

Exploring the Silent Struggle: Mental Health of Healthcare Professionals in Demanding Environments

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ABSTRACT: People worldwide observe the phenomenon of burnout, characterized by both emotional and physical states, among healthcare professionals; however, a rise in burnout in healthcare is being noticed in this century. Using sources from previous years, this paper identifies suspected trends. Professionals may experience surges of emotional strain, physical exhaustion, and psychological fatigue. Registered nurses, social workers, therapists, and other healthcare professionals deal with these symptoms. Workers in hospital management, patient registration, and other critical yet undervalued roles have not received the same mental health awareness as other professions. Environmental conditions may also influence emotional health and physical symptoms. Healthcare workers who perform in high-risk settings have been known to experience more burnout than others, raising questions about comparative burnout rates in various environments. This study investigates the hierarchical structure of hospital staff and how misaligned leadership strategies can cause increased burnout rates and turnover. Institutionalized positive feedback loops are finely ingrained in hospital workers, often because of neglected communication between superiors and workers. Such loops persist unless leadership intervenes. To confront this, this mixed-methods literature review examines the underlying reasons why healthcare workers experience poor mental health and identifies the systematic loop that communities and employers can act on.

KEYWORDS: Psychology, Health Psychology, Healthcare, Burnout, Mental Health.

■ Introduction

Classic signs of anxiety and depression distinguish the burnout psychological condition. In some cases, workers can develop complex mental health problems, such as impostor syndrome, as a result of daily burnout. Another common symptom of burnout is feeling depleted and “having nothing in the tank.” In 2018, around 32% of healthcare workers reported feeling burned out, a statistic that increased to 46% by 2022.^{1,2} A flooding feeling of guilt, dread, and melancholy will also likely appear after burnout. Workers' attitudes and bedside manners can be negatively affected when severe exhaustion occurs. Hostility, ignorance, and feelings of anger among physicians are likely to rise when the syndrome occurs.³

Statistics of Physician Burnout:

According to multiple surveys from the Massachusetts General Physicians Organization, researchers surveyed 1373 physicians in 2017, 2019, and 2021. The respective percentages of physician burnout reported were 44.4%, 41.9%, and 50.4%. Considering the COVID-19 pandemic, the rates in 2021 and 2022 nationally have recorded the highest percentage of burnout in the healthcare sector. The acute increase in cases, deaths, and infections affected almost 50% of physicians, as attested by the Maslach Burnout Inventory.^{4,5}

High Burnout Rates Even With Support:

Since the highs of COVID-19, many hospitals and clinics have become more aware of the profound impact that physician burnout can have on healthcare workers. However, despite this growing recognition, burnout rates remain alarmingly

high, with nearly 45% of all healthcare workers in the United States experiencing exhaustion. This marks a slight improvement from previous years, such as 2023, which recorded almost half of physicians being burnt out.^{6,7} The minimal progress does not constitute a fall-off in awareness of physician burnout. These numbers continue to exceed the 44% burnout rate recorded before the pandemic,⁶ underscoring the need for on-going attention and intervention by healthcare leadership.

Unorthodox Healthcare Provider Fatigue:

While physician and nurse burnout have received more attention recently, emerging research highlights that burnout is not limited to the traditional clinical roles but instead extends beyond them. In the COVID-19 period, a study concluded that 60 to 70% of medical students and residents experienced burnout symptoms, including 43% reporting work overload, 38% reporting anxiety/depression, and 49% of healthcare workers reported the overall presence of burnout.⁸ Another study found that more than half of frontline healthcare workers suffered adverse health effects. The same study also reported that three in ten needed mental health support.⁹ Figure 1 displays the detailed symptoms healthcare workers experienced.

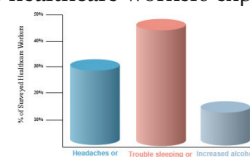


Figure 1: A comparative analysis of the physical symptoms experienced by primary healthcare workers. Various professions were surveyed and examined to determine if the occurrences of these symptoms differed greatly across occupations.

