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UNIVERSITY OF SAN FRANCISCO

CHANGE THE WORLD FROM HERE

**Burnout: An examination of how human services' cultures impact
person-centered care and job satisfaction**

by

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Capstone Research Report Submitted in Partial Fulfilment

of the Requirements for the

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in the School of Management

directed by Dr. Richard Gregory Johnson III

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Abstract

In a world that demands the constant requirement of adaptability and technology, the need for ‘hands on the ground’ continues to persist, and perhaps even grow. This research project explores burnout in the healthcare and nonprofit settings, as a pre-existing and ongoing issue, that was brought to centre-stage during the Covid-19 pandemic. The researcher explores the intersections of burnout with workplace culture, person-centered care (PCC), sweat equity and duty-of-care, through expert interviews and literature reviews. Data collected provides an immediate understanding of current workplace cultures and environments for human service providers, in both healthcare and nonprofit sectors. While the data provides unequivocally clear insight into the negative impacts of burnout, further research is required to gain a more detailed, wide-scale analysis of the true extent of burnout. The lack of information available regarding the management and prevention of burnout in the healthcare and nonprofit sectors, suggests a need for further research into current guidelines, protocols, and support services that advocate for healthy and sustainable workplace cultures. The intersection between human service providers and a culture of burnout became glaringly obvious throughout the Covid-19 pandemic. Nevertheless, as demonstrated in the following research, numerous factors contribute to enable and normalise the persistence of burnout within human services.

Keywords: person-centered care, burnout, workplace culture, advocate, staff retention.

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Section 1. Introduction

Burnout; an ever present and ongoing problem that impedes the healthcare and nonprofit sectors' workforce. In light of the recent Covid-19 pandemic, the demand for numbers on the ground within healthcare and nonprofit organizations, became glaringly clear. Not only was the demand for healthcare workers and human services increased during this time, it was also put in the spotlight. As the entire world stopped and faced lockdown, human services providers' work multiplied and became the centre of attention, as they faced the pandemic front on. The pandemic not only highlighted the heroism of healthcare workers, but it shone a light on the true stress, fatigue, pressure and expectations that exists within the sector. The added stress of a highly infectious virus, in combination with the sudden spotlight that was shining on the healthcare system, saw the issue of burnout being publicized. Though a pre-existing issue, burnout was both highlighted and heightened throughout the pandemic. As the Covid-19 virus becomes less novel and settles into the background of our new 'normal', one has to wonder how ongoing pressures continue to impact human service providers.

Casarella defined burnout as "a form of exhaustion caused by constantly feeling swamped. It is a result of excessive and prolonged emotional, physical, and mental stress. In many cases, burnout is related to one's job" (2022). The nature of the human services sector exposes employees to the causes of burnout. Individuals working in healthcare or

with nonprofits, who serve vulnerable populations, are constantly providing services that demand a high level of emotional strength. In addition to this, the physical and mental toll that often comes with the job, contributes to exhaustion. Because of these environments, individuals are vulnerable culprits of burnout. To add to this, the question has to be asked about whether workplace cultures or ‘norms’ are a causative and contributing factor of burnout. A workplace that expects unrealistic workloads is bound to contribute to a culture that fosters the normalization of stress, fatigue and sweat equity.

Burnout was first introduced as a concept in the 1970’s by Herbert Freudenberger, an American Psychologist and Psychotherapist. Freudenberger described the term as an experience or mental state, rather than a condition. In his initial article explaining the term, Freudenberger states that the “dedicated and committed” and the “individual that has a need to give” are prone to burn-out (1974, pp. 161-162,). The interconnection between healthcare and nonprofit organization exists when we look into the *why* behind both sectors. Both sectors exist to serve the needs of humans and are seen as essential for the survival and health of individuals and communities. Freudenberger discussed the intersection of these sectors in relation to the nature of individuals who provide such services.

Those of us who work in free clinics, therapeutic communities, hot lines, crisis intervention centers, women’s clinics, gay centers, runaway houses, are people who are seeking to respond to the recognized needs of people. We would rather put up than shut up... it is precisely because we are dedicated that we walk into a

burn-out trap. We work too much, too long and too intensely. We feel pressure from within to work and help and we feel pressure from the outside to give (Freudenberger 1974, p. 161).

Since then, burnout has become a more commonly used and understood term, particularly amidst the global pandemic. Though there are ongoing studies and scientific debates over burnout specifics and diagnosis's (Heinemann & Heinemann 2017), the impact and prevalence of the issue is indisputable.

The World Health Organization (WHO) stated that burnout is not classified as a medical condition, but rather an “occupational phenomenon” (WHO, 2019). In their description of burnout, it is described as “a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed” (2019). Following their definition, WHO characterized burnout by three key dimensions;

- energy depletion or exhaustion
- increased mental distance from one’s job, cynicism or negativism for one’s job
- Professional efficacy reduction.

The prevalence of burnout in today’s social and human services sector is undeniably clear. As the world continues to recover from the Covid-19 pandemic, individuals and organizations are facing the ongoing stressors, putting them at a higher risk of burnout.

“Anyone exposed to chronically stressful conditions can experience burnout, but human services employees, first responders, and those in educational services are at an even higher risk, especially as the public continues to resist COVID-19 prevention measures” (Abramson, 2022).

The American Psychological Association found in a 2021 work and well-being survey, that 79% of participants had experienced work-related stress. 26% reported work-related stress causing a lack of motivation, interest or energy. Cognitive weariness was reported by 36% of employees, as well as 32% having reported emotional exhaustion. The most alarming result was that 44% reported physical fatigue; an increase of 39% since the 2019 survey (Abramson, 2022). These statistics not only demonstrate the high number of individuals experiencing the consequences of burnout, but also highlight the alarming fact that it has increased immensely in recent years.

The recognition of burnout is apparent, however there seems to be a need to explore the underlying causes and commonalities that are enabling, and potentially fostering, the rise of burnout occurrences within human services. The intersection between burnout and human services – where the nature of services and workplace cultures are both major factors, appears to require further research. The following report entails a literature review, where burnout and the relevant contributing factors are explored, expert interviews with a thorough data analysis, and recommendations for necessary changes in response to the findings.

Section 2: Literature Review

Burnout is a major systemic issue. Its prevalence is clear, yet the real issue lies in the root causes and consequences of burnout. Burnout can be totally debilitating and detrimental to the health and productivity of individuals and organizations within the human services sector. The following literature review takes a closer look at the emergence of burnout, the concepts that underpin both nonprofit organizations and healthcare settings, the effects of a global pandemic on the topic, and the nature of services being provided which ultimately contributing to the cause of burnout. Relevant literature provides a basic understanding of what burnout is, and enables the reader to think further about the intersection of affected populations and their common causative traits. Ultimately, the research aims to provide insight regarding the health of employees within nonprofit organizations and healthcare settings, and the perceived secondary, yet direct impact this has on patients or recipients of the relevant services.

