Burnout

in Nursing

Are We Blaming the Victim?

by Lucy Heim Miller

"Their message is clear: if you, nurse, are stressed, and burning out, get a handle on it! Does this prescription make sense?"

Burnout in nursing is not new. Whether one uses Roberta McAbee's definition as "physical, mental, and emotional exhaustion, as well as professional disengagement from the work setting as a result of occupational stress," or Bonnie Moody's, as "staff who have become Krispy Critters!," all of us in nursing recognize when our colleagues have reached a chronically numbed-out, crabby, discouraged point in their practices.

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We know burnout's signs and symptoms, but what about the cure? And are those suggesting that cure in touch with the nurse of the '90s?

Focusing in the occupational health arena, Susan Lee Crawford, while noting her recommendations cannot be effected overnight, suggests incorporating a model of stress management in the workplace. Her model incorporates the "whole person stress management" perspective which delineates healing techniques in the "physical, social, spiritual, intellectual/mental, emotional, and environmental" domains. McAbee prescribes "buffering factors" such as "a sense of competence, control, or pleasure in one's work; control over aspects of one's practice; and lifestyle management." But recognizing that organizational and social support are more complex, she suggests "supportive communication, autonomy, and environmental factors."

Looking at burnout from the perspective of recruitment and retention in critical care areas, Lynn Doering says that "decentralization, primary nursing, and clinical ladder advancement, all designed to enhance self-esteem and self-actualization," may be the solution. In other words, if you feel better about yourself, burnout can be prevented.

Echoing these sentiments, Ruth Dailey Grainger says that we can "beat burnout" by using a long list of preventive strategies or remedies such as "positive thinking, relaxation, problem solving, and physical exercise."

And strategizing for the mental health setting, Carol G. and James W. Macinick suggest "training programs, rotating work responsibility, maintaining a warm and positive atmosphere, having an open-door policy for managers, and offering in-service training to enhance knowledge and skills."

These plans for burnout prevention and remediation, while not exhaustive, are representative of those suggested in nursing literature over the last five years. They are likely resources for any responsible nurse to survey in order to diagnose burnout and develop a plan for its prevention and/or remediation.

Their message is clear: if you, nurse, are stressed, and burning out, get a handle on it!

Does this prescription make sense? Yes and no.

Yes, it does make sense to survey recent professional literature to learn of the problems in the profession.

And no, because what is suggested is already obsolete!

Why? Because the amount and speed of change in healthcare over the past five years has been immense, and premises that were logical five or ten years ago don't hold up today. Uniformly, the experts' "solution" to burnout is predicated upon the nurse adapting to the job — *as if the job were reasonable and burnout was a maladaptive response!*

The reality is quite different. In the past five years, professional nursing has faced a money crunch and, while headlines haven't blasted nursing as the villain in the current cost crisis, nurses have nonetheless emerged as one of the main culprits, in essence bearing the "cost of the crime."

In the scramble by insurance companies, pharmaceutical firms, organized medicine, and healthcare administrators to maintain profits, they have adopted the "sicker-quicker" route for healthcare consumers. How? Cheaper employees!

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To hold hospitalization costs down, hospitals now allow only the sickest people to be hospitalized, and then — via diagnostic related groups, case management, clinical care pathways, and other hospital euphemisms — limit how long they can stay to the average amount of time their diagnoses need for remediation.

For nursing, this translates into more difficulty administering patient care in a technical sense — more tubes, more IVs, more medications, and more treatments. No longer do hospitals treat patients who are able to perform any degree of self care, so nurses are now called upon to utilize skilled observation and treatment for the majority.

New hospital policies also mean a daily escalation in the number of admissions and discharges — "get 'em in, fix 'em, get 'em out, and fast!" Ultimately, this results in a much more arduous workload, with no time to catch our breath. So where is one of the main sources of job satisfaction for nurses, the camaraderie of spending small amounts of time with our peers, discussing cases, learning new techniques, and receiving support?

Current workloads erode breaks, invade mealtimes, and turn each nurse into a separate, hurrying, task-driven worker trying to beat the clock. As in manufacturing, where this scenario is called a "work speed-up," hospitals are now saving money by keeping the number of their workers and their workers' pay constant, but increasing their workload — more output for the dollar.

This compounds the "sicker-quicker" phenomenon. Nurses, knowing that their jobs are precarious, that they will not work at all if the census drops, and that they will not be paid for unrequested days off, now spend 100 percent of their stamina with no agreed-upon ceiling for their workload.