Reported symptoms included 47% having trouble sleeping or sleeping too much, 31% reporting frequent headaches or stomachaches, and 16% resorting to increasing their alcohol or drug use. However, the most concerning statistic was that 18% of healthcare workers believed they needed mental health care but did not receive it.

Our research-informed analytical paper has contributed the following:

1. A comprehensive analysis of burnout causes and effects across diverse healthcare roles.
2. A unique synthesis of pre- and post-COVID factors, offering insights rarely addressed in existing literature.
3. Critical observations on systemic trends, organizational responsibility, and overlooked gaps that could reshape how we understand and tackle burnout.

Overview of Paper Structure:

The techniques used to extract, highlight, categorize, and analyse the central themes of the references are outlined in Section 2. Section 3 details the findings regarding the roots of modern physician burnout across all healthcare careers. Physician burnout and the effects it can have on patients will be discussed in Section 4. A comprehensive investigation into the impact of burnout on healthcare employees is included in Section 5. A note by the author emphasizing the next steps to be taken by other individuals and organizations is found in Section 6. A summary of this paper's findings and its limitations is provided in Section 7. Figure 2 illustrates the layout of this paper.

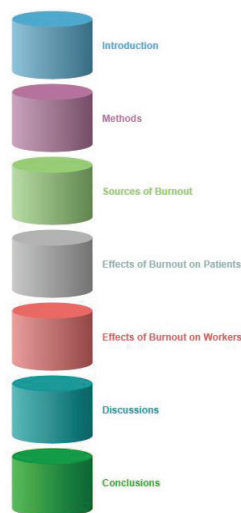


Figure 2: The layout of our analysis is designed to present topics in a systematic and organized manner. Clarity and assurance of relevance are the aims of the structural organization in this paper.

■ Methods

Searches using keywords (burnout, stress, healthcare, anxiety) were conducted, targeting research papers and surveys. Searches were conducted on database engines and journals focusing on research articles, including Google Scholar, the National Library of Medicine, the American Medical Association, and other relevant publishers and journals. These three databases were used to guarantee authentic papers and keep

our findings accurate. Results were thoroughly scanned manually for recent (2020 onwards) important survey findings, editorials, reports, informative reviews, and systematic reviews. We also included foundational sources dating back to the 2010s to review trends and establish the historical relevance burnout has had and continues to have today. We considered papers published before 2000 to be outdated in order to keep our data relevant. Figure 3a illustrates the percentages of references used from each era.

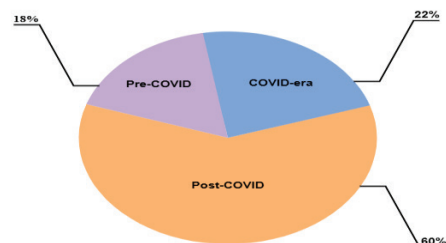


Figure 3a: Pie chart illustrating the percentage of citations across different eras. An emphasis on post-COVID can be noted while also observing the contributions of both the pre- and during periods.

This review has 50 unique citations, 60% of which were published in or after 2023, commonly known as the post-COVID era. The 18% and 22% represent the pre-COVID and COVID-era, respectively. Earlier studies laid the foundation for observing growing trends and continuous observation over the decades. This provides additional insight into the evolution of burnout. The type of information provided is crucial to a paper's reliability and quality. Figure 3b displays different sources that this paper has analyzed below.

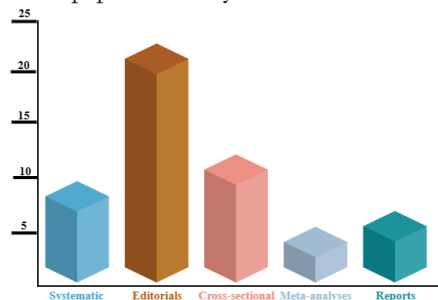


Figure 3b: A breakdown of references categorized by the different study types according to each source. Although editorials have a notable dominance in number, their main purpose is to provide multiple aspects of how burnout can be expressed. The majority of physical symptoms and psychological symptoms were derived from comprehensive cross-sectional studies and reviews.

