Health Care Workers at Risk

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Abstract: Health-care workers are at extreme risk not only of psychological but somatic disorders as well. Present paper - while presenting the outline of the poor situation of physicians and health-care professionals - strives to enumerate circumstantial factors that induce the probability of negative physical and biological consequences as well as occurrence and extent of burnout. It also aspires to cite all those features that can help diminish these negative outcomes.

Keywords: health-care, stress, burnout, social support, control

State of health of health-care professionals

The peculiar development of the physicians' morbidity and mortality rates has been in the centre of the attention of medical sociology researchers worldwide since the advent of the second half of the 20th Century (Győrffy and Ádám, 2004b). According to a study conducted by László Molnár in 1988 (Molnár and Mezey, 1991), 20 percent of the physicians under the age of 39 was suffering from some chronic disease. As compared with the average population and people with other intellectual occupations, middle-aged physicians showed an extremely high rate of deaths by infarction. Both international and domestic studies show a significant incidence of psychic disorders, dependency on alcohol and drugs, and suicide among physicians (Pikó, Piczil, 2000; Pikó, 2006; Tyssen et al., 2001). In Western Europe and the USA, physicians are healthier in somatic, but sicker in mental, terms than the average population. In Hungary, however, even the health indicators of health care workers are worse than those of the total population with very bad rates, in any case. The incidence rate of suicide ideas shows a higher prevalance among physicians than average figures pertaining to the total population (Tyssen et al., 2001; Arnetz et al., 1987; Boxer, Burnett, Sweanson, 1995). The latter phenomenon is especially remarkable in the light of the fact that the ultimate objective of the medical profession is the preservation of life.

Dealing with human problems frequently costs helpers the upset of their own psychic balance. Based on experience, the group at risk includes individuals who, for a relatively long time, have been pursuing a job in connection with humans,

requires permanent concentration, and involves emotional stress, while they cannot count on obvious and conspicuous results quickly (Wheeler and Riding, 1994, Lazányi, Molnár, Szluha, 2007; Szluha, Lazányi, Molnár, 2007). Health care workers often report physical and emotional exhaustion, depersonalisation, and a diminished sensation of self-realisation through work (Zammuner, Lotto, Galli, 2003; Maslach and Jackson, 1981a, 1981b; Maslach, 1993; Lee and Ashforth, 1996). However, the risk of the burnout syndrome is inherent in all professions dealing with humans. Burnout is associated with multiple psychosomatic symptoms such as decrease in performance, profession-related and self-evaluation problems, insomnia, a chronic sensation of fatigue, chronic dependency on caffeine and nicotine, alcohol and drug addiction, anxiety and depression (Fekete, 1991).

In 2001 in the United States, the burnout incidence among physicians was 22 % (Linzer et al., 2001). Also in the USA, burnout was detectable with more than half of all oncologists (56 %) (Whippen and Canellos, 1991). The Hungarian situation is even worse. Health care institutions have always been deemed to be at considerable risk in terms of burnout (Pikó, Piczil, 2006). Among physicians researched by Szilvia Ádám and her colleagues (2009) the prevalence of high level emotional exhaustion was 30, the high level depersonalisation was 40-60, and the high degree of decrease in personal performance was almost 100 %.

Female Health Care Workers at Extreme Risk

In Hungary, more than half of the physicians, and about 80 percent of health care workers, are women. The expansion of female employment has, however, failed to go hand in hand with decreasing burdens of household duties and child care (Tóth, 1995). Unfortunately, the general health condition and life expectancy of female health care workers have not been investigated yet, though the severity of the conflict of roles, arising from a state of being a physician, a woman, a wife, and a mother simultaneously, is corroborated by numerous demographic data. The female physicians' life expectancy at birth was 68 years in 1988, which was six years less than the average female life expectancy of the day. According to a startling finding, 51.5 per cent of the female physicians and 34.2 per cent of the male physicians at Semmelweis Medical University (Budapest) had died prior to their age of retirement (Molnár and Mezey, 1991). At a national level, the female physicians had died before reaching their retirement age at a rate as high as 37.7 per cent even in 2000 (Molnár and Feith).

Returning home after having spent her workday under extreme physical and psychic pressures, a mother / wife will either find some outlet for her stress or keep it to herself, and be left alone with her problems. Neither alternative will offer a solution in the long run. For this reason, women employed in health care

jobs which require above-average levels of commitment and skill, are more often divorcees, widows, or just living apart and, in most cases, childless (Nagy, 2001). While such a marital status implies less domestic troubles (with babysitting during night duties, family conflicts, attendance to invalid dependents, etc), it is solitude that aggravates the risk female health care workers are exposed to in any case. It is a generally known fact that the quality of one's social relationships, and the degree of relaxation involved in social support one enjoys are essential factors in tackling (vital) events full of stress.

The death rate of male physicians over 40 exceeds the mortality of the total population (Molnár and Mezey, 1991), while that of female physicians is even worse than the male average, a state-of-affairs presumably produced by the marked conflict situation which the incompatibility between a woman's profession and her role in the family implies. Impacts of stress at work destructive to health are particularly seen on female health care workers. With women, long working hours and high emotional and physical strain lead to chronic diseases and infarction more often (Haynes and Feinleib, 1980; Haynes, Eaker, Feinleib, 1984; Theorell, 1991).

Female physicians are in a situation even worse than that. Based on findings by Ádám, Győrffy and Susánszky (2008), the rates of emotional exhaustion, and those of conflicts between job and family, are significantly higher among woman physicians than their male counterparts. Furthermore, research data showed that the set of woman physicians with high rates of job / family conflicts was significantly correlated with that of those scoring high in burnout.