More specifically, this review analyses the emergence and definition of burnout, according to recent and past literature. It provides insight into the effect that Covid-19 had on the prevalence of burnout. Sweat equity and culture within human services are major players when it comes to burnout, yet appear to be easily overlooked in recent literature pertaining to the issue. Burnout has major effects; employees and workplaces face the immediate consequences. Analysing the model of person-centered care, the notion of duty of care, and the ethical considerations within the topic is essential to consider the full impact and potential contributors of burnout. As nonprofit organizations

and healthcare settings both exist to provide human services, the underlying concepts of both sectors must be recognized as a clear intersection and common contributors when considering burnout.

The Emergence and Defining of Burnout

Burnout was first coined in 1974, yet remains in murky waters regarding the specificities of its defining terms and measurements. When the term was first coined by Freudenberger, it was used to describe a state or experience that affected employees in professions demanding empathy and compassion. Since then, and after extensive research, in 2015 the term was re-categorized in the International Classification of Diseases (ICD) as a mental state, rather than an amorphous concept. Then in 2019, burnout was re-classified again from a mental state to an occupational syndrome, despite not yet being considered a medical diagnosis (Feldman, 2020). Today, burnout is still classified as an occupational syndrome with varying definitions, despite extensive research on the syndrome. In 2023, the ICD referred to burnout as a “physical and emotional exhaustion state” (2023).

Though the defining of burnout with key terms and measures has not yet been standardized, research appeared to remain consistent when stating the symptoms, affected populations and consequences of burnout. Failure to standardize the defining terms and measurements of the syndrome is bound to raise concern as it stands as a barrier; preventing further research, statistics and potential preventative measures from being instigated. There is currently no globally recognized measurement for assessing burnout,

making research studies and assessments of burnout difficult to compare. This remains a barrier in research, potentially related to the lack of standardization of the term and syndrome.

The majority of research pertaining to burnout has involved medical employees, though it applies to conditions of equivalent or similar nature as those experienced within nonprofit organizations. Studies related to burnout reveal alarmingly high rates of employees experiencing the associated symptoms. The response to such high rates of burnout is evident in the increasing implementation of well-being resources, stress management support, and intervention programs and policies across organizations and systems. This is an important change to note since the origin of the term burnout, as it demonstrates the power that research holds in addressing such large-scale issues.

Burnout was initially described by Freudenberger as a state that affected “the dedicated and the committed” and “that individual that has a need to give” (1974, p. 161-162). It was assumed to affect primarily “helping” professions that involve a high demand of empathy, compassion, and ultimately, a deep emotional connection (Feldman, 2020). More recent research indicated a broader range of affected professions. A systematic review conducted in 2017 found that burnout is not specifically correlated to professions with high empathy and compassion demands; rather it is correlated to the imbalance between work demands and resources (Salvagioni et al., 2017). The study found that anyone experiencing demands, such as work expectations and time pressures, that were unmatched available resources, such as support, time and autonomy; were

vulnerable to burnout. This shift of perceived affected populations is crucial to identify, as the definition, consequences and affected populations of burnout are essential to understand for ongoing research and understanding.

Burnout was initially thought to affect individuals one year after commencing at a particular workplace; “It usually occurs about one year after someone has begun working in an institution” (Freudenberger, 1974). More recent research revealed differing statistics, as individuals of numerous age groups and varying years of experience at a workplace experience symptoms of burnout (Feldman, 2020).

With a clear prevalence, understanding the progression of burnout; from a newly recognized mental state, to an extensively researched and known occupational syndrome, is important to enable effective ongoing research. The lack of specification regarding the assessment and definition of burnout remains a barrier for more precise research, prevention and treatment development from occurring. The consistencies in recent research outline burnout as an occupational syndrome that affects countless individuals from varying professions, as a result of ongoing and unmanaged stress. This provides important context, confirms prevalence, and provides a base understanding for the current interpretation of burnout.

The Development of Burnout Amidst a Pandemic

In light of the recent Covid-19 pandemic, the demand for human services was extenuated. Not only was the demand for healthcare workers and human services

increased during this pressing time, it was made the spotlight of the world. The pre-existing issue of burnout became even more prevalent as healthcare workers were put on a pedestal and given a voice.

Burnout is a pre-existing issue that dates back many years prior to the coronavirus pandemic. Just one year after the WHO declared burnout as an occupational phenomenon, covid-19 forced dramatic changes on workplaces and added unforeseen stressors to human service occupations. Leiter and Maslach discussed the relationships between people and their jobs in *The Burnout Challenge* (2022). They discussed the intersection between covid-19, workplaces and burnout. They discussed how and why burnout increased during the pandemic; “If conditions and requirements set by a workplace are out of sync with the needs of people who work there, this bad fit in the person-job relationship will cause both to suffer.” (Leiter & Maslach, 2022, p. 6) This issue of mismatching reflects the notion that burnout is a result of workplace stressors that are not successfully managed.

Many decades of research on various risk factors in the workplace (such as high demands, toxic hazards, job insecurity, lack of control, and so on) have shown that unhealthy job environments harm employees both physically and mentally, with ultimate damage to the economic bottom line (Leiter & Maslach, 2022, p. 6).

Covid-19 enhanced factors that already contributed to burnout within workplaces, where cynicism, despair and unhappiness were already associated. Though employees were already facing burnout in the human services sector, the pandemic demonstrated

quite clearly, that structural and systematic policies are a major contributor to burnout. For example, staff shortages in combination with high patient/client demand was the perfect misalignment, causing immediate workplace stress. The increased number of patients, in combination with the immediate need for re-structuring, new protective equipment, new protocols and personal health risks, is the perfect storm of burnout risk factors.

It's no surprise the pandemic contributed to the negative impacts of burnout. The issue of moral distress is addressed in literature discussing the intersection between covid-19 and burnout. The workplace culture and innate pressures of human service providers is a major contributor to burnout. Results from a study conducted during the peak of the covid-19 pandemic indicated that burnout was directly correlated with moral distress, organizational support, personal resilience and employee turnover; "Moreover, 49% of the participants were considering leaving. The reasons were related to lack of administrative support, poor work environment and safety concerns" (Rheaume & Breau, 2022). This calls into question whether the main contributors of burnout are related to workplace culture, structural flaws, or the nature of the work itself.

The study concluded that nurses who were more resilient and received more organizational support, experienced reduced burnout symptoms and were less likely to consider leaving their job. On the contrary, those receiving less organizational support and experiencing higher moral distress, were more prone to burnout and subsequently more inclined to leave their occupation.

Figure 1 – Final Mediation Model

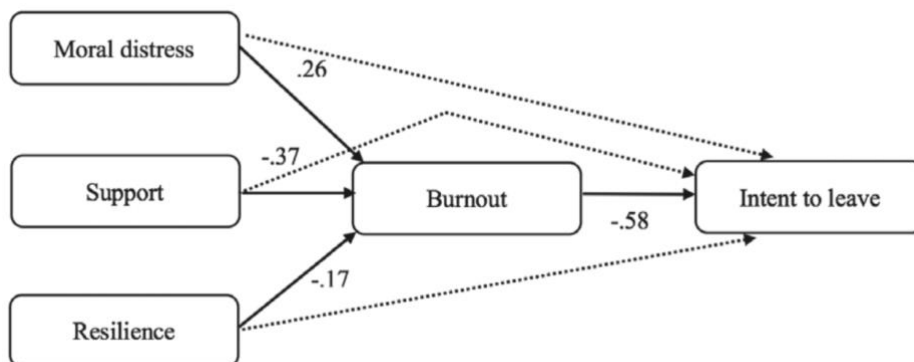


Figure 1 - <https://web.p.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=10&sid=d8a00734-7fca-460e-bc96-762f1ec23f5b%40redis>.

