The Significance of Burnout in Healthcare

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In recent years, burnout syndrome has been one of the most discussed mental and physical health problems in modern societies. In an enormous world that faces many socio-economic challenges, individuals experience increasing pressure daily. This pressure is particularly seen in the workplace. Many individuals often spend more time at work than in their own homes. As a result, employees, managers, and others working in various industries and regions all around the world suffer. These individuals experience a daily feeling of fatigue, exhaustion, all of which are the most prominent signs of burnout syndrome. Burnout is a highly impracticable type of stress disorder. Since burnout was first discovered in the early 1970s, researchers have been focusing on this complex phenomenon, specifically in the healthcare community. The healthcare industry is known for its complexity and intensity, making it one of the most common places to witness burnout. Health care workers are an indispensable and strong part of the nation's workforce. Before the pandemic, during, and after will continue to grow and save countless lives. Understanding medical burnout and having strategies at the organizational level to prevent it will help avoid future tragedies. While the signs and symptoms of burnout are feelings most experience daily, the long-lasting effects of burnout are detrimental to society. Burnout syndrome imposes a serious threat on the health and wellness of active members of the healthcare community.

The conception of burnout was introduced by Herbert Freudenberger in 1974. He is considered the founding father of the concept when he observed a loss of motive and reduced commitment among volunteers at a free mental health clinic in New York City (Dall'Ora et. al, 2020). Dr. Freudenberger was no stranger to stress according to the *New York Times*. He was born in Frankfurt, Germany in 1926 and by the time he was 12 years old, his family, like other Jewish families face persecution at the hand of the Nazis. Herbert used his father's passport and left Germany by himself before ultimately arriving in New York. He spent a grave amount of time on the street before a family member took him in as he was enrolling in night classes at Brooklyn College. After graduation, he earned a doctorate from New York University and received his analyst's training at the National Psychological Association for Psychoanalysis. As a psychologist he did not confine himself, he went into the streets and established free clinics for addicts and others. The term burnout was used to describe a particular experience and mental state in the workplace even before it became a psychologically and clinically relevant condition. For Herbert, burnout occurs in contexts that require a significant volume of emotional work,

compassion, participation, and motivation. In the 1974 article, Freudenberger describes the state of being burned out as "becoming exhausted by making excessive demands on energy, strength, or resources" in the workplace (Freudenberger, 1974). Freudenberger's initial work was followed by a significant number of psychological and medical studies, starting with research by Christina Maslach and her colleagues in the late 1970s and early 1980s (Heinemann, 2017). Maslach was one of the pioneers in burnout research and is still one of the most prominent scholars in this field.

The cooperative psychologist Maslach focused on the measurement of burnout. Based on the three dimensions of burnout, which are exhaustion, cynicism, and inefficacy, she developed the Maslach Burnout Inventory (MBI), which is still the most widely used questionnaire for measuring burnout today (Heinemann, 2017). The first phase targeted naming this new "syndrome." It is important to mention that at this time the research was based on observations and interviews in the health care sector (Heinemann, 2017). The mechanism by which burnout occurs is multifaceted but commonly ascends from an absence of resources, stresses of work, personal conflicts, and a lack of coping mechanisms (Agha, 2018). According to *Burnout in Nursing: A Theoretical Review* by Chiara Dall'Ora, Jane Ball, Maria Renius, and Peter Griffiths, Maslach theorized that burnout is a state, which occurs as a result of a prolonged mismatch between a person and at least one of the following six dimensions of work:

1. Workload: excessive workload and demands, so that recovery cannot be achieved.
2. Control: employees do not have sufficient control over the resources needed to complete or accomplish their job.
3. Reward: lack of adequate reward for the job done. Rewards can be financial, social, and intrinsic.
4. Community: employees do not perceive a sense of positive connections with their colleagues and managers, leading to frustration and reducing the likelihood of social support.
5. Fairness: a person perceiving unfairness at the workplace, including inequity of workload and pay.
6. Values: employees feel constrained by their job to act against their values and their aspiration or when they experience conflicts between the organization's values.

