The Medicalization of Burnout Between Professional Authenticity and Bioethical Challenges

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Abstract
Contemporary society attests to an increasing rate of burnout which creates tensions between individuals and professional environments. Initially considered specific to human services personnel, burnout has extended beyond healthcare to organizational leaders and entrepreneurs. This study examines the medicalization of burnout through bioethical principles, exploring tensions between medical intervention and professional authenticity. A demedicalization model emphasizing holistic health is proposed, addressing individual, organizational, and social levels while maintaining professional integrity without reducing the phenomenon to medical diagnosis and treatment alone.

Keywords: *Burnout; medicalization; demedicalization; bioethics; professional authenticity; holistic health;*

1. Introduction

In contemporary society, there is an increasing rate of burnout which creates a series of tensions between individuals and professional environments. If initially it was considered that burnout is specific only to personnel working in the field of human services, subsequently, the burnout phenomenon has been recognized as extending beyond the health sector including among leaders and personnel in organizations, entrepreneurs, etc.

In contemporary society, burnout has become an alarming problem as presented by statistical data. It is quite worrying, given that globally, levels of professional exhaustion have increased to 40% and, as a result, 36% of employees globally have experienced cognitive fatigue, 32% have suffered from emotional exhaustion, and 44% have experienced physical fatigue (Vaitkevich, 2020). A major impact on burnout, which contributed to producing changes in the contemporary occupational environment, is attributed to the COVID-19 pandemic. Isolation, remote work, have demonstrated that they affect human mental health, relationships with peers, employee-employer contact, etc., consequences that will persist in the long term. In such a context, recognizing the situation and addressing occupational exhaustion from multilateral perspectives allows the possibility of

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taking various measures at various levels - public, familial, occupational environment - to ensure individual well-being.

Contemporary medicine, as never before, is interested in the human body. As a result, the medicalization of life and the increasingly evident control of medicine and its related fields - pharmaceutical, dietetics, body maintenance - are produced. All these require ethical conditioning, especially when we refer to a living body. The body is seen as an instrument at a macro level of political and medical decisions, where there is no room for autonomy and individualism. Thus, all decisions are administered and regulated at the central level and must be respected. Therefore, economic efficiency and utility are oriented in two directions. The first direction assumes that people must be healthy in order to be able to work efficiently. And the second assumes that a sick person generates additional costs for the community and system (Clark, 2014).

This evolution of the burnout phenomenon has also been favoured by a series of changes related to the ways in which today's adults work - a considerable increase in the number of employed workers who have sedentary behaviour - office work and other occupations with reduced activity. Adults currently have an average of 9.5 hours per day of sedentary time (this includes commuting time spent sitting in motorized vehicles or leisure time spent in front of computers and televisions) (Cărăuş, 2022).

The inclusion of burnout in ICD-11 (International Classification of Diseases 11th Revision - The global standard for diagnostic health information) in 2019 as an ”occupational phenomenon” (WHO, 2019), legitimizes medical intervention which falls under the incidence of medicalization that appears to us as an intermediary with an entire arsenal of medical services, therapy, counselling, etc. Despite all the transformations that have occurred throughout history regarding the pathological picture, it is certain, however, that medicalization is a phenomenon especially characteristic of contemporary society, precisely because individuals seem to be more sensitive than ever to any pain, to the emotional state they experience and which sets in with the loss of a close person, or due to a failure on a professional, personal level, etc. Professional exhaustion represents a manifestation of great complexity with impact both on performance at work and on interpersonal relationships.

The major concern of the study is based on highlighting the tension between medicalization and authenticity as well as the relevance of bioethics in managing the state of burnout. In this context, a dilemma appears between therapeutic responsibility and professional integrity when, more than ever in contemporary society, work capacity is maintained by medicalization to cope with systemic challenges of an (economic, social, legal, etc.) order. At the same time, the pressure that falls on the employee's shoulders to cope with the multitude of job requirements places them in a vulnerable position of having their personal

authenticity compromised by appealing to medicalization to comply with external expectations.

1.1. Historical perspectives on burnout

This subject was first addressed in the mid-1970s by the German psychoanalyst Freudenberger, which later became the subject of many studies. During his activity at the clinic in New York, which treated people dependent on the use of various substances, he introduced and used for the first time the term burnout in the article ”Staff burn-out’’ published in 1974 (Freudenberger, 1974).

In the 1990s, wanting to revise the concept, researchers Christina Maslach and Leiter proposed a model valid in other professional fields than those of services, offering the following definition: ”Burnout is the index of dislocation between what people are and what they have to do, it represents erosion in value, dignity, spirit and desire - an erosion of the human soul. It is a disease that spreads gradually and continuously over time, placing people in a downward spiral from which recovery is difficult’’ (Maslach, & Leiter, 1997).