Of important note from this study is the correlation between burnout and the nature of the work, which is reflected in individuals' moral distress and resilience, as well as the direct correlation between workplace support and organizational structures. These conditions of moral distress and poor workplace support are important to note because of their prevalence in human services. Caring for human beings is a major responsibility that comes with an underlying, unspoken pressure. Not to mention, the burden that comes with knowing the potential consequences of completing the job poorly. The weight of the human services sector is clear, yet governmental and structural policy still enables poor workplace conditions to contribute to the symptoms of burnout, on top of the underlying pressures of the work itself (Fateminia et al., 2022). As confirmed in literature, the Covid-19 pandemic was a demonstration of how essential human services employees are

(Clary & Rose, 2022), and how critical the problem of burnout is as it poses the risk of impeding such services.

Despite the Covid-19 pandemic being a major catalyst for the current, highly problematic and dominant issue of burnout, it may have also been a blessing in disguise. Putting human services under such sudden, increased demands through the thick of the pandemic created a spotlight that zoomed in on the sector. This highlighted the issue of burnout whilst it was at an all-time high, despite the issue having been prevalent for years already. In some senses, despite contributing to the problem, the pandemic sparked a timely reminder and overdue conversation about burnout, that otherwise may not have presented itself. Going forward, organizations and groups should leverage this awareness and publicity, to generate ongoing change and systematic improvements toward burnout prevention.

Sweat Equity as a Business Model

Sweat equity is essential for the success of the nonprofit sector, and arguably, plays a major role in the success of all human service provider organizations. Sweat equity can be defined as “a person or company’s contribution toward a business venture or other project. Sweat equity is generally not monetary and, in most cases, comes in the form of physical labor, mental effort, and time” (Kenton, 2022). Sweat equity is the unpaid time and labor that is put into an organization or project and is important to consider in light of the major factors that contribute to burnout. Nonprofit organizations and the social sector in particular, are reliant on sweat equity.

When funding doesn't cover the full cost of delivering programs, nonprofits close the gap through sweat equity—we overwork and underpay our people, relying on volunteer and in-kind support. While having people volunteer is fantastic, we continually ask staff to put in 60-hour weeks without childcare benefits, proper healthcare, or retirement plans... Aiming for “opportunity for all” through exploiting the staff of nonprofits is no path to success. (Greco, 2018)

Although volunteers are great and remain necessary, relying on sweat equity as an essential aspect of the nonprofit business model is not equitable or sustainable. This structure within the social sector could be contributing to the burnout of the very people who keep it afloat.

Burnout occurs when individuals experience ongoing and unaddressed stress, due to factors such as high workloads and poor remuneration. Sweat equity fosters precisely that, as it relies on individuals working for very little, or no financial return. The social sector demands vigorous emotional and mental input from its employees and volunteers, on top of the labor and time they dedicate to the work. This combination of over-worked, underpaid, and emotionally taxed individuals is the perfect storm; making individuals vulnerable to burnout.

An extensive portion of the social sector is made up of nonprofit organizations. This, in combination with the importance of an effective healthcare system, is an alarming reason to ensure optimal conditions for the individuals involved in both sectors. The most recent Health of the U.S. Nonprofit Sector: Quarterly Review, highlighted that

“U.S. nonprofits contributed \$1.5 trillion to the economy in the fourth quarter of 2022” (Independent Sector, 2023). This number alone speaks to the importance of the social sector, to both the U.S. economy and the rest of the world.

Understanding factors, such as sweat equity, that may contribute to burnout in nonprofit organizations and within healthcare is essential. California volunteer laws are one of these factors. The definition of a volunteer within the nonprofit sector, as stated by the California Labor Code, confirms that all volunteers within the sector are performing sweat equity, as they cannot gain compensation for their work.

An individual who performs work for civic, charitable, or humanitarian reasons for a public agency or corporation qualified under Section 501(c)(3) of the Internal Revenue Code as a tax-exempt organization, without promise, expectation, or receipt of any compensation for work performed (California Legislative Information, 2022).

Though volunteer work is precisely that; voluntary, it still carries with it the stressors and pressure of the work’s nature. Volunteers, as well as employees, in the human services sectors are involved in work of a unique nature. This nature sees individuals sacrifice additional time, physical labor and emotional toil because of their passion and dedication for the work. This culture is what keeps the sector alive, but could also be to its detriment.

Sweat equity is not typically associated with healthcare professions such as nursing; yet ample research is available about the underpaying and burnout of nurses. This notion of underpaid nurses could also be considered as nurses contributing sweat equity, as their contributions and sacrifices remain uncompensated.

Literature surrounding sweat equity in the social sectors, specifically the nonprofit sector, is scarce. Lack of research regarding the intersection between burnout and sweat equity is a limitation to further understanding of the current contributors to burnout. Further research into the nonprofit sector and the effects of sweat equity, as an extremely relevant factor, would provide critical information for the development of future burnout prevention strategies.

Workplace Culture

Workplace culture is directly related to the efficiency, relationships, job satisfaction and wellness of individuals in an organization. Organizational culture refers to the standards, commonly held beliefs, values and attitudes shared by those within an organization. It can be defined as “the organizational norms and expectations regarding how people behave and how things are done in an organization” (Aarons & Sawitzky, 2006). Organizational culture is influenced by diverse characteristics, policies and practices that are inherent to the organization, leadership figures and management structures. Literature indicates a direct relationship between supportive workplace culture and positive employee outcomes, including reduced burnout rates.

Organizations with constructive/clan culture to be more successful as these environments foster supportiveness and embrace collective values, customs and social behaviour, while negative or defensive culture creates conformity and submissiveness and is associated with poor work attitudes such as divergence from evidence-based practice, job burnout and staff turnover. (Boamah, 2022)

Significant findings from recent literature include the findings of Boamah; revealing a correlation between unsupportive workplace culture and burnout (2022). This compliments the notion that supportive cultures reduce the risk of burnout, as reported by Burns et al. (2021). A study on patient safety culture found that “overall, a better patient safety culture reduced health care workers’ burnout” (Kim et al. 2023, p.84). This finding is interesting, yet not surprising, considering the causative factors of burnout. A culture of patient safety involves elements such as adequate staffing ratios, a sense of teamwork, effective communication, ongoing education and reasonably upheld work/rest protocols. These factors are an intersection between burnout and patient safety; a culture of patient safety decreases workplace stress and increases job satisfaction, ultimately reducing burnout risks.

Patient safety and Person-Centered Care (PCC)

The World Health Organization (2020) announced that the theme of World Patient Safety Day 2020 was “Health worker safety: a priority for patient safety,” (Kim et al. 2023). In order to provide patient safety, health care workers or anyone providing a service; must first be working safely and in safety. Unsafe employee conditions are not

sustainable, nor are they conducive to best practices. Person-centered care is a worldwide concept concerned with the provision of care that is catered to every individual, rather than systems designed generically around diseases and institutions (Byrne et al., 2020). The intention of person-centered care is to involve patients in their own care, enabling them to ‘steer the ship’ whilst others keep the ship moving forward. PCC means empowerment and personal autonomy are essential. “... recognizing that before people become patients, they need to be informed and empowered in promoting and protecting their own health” (WHO 2007).