After the development of the MBI in the early 1980s, the focus of burnout research changed. This syndrome became apparent in more and more occupations. It was also analytically described concerning established concepts such as job stress, job satisfaction, and organizational commitment (Maslach et al., 2001). The MBI appeared to provide a common understanding of the concept and suggested that it was an enormous problem. Making it possible to measure burnout without the necessity of questioning or reflecting on the basic assumptions relating to this mental condition and its societal implications (Maslach et al., 2001). If only one of the following six dimensions of work classifies an employee as experiencing burnout, according to Maslach's theory, there are probably millions upon millions of individuals suffering. With this coming to the surface, millions of people are questioning their feelings towards their work life.

There is number of published articles on burnout that reveal this historic development and growing interest in the concept since Herbert and Christina. According to *Burnout Research: Emergence and scientific investigation of a contested diagnosis*, ran a study on articles containing the term *burnout* in their titles published up to the end of 2011. This resulted in 1,225 articles. Figure 1 shows the number of published articles per year from 1978 to 2011.

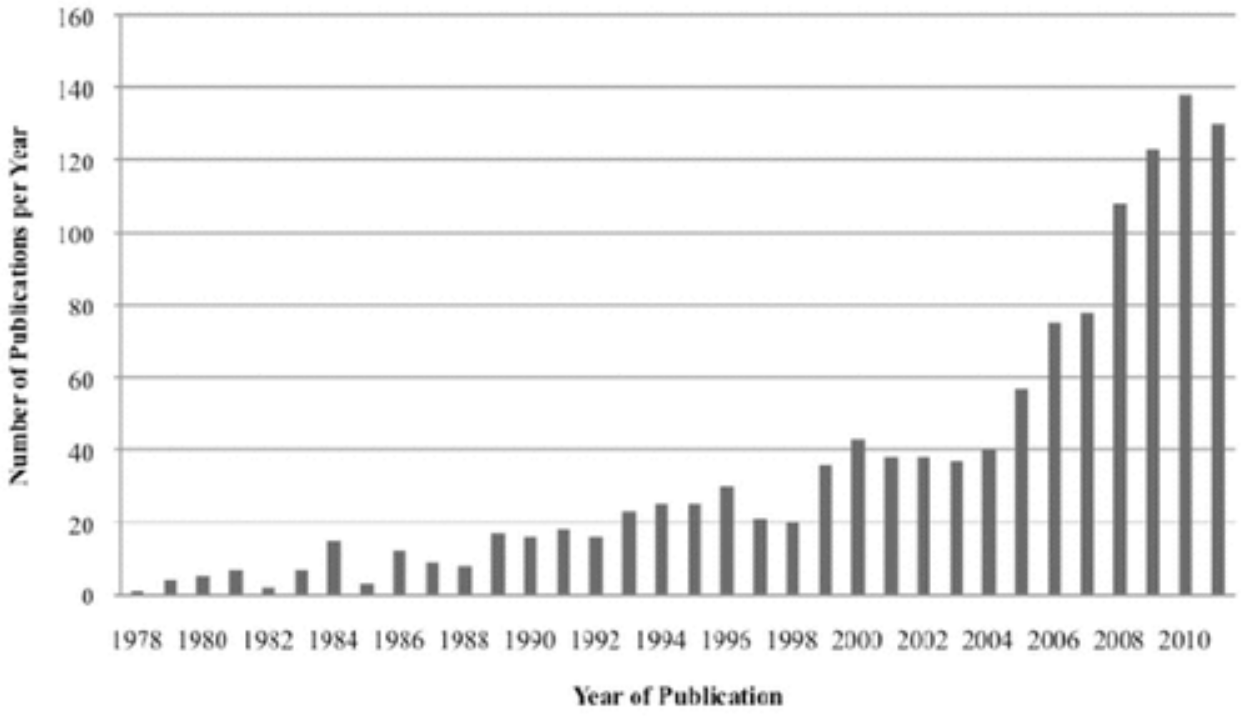

Figure 1. Number of publications on burnout from 1978 to 2011.

