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Burn-out in the health workforce during the COVID-19 pandemic: opportunities for workplace and leadership approaches to improve well-being

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ABSTRACT

Background Burn-out is a long-standing problem among healthcare workers (HCWs) and leads to poorer quality and less safe patient care, lower patient satisfaction, absenteeism and reduced workforce retention. Crises such as the pandemic not only generate new challenges but also intensify existing workplace stresses and chronic workforce shortages. As the COVID-19 pandemic continues, the global health workforce is burnt-out and under immense pressure, with multiple individual, organisational and healthcare system drivers.

Method In this article, we examine how key organisational and leadership approaches can facilitate mental health support for HCWs and identify strategies to support HCWs that are critical for supporting workforce well-being during the pandemic.

Results We identified 12 key approaches at the organisational and individual levels for healthcare leadership to support workforce well-being during the COVID-19 crisis. These approaches may inform leadership responses to future crises.

Conclusion Governments, healthcare organisations and leaders must invest and deliver long-term measures to value, support and retain the health workforce to preserve high-quality healthcare.

INTRODUCTION

As we continue to adapt to living with the COVID-19 pandemic and new variants of SARS-CoV-2, the global health workforce remains under immense pressure. With each wave of infection, healthcare workers (HCWs) have had to adapt to many challenges, including heavy workloads, new information, roles and work practices, new guidelines and policies, and immense social changes within health organisations and the broader community. It is unsurprising, therefore, that levels of burn-out are high and reports of wanting to leave the health profession abound in Australia and internationally.¹⁻⁵ Now more than ever, it is crucial that we retain our existing, highly skilled HCWs, and incentivise training and recruitment of new staff to ensure a sustainable workforce for long term. Underpinning these aims, we urgently need new workplace and leadership approaches that focus on HCW well-being.

Drivers and consequences of burn-out

Burn-out is defined as a syndrome of depersonalisation, emotional exhaustion and a sense of low personal accomplishment leading to decreased effectiveness at work.⁶ Burn-out among HCWs is a long-standing issue and is well recognised to lead to poorer quality

and less safe patient care, lower patient satisfaction, less professionalism, reduced work engagement and productivity, absenteeism and high workforce turnover.⁷⁻⁹ For affected individuals, repercussions include broken relationships, alcohol and substance abuse, depression and suicide.⁸ Many factors contribute to burn-out, including oppressive professional hierarchies,¹⁰ high workloads, inefficient work environments, poor work-life balance, lack of workplace flexibility, autonomy and control, loss of meaning in work, exposure to patient suffering and death, and experience with medical errors and malpractice suits.⁸

The Australian COVID-19 Frontline Healthcare Workers Study investigated the prevalence and severity of mental health symptoms among frontline HCWs during the first year of pandemic.^{1, 3 11-15} To our knowledge, this was the largest (n=9518), national, multiprofessional study (including people from all healthcare roles in primary and secondary care) on this topic globally. Our research identified that burn-out was common, with 71% experiencing *moderate to severe* symptoms of emotional exhaustion and 37% experiencing *moderate to severe* depersonalisation.³ Additionally, *moderate to severe* symptoms of other mental illnesses were common, including post-traumatic stress disorder (41%), anxiety (28%) and depression (28%).³ Concerningly, 1 in 10 Australian HCWs reported occasional or frequent thoughts of suicide or self-harm during the pandemic.¹¹ Despite HCWs recognising they were experiencing mental health symptoms, engagement with existing psychological support services was low.¹² Only 1 in 5 HCWs sought help from a doctor or psychologist and fewer than 1 in 10 used an employee or professional support programme for mental health symptoms; three-quarters used no formal support at all.¹² Importantly, similar findings have been reported among HCWs internationally during the pandemic.^{2, 4}

Factors associated with burn-out during the pandemic have been identified at the individual, organisational and broader healthcare system levels. HCWs who were women, younger and those with pre-existing mental illnesses were more at risk of burn-out.^{3-5 16} Organisational-level factors associated with burn-out included: exposure to patients with COVID-19, working in emergency departments, inadequate staffing, lack of resources or training and communications or support from healthcare organisations that were perceived to be untimely or unhelpful.^{3-5 13} Furthermore, disruptions to the healthcare system broadly have universally affected HCWs. Intermittent surges in healthcare demand combined with frequent



