicine and Pharmacy, Iasi, Romania
”Sf. Spiridon“ Emergency County Clinical Hospital, 3rd Medical Clinic, Iasi, Romania
E-mail: ciprianrezus@yahoo.com

Abstract

Medical staff are exposed to high levels of stress throughout their careers and are likely to suffer from burnout syndrome, with repercussions not only on themselves but also on patients and the healthcare system. Affected doctors are at increased risk of making wrong decisions, having a hostile attitude towards patients and difficult relationships with co-workers. The most studied measuring instrument in the literature is the Maslach Burnout Inventory (MBI), introduced in 1981. This indicator has become a standard tool for measuring the level of burnout. MBI provides a three-dimensional description of the syndrome, such as emotional exhaustion, depersonalization, and lack of professional fulfillment.

Keywords: burnout syndrome, stress, physical exhaustion, medical staff.

Introduction

Occupational stress is a serious health and safety problem in the workplace, with a negative impact on the organization and its employees, even registering deaths from this cause. In the European Union, stress at work represents the second health problem related to professional activity, after strictly medical conditions, with direct and indirect consequences on the workforce (Lenzo, Indelicato, Grisolia, Toffle, & Quattropani, 2016).

Herbert J. Freudenberger, an American psychologist of German origin, was one of the first to describe the symptoms of exhaustion professionally and conducted a comprehensive burnout study. He described burnout as "Disappearance of motivation or incentive, especially if devotion to a cause or relationship fails to produce the desired results."

Particular aspects of burnout syndrome in medical staff

In the hospital environment, the health of those who take care of the health of their peers requires the approach at the level of the health and safety department at work and with the input of other specialists and first of all with the clinical psychologist or the psychology of work (Rizo-Baeza et al., 2018).

The medical staff is at the top of the statistics regarding the professional categories affected by the professional stress through great responsibilities, confronting dramatic situations, strong negative emotions, worsening the patient's situation over time despite the efforts or even the death of the patient.

In daily practice, various stages are used in the analysis of the evolution of burnout syndrome. Starting from the definition of Christine Maslach and Susan E. Jackson, the measurement of burnout syndrome analyzes three dimensions: emotional exhaustion with symptoms related to attitudes and feelings, physical exhaustion with the presence of physical symptoms and behavioral symptoms with low productivity, dissatisfaction in the workplace. People who go beyond their limits through a marathon determined by the high expectations of themselves and others, get to make statements such as: "I feel tired", "I enjoy nothing" or "I feel at the end of the powers". While some are already home, there are many others for whom the end of the workday is still far away. Exhausted from the work they do, they cannot even mobilize to do something in their spare time with family or friends. Those who take homework surpluses or worries at work are at risk of burnout (Kamal et al., 2016; Martins Pereira, Teixeira, Carvalho & Hernández-Marrero, 2016).

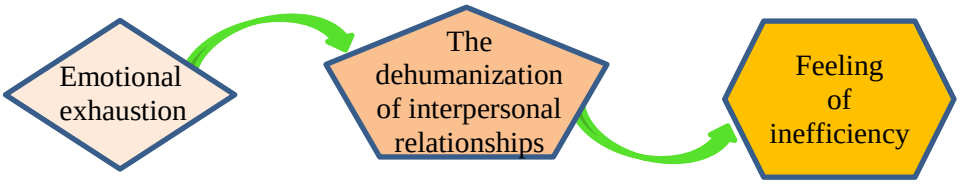
The qualitative impact of burnout syndrome

Dehumanizing interpersonal relationships or depersonalization: the person distances himself from those he cares for or from his work colleagues, manifesting an attitude of indifference, even cynicism through effective draining and relational coldness.

The diminution of professional involvement, the feeling of professional fulfillment is either a consequence or a combination of the other two dimensions of professional exhaustion. However, it is considered that the feeling of inefficiency felt by the individual develops more in parallel with the other two dimensions than as a consequence of them.

With the individualization of the three dimensions, several theories have emerged regarding the evolution of burnout. In the model proposed by Maslach, Schaufeli (Maslach, Schaufeli & Leiter, 2001), the sequence of the three dimensions is different, one of the three preceding the other two. In this model, the chronology is the one shown in the following figure:

Fig. 1. The sequence of burnout dimensions



The psychological aspect of prolonged professional stress

Stress factors for palliative care practitioners are:

- the manifestations of the disease, the unexpected changes
- frustrations related to the worsening of the situation despite the efforts
- dramatic cases, traumatic images, periods with numerous deaths
- excessive emotional involvement
- "difficult" patients / families
- single patients
- the conspiracy of silence, ingratitude
- a high volume of work
- teamwork, changes in the organization
- poor professional relations
- situations in which the tasks are not correlated with the abilities of the employees

Perfectionist and self-critical people, with unrealistic expectations, young practitioners, female staff (through fulfilling multiple roles - family, career), people who cannot delegate tasks are more prone to burnout syndrome (Nyatanga, 2014).