What a bargain! We are expected to work very fast and very hard if we get to work at all, and to try to build our lives knowing there will be an unspecified number of days we're laid-off without pay.

We also know that when the census swells, overtime pay becomes history. Management, in shifting non-supervisory level nurses to salaried positions, sells this policy as a benefit that allows "personal flexibility." But the liability we incur from onerous workloads that extend the eight-hour shift well beyond its limits means less protection for nurses — no overtime, straight-time pay for extra days, and no compensatory time. In terms of dollars, the nurse loses.

At this point, nurses are working very hard, very fast, caring for technically complex patients. They experience frequent erosion of rest time, break time, and meal time, and live with the constant knowledge that on each workday, they are in jeopardy of being laid off with no pay (if census drops), and with no hope of overtime pay to make up the losses.

Add to this formula "cross-training." This new management approach covers two ideas. One is to teach different categories of professionals to assume tasks from each other's domains, the better to increase their individual package of skills and become moreversatile. For instance, licensed registered nurses, pharmacists, social workers, and physical therapists would overlap areas of skill competence, and the employer could offer care without employing as many specialists. This is not new to nursing — we routinely per form auxiliary skills when other professionals go home at night! Nevertheless, as fewer and fewer jobs are deemed to require the specialized skills of a nurse, cross-training means a reconfiguring of turf margins and raises questions about job security.

The other cross-training approach blurs the boundaries between licensed and unlicensed personnel. For instance, people hired with no external credential, or a very limited technical certificate, are trained in-house to do tasks previously restricted to licensed personnel. In *USA Today*, Marilyn Elias notes the shift in caregiving "from R.N.s to aides," crystallizing its success when utilized by the Voluntary Hospital Association of America in 1992. And an R.N., Pettey Ross, who served on the Texas Board of Nursing, has said that in cross-training, nursing might be throwing the baby out with the bathwater, as the profession has never identified what the "core" of nursing is.

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Nonetheless, cross-training is mushrooming nationally. Ward clerks are taught to administer EKGs, transportation workers to perform direct patient care, and nurses' aides to administer all sorts of medications. All these changes affect the professional nurse at several levels. *The American Nurse* reports that a "survey finds loss of R.N.s jeopardizes patient safety." Stress develops in adapting to redesigned work patterns and basic fears increase about being replaced entirely by unlicensed workers, or by having to be responsible for a horde of marginally trained caregivers. Most important is the erosion of the basis on which we became nurses at all — to give humane, educated care to those in need.

So the question is, "Is burnout a problem each nurse ought to be preventing, individually, with a series of prescriptions for the improvement of self-esteem, for relaxation, or for any other sort of self-improvement?" Or, are these palliatives obsolete?

After all, aren't these professed "solutions" tantamount to counseling the rape victim to keep quiet about the abuse, look for ways she might have been at fault, and improve *herself*, when, in fact, she needs to be helped to speak out and indict the perpetrator? Where did the belief arise that nurses are the fat-to-be-trimmed for a leaner healthcare system? When do nurse-leaders cease being reasonable in asking each nurse to work faster, harder, smarter, all the while shedding various pieces of the nursing role to a hodgepodge of so-called caregivers?

Given the situation that currently exists, and the bleak projections for nursing's immediate future, isn't it time for nurses, themselves, to reframe the issue of burnout as a predictable response to an unpredictable, unresponsive, oppressive work situation?

In other words, when will our profession finally conclude that immensely powerful hospital administration market forces, organized medicine, and third-party payers are the culprits in our devolving healthcare scene — and nursing is the victim?

When will nursing administrators stop teaching staff R.N.s to be good little, passive little, non-combative little girls? And when will nurses stop being victimized and stop cooperating with their adversaries?

Before so many of us are burned to a crisp and/or replaced that we won't even be missed, isn't it about time we fought back?

[LUCY HEIM MILLER, Ph.D., R.N., teaches nursing at Valdosta State University in rural South Georgia. At staff nurse through supervisory levels, she has practiced nursing in maternity, staff education, rehabilitation, medical-surgical, and child-adolescent psychiatry. Currently, she teaches leadership and management, theory, and curriculum design, and is writing a Nursing Issues textbook.]

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REVOLUTION
Looks at Clinical Nursing. Burnout in Nursing — Are We Blaming the Victim ?
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Synopsis - The “experts “ say that burnout is nursing’s problem: all we have to do is adapt to the unadaptable! “NO WAY” says the author. Nurses have to fight back.