In consideration of the psychosomatic approach to the emergence of diseases, Zsuzsa Győrffy's findings are not suprising at all. In her investigations, she found that disorders relating to conception and pregnancy, such as spontaneous abortion, endangered pregnancy, or infertility, were predominant among the female physicians' health indicators (Győrffy and Ádám, 2003; Ádám and Győrffy, 2003). Based on deep-interview research accomplished in 2002, 74 per cent of the female physicians interviewed reported troubles related to pregnancy or delivery (Győrffy et al., 2004). International literature makes numerous references to the fact that work stress inherent in the medical profession affects pregnancy and delivery adversely (Phillips, 2000; Levey, 2001; Palepu and Herbert, 2002). Swedish studies show that overtime work and a changing work schedule increase the probability of abortion (Axelsson, Rylander, Molin, 1989). The probability will grow even higher if the pregnant woman has already had a child (or children). The Canadian researchers' findings prove that working in the evenings or night shifts produces a rate of spontaneous abortions three or four times as high as usual (Infante-Rivard et al., 1993).

Risk factors

The level of stress at work health-care workers are exposed to is significantly higher than workers in other professions are (Wall et al., 1997). Offering both physical and mental stressors in large numbers, health care is considered to be a working environment with extremely high levels of stress (Lambert, Lambert, Ito, 2004; Pikó, 1999; Wheeler and Riding, 1994). In their turn, increased stress levels adversely affect the health care workers' satisfaction with their jobs (Ramirez et al., 1996), and with their lives (Mackenzie, Poulin, Seidman-Carlson, 2006), as well their mental health and well-being (Agüir and Burillo, 2004; Zammuner and Galli, 2005). They also induce an intention to change career (Kovácsné Tóth et al., 2004) or, very often, burnout (Allen and Mellor, 2002; Pikó, 2006).

According to literature data, there are many factors that could induce workplace stress. First I will enumerate research findings that addressed definite stressors, and enumerate some complex theories of workplace stressors, that were tested in health-care settings afterwards.

<u>Pressure</u>

In spite of increasing patient turnovers, the number of health care workers, especially that of health care professionals, has been decreasing in Hungary, which has, in turn, led to increased workload.

A comprehensive survey of health care workers' workload was conducted in 1989 (Bán, 1989). It was found that workloads in both mental-intellectual and physical terms were so high that they pressed back or even prevented mental guidance to patients and their mobilization and preparation for home life. A nurse's working minutes spent on each patient depend on the nurse's workload. Drawing comparisons between time and staff head counts available on the one hand and number of patients to be attended on, and amount of such other tasks, e.g. getting patients, instruments, and examination rooms ready, or finding case records, as most of worktime may be spent on, on the other hand, Bán arrived at the conclusion that health care workers' workload in Hungary exceeded international averages significantly. Based on data from relevant literature, attendance on a ward patient takes a nurse 210 working minutes a day on an average, as opposed to 179 in Hungarian general medical wards, and 98 in Hungarian chronic wards, under review as found by Bán. His findings are so much more alarming as physical overload may lead to inattention, forgetfulness, low spirits, and, ultimately, inadequate attendance on patients.

When it comes to the statutory regulation of work time-to-rest time ratios, the medical profession is usually an exception to the rule (Weinger and Ebden, 2002). In a few sectors of health care, physicians and nurses spend times at work well in excess of respective statutory requirements (especially due to the hospital night duty system). Practitioners of most medical trades shall do their share at weekends, during bank holidays, in the afternoons, and at nights as well. The

multiple-shift rule of work and (night) duty system affect health care workers' physical and emotional loads considerably. Efforts made to cope with variations in the rythm of work consume extra energy. Undertaking night duties or multiple shifts in succession is essential for the continuous operation of any health care institution as well as a must for employees in order to tackle their daily financial problems (Molnár and Feith, 2000).

The lengthening of work time and chronological reorganization of work performance may induce various physical and psychic disorders. Close correlation of cardiovascular diseases and mortality with low control over the work schedule has already been demonstrated by early medical-sociological studies (Karasek et al., 1981). Emergence of mental disorders with physicians often coincides with their low levels of control over work (Firth and Cozens, 1997; Hsu and Marshall, 1997). Based on literary data, physicians accomplishing a lot of night and weekend duties, and dealing with a lot of patients in severe conditions, are particularly at risk of burnout (Szicsek, 1995; Firth and Cozens, 1987).

In view of the psychic and health impact of work stress, the amount of leisure time available to one and length of holidays one can take and spend on active recreation, are also key factors. Working in multiple shifts does not only shorten the amount of leisure time available to one, but has its effect also felt on the way one can make use of such leisure time. Night duties and multiple shifts done in succession, - often involving continuous work as long as 24 hours at a stretch, - interfere with social relations, and render the organization of one's family life difficult. Such difficulties are encountered by women to a particularly great extent. While women are supposed to give their families preference over their jobs and, hence, cannot help suffering more cognitive and actual conflicts than their male colleagues do, they have more difficulty in tolerating the reorganization of their biorhythm physiologically (Agüir, Hoyos, Bolumar, 1993).

Encountering and undertaking the management of social issues such as unemployment or "taking shelter in sickness," have become, by now, part of the health care workers' daily routine. Health care workers are supposed to satisfy emotional demands as well as fulfil professional duties thereby aggravating their general overload. To make their situation even worse, they should not give utterance to their stress, frustration, or impatience. They should refrain from displaying their emotions during their everyday work because such display would be contrary to the way they are expected to behave at work. Stress will thus become the source of multiple psychic disorders, or even lead to burnout in extreme cases.

