|  |
| --- |
| **NAME:** **EXAM ROOM: Time: 80 minutes**  |

**READING 1** (15 points)

A Over the last several decades, major changes have happened in much of the workplace. Budgets have been cut, workers have lost their occupations, so fewer employees have had to carry out the same amount of work. As a result of such changes, the pace of work is faster than it did in the past and now, more and more workers feel under pressure. Moreover, controlling the volume of work workers do has become ineffective, as well. A worker who says ‘NO’ to more work can be seen as someone who is not a team player. At worst, saying NO can be viewed by an employer as unacceptable, and may even cause a worker to lose a job. In addition to this, setting clear boundaries between work and personal time has become, for many, impossible. Workers cannot find a work–life balance as a consequence of ‘constant connectivity’. They are frequently expected by their employers to check their email at work and at home. Employers would like to reach them at any time of the day or night, including holiday. This results in even greater stress on employees. Eventually, the volume and pace of work break down many workers and they end up with suffering from career burnout.

B Defined as “*a special type of work-related stress*”, career burnout has been coined by two American human resource professors, Christina Maslach and Susan Jackson. Doing extensive research on various employee groups such as day care workers, mental health staff, police officers, and educators, Maslach and Jackson have come up with three dimensional model for the concept of career burnout. These are exhaustion, cynicism, and sense of ineffectiveness. A worker with career burnout experience at least one of these dimensions. The first dimension, exhaustion, is often accompanied by a general tiredness, the inability to sleep properly at night, physical slowness, and several symptoms including stomach problems, and headaches. The second dimension, cynicism, is related to employees’ negative feelings towards the recipients of their services such as clients, patients and students, etc. The third one, sense of ineffectiveness, involves a tendency to evaluate oneself negatively. This causes workers to have doubts about their self- worth and their accomplishments seem unimportant to them.

C Additionally, burnout workers, in general, go through adverse experiences. Underlined by Contenta in his book called *The Consequences of Burnout on Employees,* these employees often become unrecognizable to their colleagues, particularly as they limit their social and other interactions. Their behavior also changes. They may show signs of depression or anger, and may turn to drugs or alcohol or employ other dysfunctional coping behaviors in an effort to deal with the stress. In line with what Contenta has mentioned in his work, some other research has revealed a correlation between burnout and various marital and family problems. Moreover, in another work of Contenta with his colleague, Leibzing, it is also underscored that stress and burnout may cause memory loss, and the shrinking of neurons in the brain. Referring to [one study](http://www.psychologicalscience.org/observer/burnout-and-the-brain) among burnout sufferers, these two researchers highlight that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. As a part of the natural aging process, this part normally gets smaller but this effect is more common in participants who experience burnout.

D So, what are the major factors that lead to career burnout among employees? One major contributing factor to burnout is, of course, overwork. Today, even in industrialized countries, overwork has been found to contribute to serious illnesses and, somewhat surprisingly, deaths. In countries such as Japan, for example, death from overwork even has a name – karoshi. Since the 1980s, 30,000 Japanese have been recognized officially as having been victims of karoshi, i.e., their deaths have been recorded as having come about as a result of overwork. As for other industrialized countries, it has become more common to find statistics on workplace stress and the role it plays in serious health problems and even deaths. The president of the American Institute of Stress (AIS), Paul Rosch, says that chronic workplace stress often leads to significant health problems such as high blood pressure, cardiovascular disease and heart attacks. It can worsen many already existing conditions.

E Interestingly, it has been discovered that like overwork, underwork is another main source of workplace stress. Underwork includes some aspects such as not being challenged enough on the job, or not having enough work to do, or lacking interest in the tasks that need to be done, or trying to look busy because there is not enough work. Certain experts who deal with this syndrome call it ‘boreout’ – a syndrome with symptoms almost identical to burnout. Peter Werder, the co-author of *Diagnosis Boreout* with Rothlin, estimates 15 per cent of all office staff are at risk of boreout because they are “seriously under-challenged”. Werder and Rothlin in their book point out a study on wasted time at work carried out by American Salary.com. among 10,000 workers. One-third of all the employees surveyed said they wasted time because they did not have enough work to do. The study also revealed that employees were paid $ 759 billion per year for work which they didn’t do. Using the internet for personal use made up 44.7 percent of the time wasted, followed by socializing with co- workers at 23.4 percent. Workers also conducted personal business (6.8 percent), made personal phone calls (2.3 percent) or ran errands (3.1 percent) during work time.