PCC is concerned with all people. Years ago, WHO published studies regarding the challenges faced by the healthcare system with a particular focus on PCC. They discussed the importance of mental health within the system, highlighting that PCC cannot possibly be provided by individuals who, themselves, are not being supported or empowered, and are experiencing a lack of job satisfaction and cynicism.

In addition, health practitioners are people, and health care organizations and systems are made up of people. Their needs should also be considered, and they must be empowered to change the system for the better. That is, a people-centred approach involves a balanced consideration of the rights and needs as well as the responsibilities and capacities of all the constituents and stakeholders of the health care system. (WHO 2007).

Burnout is directly related to poor job satisfaction, cynicism, poor health and stress. With an extreme demand for social services and overloaded healthcare systems,

healthcare providers and stakeholders within the nonprofit sector cannot possibly provide effective PCC. Muñoz-Rubilar et al. summarized the issue by stating; “It may not be possible to ensure both a person-centred focus and a population health focus, since these two concepts might be in opposition.” (2022). Byrne et al. found that the underlying issue with PCC is its rhetoric nature, currently standing conceptually, with varying definitions, disparities in interpretation, and lack of clear practical implementation across fields (2020).

Burnout has a clear intersection with PCC and patient safety, as it remains a major barrier to best practices. A meta-analysis by Garcia et al. looked into the relationship between burnout and patient safety, finding a direct relationship between levels of burnout and worsening patient safety (2019). In order to provide PCC, patient safety must first be achieved. When patient safety is at risk because of burnout, PCC seems more like a luxury, when in reality it should be the bare minimum. The study concluded that avoiding exhaustion and burnout of employees is important for patient safety (Garcia et al. 2019). PCC is a conceptual framework that promotes the holistic wellbeing of a person, typically considered in reference to a patient.

Whilst the concept requires standardization, promoting PCC amongst employees could positively impact workplace cultures, ultimately reducing burnout, improving patient safety and enabling the provision of more effective PCC.

Duty of Care

Duty of care refers to the obligations of individuals to act, treat and approach the consumer or patient in a particular way, in accordance with the standards and expectations of a particular setting or role (Sheahan & Lamont, 2020). Duty of care in healthcare settings is a legal obligation, whereby practitioners and professionals are expected to provide ‘reasonable care’ to their patients (Sheahan & Lamont, 2020). For the purpose of this research, duty of care is being analysed from an ethical standpoint; as individuals’ perception of personal duty of care and responsibility in the social sector could be a contributor to the risk of burnout.

The social sector provides services, including healthcare, to vulnerable individuals and populations. This factor alone adds a sense of responsibility and trust to the work being done by those in the sector. Though the social sector is highly regarded because of this sense of responsibility and trust, what also comes with it is a high level of stress and psychological demand. A study by Muñoz-Rubilar et al. (2022) looked into the correlation between nurses’ well-being and duty of care. The study highlighted the question: “What are a nurse's duties when their psychological well-being is being negatively impacted?” (Muñoz-Rubilar et al., 2022). A duty of care in the healthcare setting, as demonstrated by the covid-19 pandemic; brings about pressures to sacrifice personal needs and wellbeing for the sake of others.

In practice, the duty to care imposes nurses to act in the best interests of their patients. However, one has an inherent responsibility to take care of their health, as well as that of their family. On the contrary, as low well-being was associated

with disagreement with the duty to care statement, nurses must be supported to navigate and balance between ethical concerns, duties and well-being (Muñoz-Rubilar et al., 2022).

Knowing the potential or likely consequences of putting personal well-being before the needs of the consumer comes with significant psychological costs. Despite organizational policies and practices that protect employees within the social and human services sector, the innate, internal pressure and guilt that comes with the nature of the work is undeniable. The sense of a duty of care goes beyond what can be legally defined or outlined in policies.

Knowing that stress, cynicism, increased demand and unmatched expectations are all factors that contribute to burnout, positions with a duty of care should be also considered a risk factor as it can lead to all of these things. Lack of research into the relationship and correlation between duty of care and burnout is a barrier to further understanding of the relationship. This is an intersection that should be considered when discussing burnout and the factors that influence the culture of nonprofit organizations and healthcare settings.

Section 3: Methods and Approaches

The purpose of the following research is to identify trends, patterns and gaps in nursing and nonprofit culture that contribute to the burnout of its employees. The research serves to advocate for individuals working in the human services sector, where which burnout is so prevalent, as well as the patients and recipients of such services whom face the subsequent impacts of burnout. The researcher compared the perspectives, cultural ‘norms’, and first-hand experiences of healthcare professionals and nonprofit employees with the available literature on burnout. The researcher identified and assessed how burnout is defined and discussed in relation to workplace culture, staffing, stress and emotional toll, with the intention of accurately understanding how its prevalence is depicted in literature.

Research involved a literature review and expert interviews. The literature review focused on identifying linkage between burnout and workplace cultures or environments. The researcher assessed literature that discussed and defined burnout and its progression since the covid-19 pandemic, sweat equity, person-centered care, workplace culture, and duty of care.

Nurses are a dominant presence in the healthcare field and are at the forefront of person-centered care and human services. When engaging participants for data analysis, the researcher selected nurses with varying experience and differing expertise, to allow for broad perspectives from the profession. The researcher conducted 4 expert interviews with individuals currently active in the healthcare and nonprofit sectors (Registered

Nurse on a paediatric unit at a public hospital, Registered Nurse on a Psychiatric unit at a public hospital, employee and volunteer of 43 years within the nonprofit sector, Executive Director of a nonprofit organization).

The standardized Population, Intervention, Comparison and Outcome (PICO) format was used to investigate the relationship between burnout and workplace cultures (population) in the context of human/social services (intervention) by observing their correlation through experiences, attitudes, and perspectives of employees (comparison) and analysing such associations to understand the problem (outcome).

The literature review and expert interviews were structured according to, and to serve the purpose of, answering the following research questions:

RQ 1: Do the effects of burnout (physical and emotional stress, cynicism, poor job satisfaction, fatigue) in social/human services result in decreased quality of person-centered care for recipients of human services?

RQ 2: Does the healthcare or nonprofit environment (as a workplace) reinforce or encourage a culture of poor work/life balance as a result of socially accepted 'norms'?

RQ 3: Is burnout a consequence of the nature of work within human services, or is it a direct reflection of under-paid and over-worked employees within the sector?

Personal Standpoint and Professional Expertise

As the researcher, it is important to disclose my personal standpoint and professional expertise, as it is relevant to the field of study and targeted demographic. As a Registered Nurse who works in a public hospital, and a volunteer for nonprofit organizations, I have personal views, perspectives and experiences within the space. As a nursing student during the outbreak of Covid-19 and having worked in the hospital setting amidst the pandemic, I recognize my personal bias and empathy for both nonprofit employees and healthcare professionals. I consider burnout to be a major fault in both the healthcare and nonprofit sectors, as staffing continues to fall short of the increasing public demand on both sectors. I view burnout as a safety risk to patients and recipients of social services, as employees cannot provide effective care, when they themselves, are working in cultures and conditions that result in stress, fatigue and negativity toward the job. I recognize this as a strong bias and will be implementing strategies into the data collection process to prevent implicit or known bias from interfering with results.