The emotional and psychic overload is a phenomenon very often rendered subject to studies of people practising caring professions (Spickard, Gabbe, Christenseni, 2002; Mark, 2005). In Hungary, it has been studied among nurses (Piczil and Pikó, 2003; Pikó, 2006; Szemlédy, 2004) as well as physicians (Győrffy and Ádám, 2004a, 2004b; Győrffy et al., 2004). Most often, studies focus on the trio

of depersonalization, emotional exhaustion, and decrease in performance and, besides, on stress at work (Maslach and Goldberg, 1998), to which the development of the former three can be ultimately attributed. On the other hand, job dissatisfaction, career changing, impairment of one's self-image, and emergence of psychosomatic symptoms is studied as consequences (Jeanneau and Armelius, 2000; Leiter, 1992; Murray, 2002; Ramirez et al., 1996). To sum up, extensive research has been devoted to the various psycho-social characteristics of working environments and their impact on workers, while few treatises deal with the emotional labour of health care workers. Hungarian literature makes only tangential mentions of emotional labour in connection with the emotional exhaustion component of burnout.

Health care workers are continuously working under emotional and psychic pressure. Maslach (1982) tested thousands of American and foreign people in caring professions for the burnout syndrome and found that, out of all stressors at work, adverse staff-to-patients ratios, improper working conditions, long working time and/or shift work and too much time spent on direct physician/nurse/patient interactions were the ones that had their effects felt the most.

Components of work stress inherent in the labour organization were as follows:
– duties not clearly defined
– simultaneous working in multiple teams
– lack of team-spirit
  ○ no seconding by senior staff
    ▪ jobs to do beyond one's competence (jobs seemingly unfeasible)
– shortage of labour
  ○ accumulation of health care-related (treatment-related) and administrative jobs
  ○ shortage of physicians and health care professionals
  ○ accumulation of responsibilities
  ○ unskilled staff
    ▪ defective performance of work
    ▪ training needs increasing the staff's workload further
– inadequate communication
– adverse occupational climate
– conflicts
  ○ technical disagreements within a multidisciplinary team (e.g. onco-team)
  ○ conflicts arising from resource allocation to teams
  ○ doubts about patient orientation (a health care professional to tell or not to tell a patient a fact which a physician has refrained from telling)
  ○ conflicts arising from undefined jobs and spheres of authority with health care staff within or outside a health care institution

- rapid changes in the health care system
  - insufficient communication of changes
  - incapacity to influence decisions on changes
  - uncertainty (of existence) resulting from continuous change

Incongruent rewarding

Siegrist (1996) finds proportion, or rather imbalance, of effort to reward to be a major potential for development of disease. In the context of a working environment, disproportion means that the reward system is not congruous with the high levels of workload, or employees do not have control over such factors. Based on Siegrist's theory, it is job characteristics such as work in shifts, high workload, noise, or bad working conditions as well as remuneration / reward system characteristics such as uncertainty of employment, enforced transfer, downgrading, or lack of professional advancement that have influence on employees' potential for disease. Siegrist differentiates between two coping variables, namely vigor and immersion, reflecting an employee's attitude towards a particular situation. According to his findings, employees choosing immersion produced cardiovascular diseases, while workload and lack of control over reward were found to be risk factors even with those who chose to adopt an active mode of coping and take positive efforts.

Lack of control

Several treatises emphasize the fact that little control over performace is instrumental in the development and persistence of burnout (Ramirez et al., 1996; Agius et al., 1996; Cooper, 1989).

Factors of control over performance of work are as follows:
- control over schedule of work
  - breaks
  - working hours
  - number of patients to attend to
  - amount of administrative duties
- features of occupational infrastructure
- nature of team-work

Different nature of illnesses treated

Norbeck's (1985) studies lead us to the conclusion that higher levels of work stress induce lower satisfaction and often give rise to psychological symptoms. According to Jones (1987), differing levels of exposure to emotional and other stresses exist in different hospital sections because of the dissimilarity of patients and diseases.

Complex models

Offering their 'job demand – control – support' model, Karasek and Theorell (1990) argue that organizational factors play a key role. Similarly to Siegrist's findings, they found close correlations between workload, control, and employees' stress levels at work. This model broadens out the notion of control by identifying control dimensions such as usage of capabilities and decision-making power, and introduces the concept of social support (social / emotional support and additional help to fulfilment of duties) as a positive organizational factor.

Studying Karasek's model, De Jonge et alii (1999) concluded that while control itself is an inhomogeneous phenomenon, workload has also got three different dimensions. They differentiated between physical, psychic, and emotional workload. In line with the findings outlined in the section on the negative affects of emotional labour, their findings gave evidence of an increased rate of psychosomatic complaints in jobs involving increased levels of emotional workload.

Having deep interviewed 57 physicians, Zsuzsa Győrffy and Szilvia Ádám (2004b) identified six categories of factors producing burnout:
- problems arising from lack of time (defective fulfilment of duties, fatigue, lack of sleep, private life being pushed into the background);
- consequences of financial factors (necessity to do extra work, frequent night duty, lack of help in household duties or child care);
- occupational factors (occupational climate, routine duties, lack of autonomy, bad managerial style, lack of team-spirit);
- treatment of patients as objects or pieces of work;
- aversion to patients;
- role conflicts.

Heck and Ehle (1990) studied factors impeding the performance of work by health care workers. Having added up the opinions of 203 nurses, they identified 12 crucial occupational factors. The five stress factors of utmost importance were found to include attendance to patients in death agony, family conflicts arising from occupational causes; the insufficiency of intra-communal communications; the negative perception of physician/nurse/patient relations; and physical strain.