In the year 1989, the rate of publications per year increased and continued to upsurge. According to this research, the number consistently grew for the next 10 years. Since 2005, there has been a significant number of published articles on burnout syndrome. It can be argued that the rise of burnout since 2005 is due to the scientific interest in mental status. Mental status has been a growing concept in society. With that being said, professionals are increasingly studying and researching burnout to describe the feelings that are resulting from the growing demands in the workplace. The largest struggle in burnout research is adopting a diagnosis. Despite the societal importance and extensive research of the term *burnout* in everyday life, however, there is a debate among scientists about what burnout is, what symptoms are associated with it, and whether or not burnout syndrome is a distinct mental disorder (Heinemann, 2017). Psychologists like Maslach, are trying to assess the levels of distress but also discriminating between cases and non-cases of burnout. Burnout today is established as a medical diagnosis in only a few countries, such as the Netherlands and Sweden (Samra, 2018). Burnout is still not completely accepted as a mental disorder in the academic field, but it is greatly seen in a variety of occupations.

Burnout has been studied and diagnosed in a variety of occupations such as social workers, teachers, construction workers, business workers, and healthcare workers. Some studies report burnout prevalence rates of up to 69% in a given population, (Heinemann, 2017). Approximately 30% in teachers, 31% in medical students, and between 44% and 68.6% in medical oncologists (Heinemann, 2017). This is an increasing problem in the healthcare community as Herbert emphasized in 1974. Individuals in the medical workforce are chronically exposed to extremely stressful working environments, coupled with high expectations, low resources, and even lower funding. According to *Burnout in Healthcare Professionals* by Adnan Agha, burnout seems to affect healthcare professionals nearly twice as much as an average member of the working population. The 2020 Medscape National Physician Burnout and Suicide Report ranked the incidence of burnout in 29 medical specialties. The top three medical specialists for burnout are urology (54%), neurology (50%), and nephrology (49%). The lowest incidence of burnout is reported in general surgery (35%), psychiatry (35%), and orthopedics (34%). Anesthesiology comes in 16th place with 41%, emergency medicine in place 14 with 43%, and critical care in place 10 with a reported incidence of burnout of 44% (Hert, 2020). Health care providers are trained to put the needs of others before themselves and spend each working day exposed to the

emotional/physical strain of dealing with individuals who are sick or dying. Over time, growing research and more importantly policy interest and how different work organization impacts difficult outcomes in the medical field, specifically, nursing.

While nurses are focused on the goal of providing the best care for their patients, they may not always be doing the same with themselves. Working in a fast-paced environment, taking long shifts, and dealing with the emotional toll of being in a healthcare setting can lead to chronic stress and eventually, burnout. Other factors that were categorized as predictors of burnout in the nursing literature were low/inadequate nurse staffing levels, ≥ 12-h shifts, low schedule flexibility, time pressure, high job, and psychological demands, low task variety, role conflict, low autonomy, negative nurse-physician relationship, poor supervisor/leader support, poor leadership, negative team relationship, and job insecurity (Dall'Ora et al., 2020). A powerful stressor in the nursing community is the impact of the nursing shortage. According to the Bureau of Labor Statistics, the employment rates of a registered nurses will increase 12% between 2018 and 2028 (University of St. Augustine, 2020). This is much faster than the average occupation rate. The American Nursing Association (ANA) has emphasized the need for more nurses, testifying, "while the nursing shortage presents opportunities for nurses, there are potential negative implications, too. Nurses often need to work long hours under stressful conditions, which can result in fatigue, injury and job dissatisfaction". As we now start to recognize the occurrence and effects of burnout amongst nurses, healthcare organizations, patient support groups as well as the American Nursing Association (ANA) have become concerned that this may negatively impact nurse effectiveness and patient safety. Research also shows that when nurses are experiencing burnout the rates of sickness absences increase. Looking at data from 2016 confirms that work-related stress (including burnout) accounted for 37% of all work-related cases of ill-health and 45% of all working days lost due to ill-health (Agha, 2018). Consequently, it was the highest narrated work-related illness, with an average of 23.9 working days lost per worker (Agha, 2018). Along with the work-related illness and other feelings of burnout syndrome nurses are more likely to experience suicidal thoughts. Researchers used data from a questionnaire in November 2017 to 86,858 nurses and a sample of 5,198 general workforce members. This survey was designed to address indicators of emotional exhaustion and a low sense of personal accomplishment. All of which are indicators of burnout. Questions about depression and how likely these nurses were to seek professional help if a serious emotional