To contextualize the meaning of burnout, an emphasis was placed on editorials (44%). Psychological topics often require qualitative and quantitative data for conceptual understanding, especially in the case of burnout. This paper uses qualitative data, such as data sets from the Maslach Burnout Inventory, as well as editorials that contained observations of burnout by professionals. Furthermore, editorials also added expert insight and framed burnout as a condition. Quantitative data, including statistics from the Maslach Burnout Inventory and EHR burnout rates, were also implemented for identifying patterns and supporting qualitative claims. Combined with empirical claims (39%), this paper integrates both veteran perspectives and data-driven sources “with the method of Triangulation,”

resulting in analytical depth and practical relevance that strengthen the reader's understanding. The origin of a study can significantly impact the results recorded; some regional areas may yield different outcomes due to varying societal norms or systematic factors. Figure 3c summarizes the makeup of the empirical studies referenced in this paper below.

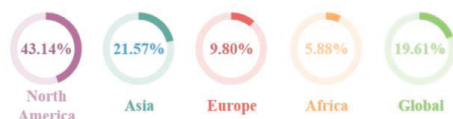


Figure 3c: The percentages of the manually calculated summary of empirical citations. A majority of psychological journals are located in the North American continent, thus a prominence in North American studies can be seen.

Researchers have conducted the majority of burnout studies in North America. The United States of America was the primary contributor in North America. Asia was the 2nd largest contributor with 21.57%, and countries such as China, India, and Saudi Arabia are demonstrating their growing healthcare systems and rapidly evolving technology. Europe's 9.80% included studies conducted by a variety of countries, such as Romania, Spain, and the Netherlands. Africa conducted 5.88% of the studies and presented stressors for healthcare workers and underprivileged settings. Finally, 19.6% of the studies were multinational, and all of these studies enhanced this paper's ability to comparatively understand burnout and the association of certain regional factors with it. To achieve these statistics, each study was identified and sorted by continent of origin. Percentage calculation was then used to determine the portions above.

Sources of Burnout:

Psychological Hardships in Varying Specialties:

Some healthcare workers experience higher levels of emotional dysfunction than in other specialties, such as ER rooms and trauma centers.¹⁰ Psychological distress that has been commonly observed in physicians includes acute episodes of irritability, frustration, anxiety, self-doubt, and depression.¹¹ Workers in high-intensity settings, such as emergency rooms and trauma centers, often exhibit greater depersonalization or detachment from their patients compared to those in other specialties.⁶ Despite the rigorous education that medicine requires, one subject is often overlooked. It remains a crucial gap, that is, teaching healthcare professionals how to balance work and personal life healthily.¹⁰ This balance is vital as it will determine career trajectory as well as the ability to sustain and handle psychological distress. Even if balance is maintained by the individual, leadership and its organization play a big role in the worker's life.¹²

Poor Leadership and Impact:

Defective leadership can have a tremendous impact on healthcare workers. Toxic behavior by a leader can lead to the spread of cynical attitudes and cause chain reactions throughout the workplace hierarchy.¹³ The ramifications of poor leadership can lead to many negative effects, as shown in Figure 4.

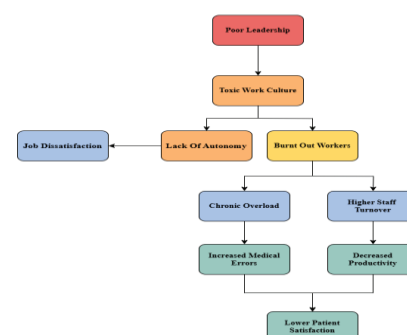


Figure 4: A flow chart presenting the consequences of poor leadership. Arrows leading down or sideways indicate that the previous box is the root cause of the new consequence. Warmer colors on the diagram indicate direct reactions of toxic management, while cooler colors show the indirect consequences of those reactions.