According to Kelly (1985), health care workers may encounter five types of stress situation at work: conflicts arising from interactions with patients, colleagues (i.e. other health care workers), or superiors, with those rooted in the working environment and related to knowledge and skills.

Studying stress at work among hospice and intensive nurses, Bené and Foxall (1991) found that interactions with physicians, the emotional demands of their job, uncertainties originating in the nature of diseases, workload, and the shortage of resource supply were regarded as the main sources of stress with the majority of the data suppliers. On the other hand, challenges arising from labour organization such as the rotation of jobs, migration between caring units as well as supervision were acknowledged as useful and not considered as sources of stress.

Sonneck (1982) defines the health care professionals's workload as the result of three dimensions: physical and emotional stress inherent in the nature of the medical profession; the impact of the labour organizations; and control over the performance of work. This structure is capable of combining all three theories outlined above, while allowing a classification of stress factors at work as presented in the supplementary literature.

As represented above, the stressors are numerous and various. Components of stress inherent in the nature of the medical profession are as follows:

1. high physical and psychic pressures
    - increasing workloads and lengthening working time
    - work in shifts
    - night duty system
        - upset of the balance between work and private life
        - negative impact of the nature of work on chances of recreation
    - administrative duties
    - cleaning jobs for health care professionals
    - great responsibility
    - frequent crisis situations
2. low earnings
    - necessity to do extra work
    - being frequently on night duty
    - lack of paid help in household duties or child care
3. lack of moral recognition
4. levels of emotional and psychic pressure varying with the types of disease
    - diagnostic difficulties
    - telling a patient a diagnosis of tumour or incurability
    - making a patient acknowledge a status of alteration
    - managing vain hopes of an incurable patient
    - mental guidance to an incurable patient
    - emotional and mental load arising from attachment developed to a patient
    - unfair behaviour of a patient towards health care staff
    - job-related failure (e.g. unsuccessful treatment, failing resuscitation)
    - losing a patient (especially where an attachment has developed)
        - emotional exhaustion, apathy
        - impaired self-evaluation
    – easy access to drugs

How to mitigate the effect of stressors

High workload combined with low support and little control is the cause of multiple psychosomatic diseases. According to the DCS (demand-control-support) theory, however, a supporting occupational climate, social support by colleagues, and a subjective sensation of control over work have a moderating effect on stress arising from workload (Johnson and Hall, 1988; Karasek and Theorell, 1990). Similarly, Van Vegchel et al. (2004) arrived at the conclusion that burnout and, especially, its emotional exhaustion component correlated positively with quantitative job demands and the number of standards regulating the display of one's emotions, while negatively with control over working and social support. In their research, Himmel, Dietrich, Kochen (2000) and Greenglass, Wolpin, Burke (1994) found that information and material support given by colleagues would reduce the risk of burnout significantly. The forthcoming section strives to cite all the stress-moderating factors that have been researched in health-care setting.

Span of control

Investigations of Van Vegchel et al. (2001, 2002) show that the health care workers' burnout is dependent upon quantitative and emotional demands, control over work, and social support. It was found that control over work affected all the three dimensions of burnout significantly. For this reason, health care institutions should make sure that they allow their employees to exercise the highest possible level of control. Nurses interviewed thought that enrichment of labour and decentralization would offer a solution to the problem and, besides, if the task-oriented approach of their organization had been replaced by a patient-oriented one, they could have carried out their mission of healing and caring more easily. Schneider et al. (1998) are in favour of a patient-oriented health care organization too, holding the opinion that shifting the focus in health care institutions would allow employees to use their empathy and creativity for the benefit of the patients. By doing so, the patients' well-being could be improved as well as health care workers would perceive their own efforts more important and efficient.

Van Vegchel et al. (2005) found control over work to correlate with standards pertaining to the display of emotions. This correlation was found to be relevant in both senses. On the one hand, the quality of emotional displays when strictly regulated reduces the sense of personal freedom, while increasing the sensation of being under control. On the other hand, transfer of control over work often leads to the internalization of organizational standards (pertaining to emotional displays), which, in turn, eases external emotional pressures and the sensation of emotional dissonance. The concept of client-oriented control (Dormann et al., 2003) is based on a similar approach. According to this concept, health care institutions should set the goal of patient satisfaction for their employees rather than regulate means and manners of everyday performance of work. Client-oriented control would give health care workers more freedom to make decisions

for the patients' benefit and, ultimately, produce a client-oriented organization instead of a task-oriented one.

Restitution

The high levels of emotional demand also showed a correlation with all the three burnout dimensions (Van Vegchel et al., 2004). To lessen the emotional load of health care workers, duties requiring and those not requiring emotional labour should be performed in rotation. A rest area or communal room designed to enable health care workers to get away from their emotionally burdensome tasks would also be useful.