To avoid the hindrance or persuasion of any interview responses, my personal perspectives and opinions regarding burnout or workplace culture will not be disclosed in the interviews throughout the data collection process.

Section 4. Data Analysis

The aim of this research was to identify commonalities between the attitudes, experiences and perspectives of individuals in nonprofit organizations and healthcare settings, to identify how the culture and nature of such environments contributes to burnout. Expert, qualitative interviews explored the concepts of burnout, the factors that contribute to burnout, and how the workplace environments of each interviewee have contributed to their experiences. A thematic content analysis was conducted to analyze interview content, to identify common themes and patterns within the data.

Expert Interviews

Expert interviews were completed to gain insight into the relevant experiences and perspectives of current employees within the nursing, healthcare, and nonprofit organization settings. A semi-structures interview format was followed for each interview, with open-ended questions allowing for follow up questions and the ability to organically explore alternate topics, where appropriate. The researcher provided interviewees with the semi-structured interview questions and formatting three days prior to their interview. The semi-structured interview questions and format can be found in appendix A. Interviews were conducted in April 2023. To maintain the privacy and preserve the professional and personal positions of each participant, in accordance with ethical practices involving human research subjects; anonymity of interviewees will be maintained.

Six interview candidates were identified and contacted for the purpose of interviewing. One individual from a collegiate level, educational institution failed to respond and one individual from a large healthcare nonprofit organization declined. Four interviewees completed the interview process; two Registered Nurses from large nonprofit organizations, one long-term volunteer and employee within the nonprofit sector and one Executive Director from a smaller nonprofit organization.

Expert Interview - Participant #1

Participant #1 is a Registered Nurse on the psychiatric unit of a public hospital, specialized in psychiatric care and a certified clinical coach and preceptor in this field. This individual also works as a casual employee in the emergency department, with years of experience in numerous hospital settings as a professional healthcare provider. It was immediately clear that this interviewee was passionate and knowledgeable about the concept of burnout in the healthcare setting, expressing personal experiences and perspectives on the topic. It was clear this individual associated burnout with high levels of stress and unrealistic work expectations, defining burnout as “when your practice is impeded due to extenuating stress or unrealistic expectations places on a clinician, professional or employee” (Participant #1).

When discussing the causes of burnout, the participant was certain about the influence of work expectations, staffing and pressure having a large role to play, stating that the main cause was “Understaffing!” (Participant #1). The participant elaborated on

this by explaining that the combination of unrealistic expectations alongside a reduced and understaffed workforce, was the perfect storm for burnout.

Despite working in the field of psychology, a notable takeaway from this interview was the emittance of any discussion surrounding the impact of burnout on patient's. Discussion surrounding the lack of a clear diagnosis and consistent medical definition of the term was perceived as a major barrier to the solution. Discussions regarding how burnout is perceived at a social level were raised in regard to this topic, with concern for how serious the idea of burnout is, or isn't, being taken at a professional level.

A common factor that continued to rise throughout this interview were the secondary consequences of burnout on patients. A direct correlation was drawn between burnout and quality of professionalism, effectiveness and attitudes as a healthcare professional.

... I think people start to fall into patterns of poor practice; increased errors, shorter fuses and short tempered, and increased absence from work. Then on top of this, I think their practice is affected in other ways because of the physical consequences of burnout, such as lack of sleep, substance abuse and stress. Then, both the emotional and physical consequences combine, causing their practice to be severely impeded and their general health to deteriorate. So, each of these 'personal' effects come first, which have a secondary impact on their professional practice and performance, which directly affects the patients. – Participant #1

Participant #1 made a point of difference in the interview, speaking on staff shortages within the workplace as a major consequence of burnout, rather than a cause. We discussed the many consequences of burnout, including mental health deterioration, overwhelm, increased stress levels, neglected self-care, resent toward one's job, decreased productivity, substance misuse and physical illness, yet staff shortages stood out.

... it's like a snowball effect; when there's staff shortages, other staff have to compensate for the absentees, and then because those people are becoming increasingly stressed from picking up extra shifts and workloads, they burn out, and so it's just like this systemic, cyclical process. It's a terrible systemic cycle, so if there's not support put in place and adequate staffing, then it just continues to happen. – Participant #1

When discussing culture within healthcare settings and its effect on burnout, it was clear that pressures did not come from other nurses or managers, rather they came from higher up within the organization. It was noted that in personal experiences, colleagues never pressured each other to work more or complete unrealistic tasks. The culture of burnout was fostered at more of a systemic and organizational level; “they are trying to run on an oily rag and utilize limited resources, aka nurses, because they don't have the money to pay a bigger workforce” (Participant #1).

Expert Interview – Participant #2

Participant #2 is a Registered Nurse who works in the paediatric and adolescent ward of a public hospital. Having completed postgraduate study in paediatric nursing and working in the specialty for years, this participant has extensive experience on the ward setting amongst a multidiscipline team of healthcare professionals. A trend identified in this interview was a strong perspective on the importance of person and family-centered care, as well as work-life balance. The interviewee expressed a clear understanding and personal experiences with burnout. Burnout was defined as:

Burnout to me is exhaustion, it's not being able to function to your full capacity.

It can include a multitude of things; it can be mental, it can be physical, and it can be emotional, which can all combine and contribute to burnout. – Participant #2

This interviewee discussed being overworked and understaffed as the main cause of burnout in the healthcare setting. The idea that staff shortages were both a cause and a consequence of burnout was a strong opinion and experience from participant #2. Within this, the concept of duty of care was brought up as an additional factor that contributes to the emotional toll of burnout.

Because we're understaffed we are asked to work extra hours and it's very hard to say no. It's very hard to say no because you know that if no one is found to work extra hours it will directly impact the patients care, and you obviously have a sense of duty for their care. – Participant #2

The idea that burnout is a dangerous and systemic cycle was discussed, in relation to the sense of guilt and innate responsibilities of the job. The interviewee discussed how the nature of the work plays a major role in burnout, on top of the structural and organizational flaws of the workforce.

... even though you may have worked the past 4 shifts – if there is nobody left, you take it upon yourself because you feel guilty otherwise. You feel as though it's your responsibility to ensure those patients receive the best care, even when you've done more than expected in your role. It's a dangerous cycle that makes saying no extremely hard. – Participant #2

The personal experiences shared by participant #2 speak volumes to the perceived impact of burnout in the healthcare setting. Burnout may present itself subtly and can be experienced for long periods of time, yet individuals remain at work with poor practices and attitudes. This was described as one of the most dangerous, yet most common experiences with burnout within the workplace. The minor, yet detrimental difference between an individual who is tired and emotionally drained, and one who can strive for excellent care, is the real consequence of burnout.

