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ARTICLES

Ethics in human resource management: potential for burnout among healthcare workers in ART and community care centres

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Abstract

This paper examines ethical dilemmas in providing care for people with HIV/AIDS. Healthcare providers in this sector are overworked, particularly in the high prevalence states. They are faced with the dual burden of the physical and the emotional risks of providing this care. The emotional risks result from their inability to control their work environment, while having to deal with the social and cultural dimensions of patients' experiences. The physical risk is addressed to some extent by post exposure prophylaxis. But the emotional risk is largely left to the individual and there is little by way of institutional responsibility for minimising this. The guidelines for training workers in care and support programmes do not include any detailed institutional mechanisms for reducing workplace stress. This aspect of the programme needs to be examined for its ethical justification. The omission of institutional mechanisms to reduce the emotional risks experienced by healthcare providers in the HIV/AIDS sector could be a function of lack of coordination across different stakeholders in programme development. This can be addressed in further formulations of the programme. Whatever the reasons may be for overlooking these needs, the ethics of this choice need to be carefully reviewed.

The Indian effort in preventing HIV infection, and providing care, support and treatment for those affected by it, has been characterised by national level planning and local level realisation. The National AIDS Control Organisation (NACO) is responsible for the implementation of the National AIDS Control Programme (NACP) (1). In this essay we propose to examine the NACP Phase III programme for care and support for persons with HIV/AIDS in terms of the burden that it puts on healthcare workers. Such care is significant and different from care provision in other circumstances because it carries with it the physical risk of infection, the emotional risk of stigma and discrimination, and moral dilemmas due to concerns about confidentiality, treatment options, and coping with the ongoing loss of young people dying in the prime of their lives (2). We examine the workload in terms of worker-client ratios to determine the physical burden of care. The potential for emotional distress in the work setting is described using two case studies, one of a medical officer at a care centre and another of a senior care provider/researcher. We expect that the requirements for setting up organisations for the care of people living with HIV/AIDS (PLHA) include mechanisms both at the individual and at the institutional level to prevent burnout due to work-related stress. The extent to which this is fulfilled is examined using a framework of justice (3). The aim here is to situate the ethical dilemmas in providing care for PLHA from a public health policy perspective. Should the provision of care for PLHA take precedence over the need for protecting workers in the field? Should the programme leave it to individual workers to evolve coping strategies against burnout, or should it address this potential at the institutional and individual levels by having institutional norms and also having individuals undergo training for prevention of burnout?

The National AIDS Control Programme - Phase III

The National AIDS Control Programme (NACP), in its third phase, aims to halt and reverse the epidemic in India through a four-pronged strategy that includes prevention, provision of care, strengthening of infrastructure, and manpower and information management systems (4). As part of NACP III, a network of anti-retroviral therapy (ART) centres and community care centres (CCCs) has been set up in medical colleges, district hospitals and non-profit charitable institutions, with a mandate to provide counselling for drug adherence, nutritional needs, treatment support, referral and outreach for follow up, social support and legal services to PLHA (5).

The staffing pattern of ART centres and CCCs

The size of an ART centre and the staffing pattern are determined by the number of PLHA – alive and on ART - who are registered at that centre. For centres with PLHA less than 500 on ART, the total staff strength is five key employees; for centres with 500-1,000 PLHA, the recommended staff strength is eight; for centres with 1,000-2,000 PLHA, the recommended strength is nine and for centres with more than 2,000 PLHA, it is 12 (6).

CCCs provide continuity of care and support to PLHA within the community and facilitate adherence to treatment when they are on ART treatment.

The CCC is provided with an average staff strength of 14.5: 5.5 are healthcare providers, four are community-level outreach workers and five are administrative or other staff (7). There is limited scope for taking leave and this pattern of staffing puts a tremendous burden of care on healthcare providers and outreach workers.

Table 1. NACO guidelines for staffing at Anti-Retroviral Treatment centres, 2008				
Staff pattern	**Number of PLHA alive and on ART**			
	<500	**500-1000**	**1000-2000**	**>2000**
Senior medical officer	1	1	1	1
Medical officer	None	1	1	2
Laboratory technician	1	1	1	1
Counsellor	1	1	2	4
Pharmacist	None	1	1	1
Record keeper cum DEO	1	1	1	1
Nurse	1	1	1	1
Community care coordinator	None	1	1	1

Source: NACO. Operational guidelines for ART centres. [Internet]. [cited 2010 Mar 6].

