For more than 2 years, the world has been upended by the COVID-19 pandemic. Arguably, no other group has experienced challenges as intense and unrelenting during this time as hospital-based health care workers (HCWs). These individuals have played, and continue to play, a key role in the battle against COVID-19, risking psychological and physical safety in the face of this historic pandemic. Mounting evidence shows that HCWs have experienced acute psychological distress, with alarmingly high rates of anxiety, depression, burnout, and sleep disturbances that are likely to persist beyond these recurring waves of the COVID-19 outbreak.1

Prior to the pandemic, burnout in particular was common, with almost half of practicing US physicians reporting at least 1 symptom of burnout.2 This prompted the National Academy of Medicine in 2019 to publish a report outlining the causes and consequences of burnout, as well as proposing a framework for a systems approach to take action to mitigate burnout risk. Now, almost 3 years later, and in light of the current pandemic, the US Surgeon General published an advisory on addressing HCW burnout, further underscoring that conducting investigations and supporting HCW well-being must be a national priority.3

In this present study, Sexton and colleagues4 reported their findings examining emotional exhaustion (EE, one dimension of burnout) before (September 2019) and at 2 time points during the COVID-19 pandemic (September 2020 and September 2021/December 2021/January 2022) in more than 30,000 participants across 76 community hospitals in the US. Overall rates of EE were 31.8% (95% CI, 30.0%-33.7%) in 2019, 34.6% (95% CI, 32.5%-36.8%) in 2020, and 40.4% (95% CI, 38.1%-42.8%) in 2021/2022, a proportional increase of 26.9% (95% CI, 22.2%-31.8%) during this time. In nurses, rates of EE increased steadily from baseline over the next 2 years (40.6% [95% CI, 38.4%-42.9%] to 46.5% [95% CI, 44.0%-49.1%] to 49.2% [95% CI, 46.5%-51.9%]). In physicians, rates reduced initially from 2019 to 2020 (32% [95% CI, 29%-35%] to 28% [95% CI, 26%-31%]), before a sharp rebound from 2020 to 2021/2022 (38% [95% CI, 35%-41%]). The category for all others, comprising all non-physician and non-nurses (eg, pharmacists, technicians, therapists, clinical social workers), showed a steady increase from 2019 to 2021/2022 (31% [95% CI, 30%-33%] to 36% [95% CI, 34%-38%] to 41% [95% CI, 38%-43%]).

Sexton and colleagues4 suggest potential contributors to EE in HCWs, including some that may have been uniquely exacerbated during the COVID-19 pandemic. They point to the overt politicization of public health during the pandemic and state that HCWs have had to contend with an intensification of incivility directed at them for following COVID-19 protocols. This claim is well aligned with several studies demonstrating a high prevalence of work-related violence (including verbal and physical) reported by HCWs during the pandemic, which is associated with burnout risk.5 At this time, at least 6 US states have passed or introduced legislation to protect HCWs from workplace violence. More evidence is needed to support such policy efforts by examining the adverse effects of workplace violence on individual, patient, and organizational outcomes.

Sexton et al,4 as well as others,6 also point to the role of clerical tasks, such as electronic health record (EHR) documentation burden, as a contributor to EE. They suggest that the temporary flexibility and decrease in EHR requirements during the pandemic (eg, due to gubernatorial executive orders that provided temporary relief of standard documentation mandates) may have accounted for the decline in EE reported by physicians in 2020. EHR use data were not collected in the current
study and therefore cannot be linked directly to EE in this cohort of physicians, nurses, and others. Yet, the ramifications of EHR documentation burden on HCWs should be further explored as a potential factor influencing burnout risk.

The COVID-19 pandemic has illuminated, and likely exacerbated, the cracks in the foundation of how health care systems are able to meet a high demand for patient care across the health continuum. Some may argue that we are now witnessing these cracks become burnout-related sinkholes, as there have been increasingly higher rates of HCW absenteeism and turnover. It is important to note that most of the existing evidence has concentrated on burnout in physicians and nurses. Other HCW disciplines (eg, respiratory therapists, pharmacists, nursing assistants) are understudied and may have unique experiences and factors that contribute to burnout.

Furthermore, evidence about burnout experienced by HCWs outside of hospitals (eg, primary care; community-based settings) is lacking. Roles and responsibilities, team dynamics, and geographically reliant resources may play a role in HCW burnout and are dependent on the care delivery setting. Future research should consider isolating these variables to better determine discipline- or setting-specific factors so that we may inform the development and testing of targeted burnout mitigation interventions across the board.

Although the Sexton et al study4 spanned 3 years, individuals’ responses were not linked across the follow-up, rendering it a cross-sectional survey comparing group-level differences in 3 waves. This design, while impressive in capturing group-level measures of COVID-19–related EE in a large sample, limits our ability to observe burnout trajectories and potential recovery phases at the individual level. Researchers should pursue longitudinal real-time data collection to determine which organizational (eg, leadership support, physical resources), structural (eg, staffing ratios, team compositions), and individual (eg, emotional and social support, pre-existing psychological health, behaviors) factors are contributing to HCW burnout and other related health risks. Doing so may enhance our ability to inform interventions and policy changes that mitigate risk and promote effective recovery.

As we continue to understand the scope of HCW burnout and its implications, it is necessary to broaden our efforts from focusing on the prevalence, to defining protective factors and establishing mitigation approaches. What are the psychosocial factors or modifiable behaviors that may be protective or buffer against the development of burnout in HCWs at the individual and/or organizational level? How can these factors be leveraged to inform preventive or treatment-based approaches to address HCW burnout in the wake of the COVID-19 pandemic? For example, there is emerging evidence that sleep disturbance is one risk factor for burnout,7 and therefore, established countermeasures to promote healthy sleep in HCWs may be a beneficial approach to reduce the burden of burnout.

Researchers and policymakers traditionally rely on big data and empirical surveys to guide policy and practice. It is critical that we pay more attention to the many qualitative studies that were conducted throughout the pandemic related to HCW burnout. These studies would be useful to help interpret survey responses, such as the data collected in this present study. As Sexton et al noted,4 burnout is a unique construct that is highly dependent on a multitude of personal and professional factors. Not all latent constructs can be validly assessed using empirical tools (eg, scales, questionnaires) across various populations. Mixed-methods approaches, as well as attempts at the synthesis of data from different study designs, may more effectively shed light on clinical and professional experiences.

Finally, with many existing studies highlighting everything that went wrong during the pandemic, we should now focus attention to the increased amount of literature about how HCWs refined infection control practices, used innovative and novel adaptations to deliver care, broke down the silos of discipline-specific responsibilities, and redefined clinical team compositions. We must harness the lessons learned from this pandemic so that we can reshape approaches to care delivery, improve HCW training, and conduct rigorous research needed to develop strategies to promote HCW well-being. Doing so will support a healthy and secure health care workforce as we emerge from this pandemic and in the face of potential future crises.
REFERENCES