In paediatrics, I can go in and just do the observations, or I can go in and do the observations, I can have some fun, I can have a joke and I can make it a fun and less traumatic “hospital” experience for the children. Failure to give that bit extra to make it a better experience is one of the first and biggest consequences of burnout. – Participant #2

The interviewee not only expressed strong perspectives regarding the issue of burnout as an ongoing and unaddressed cyclic issue, but also highlighted that a healthy work-life balance is highly encouraged by colleagues in the workplace. The idea that workplace culture was fostering an environment of burnout was not supported, yet the idea that healthcare structures and ‘norms’ are fostering burnout was agreed.

Expert interview – Participant #3

Participant #3 has been an employee within the nonprofit sector for 43 years, currently working in a part-time position at a large healthcare nonprofit organization in the Bay Area. This individual has also been involved in the nonprofit sector in a voluntary capacity for various organizations and religious groups.

The third interview had a slight shift in tone in comparison to the first two. Other than the obvious difference being that this participant is working in a nursing capacity, the main factor that differentiated this interview was the perception of burnout from personal experiences. Rather than having immediate personal experiences to share from witnessing and experiencing burnout in the workplace, the interviewee initially spoke about burnout as if it was separate from their own workplace. After discussing numerous relevant topics, the individual appeared to relate more with burnout and express a closer relationship with the concept and its consequences.

A prominent factor discussed was the combination of staff shortages and low income within the nonprofit sector. The stigmas surrounding the nonprofit sector often include the lack of pay or sense that no one can personally make a profit within the

sector. Though these are just that, a stereotype; they also remain true in a literal sense. From personal experience, the nonprofit sector struggles when it comes to staff retention, and staff numbers. The workloads are often far too high and unrealistic for the capacity of the employees. This combination of unrealistic expectations and lack of people to complete the work, is what causes ongoing stress, fatigue, resentment and ultimately burnout within the sector.

Being over worked and constantly asked to complete tasks that are extremely time-consuming, stressful and often tiring, is exhausting and frustrating, particularly when the pay doesn't provide incentive. – Participant #3

This interviewee brought up the structures and 'norms' of the nonprofit sector, discussing the many flaws that enable the sector to continue functioning. One of these downfalls being the concept of sweat equity. Though sweat equity and volunteer work was noted as an essential and wonderful part of the sector, it was pointed out that sweat equity as an essential part of the business model is a recipe for disaster when considering the causes of burnout. Sweat equity is the labor and time dedicated to the organization without compensation. It was discussed that sweat equity is contributed not only by volunteers, but also by the employees who are paid for less than the work they actually completed for the organization, meaning any time or work done above such pay, could be considered sweat equity. This difference, or this sweat equity, is a major contributor to the causes of burnout.

It was also noted in this interview that the emotional toll of the services being provided are often extremely high. Working with populations who often cannot access healthcare, safe housing, meals or safety, has a major emotional element and presents a sense of duty to employees delivering the services. Similar to previous interviews, this duty makes it extremely difficult to say no or prioritize personal health.

Expert Interview – Participant #4

Participant #4 is the Executive Director of a relatively young nonprofit organization that was founded in 2018. Prior to this position, this individual was heavily involved in numerous different nonprofit organizations in a voluntary capacity. This individual has just over five years of experience within human services organizations.

The fourth interview, whilst similar to the previous one, carried an overall sense of questioning as to why burnout is normalized in the nonprofit sector. Having worked in the for-profit sector up until recent years, the interviewee expressed feeling of shock and disapproval regarding the systems within the nonprofit sector. Often comparing nonprofit organizational structures and policies with for-profit experiences, the individual appeared to have difficulty comprehending the environments and conditions in which nonprofit organizations operated.

To have one sector that makes too much money for its own good doing completely un-helpful work, and another that is criticized for appearing to make too much profit doing humanitarian work, is just criminal! – Participant #4

This discussion surfaced the notion of sweat equity and the idea of normalized cultures within the nonprofit sectors and healthcare settings. Another question raised by the interviewee was the fact that burnout is not discussed within the workforce, based on personal experiences. The recent publicizing of burnout throughout the covid-19 pandemic created such needed awareness of the pre-existing issue, and yet nonprofit organizations remain dismissed from consideration. Of course, the umbrella term of “human services” includes the nonprofit sector, however the true extent of the issue within the sector, appears to remain un-identified and unrecognized in both literature and media.

When addressing the relationship between burnout and quality of care, it was evident that the individual drew a direct and undeniable correlation between the two, stating that “someone who is tired, run-down, emotionally drained and starting to resent the organization, cannot possibly provide the same level of effective care than they otherwise would” (Participant #4). Based on research, I agree with this statement wholly. Regardless of the symptoms being experienced, burnout impacts individuals’ ability to think, respond, act and be present within the environment.

The emotional nature of the work not only contributes to the workload, but also an element of the work that requires a high level of attention and a particular skill set. The ability to respond appropriately, without bias and with compassion and empathy within the human services sector is absolutely necessary because of the emotional nature of the lived experienced and work at hand. When an individual’s mental or physical state is compromised, their ability to provide this emotional awareness is also compromised.

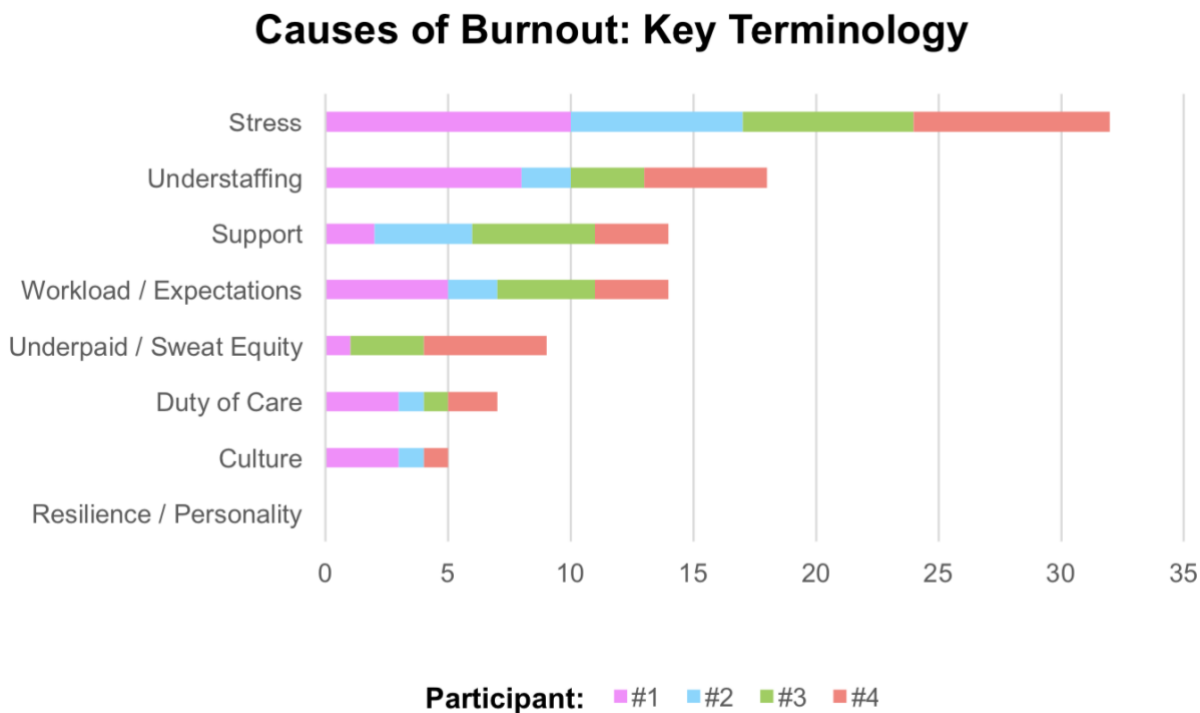
Participant #4 highlighted that on top of the systemic and structural flaws, this is essential to recognize.