Availablefrom:http://www.nacoonline.org/upload/Care%20&%20Treatment/ART%20operational%20%20guidelines%202008.pdf (6)

Table 2. NACO guidelines for staffing pattern of Community Care Centres, 2007	
Staff pattern	**Number**
Doctor	1 fulltime or 2 part-time
Project coordinator	1 fulltime
Counsellor	1 fulltime
Outreach workers	4
Lab technician	1 part-time
Nurses	3
Cook	1
Janitor	2
Helper	1

Note: A part time worker was counted as 0.5 worker on the assumption that they would contribute half the time that a full time worker would.

Source: NACO. Operational guidelines for community care centres. [Internet]. [cited 2010 Mar 4] (7).

Available from: http://www.nacoonline.org/upload/Publication/Treatment%20Care%20and%20support/Guidelines%20for%20Community%20Care%20Centre%20-.pdf

Examining the workload: burden of care across various healthcare providers

We have estimated the potential burden of work for healthcare workers, such as medical officers, nurses and counsellors, in the CCC and ART centres across states, comparing the client-provider ratios in these states. The work burden in high prevalence states like Tamil Nadu and Maharashtra exceeds 1,000 clients per year per worker. The work burden seems to be lower for nurses than for counsellors and medical officers, but it should be remembered that nurses tend to meet clients far more frequently than do medical officers, and therefore their actual burden of work would be higher. In all cases, this estimate of the work burden is an underestimate at best. Therefore the workloads for all these workers would, actually, be higher.

Method of estimation for Table 3: Using the project director's review meeting report (9), we obtained the number of PLHA ever registered, and the number of PLHA ever registered for ART. We obtained the number of HIV/AIDS patients ever registered and not on ART as 4,15,570. These patients were distributed across the various states using the percentage distribution of patients in India alive and on ART(8). This yielded an estimate of the number of ever registered patients on ART and not on ART. This total represents the overall workload across the different states. To estimate the number of medical officers, nurses and counsellors, we multiplied the number of functional ART centres and CCCs by the recommended pattern of such employees for each state. This is because we have used the recommended and not the actually observed pattern(6.7). We expect that the numbers actually employed would be less than or equal to the recommended contingent. We make this assumption as this is the pattern that obtains across other areas of care provision in the health sector. The estimate of the work burden is a ratio of the number of patients to the

Table 3: Estimated distribution of workload* of doctors, counsellors and nurses at ART and CCC in states of India, 2009				
Type of prevalence	**State**	**Doctor-client ratio (per doctor)**	**Counsellor- client ratio (per counsellor)**	**Nurse-client ratio (per nurse)**
High prevalence	Tamil Nadu	1,016	1,016	650
	Maharashtra	1,552	1,552	1,150
	Andhra Pradesh	1,622	1,622	1,048
	Karnataka	1,091	1,091	818
Medium prevalence	Manipur	757	757	568
	Nagaland	320	320	240
	Rajasthan	1,179	1,179	806
Low prevalence	Gujarat	1,697	1,697	1,194
	West Bengal	760	760	417
	Orissa	434	434	265
	Total	1,110	1,110	774

*Source: * Estimated for this case study using the listed sources (6-9).*

number of care providers. Clearly the denominators in the ratio have the potential to overestimate the number of healthcare professionals. Therefore the estimate of the work burden can be considered to be conservative at best.

Burnout and its consequences among health workers in HIV/AIDS care

Boxes 1 and 2 describe the dilemmas of specific healthcare providers in different contexts.

Case study of a medical officer's experience with an HIV discordant couple

A 35 year old male, Mr M, visited the outpatient department of a continuous care centre (CCC) in Tamil Nadu. After testing positive for HIV, the counsellor counselled Mr M about marriage, its implications for his partner and for himself. Later the counsellor and the other staff, through their common sources, learned that Mr M had subsequently married and that his wife was expecting a child.

Mr M visited the CCC for counselling and baseline investigations preparatory to anti-retroviral therapy (ART). During his visit, the staff in the centre accused Mr M of destroying the life of his wife by having sex despite his HIV positive status. They rebuked Mr M for having acted irresponsibly despite receiving their advice.