According to Péter Molnár and Márta Csabai (1994), burnout can be prevented. The commencement of the cycle can be warded off by keeping the initial excessive enthusiasm under control. The following preventive check-points are recommended:
- sound aloofness: letting problems be seen objectively;
- intellectual and rational approach to situations full of stress;
- reduction of excessive involvement in interactions full of stress;
- social and working interactions between health care workers, of a supporting and relaxing character and allowing the sharing of responsibility;

Ward climate

Based on a research by Heck and Ehle (1990), it can also be concluded that a good climate at one's hospital ward. Ward climate consists of:
- tone of communication;
- consideration of proposals;
- physicians' broad-mindedness to the nurses' problems;
- conversations about attendance to patients in death agony;
- ongoing training

Numerous treatises deal with the way factors relating to the working environment act upon the health care professionals' physical and mental health (Agüir and Burillo, 2004; Leiter, 1992; Murray, 2002; Pikó, 1999; Ramirez et al., 1996; Wheeler and Riding, 1994; Zammuner and Galli, 2005). According to the theory of organizational support (Eisenberg et al., 2001), non-financial benefits may, to a high degree, contribute to burnout prevention, to higher satisfaction with and love of one's job, as well as to improved work performance, ultimately producing better physical-mental health and a sensation of well-being. For this reason, a proper psycho-social climate plays a key role in prevention. A fine and pleasing physical environment with a pleasant general effect of equipment and furniture will alleviate work stress (Rhoades and Eisenberg, 2002).

The supporting function of one's working environment acts as a protective factor. Social-emotional support provided by one's superiors, an awareness of the

importance of one's profession, the enhancement and recognition of one's commitment to the organization, and the granting of autonomy, may all contribute to the attenuation of psychic pressures inherent in health care work (Lambert, Lambert, Ito, 2004). Such means are particularly efficient if employed in the course of case discussions, staff meetings, professional extension training sessions, or supervisory events. Remedies requiring organizational support may include the granting of the complementarity of jobs with similar profiles, job enrichment, the changing of team compositions, and a variable work schedule (Ramirez et al., 1996). The granting of opportunity for professional improvement is another useful means to prevent lethargy and indifference. Professional extension training may augment one's network of social relations as well as render one's everyday work efforts more interesting and motivated. Furthermore, a requirement to translate new knowledge and theories into practice may add new challenges to the daily routine (Zammuner, Lotto, Galli, 2003).

Identification with one's profession:

Positive identification with one's profession, is also identified as one of the most useful weapons in the fight against work stress (Heck and Ehle, 1990). This factor has been associated with the following variables:

- fulfilment of one's professional expectations;

- re-election of one's profession;

- treatment of the patients' relations;

- age.

Based on studies by Győrffy and Ádám (2004b), one's early commitment to and juvenile ambitions for a profession may reduce the intensity and frequency of stress situations occurring later, and help one to find one's proper balance. An individual with an early commitment is more self-confident and ambitious and possesses greater internal control than those who have elected to take up health care as their profession at a more advanced age (Bowman and Allen, 1990, Szluha et al, 2008).

Social Support

In another treatise of theirs, Győrffy and Ádám (2004a) call attention to the importance of the caregivers' off-the-job life and that of recreation, as:

- an understanding and accepting attitude towards the patients' relations;

- division of labour within one's family;

- leisure time.

Their studies show that the measure of social support as one perceives it as well as its relaxing power, the breadth and depth of the network of one's social relationships, affect one's coping potential significantly. The amount of leisure

time available to one, the number of days off one can take a year, and the ways one can spend one's days of leisure, are factors not to be ignored either when it comes to stress reduction and recreation. According to an old-established practice in several Western-European countries, experts working in some intellectual field are granted a free paid year off every seventh year of their service. This period of time can be used for an overall physical, mental, and emotional regeneration and bringing one up to one's full strength (Győrffy et al, 2004). A solution like that seems, however, rather utopian in health care in particular, and generally in Hungary.

A study of Greenglass and Burke (1995) proves that the fellow-workers' emotional support will not only alleviate such feelings as cynicism, uncertainty about work, or sensation of futility of efforts resulting from detrimental work, but will lead to improved self-evaluation and a sense of being important.

'Bálint Groups' represent a special form of social support. Each group is a closed community of 10 to 15 persons, existing for two to three years. It consist of healthcare professionals who treat patients with similar diseases, and encounter similar problems during their everyday work. Group sessions provide an opportunity for attendees to use their fantasy and creativity to discuss problems which any member of the Group has experienced. Through a collective learning process, and reflection and supervision of their own activities, Group members will become capable of practising an improved self-recognition, revising their professional identity, and altering their job-related attitude / personality. In other words, the Bálint Group approach has been designed to explore the psychological background of medical work in order to help improve the quality of healthcare acitivies and, at the same time, protect the mental hygiene of physicians. Work in a Bálint Group is often called a practical assessment of physician / patient interactions.

Summary, conclusions

Caring professions in general and health-care jobs especially are tiring. There are many aspects of workplace stress that can not be (totally) controlled by employers. Social support for excample is an essential element of preventing burnout. However, not even work climate, - and the private sphere of the individual even less likely, - can be fostered by the employers mere will. The first is something embedded (or not) in the organisational culture, and so, hard to change. The second one is mostly dependent on individualistic features, such as personality és emotional intelligence. As individualistic and hard to alter traits go identification with one's profession is also an example.

However, organisations (employers and leaders) do not lack resources. What is more, it is in their own interest to moderate workplace stress, and through it negative behavioral patterns, such as high turnover rates, or absenteeism, and negative psychosocial consequences like burnout emotional exhaustion or job estrangement.

Excess workload is something that can be alleviated by employers. Time for recreation and recuperation can be preprogrammed, work can be organised accordingly. Excellency at work can be rewarded, overtimes compensated. Even organisational commitment, and through it identification with one's profession can be gained through impartial, fair and at the same time motivating reimbursement. Employers may lessen the psychological burden on health-care workers by job enrichment and job enlargement, or leaders might decide to decrease the span of control, with this lessening the obligatory behavioral expectations.

References

[1.] Ádám Sz., Gyõrffy Zs. (2003): Orvosnõk az anyaságról. Esély, 3. pp. 86-92.