The ultimate result of poor leadership is a decrease in patient satisfaction and job satisfaction. Although these may be the tangible outcomes, there are plenty of other results that are less discernible. Higher staff turnover, decreased productivity, and medical errors all contribute to an increased cost, which the organization must bear.¹⁴ Studies on toxic leadership and its impact on nursing staff have shown that poor leadership by nurse managers significantly contributes to the outcomes mentioned earlier. It is worth noting that all these chronological events are associated with symptoms of burnout. Multiple surveys found that nurses with toxic nurse managers were more likely to leave their jobs, less satisfied with their work, disengaged with their patients, and had an overall higher amount of stress.¹⁵⁻¹⁷ The toxic leadership exhibited by NMs can be applied to any other leadership role, such as attending physicians, heads of certain specialties, department chiefs, administrative officers, and other equally high-ranking positions. The typical healthcare hierarchy can be seen below in Figure 5.

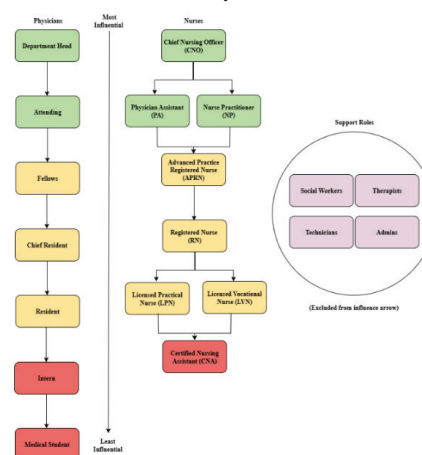


Figure 5: The typical hierarchy of healthcare workers in a hospital. The arrows show the managerial connection between two roles. The role the arrow is pointing towards is the inferior and less experienced position. The less experienced the position is, the less influence it has on others. Entry-level or beginner jobs typically do not contribute much to workplace toxicity, while experienced roles do.

Explanation of Healthcare Worker Roles:

This chart's color scheme also gives us some additional information: jobs with the color green tend to have higher ed-

ucation and more responsibilities in terms of leading the rest, since they are usually more experienced. Yellow indicates the middle of the hierarchy; these jobs have more power and freedom, but they are not primarily a leadership role. These jobs will have an equivalent split between work and learning. Red is at the bottom of the hierarchy; they usually have a limited scope of work and tend to focus on learning and preparing for the next job. Finally, purple jobs are the outliers that lack their own hierarchy. Still, they support the healthcare system in less visible ways, such as emotionally, logistically, and organizationally.

Electronic Health Records:

One common duty of any healthcare worker is paperwork. It is a staple in every health network, for without it, keeping track of patients and being organized would be much more challenging. Even though clinical documentation is a necessity, it has a profound impact on workers and is the reason why many have developed “documentation burnout.” Electronic Health Records, or “EHRs,” have been primarily used in modern times to document any sort of information related to patients or hospital administration. A 2015 study revealed that around 80% of hospitals had implemented elements of EHRs in their documentation systems.¹⁸ Even though EHRs have reduced the physical amount of paperwork, their side effects are now being linked to burnout. One paper published in 2021 described EHRs as being in their “infancy” stage.¹⁹ It also reported unintended consequences on workers, such as increased medical errors, patient safety mishaps, lower quality of documentation, and increased staff turnover. Workers tend to spend more time on EHRs when compared to traditional ways. Usability has been a primary reason why many nurses become burned out; the burden of recording large amounts of data with complex technology has led to burnout, according to one study.²⁰ However, one study focusing on the impact of AI scribes on clinical documentation has seen promising results. They found that AI led to greater efficiency and alleviated documentation burnout in some healthcare providers.²¹