Daily events and their impact can be measured using the stress scale created by Thomas H. Holmes and Richard H. Rahe (table 1). A score of 150-300 points out an increased risk of being affected by stress (Holmes & Rahe, 1967)

Table 1. Stress share of daily situations after Holmes and Rahe

Spouse's death	100	New work tasks, promotion	39
Serious illness of the spouse	80	Family conflicts	29
Divorce	73	The child leaves the home overuse	29
Death of a close relative	63	Changes in lifestyle, habits	28
Serious illness or accident	53	The beginning or the end of a child's schooling	25
Marriage	50	Conflicts at work with bosses	25
Loss of work	47	Conflicts with colleagues	23
Marital problems	45	Home change	20
Retirement	45	New leisure activities	19

The death of a friend	42	Changes in the life of society	18
Car accident	42	Changing the sleep period	16
Task	40	Changing the power supply	15
Premature birth	40	Extended family visits	15
Sexual problems	39	Vacation	13
Surgery	39	Christmas holidays	12
Change of financial conditions	39	Minor violation of legality	11

Stress reactions are presented in Table 1 and 2.

Table 2. *Physiological* reactions to stress

Skeletal-muscular system	muscle spasms, muscle, tics, dyspnea, hyperventilation
Cardiovascular system	tachycardia, arrhythmias, high blood pressure
Gastrointestinal system	salivation, dryness, gastrointestinal transit disorders
Dermal level	hyper-sweating, allergies / irritations

Table 3. Rophylactic measures of burnout syndrome

Emotional reactions to stress	frustration, hostility, anxiety, nervousness, anxiety, depression, demoralization, dissatisfaction, feeling of powerlessness, negative self-evaluation, guilt
Cognitive reactions to stress	short- and long-term memory deterioration, decreased concentration, increased error and confusion, decreased decision-making, planning, and organization, reduced creativity
Behavioral reactions to stress	decreased performance, absenteeism, aggression, deterioration of interpersonal relationships, excess or loss of appetite, insomnia, increased alcohol use, tobacco, coffee, suicide

Exhaustion of compassion refers to a series of changes in the cognitive, emotional and behavioral levels that occur as a result of the desire to help or the inability to help those who have experienced some form of trauma (the negative impact of interaction with people who have suffered a trauma).

Risk factors involved in the onset of burnout:

- related to the workplace:
  - a persistent overload at the workplace
  - a feeling of lack of control over work activity
  - a lack of support from colleagues
- problems during childhood and adolescence: a stable childhood was defined as including physical health, a warm parental relationship, an atmosphere in a cohesive and warm family, the closeness of at least one brother, school and sports performance
- personality: compulsive behaviors are those that mix doubt, feelings of guilt and an exaggerated sense of responsibility
- family stressors
- medical women have a 60% higher risk of developing burnout than men.

A 2007 study brings a similar list of risk factors involved in the onset of burnout syndrome in oncology surgeons (Krainik, Muszalska & Rogiewicz, 2007):

- the duration of the preparation and the delay of the reward
- financial aspects (salary, budget, management)
- limited control over the provision of medical services
- annoyance and guilt generated by the loss of a patient or by an unsatisfactory result

- insufficient time for research and insufficient funding
- increased working time and overtime
- feels isolated / wasting time in contact with colleagues
- an imbalance between career and family
- inefficient and / or hostile working environment
- gender and age issues

Staging of burnout syndrome

The burnout stages are:

- compulsion in affirmation
- excessive involvement in work
- neglecting needs
- the inability of the person to identify the source of the conflict
- review of values
- denial of problems
- withdrawal
- behavioral changes become evident to others
- depersonalization
- the feeling of inner emptiness
- depression
- burnout syndrome

Answers from professionals:

- Become cynical about a patient
- I lack passion/care for patients and their families
- My level of empathy towards a family decreases
- I'm irritable
- I am not employed when I am at work
- I have overly emotional reactions to various situations
- I lack the enthusiasm to go to work in the morning
- I spend a lot of time thinking about a patient, especially when I'm not at work
- I judge a patient/family or a colleague

Repeated relapse of trauma (through intrusive thoughts, return of the same type of dreams, flashbacks) or conversely, affective "anesthesia", detachment and alienation of life, repression of a traumatic event, are typical models of reaction to traumatic experiences, both requiring psychiatric interventions (Martins Pereira, Fonseca, & Sofia Carvalho., 2011).