Subsequently, Mr M met with a young doctor in the centre who was willing to listen to his side of the story. According to Mr M, his stepbrother died of HIV/AIDS. At the time of his death no one in the family was aware of the HIV status of the brother's wife and no attempt was made to encourage her to learn of her HIV status. Subsequent to his stepbrother's death, Mr M had sexual relations with his widowed sister-in-law. Three years later, M developed symptoms of tuberculosis. In a primary health centre, Mr M was diagnosed with HIV-TB. Mr M was referred to a CCC run by a non-governmental organisation and received regular pre-ART care. He was always accompanied at the CCC by his sister-in-law. He was not eligible for ART since his CD4 count was above 200. After a year, Mr M dropped out and stopped visiting the CCC.

Mr M told the doctor that his family pressured him to get married. His parents were not aware that he was HIV positive. An older brother found a young woman from a poor family and arranged for their marriage. His family told the young woman that Mr M had suffered from tuberculosis. They told her that Mr M had to use condoms while having sex to prevent transmission of TB. Fearing that his marriage would break down, Mr M did not disclose his HIV status to his wife. Subsequently, she was willing to bear a child through the other brother of Mr M and became pregnant.

After hearing Mr M's story, the doctor at the CCC wanted Mr M to bring his wife for HIV counselling and testing. Mr M was unwilling to do that and the doctor was in a quandary as to what course to follow next. Before he could resolve the problem, Mr M developed further complications and was admitted as an inpatient at the centre. His wife visited him here and during her visit a staff nurse referred her to an integrated counselling and testing centre for HIV counselling and testing. She was found to be negative. The counsellor revealed the HIV status of her husband. She was initially shocked but later accepted it, saying that she was willing to sacrifice her life as she was happy with him.

Case study of a senior healthcare provider and researcher in the initial phase of the HIV epidemic

A senior medical professional works in a leading tertiary care institution undertaking research on HIV/AIDS and treating patients. He described the experiences that led to his burnout in the early 1990s as he worked in a clinic providing care for HIV/AIDS patients. In the initial phase of the epidemic, he worked exclusively with about three medical practitioners, accompanying nurses and a social worker. As the senior person in charge of the HIV/AIDS care clinic he had to bear the brunt of both administrative and clinical responsibilities while simultaneously carrying out epidemiological research on HIV/AIDS. He had to depend on his own personal contacts and social capital within the institution to run his clinic.

The institution did not want the notoriety of being an HIV/AIDS hospital and was therefore unwilling to lend direct support to the clinic. People working under him could approach him for counselling when stressed. For his own needs, he approached the hospital's psychiatric services. At that time, the possibility of burnout in HIV/AIDS was not well recognised and the stress he was experiencing did not receive much professional psychiatric help. The everyday burden of care provision with its accompanying risk of imminent patient deaths, the lack of treatment options and of coping mechanisms - all these were highly distressing for this senior medical professional. Eventually he was relieved of the responsibilities of running the clinic on a daily basis and the everyday stressors were no longer a part of his life.

Burnout and its consequences in HIV/AIDS care

Burnout is a state of mental exhaustion resulting from chronic stress in the working situation (10, 11). It has three dimensions; the experience of being emotionally exhausted (emotional exhaustion), negative attitudes and feelings towards the recipients of service (depersonalisation) and feelings of low accomplishment and professional failure (lack of personal accomplishment) (10,11). Research examining burnout in health situations has studied healthcare workers in highly charged environments like emergency departments (12,13) or emotionally and physically stressful conditions like working with HIV/AIDS patients (14-18) or cancer patients (19) or those working with mental health patients (20).

Healthcare providers working in the area of HIV/AIDS care have been studied for their proneness to burnout syndrome, especially when HIV prevalence is high among the population and among the providers. Burnout has been described in high prevalence areas such as south eastern Africa which is known to have deficiencies in training capacity, distribution and skill mix and the capacity to retain medical and caring professionals (17,18). Healthcare workers in HIV/AIDS are particularly vulnerable because of the physical risk of infection (2) and the fear of stigma and discrimination due to the disease (2,21). The burden here includes the risk of needlestick injuries, where the noted sero-conversion rate was 0.36% (22); very high requirements with respect to treatment adherence; drug resistance and treatment failure and co-morbidities that have to be dealt with both within the clinic and in the community (2). This feature is what distinguishes it from other similarly frustrating circumstances faced by healthcare providers. Care provision for HIV/AIDS also increases the burden for workers who are not directly in the frontline of treatment - particularly when there is a shortage of appropriate infrastructure and equipment to deal with the problem (21).