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furloughing of staff and the reduced inflow of international workers have necessitated increased hours, role changes and redeployment for some HCWs, while others have faced job insecurity and income stress due to the cancellation of 'non-essential' healthcare procedures.¹³ At a broader health system level, the pandemic has exacerbated structural and intersectional systems of discrimination, with women, lower-wage HCWs (such as aged care workers) and migrant workers being disproportionately affected.^{17–19}

Another major issue described by many HCWs was moral distress. This occurs when HCWs are unable to provide high-quality, patient care consistent with their values and training, for example, due to high demands, resource scarcity, deferment or cancellation of usual care or restrictions preventing families from visiting dying loved ones.^{14 20} Such conditions create many challenges and are generally not easy to resolve. Moral distress is important for many reasons, but not least because it is linked to burn-out and loss of job satisfaction^{14 20} and may occur in workforces with high levels of resilience.³ The notion of moral distress is helpful, as it shifts the locus of the responsibility away from the individual, to the harms caused by complex systemic factors, which require HCWs to act in ways that are contrary to their personal and professional values.

Investing in workforce well-being

While crises such as the pandemic generate many new challenges, crises also highlight the day-to-day 'cracks in the system' by intensifying existing workplace stresses and chronic workforce shortages.¹⁵ Over 2021 and 2022, some Australian State and Federal governments introduced short-term payment initiatives for HCWs, students and aged care staff to facilitate workforce retention and attract overseas-trained health professionals.^{21–23} While being adequately paid is crucial, administrative issues, delayed payments and incentives excluding HCWs in community and private settings have led to criticism of these schemes.^{24 25} In late 2020, the government of the Australian state of Victoria invested \$A9.8 million for a virtual Healthcare Worker Well-being Centre.²⁶ While a promising initiative, substantially more long-term investment is required, and tangible benefits from such programmes need to be demonstrated. Importantly, failing to adequately invest in safeguarding HCW well-being may result in substantial long-term economic impacts on governments and healthcare organisations. Such costs are difficult to quantify; however, poor workplace well-being, low staff retention and low-quality patient care may generate additional costs related to training greater numbers of new HCWs and supporting less experienced staff, as well as potential legal costs that may arise from increased adverse patient events or from HCWs who develop mental health issues due to occupational factors.

Workplace and leadership approaches to promote well-being

The quadruple aims of healthcare include improving the individual experience of care, improving the health of populations, reducing the cost of healthcare and improving the experience of *providing* healthcare.²⁷ The last aim was only recently recognised and specifically acknowledges the importance of finding joy and meaning in work for individuals.²⁷ Psychological well-being in the workplace is fundamental to improving the experience of *providing* healthcare and highlights that occupational burn-out and other mental illnesses among HCWs require organisational, system-wide solutions, not approaches that focus on personal resilience, which often reinforce the blame and stigma associated with mental illness.^{3 12 13} Wellness-Centred Leadership is

a new framework that aims to cultivate leadership behaviours which promote HCW engagement and professional fulfilment. The three elements of the framework include: care about people always, cultivate individual and team relationships and inspire change.²⁸

The Australian COVID-19 Frontline Healthcare Workers Study^{13 11–15} identified 12 key areas (divided as either organisational and leadership approaches or those which support individuals) that are critical for supporting HCW well-being during the pandemic and which may have applicability to other crises (box 1). Perhaps the most important findings highlighted were the following: the need for active, authentic, visible leadership; the need for safe working environments (which is a basic human right in Australia); clear bidirectional communication and teamwork. Importantly, our 12 approaches were derived from HCWs' survey responses, thus are key change areas highlighted by HCWs themselves. Our recommended approaches share similarities with both Wellness-Centred Leadership²⁸ and the organisational strategies recommended by Shanafelt *et al*⁸ to promote physician engagement and reduce burn-out which include validating HCW lived experiences, fostering a sense of community and connectedness within the workplace and supporting flexibility and sustainable work–life balance.

In our study, HCWs described good leaders as being visible 'on the ground' (not always working in safety from home), acting in a decisive and timely manner, adopting a coordinated approach and understanding day-to-day workplace problems rather than making assumptions. Additionally, HCWs valued leaders who genuinely cared about their staff, were approachable, actively listened and responded to staff needs.¹ While it is easy to identify a never-ending list of leader attributes, critically, leaders need leadership training (ideally prior to becoming leaders) and tangible resources to achieve their objectives, both in crises and normal times. Many Australian healthcare leaders reported facing immense challenges, feeling ill-prepared, often having no prior leadership training or being pushed into leadership roles without support.¹ Many had to rapidly make decisions for which they had no experience. They felt isolated, had substantially increased workloads without additional resources and were deeply concerned about potentially putting their staff at risk.¹ Health leadership training programmes have long been available; however, training in leadership is conspicuously absent from the training curricula of undergraduate and postgraduate health professional courses.