Reasons for non-recognition:

- self-talk
- shame
- denial
- self-sacrifice
- workplace safety
- pressure
- cost

Rachel Remen said, "We are exhausted not because we don't care, but because we don't mourn. We are exhausted because we have allowed our hearts to be so filled with losses that we have no room for the care of others. "

Prophylactic measures of burnout syndrome

A comprehensive synthesis is made in a synthesis article published in 2009 in the Journal of Palliative Medicine that lists and classifies strategies for avoiding burnout syndrome in (Swetz, Harrington, Matsuyama, Shanafelt, & Lyckholm, 2009):

A. Individual strategies, namely:

Reflection at work, journaling, discussions with colleagues. The daily answer to questions such as:

- do I have burnout signs or am i healthy?
- Why do i do this?
- Do you continue to do this?
- What surprised me today?
- Participation in maintaining one's own health through diet, exercise, rest
- The existence of a plan of activities with a playful purpose
- Professional supervision through regular meeting with a mental health professional, with the express purpose of exploring personal developments in the medical-patient relationship
- The existence of a regular vacation plan, the need to opt for breaks when stressors increase.

B. Interpersonal strategies as follows:

- Strengthening relations with family and friends and extending them
- Spending time with family members, cultivating functional relationships with them
- Cultivating warm and meaningful relationships, of friendship
- Development of a support network, participation in a club of common interests
- Activism or commitment on a spiritual or religious level
- Practicing self-expressive activities and developing a sense of self: painting, music, sculpture, modeling, dance, writing, gardening
- Activities that facilitate the discovery of the meaning and meaning of one's life
- Personal development activities, counseling, professional interviewing

C. Professional strategies such as:

- interrogations of emotional events
- calling the help of colleagues, mentor, support team in palliation, presence in discussion circles.

The alarm signals for professional counseling are mentioned as the following:

- persistent feelings of sadness, fatigue, anger, futility, hopelessness, suicidal ideation, or anxiety that interfere with work or interpersonal relationships,
- use of sedatives, hypnotics or other substances: alcohol, drugs,
- other dependencies that interfere with work such as gambling,
- persistent sleep disorders: nightmares, disturbance of sleep, waking up early in the morning,
- crossing professional boundaries: inappropriate relationships with patients or their families, diminishing attention or chronic fatigue.
- prevention of burnout syndrome:
- identification of professional stressors
- encouraging the functionality of the team
- orientation to success through educational programs
- self-care

Recovery after burnout:

- Slowing down the working rhythm
- Finding support
- Reassessment of goals and priorities
- Loss recognition

The consequences of stress on medical personnel:

- Medical errors
- Affecting professionalism
- Decreased patient satisfaction
- Absenteeism
- Depression and / or suicidal ideation
- Sleeping disorders
- Road accident (Kamal et al., 2016; Nyatanga, 2014).

Conclusions

Surveillance of the health of those who provide palliative care to patients, together with the field of palliative care in general, can be a challenge for any occupational medicine physician.

At the same time, knowing the measures to prevent burnout is an obligation of every member and especially of the doctor within the palliative care team.

The physician in the palliative care team should know the characteristics of burnout syndrome and prevent its presence both in the person and in colleagues for the health and efficiency of the care team and in the interest of the patients.

The association of the role of oncologist, having an activity with the intention of curability, with the one of palliation, which implies a frequent change of roles, can lead to an increase in the preponderance of all the 3 defining elements of burnout syndrome.

Although in the field of palliative care for medical staff there are numerous potential sources of stress, burnout syndrome does not have a higher prevalence due to organizational and individual education factors, present since the beginning of the palliative care team and followed during the activity of this team.

The importance of effective communication within the palliative care team, its role and effectiveness for each member, team evaluations as well as self-assessment, permanent knowledge, and prevention education are just some of the ways that have proven effective in preventing the syndrome of burnout.

The means of prevention of burnout syndrome are applicable in any workplace within health care not only within palliative care services.

The balance in personal life, pursued both by each member and within the team, the ways of relaxation, programmed, individual and in the team, are just a few elements that make each member of the team, informed about the onset, manifestation, and evolution of burnout syndrome follow and be effectively involved both personally and within the team for the health of all its members.

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