Unhealthy Work-Life Balance:

Most causes of burnout, as explained previously, contribute to the key factor: work-life imbalance. Unlike many other careers, healthcare workers often have an unpredictable schedule. Physicians may have to take a call in the middle of the night, nurses could have to work overtime due to an important patient or surgery, and technicians could have to be on-call but off-site. Plenty of other important roles are unpredictable, and this negatively impacts their work-life balance. In COVID-19 times, a study showed that work-life balance is being disrupted primarily due to the pandemic. Although this study was not directly related to burnout, the conclusion was that higher staff turnover rates were caused by this imbalance.²² Earlier, in Figure 2, we saw that higher turnover rates lead to decreased productivity and are a cause of burnout. We can conclude from here that an imbalance of work and life leads to burnout. Another deduction we could make is that unorganized or insufficient sleep can lead to work-life imbalances and, therefore,

burnout. Systematic reviews were conducted and concluded that symptoms of burnout, such as anxiety, depression, high stress, and more, can cause sleep disturbances.^{23,24}

Effects of Burnout on Patients:

The Anatomy of the Healthcare System:

The repercussions of physician burnout can extend beyond the physicians themselves; patients may suffer dire consequences due to inadequate psychological support. Comparing the healthcare system with the human body, we can imagine patients as the blood, and physicians as the heart. Patients flow in and out, while physicians diagnose and treat. Burnout interrupts this regular pattern, and as you can imagine, the entire body is compromised. When a physician's workload exceeds their capacity to manage or experiences a cause of burnout, their quality of care tends to be poor, triggering a “looping cycle” that can jeopardize both patients' physical health and healthcare workers' mental health. This process is illustrated below in Figure 6.

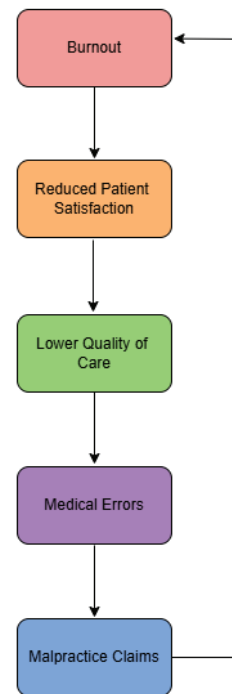


Figure 6: An example of a positive feedback cycle of patient-burnout interaction, where malpractice claims can further intensify the burnout. This loop not only applies to physicians and nurses but can also include social workers, administrators, and therapists, although they may be excluded from malpractice claims in some cases due to their differing job duties from the other professions mentioned before.

Poor Quality of Care:

The first consequence of burnout in healthcare workers is a lower quality of care. Burnout often hurries physicians to examine all their patients within a limited amount of time. As a result, lower patient-physician interaction times may occur, leading to reduced patient satisfaction.^{30,31} The relationship between physicians and their patients was also observed. Consequently, studies found that positive relationships led to reduced burnout and that ultimately led to healthier relationships, once again forming a positive feedback loop.³²

Medical Errors and Patient Satisfaction:

With poor healthcare comes a priceless cost. The safety and satisfaction of a patient cannot be easily compromised; low-quality healthcare increases the risk of doctors making clinical errors and decreases patient satisfaction during an appointment. Burnt-out physicians do not have the right mindset for taking care of people. Medical errors, which could endanger the mortality of a patient, often occur when physicians are stressed out too much. Studies have shown that higher medical and prescription errors are strongly associated with high burnout rates.^{2,33} Patient satisfaction is also likely to occur. A lowered rate of satisfaction from patients can be due to a lack of quality healthcare or even medical errors. The severity of a medical error can determine if a patient lives to see another day; with this peril, decreased satisfaction is naturally bound to occur. A meta-analysis examining patient satisfaction and burnout trends found that burnout results in a nearly doubled increase in the chance of patients being dissatisfied with their provider.³⁴