While all efforts at training are aimed at building clinical skills, not much time is devoted to building other skills that are deemed necessary for coping with stress on the worksite.

"I wonder whether others have gone through this stressful situation and how they cope with this individually, leaving the job eventually... If you work conscientiously and if your work infrastructure does not allow you to work at your potential, you would be frustrated because you cannot do what you are supposed to do..."

Health professional

Coping strategies for stress have been classified as those oriented towards the problem and those oriented towards the emotion (10). Strategies oriented towards the problem are likely to be more effective, but their effectiveness depends on the ability to control the potential stressors in the environment and the individual emotions (23). Continuing to use such strategies with limited options to control the stressors or change the environment may serve to increase work-related stress (24). Stress is high for workers who have high levels of self-efficacy but are working in environments over which they have no control (24). Health providers in the HIV/AIDS sector are in this situation. Working with HIV/AIDS patients leaves little room for avoiding emotional entanglements for healthcare workers in CCC particularly because they have no control over the life and behaviour of their clients. This is demonstrated by the case of Mr M described in Box 1, where the medical officer was not able to convince Mr M to bring his wife for testing.

HIV/AIDS brings home the legal, moral and ethical challenges in the everyday practice of care giving. In India, the law requires any person infected with HIV/AIDS to inform the potential spouse of his/her status, and fixes criminal liability for failing to do so (25). While a healthcare provider is not enjoined to disclose the HIV status of their patients to their spouses or potential partners, the law removes the potential penalties that could be imposed upon healthcare providers should they reveal the HIV status of their patients to their spouses or potential partners. This injunction itself can be problematic for a treating physician, as can be seen from the case study. What could the medical practitioner do in this case to ensure the safety of Mr M's wife? Barring frequent requests to the patient, his options were limited. Alternatively, he could use the option of possible collusion or collaboration with fellow healthcare workers to overcome the restrictions imposed by professional ethics. But such moral dilemmas do take their emotional toll on healthcare providers in these settings.

Examining programme manuals for guidance on reducing work-related stress among healthcare workers

We examined the training manual for counsellors for references to burnout and coping strategies, and the manual for setting up ART centres/community care centres for references to burnout. We concluded that the ART centre /CCC manuals (6,7) do not offer any guidance on the management of burnout or suggest any coping strategies for workers. Our conclusion is based on a word search throughout the manuals. The training manual for counsellors (26) was reviewed to identify any references to burnout or coping.

The NACO guideline for training counsellors has a supplementary section on advanced counselling skills (Module 7). The issue of burnout among caregivers and counsellors is addressed within this supplementary module. Sub-module 10 on identification and management of burnout in caregivers and counsellors describes the burnout syndrome as:

"a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who do people work of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems."

This module lists the factors that cause burnout among formal caregivers and the factors leading to stress in HIV/AIDS counselling and care. It also talks about the management of burnout. It describes possible interventions with respect to various stages of disillusionment.

Table 4. Stages of disillusionment and intervention	
Stages of disillusionment	***Intervention***
Over enthusiasm	Realism
Stagnation	Movement
Frustration	Satisfaction
Apathy	Involvement

Source: HIV counselling training modules for VCT, PPTCT ART counsellors handouts, NACO 2006: p 357.

Over enthusiasm can be countered by realism at the initiation phase to provide enabling conditions to recognise burnout. The manual calls for creating opportunities for sharing within groups and in-house or external training, and creating avenues for building social cohesion and other mechanisms of de-stressing among workers.

Movement within the employment hierarchy is suggested to combat stagnation. Apart from undergoing specialised training, mobility can include other strategies such as changes in shifts for counsellors, alternative job descriptions, more responsibility and occasionally even shifting to alternative projects. Attending conferences is also said to break the monotony of routine work.

Getting involved in other dimensions of work, or in voluntary work with other agencies, is suggested to combat frustration. The manual calls for involvement to combat the apathy. The last option to be considered in this context is leaving the field, but this should not be viewed as defeat.