Good communication is essential at all times in healthcare, but even more so during crises. HCWs who believed their organisation communicated well were significantly less likely to report mental health symptoms.¹³ HCWs universally described needing transparent, timely and consistent information to work safely and effectively and to allay fears. Furthermore, HCWs wanted to be heard and have their experiences acted on.¹ Therefore, providing regular opportunities for dialogue are essential for supporting workforce well-being.

Teamwork is essential for providing high-quality healthcare and is underpinned by cohesion, collaboration, camaraderie and connection with work colleagues. However, social restrictions during the pandemic led to disconnection of teams and removed important well-being opportunities to debrief and access peer support.¹ Creative strategies to stay connected through virtual gatherings, peer-support programmes or outdoor activities were valued and helped combat burn-out.

Stigma around mental illness is common among HCWs and contributes to poor engagement with professional or workplace well-being support programmes.^{1 12} Similarly, current support

Box 1 Approaches to support workforce well-being during the pandemic

Organisational and leadership approaches

Provide authentic visible leadership

- ⇒ Be present in clinical areas.
- ⇒ Act in a timely and decisive manner.
- ⇒ Be approachable and respond to staff needs.

Ensure a safe working environment

- ⇒ Protect physical safety through appropriate equipment, resources and training.
- ⇒ Foster psychological safety by establishing it as a core organisational value and priority.

Ensure clear bidirectional communication

- ⇒ Offer timely, focused and concise information.
- ⇒ Recognise staff expertise and seek their input.
- ⇒ Actively listen and act on insights from healthcare workers (HCWs).

- ⇒ Avoid frequent changes to guidelines unless needed.

Address common causes of moral distress

- ⇒ Engage family and friends as members of the care team, avoiding blanket visitor restrictions.
- ⇒ Support upstream prevention efforts to help avoid overburdening the healthcare system.

Actively value all healthcare workers

- ⇒ Care about all staff as individuals.
- ⇒ Actively acknowledge the work of staff, including those in less visible roles such as night shift workers.

Foster a positive workplace culture

- ⇒ Promote civility, empathy, respect and kindness.
- ⇒ Actively address bullying and discrimination.

Facilitate teamwork and connection

- ⇒ Foster safe interpersonal connections and camaraderie.
- ⇒ Strengthen relationships between disciplines, and between primary and secondary care.
- ⇒ Recognise the benefits of shared spaces such as tea rooms.

Supporting individuals

Deliver active workplace well-being programmes

- ⇒ Invest in well-being, programmes, personnel and resources.
- ⇒ Offer peer support programmes or debriefing programmes.
- ⇒ Provide psychologists on-site for HCWs.
- ⇒ Codesign support programmes locally in consultation with HCWs.
- ⇒ Ensure programmes and resources are universally accessible.
- ⇒ Destigmatise mental illness.

Provide active training programmes

- ⇒ Use simulation-based training to prepare for crises.
- ⇒ Offer training in leadership and management.

Avoid excessive individual disruption

- ⇒ Avoid multiple work role changes for individuals.
- ⇒ Avoid multiple periods of redeployment for individuals.

Offer flexible work conditions

- ⇒ Understand and meet the needs of HCWs with carer responsibilities.
- ⇒ Support requests for part time work, annual leave and sick leave.
- ⇒ Provide cover for absent staff.

Ensure appropriate remuneration and consider appropriate incentives

- ⇒ Regularly review data on gender pay gaps.
- ⇒ Advocate for improved funding for underpaid HCWs including aged care workers and general practitioners.

programmes may not align with the preferences or needs of HCWs. Healthcare organisations have a key opportunity to learn from the pandemic and co-design new, authentic well-being programmes with HCWs that they actually want and will use. Importantly, some HCWs are more at risk of burn-out and mental illness than others,³ so targeted well-being programmes designed towards the preferred psychological approaches and coping styles of those groups may help to improve acceptability, reach and effectiveness.

CONCLUSION

As the COVID-19 pandemic evolves, we are facing the biggest crisis in modern healthcare: the loss of our highly skilled health workforce through burn-out and mental illness. It is no longer optional to act. Governments, healthcare organisations and leaders must invest and deliver long-term measures to value, support and retain the health workforce to preserve high-quality healthcare.

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