Malpractice Claims:

The combination of medical errors and lower patient satisfaction, unfortunately, results in the appearance of malpractice claims. Patients have the right to be compensated if their healthcare provider has not provided them with the correct treatment; unfortunately, malpractice claims can exacerbate the situation, contributing to a vicious cycle that further burns out physicians. A study conducted on nurses and how burnout affects their malpractice rates concluded that burnout, along with several other workplace factors, increases the likelihood of medical errors and malpractice tendencies.³⁵ Another study supported this conclusion by stating that anxiety, stress, and other burnout-like symptoms led to medical errors and then malpractice that can be filed as lawsuits.³⁶ The ruthless aspect of malpractice is that if it is filed as a lawsuit, it may make healthcare workers more likely to commit another medical error, potentially leading to another lawsuit. An analysis of burnout in orthopedic surgeons discovered that surgeons with current malpractice claims filed against them were associated with more burnout, along with other factors such as poor home life and excessive workloads.³⁷

Effects of Burnout on Workers:

Variety of Burnout Effects:

Different careers have unique obligations that can be more stressful than other jobs. The type of skills needed and the quantity of work will differ. However, in general terms, we can differentiate the harshness between jobs. For example, an administrator who works at the front desk will experience less burnout compared to a nurse practitioner. We covered this at the beginning of Section 3: how some specialties experience more burnout on a daily basis than others. In this section, we will compare the burnout symptoms, rates, and consequences of a variety of careers. This gives us an idea of what type of workload, alongside the amount of work, undergoes the most pressure.

Common Physical Symptoms of Burnout:

Throughout this review, generic explanations have provided us with enough information for the findings of this analysis, but exactly what specific effects are shown in workers due to exhaustion from their work? Many studies have identified three principal effects, which are consistently observed across workers.^{9,38,39} The three main characteristics of burnout are a sense of low accomplishment, depersonalization, and emotional exhaustion. These three symptoms are often caused by a buildup of other feelings, commonly leading to an outburst of overwhelming sentiments.³⁸ A low sense of accomplishment can stem from an inefficiency of work; this inefficiency, as explained earlier, is common due to an overload of paperwork and a laborious system caused by the implementation of EHRs. With no sense of accomplishment, depersonalization can occur and wreak even more havoc. When one degrades the value of their patients, colleagues, and other professionals, we can label this as depersonalization. Treating patients without proper bedside manners and developing toxic attitudes toward coworkers are often observed in leadership roles. In Section 3, we spotted the results of poor leadership. With this definition of depersonalization, we can link the two. The last symptom is emotional exhaustion, which is defined as physical tiredness from the emotions a worker has experienced. Emotional exhaustion is often seen when the other two symptoms occur; this “holy trinity” of burnout can affect all workers, some in different ways as well.

Effects of Burnout on Physicians:

Physicians, the beating heart of the healthcare system, unfortunately, experience the highest level of burnout compared to other workers. Their outcomes differ much more than those of other roles, often with elevated severity. Burnout in physicians often comes with dangerous symptoms that are harmful to their health and others' health, and decreases in workability are a sign of poor mental health. A systematic review found that burnout, when considered from all three angles, affects physicians by increasing their use of sick leave.⁴⁰ In contrast to the mildness of sick leaves, alcoholism in burnt-out physicians is common. Alcohol abuse in healthcare is highly looked down upon, as physicians must be in the correct state of mind to treat patients and perform other clinical duties accurately. A study surveying surgeons concluded that alcoholism can be positively associated with burnout symptoms.⁴¹ Alcohol can also increase the level of burnout a physician could have, major medical errors, long working hours, a high population of the community, and low satisfaction with marriage (if a physician has a legal spouse) were associated with alcohol or substance abuse symptoms. Substance or alcohol abuse can also be linked to suicidal thoughts or actions, just like burnout. When discussing physicians, multiple studies have shown a correlation between burnout and suicidal contemplations. Several systematic reviews have highlighted the increased potential for suicide or suicidal thoughts if a physician is showing signs of poor mental health or burnout.⁴²⁻⁴⁴