[2.] Ádám, Sz. et al. (2009): Gyakori a magas fokú kiégés a háziorvosok és háziorvosi rezidensek körében, Orvosi Hetilap. 150, 7, pp. 317-323.

[3.] Ádám, Sz., Győrffy, Zs., Susánszky, É. (2008): Physician Burnout in Hungary: A Potential Role for Work--Family Conflict. Journal of Health Psychology, 13. 7. pp. 847 - 856.

[4.] Agius R.M. et al. (1996): Survey of Perceived Stress and Work Demands of Consultant Doctors. Journal of Occupational Environmental Medicine, 53. pp. 217–224.

[5.] Agüir E., Burillo T. (2004): Psychological well-being among hospital personnel: The role of family demands and psychosocial work environment. International Archives of Occupational and Environmental Health, 77. pp. 401-408.

[6.] Agüir E., Perz-Hoyos V., Bolumar S. (1993): Effect of Work Organisation on the Mental Health of Nursing Staff. Journal of Nursing Management, 1. pp. 3–8.

[7.] Allen, J., Mellor D. (2002): Work context, personal control, and burnout amongst nurses. Western Journal of Nursing Research, 24. pp. 905-917.

[8.] Arnetz B. B. et al. (1987): Suicide patterns among physicians related to other academics as well as to the general population. Acta Psychiatria Scandinavica, 75. pp. 139-143.

[9.] Axelsson G., Rylander R., Molin I. (1989): Outcome of Pregnancy in Relation to Irregular and Inconvenient Work Schedules. British Journal of Industrial Medicine, 46. pp. 393–398.

[10.] Bán M. (1989): Az ápolónői munkaterhelések vizsgálata a Budapesti Tanács kórházainak belgyógyászati osztályain. Népegészségügy, LXX. pp. 348-352.

[11.] Bené B., Foxall, Martha J. (1991): Death Anxiety and Job stress in Hospice on Medical- Surgical Nurses. The Hospice Journal, 7. 3.

[12.] Bowman M. A., Allen D. I. (1990): Stress and Women Physicians. Springer-Verlag, New York, Berlin.

[13.] Boxer P. A., Burnett C., Swanson N. (1995): Suicide and occupation: a review of the literature. Journal of Occupational Environmental Medicine, 37. pp. 442-452.

[14.] Cooper C.L., Rout U., Faragher B. (1989): Mental Health, Job Satisfaction and Job Stress among General Practiioners. British Medical Journal, 298. pp. 366–370.

[15.] de Jonge, J., Mulder, M. J., Nijhuis, F. J. (1999): The incorporation of different demand concepts in the job demand-control model: effects on health care professionals. Social Science and Medicine, 48. 9. pp. 1149-60.

[16.] Dormann C., et al. (2003): Organisationale und perso¨nliche Dienstleistungsorientierung und ihre Grundlagen: Zum Konzept des kundenorientierten Handlungsspielraums (Organizational and personal service orientation and their foundations: The concept of customer-oriented control). Zeitschrift fu¨ r Arbeits- und Organisationspsychologie, 47. pp. 194–207.

[17.] Eisenberger R., et al. (2001): Reciprocation of perceived organizational support. Journal of Applied Psychology, 86. pp. 42-51.

[18.] Fekete S. (1991): Segítõ foglalkozások kockázatai – Helfer szindróma és a burnout jelenség. Psychiatria Hungarica, 1. 1. pp. 17–29.

[19.] Firth-Cozens J. (1987): Emotional Distress in Junior House-Officers. British Medical Journal, 265. pp. 533–536.

[20.] Firth-Cozens J. (1997): Depression in doctors. In: Robertson M., Kantona E. (Eds): Depression and Physical Illness. New York. pp. 95-111.

[21.] Greenglass E. R., Burke R. (1995): Longitudinal examination of the Cherniss model of psychological burnout. Social Science and Medicine: An International Journal, 40. 10. pp. 1357-1363.

[22.] Greenglass E., Wolpin J., Burke R. (1994): A longitudinal study of psychological burnout and it's effect on psychosomatic sympthoms. Journal Of Health and Human Resources Administration, Winter. pp. 286-303.

[23.] Gyõrffy Zs., Ádám Sz. (2003): Szerepkonfliktusok az orvosnõi hivatásban. Lege Artis Medicinae, 13. 2. pp. 159-164.

[24.] Gyõrffy Zs., Ádám Sz. (2004a): Az orvosnõi hivatás magatartástudományi vizsgálata. Mentálhigiéné és Pszichoszomatika, 5. 1. pp. 27-53.

[25.] Gyõrffy Zs., Ádám Sz. (2004b): Az egészségi állapot, a munkastressz és a kiégés alakulása az orvosi hivatásban. Szociológiai Szemle, 14. pp. 107-127.

[26.] Gyõrffy Zs., Mészáros E., Ádám Sz., Kopp M. (2004): Az egészségügyben dolgozó nők gyermekvállalással és terhességgel kapcsolatos mutatói országos reprezentatív minta alapján Mentálhigiéné és Pszichoszomatika, 5. 4. pp. 321-333.

[27.] Haynes S. G., Eaker E. D., Feinleib M. (1984): The effect of employment family and job stress on coronary heart disease patterns in women. In: Gold E. (Ed): The Changing Risk of Disease in Women. Health and Co., Lexington.

[28.] Haynes S. G., Feinleib M. (1980): Women work and coronary disease: prospective findings from the Framingham heart study. American Journal of Public Health, 70. pp. 133-141.

[29.] Heck H., Ehle G. (1990): Belastungen bei Krankenschwestern (Heft 3.). Psychische und soziale Heilberufe, 42.