1.2. Dimensions of burnout

Burnout has been a concern for a number of specialists; however, the most relevant characteristic of the syndrome proves to be that of Maslach and Jackson. They elucidate three basic coordinates of this phenomenon: emotional exhaustion, depersonalization, and reduced efficacy. Emotional exhaustion is the most frequently encountered phenomenon and manifests in the form of feelings and sensations of fatigue and exhaustion from the psychological effort invested in professional activity. People affected by emotional exhaustion usually present difficulties in adapting to the work environment, in the context where they feel insufficient emotional energy to perform their work tasks and socialize with others (Maslach, & Jackson, 1981).

Depersonalization represents a response to stress through detachment, indifference, and lack of concern toward professional activity and/or the people who are its object (patients, colleagues). This involves negative or inappropriate attitudes and behaviours, irritability. Reduced efficacy - the expression of this dimension is usually a negative attitude toward aspects of one's own profession, scepticism regarding the ability to meet job requirements, giving exaggerated importance to negative results. At the same time, against the background of lower morale, productivity and capabilities decrease, along with adaptive abilities (Maslach, & Jackson, 1981).

2. Methodology

The present study adopts an approach of theoretical and critical analysis of specialized literature regarding the medicalization of burnout. The methodology is based on conceptual analysis and interpretation of the medicalization phenomenon through the prism of fundamental bioethical principles: autonomy, non-maleficence, and justice. The analysis integrates perspectives from medical sociology, bioethics, and organizational studies to examine the tensions between medical intervention and professional authenticity. The theoretical framework used combines the theory of medicalization with concepts of holistic health and demedicalization, proposing an alternative model for approaching burnout that transcends the strictly biomedical paradigm.

3. Presentation of results

3.1. Medicalization and social control

Following the elucidation of these characteristics, it is evident that the psychological sphere of the person is affected, which also marks a transit from individualization of the problem to recognition of the organizational character, which presupposes a holistic approach to health. In 1992, Conrad maintained in the work ”Medicalization and Social Control'' that medicine ”replaced'' religion as the dominant moral force in the social control of modern society (Conrad, 1992). Therefore, the permission granted to ”medical science'' projects human attention rather than on the environment, as being the source of all problems. Whatever the environment of origin and transformation of this concept over time, it is certain that currently it represents an omnipresent phenomenon, in continuous expansion, which transforms patients into passive individual's dependent on medicine and its treatments.

They are tempted to regain their balance both physically and spiritually by appealing to medicalization, trying to ignore, to inhibit these states at least for a short period of time. Through medicalization, they try to regain that well-being they experienced until the onset of the state of ”illness''. Therefore, in this study we are concerned with the dilemma between medical recognition of burnout and professional authenticity as well as the challenges that the medical model represents in relation to occupational stress from the perspective of social bioethics. Also, a demedicalization model is proposed through which we rely on preserving professional authenticity as well as interpreting the model through the prism of bioethical instruments.

Contemporary sociologists recognize the complexity of the medicalization phenomenon, which represents a process and not just a result, rather a partial than complete process, in which patients, doctors as well as other actors in the health field are targeted. However, the consequences of medicalization are largely

considered to be negative both at the individual and social level. Pathologization of normal behaviour, deprivation of individual power and submission to control by specialists in the medical field, or care models through decontextualization of experience, represent a reality specific to contemporary society. As Parens maintained in ”Enhancing Human Traits: Ethical and Social Implications'' (1998, p. 23), ”to the extent that medicine focuses on changing the human body'' for the purpose of reducing suffering, its influence captures attention and resources, far from producing changes at the level of social structures.

Concomitantly, analyses regarding the ”creation'' of diseases and patients for the purpose of promoting pharmaceutical treatments function rather than a broader political change for the purpose of extending this analysis and exploring medicalization or its inclusion in the global health agenda (Nica, 2019).

3.2. Professional authenticity and vulnerability

In contemporary society, there are various approaches regarding the justification of medicalization. One of the positions is that irrational medicalization involves assuming a series of risks such as: over-diagnosis, over-prescription, adverse effects as a result of irrational administration of medications, various procedures, services, etc., consequently the stigmatization rate increases, especially since through the legitimization of burnout, employees receive legal protection, can benefit from specialized legal support. On the other hand, individualization of problems that in fact prove to be systemic increases the risk of over-diagnosis and medical dependency, pharmaceutical products. Therefore, organizational causes are neglected and the problem is fundamentally not resolved.

