EDITORIAL

Burnout as a systemic challenge: job demands, loss cycles and the need for a workforce strategy

On the day I commenced writing this editorial, ABC News published an article highlighting the dire circumstances that the nursing profession faces at present; an unrelenting COVID-19 crisis, nurses who are burnt-out and resigning after years of challenging work conditions, and a projected national shortfall of nurses.[1,2] The article was not really news to me and I'm sure not news to any of the AJAN readership.

While the article suggests COVID-19 has been the catalyst for such calamity in our healthcare settings, workforce studies conducted by the Rosemary Bryant AO Research Centre since 2017 suggest otherwise. It is neither solely a COVID-19-related phenomenon and nor is it nursing specific; both nurses and midwives work in very challenging work environments, an increasing number are burnt out, and the proportion of those considering leaving either profession is growing.[3-5]

To use a sporting analogy; if we imagine nurses and midwives are a football team and transpose the current working environment to the playing field, we would likely have a situation where the team would be losing each week simply because they don't have enough players on the field (lack of staff). In this situation, coaching staff are at a loss because there are too few new recruits and the league isn't offering any solutions (poor workforce attraction and renewal). After weeks of striving, with players covering multiple positions and taking on roles they have less experience in (inadequate skill mix), the team now find themselves at the bottom of the ladder, morale is extremely low, some players are sick of playing (i.e., burnt out) and some are consider changing teams or leaving the sport entirely.

Somehow, I can't imagine the AFL letting a team on the field without enough players due to unfairness and safety concerns. So why aren't our health system leaders and politicians not embarrassed by the current 'state of play' in our healthcare services? After all, we are spending a lot of money training our healthcare professionals[6] – it seems counter-intuitive to provide them with working conditions that drive them to want to leave.

As noted in the ABC article, lower job engagement and higher burnout are precipitating factors that lead people to exit their roles or their profession entirely. Burnout (or lack thereof) is the barometer of a healthy workforce, and the factor that determines a good day 'on the field' or a bad day, irrespective of how hard it was.

What I will attempt to convey though this discussion is that burnout emerges through a complex interaction between the individual, the working environment, and the system in which that working environment operates. Similarly, the solutions required are not necessarily straightforward and require sustained investment.

SO WHAT IS BURNOUT AND HOW DOES THE WORKING ENVIRONMENT CREATE BURNOUT?

Burnout is conceptualised as a phenomenon that is related specifically to the occupational context. Burnout was first introduced in 1974 and is now a recognised occupational risk for many healthcare workers, including nurses and midwives.[7,8] Burnout is defined in the World Health Organization International Classification of Disease 11th Revision (ICD-11) as a syndrome that results from "chronic workplace stress that has not been successfully managed".[9] The inclusion of burnout in the ICD underscores the importance of monitoring its prevalence and responding with appropriate intervention. Also, its definition reinforces that time is a critical factor; there must be *chronic* stress in place in order to create burnout.

Burnout is often measured using questionnaires and includes dimensions of exhaustion, cynicism or disengagement with work and, in some cases, perceived lack of achievement. Also, similar to other psychological phenomena (e.g., personality, depression, IQ), there are different examples of these questionnaires developed by different authors; the most popular of which is that developed by Maslach and Jackson.[10] An important distinction arises here in that authors are not necessarily adopting the same operational definition when they measure burnout. This can lead to a potentially confusing 'image' of what burnout looks like. This is something for scholars in this area to address, but, from a policy and staff support perspective, is potentially trivial. There is usually a high degree of overlap in these questionnaires, and the burnt-out profile of staff will emerge if it is there. For a more technical discussion of burnout measurement, I refer readers to an interesting article by Roelofs and colleagues who discuss measurement through both a questionnaire as well as clinically.[11]

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In healthcare settings, factors that may lead to burnout include workload, staffing levels, control over the job, job and psychological demands, twelve-hour shifts, interprofessional relations, supervisor/leader support and the work environment.[12,13] Indeed, the job role and working environment of nurses and midwives is inherently physically and emotionally demanding.[14] Exposure to traumatic events, patient and family experiences and emotions, managing a heavy workload, the physicality of the work, shift work, and interpersonal relations are all identified causes of nursing stress.[14-17] Major organisational changes can also directly influence the working environment for nurses and midwives including unit-level restructuring, increased workload, less managerial support, reduced input, and/or less resources for staff.[18] In turn, these changes to working conditions impact stress and burnout of staff.[19,20] The environment outside of work is also important too with respect to buffering work demands through additional resources the person can access (e.g., social support structures) or, indeed, exacerbating them (e.g., family demands that impact on a person's ability to recover adequately for work).

Once burnout begins to emerge in individuals, it may then lead to a range of negative workforce outcomes, including reduced job performance, job satisfaction, quality of care, patient safety, patient satisfaction and greater workforce turnover,[13] and a number of health-related factors including acute healthcare conditions, impaired sleep, sickness absence, deteriorating mental health and perceived general health.[18]

GAIN CYCLES, LOSS CYCLES AND THE NEED FOR A WORKFORCE STRATEGY TO ADDRESS BURNOUT

Burnout can be conceived as the consequence of excessive, long-term job demands without sufficient resources in which to deliver on those demands.[21] However, we know the working environment is not experienced linearly by all employees with respect to exposures and response.[22,23] People's individual history of their work experience can make a significant difference between whether one feels supported or unsupported at work, and hence, whether one is on a 'gain cycle' of work engagement or a 'loss cycle' of burnout. For example, two individuals may work in similar roles, attend similar meetings across the day, perform similar tasks, and address similar challenges. However, due to the long-term perception of balance between demands and resources, the two individuals may have opposite 'experiences' of their work for the day. The person on the 'gain cycle' is stimulated by the meetings, is satisfied by their daily tasks and reacts positively to the challenges they need to overcome. They have an 'engaged work profile'. Contrastingly, the person on the 'loss cycle' is sick of attending meetings, unstimulated by their tasks and frustrated by all the challenges they have each day. They have a 'burnt-out work profile'.

This model can also extend to the team environment, and, as nursing and midwifery are very much team professions, we must also consider that a team environment may create a similar psychological response across those individuals.

As we are now seeing this pattern emerge strongly as a system-wide issue, we therefore require a system-wide solution. First, we must avoid thinking that burnout can be addressed through a simple, workforce support intervention to 'help staff feel supported'. This is short-sighted and potentially wasteful. While workforce support interventions are important and beneficial, and certainly may assist to alleviate current stressors, they must be part of a broader, long-term workforce strategy.

Second, my observation is that the system is not currently able to provide a proactive response to reduce risk of burnout; rather there is only capacity to provide reactive solutions to current crises, which are exacerbating the risk of burnout. Hence, time, planning and adequate resourcing will be critical to long-term success of addressing burnout among the professions.

A potential solution is a sustainable workforce strategy that places the engagement of its employees as one of its central tenets. Through the strategy, we can then review the forces at work (i.e., what is driving people to experiencing work as a 'loss cycle'?), identify what is different for those who are engaged at work (those on a 'gain cycle') compared with those who are not to identify what a tipping point looks like, isolate those parts of the problem that the system can address, and begin the slow, staged process of rebuilding the engagement of our workforce. This process will not occur within a political cycle and will not succeed without system-wide engagement, so we must make plans to extend beyond the political agenda and have a joined-up approach across the nursing and midwifery professions to give our workforce a sporting chance of success.

Greg Sharplin MPsych BHsc Bsc
Research and Strategy Manager & Senior Research Fellow, Rosemary Bryant AO Research Centre, Clinical and Health Sciences, University of South Australia, Adelaide, SA, Australia

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