[30.] Himmel W., Dietrich A., Cochen M. M. (2000): Will german patients accept their family physician as a gate keeper? Journal Of General Internal Medicine, 15. 7. pp. 496-502.

[31.] Hsu K., Marshall V. (1997): Prevalence of Depression and Distress in a Large Sample of Canadian Residents, Interns and Physicians. North American Journal of Clinical Psychiatry, 144. pp. 1561–1566.

[32.] Infante-Rivard C., et al. (1993): Pregnancy Loss and Work Schedule during Pregnancy. Epidemiology, 4. pp. 73–75.

[33.] Jeanneau M., Armelius K. (2000): Self-image and burnout in psychiatric staff. Journal of Psychiatric and Mental Health Nursing, 7. pp. 399-406.

[34.] Johnson J. V., Hall E. M. (1988): Job strain, work place social support, and cardiovascular disease: A cross-sectional study of a random sample of the Swedish working population. American Journal of Public Health, 7. pp. 1336–1342.

[35.] Jones J. R. (1998): An examination of the emotional labor construct and its effects on employee outcomes. Unpublished doctoral dissertation, University of Nebraska, Lincoln.

[36.] Karasek J., et al. (1981): Job Decision Latitude, Job Demannds and Cardiovascular Disease: A Prospective Study of Swedish Men. American Journal of Public Health, 71. pp. 694–705.

[37.] Karasek R. A., Theorell T. (1990): Healthy work: Stress, productivity and the reconstruction of working life. New York: Basic Books.

[38.] Kelly J. G., Cross D. G. (1985): Stress coping behaviors and recommendations for intensive care and medical surgical ward registered nurses. Research in Nursing and Health, 4. 8. pp. 321-328.

[39.] Kovácsné Tóth Á., Feith H. J., Balázs P. (2004): A diplomás ápoló hallgatók pályaválasztási motivációja és pályaelhagyása. Nővér. 17/6. pp. 9-13.

[40.] Lambert V. A., Lambert C. E., Ito M. (2004): Workplace stressors, ways of coping and demographic characteristics as predictors of physical and mental health of Japanese hospital nurses. International Journal of Nursing Studies, 41. pp. 85-96.

[41.] Lazányi, K., Molnár, P., Szluha, K.(2007): Az érzelmi munkavégzés fogalmának bevezetése az onkológiába, Orvosi Hetilap, 148, 22, pp.1017-1021.

[42.] Lee R.T., Ashforth B.E. (1996): A meta-analytic examination of the correlates of the three dimensions of job burnout. Journal of Applied Psychology, 81. 2. pp. 123-133.

[43.] Leiter M. P. (1992): Burnout as a crisis in professional role structures: Measurement and conceptual issues. Anxiety, Stress and Coping, 5. pp. 79-93.

[44.] Levey R. E. (2001): Sources of Stress for Residents and Recommendations for Programs to Assist Them. Academic Medicine, 76. 2. pp. 142-150.

[45.] Linzer M. (2001): Society of General Internal Medicine Career Satisfaction Study Group: Predicting and Preventing Physicians Burnout: Results from the United States and the Netherlands. American Journal of Medicine, 111. 2. pp. 170–175.

[46.] Mackenzie C. S., Poulin P. A., Seidman-Carlson R. (2006): A brief mindfulness-based stress reduction intervention for nurses and nurse aides. Applied Nursing Research, 19. pp. 105-109.

[47.] Mark A.(2005): Organizing emotions in health care. Journal of Health Organization and Management Information, 19. 4-5. pp. 277-289.

[48.] Maslach C. (1982): Burnout: The cost of caring. Englewood Cliffs, NJ: Prentice-Hall.

[49.] Maslach C. (1993): Burnout: A multidimensional perspective. In: Schaufeli W. B., Maslach C., Marek T. (Eds), Professional burnout: Recent developments in theory and research. pp. 19-32. New York, NY: Hemisphere.

[50.] Maslach C., Goldberg J. (1998): Prevention of burnout: New perspectives. Applied & Preventive Psychology, 7. pp. 63-74.

[51.] Maslach C., Jackson S. E. (1981a): The measurement of experienced burnout. Journal of Occupational Behaviour, 2. pp. 99-113.

[52.] Maslach C., Jackson S. E. (1981b): Maslach Burnout Inventory. Consulting Psychologists Press, Palo Alto, CA.

[53.] Molnár L., Mezey M. (1991): Az orvosok megbetegedésérõl és halandóságáról. I.-III. Lege Artis Medicinae, 1. 8. pp. 524–528.; 9. 10. pp. 640–644; 11. pp. 966–970.

[54.] Molnár P., Csabai M. (1994): A gyógyítás pszichológiája. Budapest, Springer Hungarica.

[55.] Molnár R., Feith H. (2000): Szerepkonfliktusok megnyilvánulásai orvosnõk körében. Lege Artis Medicinae, 10. 10. pp. 810-815.

[56.] Murray M. K. (2002): The nursing shortage: Past, present, and future. Journal of Nursing Administration, 32. pp. 79-84.

[57.] Nagy B.(2001): Nõi menedzserek. Budapest: Aula.

[58.] Norbeck J. S. (1985): Perceived job stress, job satisfastion, and psychological symptoms in critical care nursing. Research in Nursing and Health, 3. 8. pp. 253-259.

[59.] Palepu A., Herbert C. P. (2002): Medical women in academia: the silences we keep. Journal of Canadian Medical Association, 167. 8. pp. 877-879.

[60.] Phillips S. P. (2000): Parenting, puppies and practise: juggling and gender in medicine. Journal of Canadian Medical Association, 162. 8. pp. 663-672.