problem arose. A total of 7,378 nurses responded to the survey; the median age was 51 years old, 92.7 percent were female, and 87.4 percent were white (Upham, 2021). The results showed the American nurses experience suicidal ideation in greater numbers than other general workers, with 403 (5.5 percent) reporting suicidal ideation within the past year. In that group of nurses who experience suicide ideation were less likely to seek professional help. This is very concerning in the medical community and brings to light the intensity of burnout.

Another contributing factor is the growing demand for healthcare providers as the baby boomer generation ages and the prevalence of chronic diseases increases. According to *Against the Growing Burden of Disease,* by Kimberly Elmslie, the director-general for the Centre for Chronic Disease Prevention, chronic disease rates are increasing at 14% each year and four out of five individuals are at risk. The rapid aging of the population has generated a large number of elderly individuals to enter assisted living or long-term care facilities. Few studies have focused on geriatric nurses employed in nursing homes, who are generally paid less and are more likely to be perceived as unskilled, and nonprofessional. Overall, geriatric nursing does not catch the eyes of new nurses, making the burnout/turnover rates high in these facilities. Along with the national nursing shortage, the pay in these facilities is lacking as well. According to *the Registered Nurse Salary in the United States*, the average salary for a registered nurse is $37.84 per hour in United States. In comparison to the $29 on average a long-term care facility registered nurse receives. According to *in a relentless pandemic, nursing-home workers are worn down and stressed out*, by The Washington Post. “The people in the community have no idea what we are going through,” said Rebecca Rufial, a licensed vocational nurse in Paris, Texas, who works a 12-hour shift every night, in charge of two halls with 40 to 50 patients, helped by only two nursing assistants. “And no one cares, either.” Despite the billions of dollars funneled into the system through emergency federal funds nursing homes have few alternatives to turn to due to the nursing shortage. Even as the coronavirus peaks, remaining staffers are worn out, often fed up with the companies they work for, and yet many say they are holding on because their patients need them and have no one else to look out for them. Although it does not make headline news and is rarely discussed, nursing home residents experience forms of elder abuse daily, largely due to the low pay and nursing shortage. Stories like Rebecca Rufial are far from out of the ordinary if one has ever worked in a geriatric facility. According to ‘Alarming’ nurse turnover rates linked to quality, payment woes in major nursing home study, median

turnover among nursing staff, factoring in data from virtually all United States nursing homes, was 94% in 2017 and 2018. More alarmingly, mean turnover rates hit 140.17% among registered nurses, 129.1% among certified nursing aides, and 114.1% among licensed practical nurses.