Expert Interview Content Analysis

The frequency of key terms used when discussing the causes of burnout, are an important indicator of prevalence and association within the healthcare and nonprofit sectors.

Table 1 – Frequency of Terminology. Key terminology used in expert interviews to describe the causes of burnout within the healthcare and nonprofit sectors.

Table 1 – Key Terminology Frequency: Causes of Burnout



As represented in the table above, stress was a clear leader, having been used dominantly in discussions regarding the causes of burnout. In comparison to literature, the reference to resilience and personality was non-existent. This suggests the lived-experiences of individuals within the field, may be different to the suggested causes found in research. Understaffing, lack of support and unrealistic workloads and expectations were all frequently used terms, suggesting a strong correlation with burnout.

Table 2 – Frequency of Terminology. Key terminology used in expert interviews to explain the effects of burnout within healthcare settings and nonprofit organizations.

Table 2 – Key Terminology Frequency: Effects of Burnout

Effects of Burnout - Key Terminology

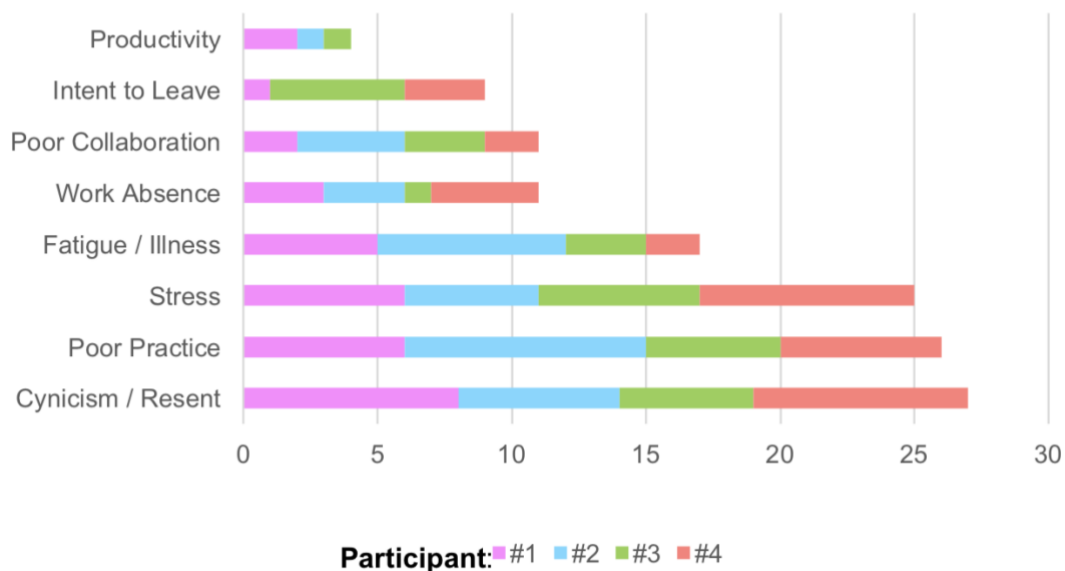


Table 2 demonstrates the prevalence of terms used and associated to the effects of burnout. As represented, cynicism and resent were most frequently used in this

discussion, closely followed by poor practice and stress. Aligned with research, feelings of cynicism or resent are one of the biggest signs and impacts of burnout. Stress is listed as a high cause and effect of burnout, which compliments the idea that healthcare and nonprofit environments foster a structural cycle of burnout, as discussed in expert interviews.

Summary of Findings

In all four interviews, individuals had a thorough and passionate perspective of burnout. Although each interview had a particular emphasis on a different element of burnout, the following themes were easily identified from the interviews:

- Structural, organizational, systemic and management factors are major contributors to burnout
- Emotional factors, such as those in duty of care and personality, play a less prominent role in burnout
- Negative attitudes towards the job are a predominant consequence of burnout
- Decreased person-centered care and quality of care is perceived as a major and immediate consequence of burnout, being directly related to the effects of burnout
- Stress is perceived as a major consequence and cause of burnout, playing a role in the cyclical nature of burnout within the human services workplace
- In contrast to literature, intent to leave was not perceived as a primary consequence of burnout, though still a relevant and major consequence

It was a clear consensus that larger organizational and systemic factors were the ultimate factors fostering environments of burnout in the healthcare and nonprofit sectors. No indication was made that colleagues or cultures within the sector were contributing or fostering an environment of underpaid, overworked and stressed employees.

Strengths and Limitations

Whilst the data collected provides an insight into what is being experienced first-hand within the sector, it does not provide a diverse or large scale assessment of burnout within human services. Further large scale research is necessary to find diverse perspectives and gain an extensive understanding of how burnout is impacting human and social services.

The interviews do provide detailed insight into the perspectives of varying experts within the field, and allow the researcher to compare experiences from the healthcare and nonprofit sectors. The timing of the research is invaluable, as the recent impact of the Covid-19 pandemic continues to affect both sectors. As the sector recovers from the increased pressures and likelihood of burnout, research conducted now provides unique and extremely valuable information that can inform burnout research and prevention going forward.

Section 5: Implications and Recommendations

My research findings show that although the nature of the work being completed within healthcare and nonprofit organizations is relevant, the structural, organizational and systematic policies and norms are perceived as the primary cause of burnout. The direct correlation between employee burnout and the quality of person-centered care being provided in human services should be of major concern. Prompt responses are necessary to address the causes of burnout and ensure patients are receiving adequate and appropriate care. It is clear that the structural norms within healthcare and nonprofit environment contribute to culture of overworked and undercompensated employees, often disguised as sweat equity in a volunteer capacity within the nonprofit sector. This suggests that burnout is the result of a larger systematic problem, where staffing, pay, patient ratios and government funding are all relevant factors.

It would be remiss to ignore the emotional demands of human services environments. The emotional demands of responding to, and handling, traumatic and personal situations on a daily basis is challenging. The mental connection in combination with the sense of responsibility and duty, is a contributing factor that should be recognised when considering the factors that contribute to a cycle of burnout.

Finally, it is evident in research that, despite its undeniable structural and cultural similarities; the nonprofit sector appears to be overlooked when considering the impacts of burnout within human services. There is an immediate need for research, education and awareness surrounding burnout in the nonprofit sector.

Data collected from the expert interviews provides insight into the current, lived experiences and perspectives of employees from within the sector, though it does not provide a holistic or broad overview of the sector as a whole. The lack of a consistent burnout definition in the reviewed literature is a major barrier to further research and understanding of the causes and potential solutions for burnout prevention.