[61.] Piczil M., Pikó B. (2003): Az ápolói hivatás pszichoszociális kihívásai: kiégettség, kockázati magatartás, társas támogatás. Egészségügyi Menedzsment, 5. pp. 29-33.

[62.] Pikó B. (1999): Work-related stress among nurses: a challenge for health care institutions. The Journal of The Royal Society of Health, 119. pp. 156.162.

[63.] Pikó B. (2006): Burnout, role conflict, job satisfaction and psychosocial health among Hungarian health care staff. International Journal of Nursing Studies, 43. pp. 311-318.

[64.] Pikó B., Piczil M. (2000): És rajtunk ki segít? Kvalitatív egészségszociológiai elemzés a nõvéri hivatásról. Esély, 11. 1. pp. 110-120.

[65.] Pikó B., Piczil M. (2006): A pszichoszociális munkakörnyezeti jellemzők összefüggése az elégedettséggel nővérek körében. Mentálhigiéné és Pszichoszomatika, 7. 4. pp. 301-310.

[66.] Ramirez A. J., et al. (1996): Mental health of hospital consultants: the effects of stress and satisfaction at work. Lancet, 53. 16. pp. 724-728.

[67.] Rhoades L., Eisenberger R. (2002): Perceived organizational support: a review of the literature. Journal of Applied Psychology, 87. pp. 698-714.

[68.] Schneider B., White S. S., Paul M. C. (1998): Linking service climate and customer perceptions of service quality: Tests of a causal model. Journal of Applied Psychology, 83. pp. 150–163.

[69.] Siegrist J. (1996): Adverse health effects of high effort/low reward conditions. Journal of Occupational Health Psychology. 1. pp. 27-41.

[70.] Sonneck G. (1992): Orvosok öngyilkossága és kiégettsége. Szenvedélybetegségek, 2. 1. pp. 28-31.

[71.] Spickard Jr. A., Gabbe S. G., Christensen J. F. (2002): Mid-career burnout in generalist and specialist physicians. Journal of the American Medical Association, 288. pp. 1447-1450.

[72.] Szemlédy I. (2004): A kiégés jelenségének vizsgálata dializáló ápolók körében. Nõvér, 17. 1. pp. 16.

[73.] Szicsek M. (1995): A szorongás megjelenése a mindennapi ápolói munkában és az alkalmazott Coping-mechanizmusok. Szakdolgozat. Budapest, ELTE BTK Pszichológia Szak. 1995. Kézirat.

[74.] Szluha, K., Lazányi, K., Horváth, Á., et. al. (2008): Az onkológiai szakdolgozók érzelmi munkájának vizsgálata a pályaválasztási motivációk tükrében, Magyar Onkológia, 52, 1, pp. 65-69.

[75.] Szluha, K., Lazányi, K., Molnár, P. (2007): Az érzelmi munka szerepe az onkológiában, Magyar Onkológia, 51, 1, pp.47-51.

[76.] Theorell T. (1991): On Cardiovascular Health in Women: Results from Epidemiological and Psychological Studies in Sweden. In: Frankenheuser M., Lundberg U., Chesney M. (Eds): Women, Work and Health. pp. 187–204. New York, Plenum Press.

[77.] Tóth O. (1995): Hogyan egyeztethető össze a nöi munka a családi szerepekkel. Info-Társadalomtudomány 32. pp. 33-37

[78.] Tyssen R., et al. (2001): Suicidal ideation among medical students and young physicians: a nationwide and prospective study of prevalence and predictors. Journal of Affective Disorders, 64. pp. 69-79.

[79.] Van Vegchel N., De Jonge J., Schaufeli W. (2005): Reviewing the effort-reward imbalance model: drawing up the balance of 45 empirical studies. Social Science and Medicine, 60. pp. 1117-1131.

[80.] Van Vegchel N., et al. (2001): Different effort constructs and effort–reward imbalance: Effects on employee well-being in ancillary health care workers. Journal of Advanced Nursing, 34. pp. 128–136.

[81.] Van Vegchel N., et al. (2002): Testing global and specific indicators of rewards in the effort–reward imbalance model: Does it make any difference? European Journal of Workand Organizational Psychology, 11. pp. 403–421.

[82.] Van Vegchel N., et al. (2004): Quantitative Versus Emotional Demands Among Swedish Human Service Employees: Moderating Effects of Job Control and Social Support. International Journal of Stress Management, 11. 1. pp. 21–40.

[83.] Wall T. D., et al. (1997): Minor psychiatric disorders in NHS trust staff: occupational and gender difference. British Journal of Psychiatry, 171. pp. 519-523.

[84.] Weinger M., Ebden P. (2002): Sleep deprivation and clinical performance. JAMA, 287. pp. 955-958.

[85.] Wheeler H., Riding R. (1994): Occupational stress in general nurses and midwives. British Journal of Nursing, 3. pp. 527-534.

[86.] Whippen D.A., Canellos G.P. (1991): Burnout Syndrome in the Practice of Oncology: Results of Random Survey of 1,000 Oncologist. Journal of Clinical Oncology, 9. pp. 1916–1921.

[87.] Zammuner V. L., Lotto L., Galli C. (2003): Regulation of emotions in the helping professions: Nature, antecedents and consequences. Australian e-Journal for the Advancement of Mental Health (AeJAMH), 2. 1. pp. 1-13.

[88.] Zammuner V.L., Galli C. (2005): Wellbeing: causes and consequences of emotion regulation in work settings. International Review of Psychiatry, 17. pp. 355-364.