The idea of authenticity offers a more prompt understanding of this phenomenon because, in relation to medicalization, the choices we make better express who we truly are. Moreover, any choice is based on a project or desire through which the way of being of the human being manifests. From this it follows that we do not always live in accordance with our way of being, moreover, we can become strangers to ourselves: ”...actions taken do not always represent us, and the beliefs we have are not always our own, and if people can be strangers to themselves, then the antidote consists in an unmediated relationship with what defines them as singular individuals. Therefore, authenticity means a way of life from which one’s own projects, choices and desires are born, that is, an existence lived in one's own way'' (Vaitkevich, 2020).

In conditions where in contemporary society it is increasingly difficult for the employee to cope with the multitude of tasks at work, an evident tension appears between performance and vulnerability. The state of vulnerability from a physical and mental point of view determines the employee to find refuge in medical products and services to remain competitive in the professional environment to continue to face challenges. For a clearer vision, it is important to

approach the medicalization of burnout through the prism of bioethical principles to elucidate whether medicalization truly solves the problems that employees suffering from burnout face or simply it is a social problem that must find its resolution at the organizational level without falling under the jurisdiction of medical jurisdiction.

3.3. Bioethical analysis of burnout medicalization

From the perspective of the principle of autonomy, evident pressure is attested regarding the choice of medical solutions, on the one hand, because that is what medicine offers us, which labels us as being sick and we need treatment, therefore everything is prepared and legitimized for us. Having a medical diagnosis, automatically a transfer occurs from perception and the ability to make decisions about one's own person to professional intervention from a medical point of view. This transfer can erode the possibility of making decisions about one's own body through the involvement of medical intervention. Another principle is that of non-maleficence; in this context, at first glance, medicalization comes to help to solve the patient's problem - tired, exhausted, anxious, etc. - on the other hand, the patient may face situations of stigmatization at work, being perceived as a fragile person, sensitive to the programs and requirements of a demanding job. In this context, it seems that the fundamental problems of the organization are also ignored and the states that the employee faces are considered of an individual nature without reflecting on an important moment, namely that exhaustion is a rational state after a period of demanding work and not at all chemical imbalances that require medical intervention. Even more difficult and bewildering is the interpretation of burnout through the prism of the principle of justice. In this state of affairs, the power of justice is prominent, which transforms a social problem into a medically justified one, through the allocation of resources for conditions that are not necessarily of a medical nature. Self-care and recourse to medical services remains the responsibility of the individual who is helped by the state through promoted policies that justify burnout, neglecting, for example, workers who are part of the informal economy, who remain helpless, which amplifies social inequities. In this context, it is very important to respect first and foremost the dignity of the employee as part of an organizational structure and to recognize and protect their state of vulnerability with which they are overwhelmed. In this context, we suggest a model beyond the biomedical one, namely that of demedicalization.

3.4. Demedicalization and holistic health

Demedicalization places great emphasis on holistic health. Holistic health presupposes responsibility toward one's own health and well-being. Therefore, we can elucidate three essential aspects: The first aspect presupposes demonstrating

responsibility through changing health behaviour through stress reduction, information regarding proper nutrition, spiritual education, etc., which are considered inseparable from the state of health to which we aspire.

The second aspect refers to encouraging a more active attitude toward health, with holistic health having the goal of substantially reducing the distance between doctor and patient. Traditional diagnosis is to be avoided in favour of a more equal exchange between the two parties. Symmetry in this relationship is very important in supporting and strengthening the patient's commitment to self-responsible medical care, which would be a significant measure of deprofessionalization.

The third aspect highlights that holistic health presupposes the extension of the traditional sphere of medicine and focus on nutrition, psychological and spiritual well-being, interpersonal relationships, etc. Holistic health ultimately reveals a major cultural shift through the transition from medicalization to demedicalization. Therefore, the behavioural component and attitude toward one's own health make the difference; structuralism in this sense offers us the possibility of reflection on the opponent of medicalization, which helps us in making optimal decisions based on risk-benefit assessment, medicalization vs. demedicalization (Lowerberg, & Fred, 1994), especially since the risk of suffering from a disease is viewed as an already existing condition, and individuals' expectations of being treated focus especially on the medical field.

4. Conclusions

This approach would have an impact both at the individual level as well as organizational and social. At the individual level, a balance between vulnerability and competence would restore the employee's confidence in their own strengths and as well as validation of the image that the person is competitive and appreciated at work with all the vulnerabilities they present that set in at a given moment without these being considered weaknesses but perceived as normal states that are part of normal human experiences.

From an organizational point of view, where perfection is claimed, in fact states are hidden that require intervention from within; there is a need to focus on an organizational culture that supports the employee beyond professional competences, which emphasizes the states and vulnerabilities with which they are overwhelmed at a certain moment within the organization.

Also, last but not least, changes at the social level through educating the public regarding what burnout represents, public policies as well as focusing on non-medical directions that can cope with the challenges that employees face.

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