F What does all this mean for the workplace? As these and other studies indicate, employees pay a high cost as a result of work-related stress. But they are not the only ones. Worldwide, the syndrome presents a serious problem for all kinds of businesses and the economy as a whole. For example, in 2012, the Agency for Safety at Work estimated that burnout disorders in Europe resulted in a yearly economic cost of approximately 70 billion euros. Several years later, in 2016, the UK’s Health and Safety Executive, an independent body that keeps an eye on work - related safety issues, estimated that job stress resulting from excessive pressure in the workplace cost the economy approximately a $730 million a year. In the United States, in the same year, a survey by the American Psychological Association found that more than 75 percent of all visits to doctors are stress-related. This results in reduced productivity, decreased job satisfaction, increased absenteeism, low morale, and the necessity for replacement workers. It is worth noting that several continents away, a 2016 University of Melbourne Health report found that, in Australia, around 45 percent of employees receive medical treatment related to mental health problems. As these figures show, burnout is a serious problem internationally.

G All these unfavorable consequences imply that recovery from burnout is a slow journey. Therefore, employers are to grab the bulls by the horns. One way to do this is to **be fair towards workers because in the eyes of the workers,** nothing causes burnout quicker than watching someone else receive preferential treatment or get credit for the wrong reasons. Moreover, employers should give employees a voice. For employees who feel as though they have no say in organizational decision-making, burnout can be a natural consequence. Next, **employers should recognize success because** every employee wants to feel needed. An unexpected pat on the back or recognition in front of peers for a job well done can be a tremendous ego boost. According to an employee engagement survey, 40 % of respondents believed that “appreciation by a supervisor” had the most impact on employee motivation in their organization. Last but not least, employees who enjoy coming to work will burn out less frequently than those who dislike their job. So, why not build a positive work environment for your employees and let them have fun, say, by having lunch-hour parties, or giving half-days off before a holiday. All in all, employers can prevent burnout from becoming a problem at their workplace if they recognize the symptoms, and take action when necessary.

H Likewise, employees can try to find a way out to get rid of career burnout. According to Ben Fanning, the author of [The Quit Alternative](http://www.benfanning.com/quit), employees are to apply certain techniques to avoid burnout. For example, instead of hanging out with negative-minded people who do nothing but complain, they can develop friendships with people who can **buffer** them from burnout. It is also crucial for them to keep their to-do-list minimal. To-do lists are definitely handy, but when they're overstuffed with difficult tasks, workers inevitably feel [anxious](https://www.psychologytoday.com/us/basics/anxiety). Thus, in addition to employers, employees can benefit from certain techniques if they are eager to overcome the problem of career burnout.

**READING 2** (15 points)

**NOT JUST FOR MEN**

**A.** Western society has seen women gain the right to vote, receive higher education, and continue careers in similar positions of authority as their male counterparts. However, in a nation that continually strives to promote equality between the sexes, it is hard to understand why something so fundamental as women's health continues to be constrained by male-oriented and male-dominated clinical research. In professional journals, authors have criticized "gaps in medical knowledge" about women, questioned how the "white male came to be the prototype of the human research subject," and commented on "gender disparities in scientific and medical knowledge base". Also, coverage in newspapers and popular magazines, including the *New York Times and Washington Post,* has added to the level of interest in these issues.

**B.** The historical evolution of policies regarding women’s participation in clinical studies over the past several decades arises from the conflict between two public policy positions: “protectionism” and “access”. As the name suggests, “protectionism” is in favour of keeping women away from research process. Actually, the emphasis on the need to protect research subjects grew rapidly in the 1950s after the news of violent treatment of the research subjects. This emphasis was later reinforced by the discovery of adverse outcomes in the children of women who had attended drug trials during pregnancy. Thus, in the mid-1970s, new regulations were designed to protect fetal injury by restricting the inclusion of pregnant women and women of childbearing potential in drug trials. On the other hand, the ones who pursue the policy of “access” argue that these guidelines and regulations to protect research subjects were overprotective and overly exclusive, and therefore dangerous to the health of women. As a result of the efforts by the supporters of “access” policy, new guidelines and regulations have emerged lately to promote increased access to health care and patients’ right to choose. This change in policy, however, still remains controversial.