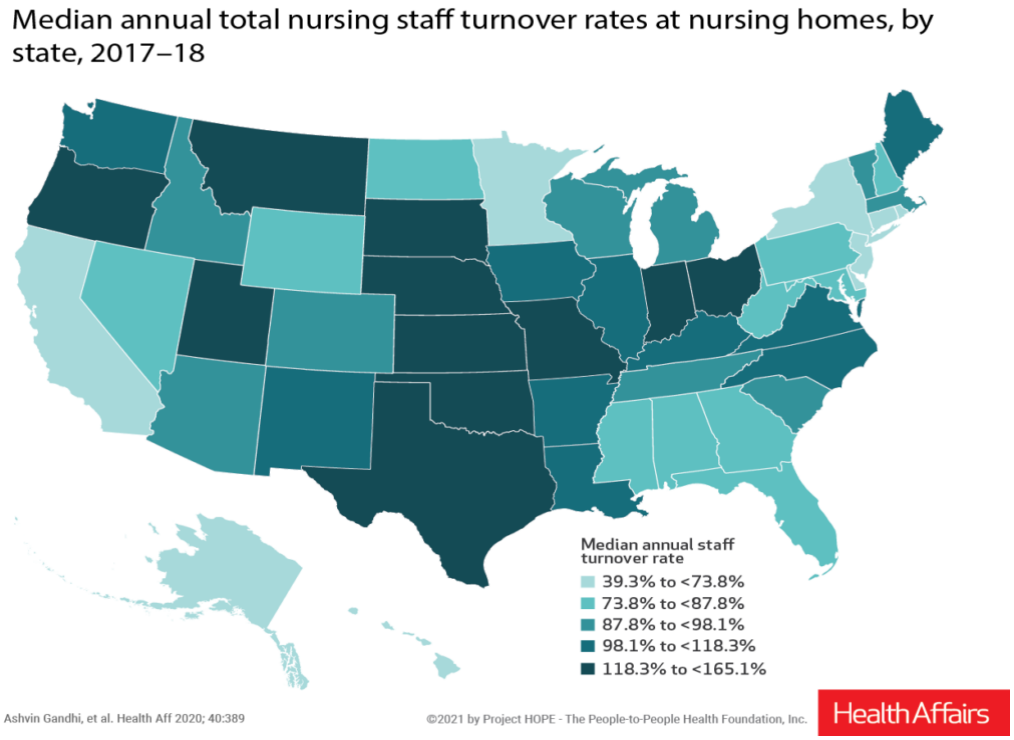

Figure 2. Median annual total nursing staff turnover rates at nursing homes, by state, 2017-18.

Kimberly Marselas, author of *'Alarming' nurse turnover rates linked to quality, payment woes in major nursing home study, median turnover among nursing staff*, found that a wide swing in turnover depending on state or quality indicators, such as overall star ratings, overall staffing levels and health inspections. Nurses with burnout also find it more difficult to motivate patients who need constant engagement and have longer term conditions (Agha, 2018). Imagine being underappreciated, overworked and underpaid and still expected to be enthusiast about every ill patient entering the facility and may never make it out. These findings suggest that burnout is indeed a serious problem in geriatrics and in other big segments of the healthcare community. As the COVID-19 pandemic upsurges burnout is only getting worse.

In the spring of 2020, the world flipped upside down due to the rise of the coronavirus pandemic cases. Many units in hospitals were converted into emergency COVID-19 units, due to a large number of patients incoming. It was expressed that many nurses feel as though they are

