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EDITORIAL

Work addiction and quality of care in healthcare: Working long hours should not be confused with addiction to work

Mark D Griffiths

Behavioural addictions are addictions that do not involve the ingestion of psychoactive substances and yet feature all the core features found in more traditional substance-based addictions (e.g., withdrawal symptoms, mood modification, tolerance, salience, conflict, and relapse) (1). Although a couple of behavioural addictions have now been formally recognized in major psychiatric and medical diagnostic manuals such as the *Diagnostic and Statistical Manual for Mental Disorders* and the *International Classification of Diseases* (i.e., addictions to gambling and gaming), all other types of behavioural addiction have not been formally recognised (e.g., addictions to sex, social media, exercise, work, etc.).

Work addiction is a controversial topic even though the concept of 'work addiction' in the form of 'workaholism' dates back to the late 1960s (2). Work addiction (like exercise addiction) has been viewed by some as a 'socially respectable addiction' (3) or a 'mixed blessings addiction' (4) particularly because addiction to work can bring some positive benefits. Moreover, there are some professions (e.g., doctors, lawyers, police inspectors) where anecdotal evidence suggests that the prevalence of work addiction is higher than that of the general working public. However, these are professions that sometimes demand very long hours. In these instances, working to the neglect of almost everything else in that person's life may not necessarily because they are addicted to work but because their job demands it. In the case of doctors, as far back as the 1970s, Vincent (4) noted that:

"Because the physician works in a 'noble cause', he sees an addiction to his work as 'noble' per se. It also provides success and a good reputation. It provides money, so gives material

comfort for his family. For a while, all this adds to his self-esteem. Problems arise when it adversely affects his marriage, family, or personal health…Two options are open with addictions – to give them up completely or to control them. If the true workaholic gives up work completely it is probably because of death. Yet there is considerable evidence that death comes sooner to the workaholic" (p.60).

There may also be a culture in such professions where there is an expectation that individuals should work around the clock and that the job comes before everything. In relation to the medical profession, Hey (5) went as far as to claim that: *"Doctors who do not subscribe to such an ethos [of work addiction] may often be criticised by other colleagues as being lazy, lacking in motivation, or unambitious"* (p.1235).

The paper by Maisonneuve and colleagues (6) in this issue of *BMJ Quality and Safety* examined work addiction in the context of the ethical climate in a Canadian healthcare setting. Using an online survey, the authors examined constructs including ethical climate, work addiction, and perceived quality of care using validated scales. They found that presence of an ethical climate reduced the extent to which employees experience work addiction, which was also associated with greater perceived quality of care and lower intention to quit the profession. These effects were most pronounced for employees with lower levels of tenure. The authors concluded that ethical climate in healthcare organisations is therefore important in reducing work addiction, particularly in newer members of staff, with likely benefits to patient care.

This study is among a growing number of papers that have investigated work addiction in healthcare settings. One of the largest studies in this area was by Schaufeli and colleagues (7). Using the Dutch Work Addiction Scale (DUWAS), they surveyed a nationwide sample of 2,115 junior doctors ('residents') in the Netherlands. They carried out a cluster analysis, which resulted in four groups: (i) workaholic residents, (ii) non-workaholic residents, (iii) hardworking residents, and (iv) compulsive working residents. Unsurprisingly, those who worked both excessively and compulsively had the most negative consequences in terms of their wellbeing, job demands, and job resources. Another study using the same dataset indicated that workaholism contributed incrementally to explaining the negative consequence of burnout and the positive consequence of good well-being (8). In another relatively large study, Azevedo and Mathias (9) examined work addiction among 1,108 Brazilian doctors using the DUWAS. They reported that 45% of their sample were "addicted" but the cut-off score

used was very low and so the majority of the so-called work addicts may not have been genuinely addicted to work. The only variable positively associated with work addiction was working more shifts. Age was negatively associated with work addiction (i.e., younger doctors were more likely to be classed as addicted to work than older doctors).

A study by Kasemy and colleagues (10) surveyed 1,080 Egyptians (540 healthcare workers [HCWs] and 540 non-HCWs). Using the DUWAS, results indicated that 24.4% HCWs were workaholic compared to 5.9% non-HCWs. Among HCWs, there was also a significant association between workaholism and (i) poor psychological health and (ii) poor quality of life. Similarly, Saiga and Yoshioka (11) surveyed 980 nurses from 10 different hospitals in Japan and reported that workaholism (using the DUWAS) was weakly negatively associated with life satisfaction. Saleem and colleagues (12) examined workaholism among 200 Pakistani doctors and found that workaholism was associated with work-family conflict, emotional exhaustion and poor psychological well-being.

Another widely used instrument is the Work Addiction Risk Test, although the cut-off for being classed as a work addict is arguably low. Studies using this instrument have reported similar findings to those using DUWAS, although sample sizes have been small. For instance, Pougnet and colleagues (13) reported the prevalence of workaholism among 162 French doctors in a university hospital to be 48%, concluding that the prevalence of work addiction was much higher among doctors than the general public. Kwak and colleagues (14) reported that 46.6% of 278 Korean nurses had mild or high work addiction, and that work addiction was associated with traumatic stress and burnout. Sheta and colleagues (15) examined work addiction among 262 Egyptian doctors and 14.5% were classed as workaholics, and workaholism was associated with lower quality of life and poorer physical health.

Burke and colleagues (16) examined workaholism among 431 Turkish doctors using the Workaholism Battery. The sample comprised work 'enthusiasts' (n=54), 'work addicts' (n=48), 'enthusiastic addicts' (n=169) and 'unengaged workers' (n=160). Interestingly, the three workaholism types reported more positive work experiences and better psychological well-being than unengaged workers, however work addicts experienced the highest prevalence of negative consequences. Such studies therefore suggest that work addiction/workaholism among those who work in the healthcare profession is associated with a wide variety of negative consequences, all of which could negatively affect patient care.

A key observation is that many studies tend to use the terms 'workaholism' and 'work addiction' interchangeably. However, I and my colleagues have argued that 'work addiction' and 'workaholism,' while overlapping, are not the same thing (17). In simple terms, 'workaholism' is a more generic and wider term than 'work addiction', and can include individuals who have an inner drive to work excessively and for long hours each day with little or no negative consequences. On the other hand, 'work addiction', by definition, always leads to more negative consequences in the long-term including relationship problems, health problems, and a neglect of everything else in the individual's life apart from work. For example, previous studies have examined 'happy workaholics' 'committed workaholics, and 'enthusiastic workaholics' (17) but few of these individuals have negative consequences as a result of working excessively.

Finally, for many working in the healthcare profession, the job is a vocation. Long shifts and long weekly hours are often the norm. In particular, junior doctors are often expected to work very long hours, but this should not be confused with work addiction. While working long hours brings its own issues, working long hours is less harmful than obsessing about work (18). In addition, unlike many other professions, in the healthcare sector, *not* working long hours may literally be a matter of life or death for some patients.

The relationships among work addiction, working long hours and the quality of patient care is therefore likely to be complex, with motivations and reasons for working long hours in healthcare being very different from those genuinely addicted to work. The work of Maisonneuve and colleagues highlights how other variables, such as ethical climate and tenure, are also likely to be important as we seek to better understand this field.

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