**C.** People who are for the inclusion of women in clinical studies believe that when women are excluded from clinical trials, the development of clinical data relevant to women’s health is inhibited. More importantly, the risk to women’s health increases. These risks arise from a serious gap in our understanding of sex differences. Even the vast majority of animal research has been conducted only on males, mostly on rodents. And women have been grossly underrepresented in human clinical trials. Dresser (2001) also states that even when both sexes are included, sex-specific analyses are generally not reported, and because most subjects are men, the findings may not be about women. A 2003 review of 258 cardiovascular treatment trials, for example, revealed that only 27 percent of the participants were women and that only a third of the trials with men and women reported data by sex. Perhaps, this explains why a young woman hospitalized with a heart attack was twice as likely to die as a young man was.

**D.** It is also believed that there are many meaningful differences between the sexes, which have implications for how clinical trials should be carried out, particularly in terms of including women in these trials. These differences by gender include differences in body size, composition, and metabolism, differences in aging along with behavioral and hormonal differences. One of the most serious issues is drug dosing, which may be affected by the physical differences between the sexes such as in weight, height and surface area. For instance, in January 2013, the U.S. Food and Drug Administration (FDA) cut the recommended dose of the nation’s most popular sleep drug, Ambien, in half for women but not for men. It was because they had determined that 15 percent of the 5.7 million American women using Ambien were experiencing driving impairment eight hours after taking the drug, compared with 3 percent of the 3.5 million male Ambien users. That’s why, Ambien is now sold in bottles with pink for women and blue labels on them for men.

**E.** Despite all these arguments for including women in clinical studies, there still remain supposedly valid concerns about including this subgroup in human subject research. That’s why, a study was conducted in Sweden upon the request of the Research Ethics Committee during 1997-1999. In the study, 26 research projects, which excluded women as subjects of medical research on diseases that are **rampant** among both men and women, were analyzed to identify their reasons for the exclusion. The qualitative analysis revealed that the reasons for the exclusion of women could be grouped into two main categories, which were the risk of damaging fetuses and the economic costs of research in women.

**F.** Researchers have feared that the inclusion of women of childbearing age in drug trials might endanger fetuses. Those in favor of excluding women of childbearing potential from clinical trials argue that potential fetuses and the reproductive capacity of women must be protected by excluding women because possible children cannot consent to their inclusion in clinical studies. Thus, they believe that consent policies created to protect research subjects do not adequately protect potential fetuses since it is the mother, rather than the child, that consents. In this way, the interests of later generations can be protected by earlier ones. Finally, as McGuire (1993), one of the leading protectionists, suggests, biologically mediated risks to future human beings should be unacceptable. He believes that biological risks resulting from drug trials pose more threat for future generations.

**G.** At the same time, investigators (e.g. Dunken, 2016) have defended their choice of males as research subjects since men are cheaper and easier to study. The hormonal change in women is viewed as a methodological complication during analysis that increases research costs because many more control groups are required. Finding enough women with the right hormonal status and then scheduling around this variability takes time and effort and thus may also increase recruitment costs. It has been suggested that the cost of clinical research could double if parallel trials are conducted among men and women. Therefore, medical researchers are caught between limited resources and their goal of answering many pressing medical questions, which forces them to **eschew** the use of women in clinical research.

**H.** However, more and more people now appear to be swinging toward the “access policy” side of the argument, where a consensus seems to be emerging in the scientific and political communities. The FDA has now several ongoing projects that will definitely improve the present status of women in medical research such as “Action Plan to Enhance Availability of Subgroup Data”. Twenty-seven action items comprise the plan, which has three main priorities: 1) quality - to improve collection, reporting, and analysis of demographic subgroup data; 2) participation - to identify barriers to enrollment for members of subgroups and to implement programs to encourage enrollment; and 3) transparency – to make data by demographic subgroup more available. The FDA also continues to educate and train their staff related to reporting, analyzing, and communicating data about women, and to partner with industry and other groups such as the National Institutes of Health to identify best practices and overcome barriers regarding women’s health and inclusion.

**I.** The FDA has the authority on the subject in the U.S., and while its current acts are a noble start, they are by no means a final solution. Rather, mandates must be issued over recommendations as soon as possible, and penalties must be imposed on those who fail to implement appropriate measures if equality in medicine is to be achieved. Women must become a priority for researchers, not remain a neglected minority.