all COVID-19 nurses. These frontline workers called countless family members and stayed at their patient's bedside with a tablet so their families could say their goodbyes. When patients were discharged, clapping and cheering filled the halls. These fleeting moments of joy soon became a highlight of the long days, weeks, months, and now years. Every patient we sent home was a victory. The nurses battled fear, exhaustion, and anxiety in a plastic gown with sweat and tears running down their bodies and the N95 face mask rubbing their skin raw, so they make sure they do not take this virus home to their loved ones. Tirelessly fighting every day at work, but it seems like nurses still cannot keep up. A recent *Washington Post/ Kaiser Family Foundation* survey of 1,327 front-line health care workers in the United States during the COVID-19 pandemic revealed that medical burnout has reached epidemic proportions. An overwhelming 55% of front-line health care workers reported burnout with the highest rate (69%) among our youngest staff, those ages 18 to 29 (Kaushik, 2021). That same age group also reported the highest negative impact of the pandemic on their mental health (75%), though a majority of all health care workers (62%) reported some mental health repercussions (Kaushik, 2021). In addition to the 21% to 35% of respondents, depending on their nursing role reported decreased career satisfaction as a result of the pandemic (*Covid-19: Impact on nurses and nursing: A in the American Journal of Nursing*). This drop-in career satisfaction was reported by 40% of nurses working in acute care settings and even higher proportions of nurses in long-term care and hospice setting pandemic (*Covid-19: Impact on nurses and nursing: A in the American Journal of Nursing*). Healthcare workers responsible for providing direct care for COVID-19 patients are more likely to have depression, anxiety, and mental distress from witnessing COVID-19 related death, extra-long work hours, and work-home life imbalances (Kaushik, 2021). Healthcare workers have been working nonstop without a full appreciation of their sacrifices. Many have suffered and sustained burnout and the devastating consequences not only on the workforce but also with patients. In the first year of the pandemic, more than 3,600 U.S. health care workers died (Kaushik, 2021). Dr. Anthony Fauci, M.D., said it best: the death of so many health care workers due to COVID-19 are "a reflection of what health care workers have done historically, by putting themselves in harm's way, by living up to the oath they take when they become physicians and nurses" (Kaushik, 2021). The pandemic has brought attention to another challenges that nurses are currently battling, workplace violence.

According to *Workplace violence among nursing professionals*, within the health care sector, nursing professionals are the most exposed to workplace violence, since they provide direct assistance to patients on a 24-hour basis. A total of 49 (88.9%) participants had experienced workplace violence, with 21 (38%) suffering verbal abuse; 14 (25.4%) experiencing mobbing; 6 (11%) reporting physical violence; 5 (9.1%) suffering sexual harassment; and 3 (5.4%) reporting racial discrimination (Bernardes et al., 2021). The types of violence that were observed included physical aggression, verbal abuse, sexual harassment, and racial discrimination. Furthermore, systemic racism, violence against Asians, and childcare crises for women in medicine have taken a tremendous toll on the mental and physical health of these minoritized groups during the pandemic (Kaushik, 2021). It is important to mention that 44 (90%) of these individuals reported that the incidents of violence could have been prevented (Bernardes et al., 2021). The less experienced nurses and those working in emergency and intensive care units reported the highest rates of violence (Bernardes et al., 2021). These acts were committed by patients and their families, as well as colleagues and supervisors. Over half the nurses who experienced abuse considered their job and reported a decrease in work-related quality of life. The *Washington Post*/Kaiser Family Foundation survey found that 26% of health care workers in hospitals are angry and 29% have reconsidered leaving the medical field. Any exposure to occupational violence can be associated with the warning signs of burnout and even death.

With all the struggles brought upon many nurses in result, many are quitting, retiring, or are leaving their jobs and entering the travel nurse agencies. According to *Newsweek.com*, the average pay for traveling nurses is now at about $3,000 to $5,000 per week a dramatic increase from the $1,000 to $2,000 per week, salary before the pandemic. The nurses who haven't left and stayed in their facilities are seeing other nurses who are coming in and making more money. This is creating a tense working environment. The COVID-19 pandemic has created a nurse staffing crisis that is forcing many hospitals to pay the top dollar to get the help they need to handle the number of patients. Traveling agencies are charging hospitals $165 to $170 an hour per nurse, while the agencies are taking a large portion it is estimated that nurses are clearing $70 to $90 an hour, which is two to three times what hospitals pay their staff nurses (*Newsweek.com)*. While staffing in hospitals has been an issue, many nursing staff throughout the United States have decided to quit their job as permanent nursing staff in a hospital and hit the road. Many hospitals

nursing have turned to travel nursing to create their schedule and mainly make more money. Therefore, this is leaving permanent staff overwhelmed with work and no incentive for staying. Health care employees are bone-tired and frustrated from being asked to work overtime, from getting screamed at and second-guessed by members of the community, and from dealing with people who chose not to get vaccinated or wear a mask due to COVID-19. With all the coverage that health care and burnout have been getting recently, we need to take action and prevent burnout and promote wellness before these acts are irreversible.