The manual further provides a checklist for evaluation. Ways of dealing with burnout are mentioned in a boxed item in the handout which is an optional component in the manual. It lists personal coping tools and asks counsellors to take responsibility for doing something about the possibility of burnout. It is remarkable that the manual recognises the possibility of burnout and builds up skills among counsellors to deal with this problem. It provides guidance on both recognition of the problem and on possible coping strategies to resolve them, at an individual level.

Potential efficacy of recommended coping strategies

These recommended coping strategies may build self efficacy skills of counsellors and serve to address the emotional aspect of burnout. Evidence indicates that strategies directed towards the problem causing burnout are more effective, but the potential for effectiveness depends on the control exercised over the work place environment (23). The ability to control this involves institutional engagement, setting norms for functioning and providing some level of autonomy to employees. These guidelines do not engage with the setting of institutional norms that may mitigate, or prevent, burnout. Recommending personal coping strategies without empowering health workers to change the work environment and develop alternative strategies for dealing with the everyday stressors is more likely to increase work-related stress (24).

"If you are serious minded in medical practice, you need ethical training, you need support systems when you are stressed, it should be part of an institutional arrangement. You cannot run a hostel or school without a school counsellor. Adults are not supposed to have stress. I have asked bankers how they handle stress and got the response that if you are very careful in your work the stress reduces. Periodically they have get-togethers, they become families. There are coping mechanisms in [the] hotel industry. They party together. We [at the work site] have big institutional family feeling- sharing consultations, team work...."

Health professional

Implications for an ethical health policy for workers in HIV/AIDS care

It has often been pointed out that the lack of a carefully enunciated policy could itself be a policy (27). Clearly, the NACP Phase III provides care and support for HIV/AIDS affected persons by viewing it as part of a larger development strategy. Care and treatment of HIV/AIDS affected persons in a non-discriminatory manner is a social responsibility. How we provide for this responsibility is a collective social choice. A just provision of healthcare would require that provision to be made in order to benefit the least advantaged groups in that society (3), using Rawls' principles of justice. Here, the reading of the most disadvantaged groups should be in favour of people affected by HIV/AIDS.

In this case, healthcare providers are overburdened, particularly in the high prevalence states. They have also been left with limited resources and their own individual agency to cope with the dual physical and emotional risks of providing care. The physical risks are addressed to some extent by the provision of post-exposure prophylaxis. But the other, emotional risk is left to various strategies to be developed by the individual with very little by way of institutional responsibility for minimising this.

It may be a very useful economic strategy to treat those providing care and support to society's particularly vulnerable groups as dispensable or replaceable; after all, others can be hired to replace those who leave due to burnout. The programme does recommend that those with severe burnout consider leaving the sector, though it also emphasises that such an action should not be considered defeat (26). One could also argue that workers in HIV/AIDS care provision have chosen this work and should therefore find their own individual resources to deal with this form of stress. However, in countries like India, most career options are not selected by choice alone; they are viewed as a means to a livelihood. So, caring for PLHA may not be a voluntary exercise; it may just be that the worker has no other alternative means of employment. Judgments about justice in healthcare cannot be blind to how social determinants produce inequalities in health status (28). By extension, judgements about justice in healthcare cannot be blind to how choices are made to earn a livelihood. Working in the HIV/AIDS sector cannot therefore be seen as a risk that is sought voluntarily. People may exercise career options by chance rather than choice (29). A fair society needs to make provisions to minimise the risks against this chance of both the physical and emotional harm associated with providing care to PLHA.

Any effort to provide for particularly vulnerable groups cannot ignore the requirements of those designated to care for these vulnerable groups, particularly when that role carries additional risks. A more ethically nuanced recognition of these risks would call for additional institutional mechanisms to be put into place to reduce the risks. It is this need that the current NACP Phase III programme ignores.

"Institutional mechanism you have to find.... Mine may be an extreme case of a burnout. There may be milder stress issues elsewhere. If it is true, the need exists. Should it be left to individuals? Should we have therapy sessions like the couch in the US? Find a personal therapist? What do we do?"

Health professional

This plea may not be an isolated one. There are many workers in the HIV/AIDS sector whose work imposes significant emotional and physical burdens, and these need a careful evaluation. The lack of institutional mechanisms for reducing workplace stress within the NACP III needs to be examined. Whatever be the reasons for overlooking these needs, the ethics of not providing institutional mechanisms need to be carefully reviewed.

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