Effects of Burnout on Nurses:

Labelling doctors as the heart, we can visualize the circulatory system as nurses. They are constantly moving, working, and dealing with high-stress environments. Consequently, they also experience tiredness from their work. Nurses typically experience similar symptoms of burnout when compared to doctors, but some unique traits have been observed only in nurses. Despite being an important factor in healthcare, nurses can often feel undervalued due to stereotypes and a lack of knowledge surrounding the field. From this stems the overlapping burnout symptoms that physicians experience, such as trouble falling asleep, recovery from work, emotional exhaustion, depression, and turnover rate.^{45, 46} Alongside environmental pressures, the blend of physical and intellectual requirements, as well as the complex nature of the job, can lead to a decline in the quality of care and efficiency.⁴⁷ Symptoms such as emotional exhaustion, depersonalization, and a sense of “failure” are also common.⁴⁵ The reason for these results may be different, though. Doctors are primarily involved in the planning of a treatment (exceptions include surgeons), while nurses are typically the ones who physically treat patients for their illnesses. Clinical mistakes are, unfortunately, expected in every job role; however, nurses may experience burnout from the “performance” aspect rather than the “prescribing” aspect that physicians are used to. Medeiros *et al.*⁴⁸ describe the burnout of nurses as a reduced “ability to provide care.” This physical element of nurses can cause the death of a patient if an error is made, which is why the roots of burnout are much different from those of physicians.

Effects of Burnout on Administrators and Therapists:

The most undervalued workers in healthcare, such as administrators, therapists, technicians, social services, and other assisting roles, are commonly overlooked when we think about burnout in healthcare jobs. The reason is mainly due to the lack of research done on these careers, as well as the amount of workplace fatigue they experience. Although these job roles are in healthcare settings, their work greatly differs from that of physicians and nurses; one study showed that administrators were more fulfilled professionally with their jobs when compared to physicians.⁴⁹ Healthcare leaders, such as CEOs, CHOs, and others, were likely to work more hours per week and naturally have burnout symptoms. 85% of administration-related workers would recommend their job to younger people, indicating personal fulfilment with their employment in a national survey conducted by Shanafelt *et al.*⁴⁹ The likely reason why administrators may experience burnout may be due to the management and the protocol operations they interact with daily. Their type of exhaustion is similar to the occupational stress that office workers experience. Therapists have also been noted to have considerably lower burnout rates when compared to other healthcare professionals. Their job entails interacting with the psychological factors of a patient rather than the physical elements. A study done on Chinese clinical therapists and an analysis of their findings found that the rates of burnout symptoms reported by the therapists were much lower than those in the same field, such as psychiatrists and nurses.⁵⁰

Effects of Burnout on Social Workers and Technicians:

Similar to the nature of therapists, social workers also interact with people daily. Social workers, however, can express different and intensified symptoms, such as cynicism, emotional detachment, and emotional absence.⁵¹ This aligns with the nature of a social worker's job. Overseeing people and the various emotions they express can be fatiguing and alter the perception of how they view others. Alsabani *et al.*⁵² surveyed anesthesiologists and anesthesiologist technicians and reported that 29% of technicians surveyed expressed workplace occupational exhaustion symptoms. 40% of the participants reported emotional tiredness, more than 50% reported depersonalization, and 76.5% expressed a lack of personal achievement. This greatly aligns with social workers' burnout rates and symptoms. Technicians are responsible for the diagnostic exams that physicians may request; they specialize in a certain field and operate the needed equipment for treatments or tests. Their work is a blend of physicians and nurses, as they contribute to the treatment of a patient while also physically registering the desired care.