National, institutional, and departmental leadership should not put the burden squarely on staff to do meditation apps, practice mindfulness, get 10% off on gym memberships, or count your steps for wellness. Instead, they must recognize the insidious nature of burnout and develop the necessary tools to prevent and treat it. There are practical changes that can be implemented in healthcare to reduce burnout and the effects of burnout. The first being recognizing burnout is the first step toward finding solution. This can start at the departmental level with peer-to-peer coaching sessions during which faculty, residents, patients and trainees have an opportunity to voice their feelings and get advice from peers on coping with burnout and promoting wellness. There is this mentality in healthcare that if you complain, you are seen as not resilient. This mindset is harmful. It can create feelings of frustration, self-judgement and hostility in the workplace. How can one be compassionate towards a patient when they are so critical of ourselves? By developing a bond through shared experience, peer-to-peer coaching can help someone work through those feelings. This strategy can also remove the hierarchy typically seen in medicine. Health care workers should understand that it is ok to be vulnerable, and a system of peer-to-peer coaching can help us understand these vulnerabilities. There is good data that people who experience adversity or a traumatic event often find a sense of personal growth as they work through their trauma. This phenomenon is called “post-traumatic growth.” We see this in world-class endurance athletes who have psychological support and can build upon their strengths to surpass perceived physical and emotional limits. The only difference between health care workers and endurance athletes is that the latter have support from their peers, coaches, and psychologists. Health care workers, by contrast, often grapple with their trauma isolated and alone. We can change that. A mental health resource page on each medical facilities website with a list of outreach programs, contact information foy psychological health support, along with a discounted employee rate would be the next step. A *Medscape* report found that almost 40% of

U.S. physicians had no workplace support to deal with grief and trauma. Health care workers are working extra-long hours, and some of them may not have the time or feel safe discussing their emotional and mental health with peers (Kaushik, 2021). For these individuals, an anonymous technique of accessing mental health resources is critical.

To work on tackling burnout additionally program directors, and faculty members should be offered training on supervising with empathy and developing a genuine dialogue with their employees. As a whole we need to move away from the automatic "How are you doing? — I'm fine" model. All employees deserve an active conversation towards their mental health, even if it is only for a few minutes. "Tell me how you are *really* doing through this pandemic or this work day? You have my undivided attention" is a powerful open-ended question and can help one feel bonded with their counterparts. In 2019, the *American Medical Association* launched the "Joy in Medicine Recognition Program," which encourages institutional leadership to improve physician wellness and reduce burnout by implementing workplace changes that improve practice, teamwork, and peer support efficiency. This program thus far has been successful and federal, state, and city governments should support such programs and encourage research into boosting health care worker wellness. Such common efforts could even advance the science of burnout during this COVID-19 pandemic.

In conclusion, the past decades have seen a growing research and policy interest around how work organizations have been impacted upon different outcomes of burnout in the medical field and other occupations. Dr. Freudenberger not only described the burnout syndrome but also understood that burnout is linked to specific working environments and organizational circumstances. He projected intervening at an organizational rather than just an individual level to progress. Along with Maslach who developed the Maslach Burnout Inventory (MBI), which globally is the most widely used instrument to measure burnout and identified burnout as a nursing 'outcome'. This phenomenon that is observed a crossing many different lines of work is this dangerous snowball. Suffering from work-related stress, exhaustion, and fatigue can lead to turnover, lower-quality care, suicidal ideation, mortality. These symptoms of exhaustion must be taken seriously. Breaking down what establishes burnout, what factors contribute to its development, and what are the larger consequences that have been noticed during this COVID-19 pandemic. Research has produced enough evidence over the last 50 years to make burnout a significant investigation and a challenge for public health.

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