■ Discussions

The phenomenon of burnout is deeply rooted in the healthcare system; it preys upon all healthcare workers. These findings indicate the various roles that burnout can impact; technicians, administrators, social workers, and therapists are also victims of the symptoms burnout causes. Due to the nature of burnout, every position will inevitably experience it at one point or more in their career. The causes can vary from poor leadership, hardships in traumatic specialties such as emergency medicine, and unhealthy work-life relationships among workers. Organizations should acknowledge the various profiles and symptoms that exhaustion can show up as by considering the potential causes of burnout in their organization. Experimenting with different approaches regarding burnout prevention and rehabilitation is recommended. Strategies that seem effective in one field may not be as effective in others. Therefore, a trial-and-error method could yield successful results.

Across virtually every burnout study, the triad of depersonalization, low accomplishment, and emotional exhaustion seems to be recorded. Symptoms that branch out from these three, such as job turnover, are serious signs that will lead to a destructive cycle if not remedied. Intense departments with high stakes, like emergency rooms and trauma centres, are bound to experience burnout; an emphasis on prevention in similar environments would be highly beneficial for productivity and job satisfaction rates among workers.

Triggers that start the destructive loops play a key role in degrading the mental well-being of workers. Toxic leadership and unsuitable systems for tracking PHI (EHR systems were designed to improve efficiency, instead, the promotion of extended working hours, overloads, and other unintended consequences seemed to be overpowering), the indirect giving into the crippling cycles, while also initiating chain reactions in the workplace. Medical errors and negative patient outcomes are

often caused by low morale and poor communication among coworkers.

One must act to spread awareness and prevent burnout to avoid the downward spiral of the situation. Malpractice lawsuits, increases in clinical errors, and lower patient satisfaction rates should be observed as a general decrease in care quality and the presence of a toxic feedback loop in the organization. Without thorough methods, identifying and breaking the loop is unfeasible.

Multifaceted studies into supportive roles in healthcare could uncover unknown symptoms of emotional exhaustion, which can potentially change our view of burnout and increase the number of observable symptoms. Traditional preventions would be adjusted, resulting in new, structured interventions and a general decrease in burnout symptoms.

Limitations of this research include inadequate information on burnout and its effects on supportive roles in healthcare settings. The availability of studies varying in different regions of the world is also insufficient. A heavy reliance on secondary sources can carry biased data and its limitations. As a result of no primary data, skewed and out-of-date findings may occur. Without a standardized tool to measure rates, comparing data is much more difficult and less uniform. The evolution of Electronic Health Records (EHRs) is continuing rapidly, and artificial intelligence and other possible integrations may soon allow EHRs to assist health professionals without the obstructive side effects. Artificial intelligence, although in early stages, could be an effective way to prevent documentation burnout in clinicians. However, more testing and development are required for this to occur. This study's goal was to extract the major findings of underrepresented roles in the healthcare setting and synthesize a digestible report. A lack of documentation limited this research and potentially led to an incomplete understanding of burnout and its effects on supportive roles.

■ Conclusion

The goal of this study was to holistically explore the causes and effects of burnout among healthcare workers. With the use of various sources from pre- and post-COVID times, multiple systemic factors were identified. Feedback loops that branched from the main three symptoms of burnout (depersonalization, emotional exhaustion, and lack of accomplishment) were the prime culprit. Other inefficiencies, such as developing EHRs, also contributed to the cycle. The discoveries in this research found that burnout is not individual but instead is a strongly rooted systemic issue that can be resolved with proper steps taken. The importance of support roles in healthcare organizations is not to be overlooked; many clinical mistakes may happen if the support roles are not given burnout awareness or prevention materials. The growing library of post-COVID mental health observations on healthcare professionals is in development. Future research could include cohort studies, programs to raise awareness of burnout and corresponding rates, and analyses like this one to address the growing problem. Burnout is something that will not resolve on its own;

it requires proactive recognition and intervention from both individuals and organizations.

■ Acknowledgments

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