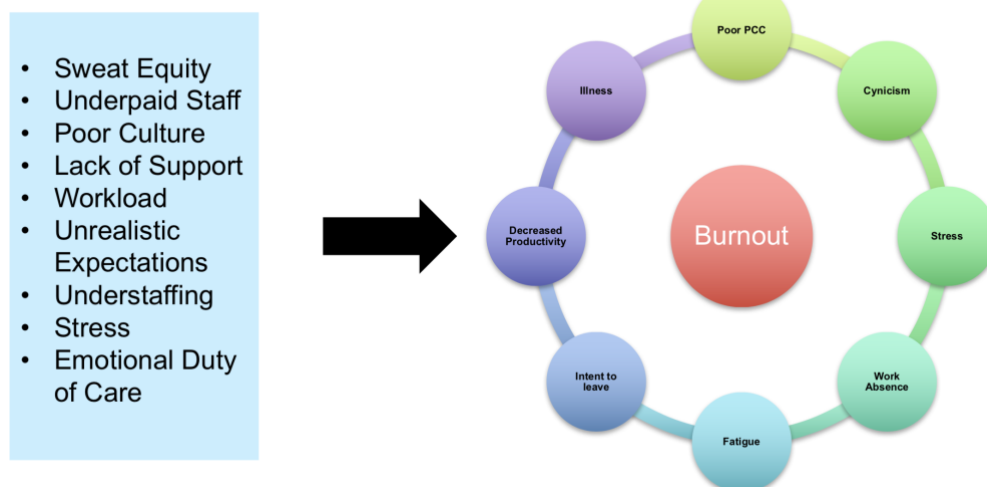
There is a need for respected leaders of healthcare systems and the nonprofit sector to step up and practically address the issue of burnout that remains at-hand. Advocacy for human services is not just needed for the improvement of workplace cultures and employee conditions; it is necessary for the provision of equitable, safe, and person-centered services. These recommendations are a reflection of the research findings:

1. **Research:** Accreditation agencies must respond to the needs of human services by funding research surrounding burnout:
 - Standardization of the definition and diagnosis of burnout
 - In depth research into the deeply-routed causes and impacts of burnout
 - Normalizing use of the concept within nonprofit organizations and in association with sweat equity
 - Understanding of the necessary support services and policies for preventing burnout within the workplace
2. **Policies:** Leaders and organizations must increase pressure on healthcare and nonprofit governing bodies to implement changes surrounding staffing ratio's, fair pay and stress/exhaustion relief policies and resources.

3. **Prepare and Respond:** While recovering from the recent height of burnout, government and organizational systems must respond pre-emptively to the ongoing issue of burnout, by investing in larger workforces, and building supportive workplace cultures.
4. **Education:** Educational institutions should implement the concept into curriculum, including the prevalence of burnout within all human services, and the skills and measures to take to prioritize personal health and wellbeing.
5. **Advocacy:** At an individual and leadership level, anyone involved in the human services sector should be advocating for the awareness of burnout and the safety of colleagues, particularly in the nonprofit sector.

Though these recommendations are ambitious, they are absolutely necessary for the beginning of major long-term changes within the nonprofit sector and healthcare systems. Before attempting to change one's understanding or perception of 'normal', they must first be enlightened to the issue. Recognising the problem is just the first step to achieving cultural and structural changes within such a major sector.

Figure 2 – Understanding the Factors of Burnout



Section 6: Conclusions

Burnout; it's hard to fathom how such a common concept and worldwide problem remains to exist without a standardized and thoroughly understood definition. An issue that covered headlines amidst a pandemic, while its stakeholders, or victims, suffered the real impacts all while keeping the world afloat. It is abundantly clear from this research that the concept or "occupational phenomenon" of burnout is familiar and experienced by employees within human services. An in-depth literature review provided context to the history of burnout, and clarification of the related concepts. The literature, in combination with the data from expert interviews, highlights how person-centered care, organizational structures, workplace environments and emotional factors, such as the duty of care, are intersected with a systemic cycle of burnout.

Burnout is the result of stress, overworked and underpaid employees, and the innate pressures that lie within the humanity of the work. The lack of services and functional structures in place to ensure adequate staffing and compensation, is an underlying and fundamental factor that causes burnout to occur. The normalcy of burnout, particularly within human services, in combination with the compassionate nature of its employees, combines to create an ongoing and extremely challenging environment in which it remains. The nature and cultures of such workplace environments cannot be held solely responsible, yet must be recognised as contributing factors. The direct negative impact of burnout on person-centered care is yet another major consequence of burnout, further highlighting the need for change. If not for the sake of employees, then for the patients and recipients of human services.

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Appendix A: Content Analysis

Cause of Burnout - Key Terms

	Participant #1	Participant #2	Participant #3	Participant #4
Sweat Equity or Underpaid	1	-	3	5
Culture	3	1	0	1
Support	2	4	5	3
Resilience or personality	-	-	-	-
Workload or expectations	5	2	4	3
Understaffed or understaffing	8	2	3	5
Stress	10	7	7	8

Effects of Burnout – Key Terms

	Participant #1	Participant #2	Participant #3	Participant #4
Intent to leave	1	0	5	3
Fatigue / Illness	5	7	3	2

Poor Person-Centered Care	6	9	5	6
Cynicism / Resent	8	6	5	8
Stress	6	5	6	8
Productivity	2	1	1	0
Work Absence	3	3	1	4
Poor Collaboration	2	4	3	2

Appendix B: Semi-structured Interview Outline

Interview format and informed consent process:

- Duration: the interview will take about 30-35 minutes
- The interview will be conducted either in person or via zoom
- I will be recording the interview to capture accurate comments and statements, as well as taking notes where deemed necessary.
- Prior to conducting the interview, we will discuss the interviewee's (your) intent and expectations for the interview, as well as anonymity for the project, of which I will agree and consent to in accordance with your preferences.
- I will ask for your verbal consent to use the information and material from the interview for my research purposes.
- I will disclose to you that you do not have to answer any questions that you do not wish to, and the interview may be paused or ended at any point if you wish to do so.

Interview Questions:

1. Can you tell me what your definition of the term "burnout" is?
 - a) Can you describe what burnout looks like in the healthcare setting?
 - b) What do you think are the main causes of burnout?
2. What would you consider to be the most common symptoms of burnout?
3. What do you think are the biggest consequences of burnout?
 - a) Have you experienced burnout or witnessed others experiencing burnout in a healthcare or nonprofit setting?
4. Do you think nurses and other healthcare professionals are over-worked?

- a) Have you experienced understaffing? If so, can you describe what this feels like and how it affects your stress and work effectiveness?
 - b) Have you ever felt pressured or expected to work longer or increased hours?
 - c) Have you ever been made to feel guilty for putting personal life before work or refusing to say yes to extra shifts, work or responsibilities?
 - d) Do you think nurses, in general, encourage each other to work more and make sacrifices for the sake of “doing good” and “helping out”, ultimately encouraging a culture of burnout?
5. What support services are available to you in your workplace to deal with stress, work/life balance and enjoyment at work?
 6. Do you think the effects of burnout (e.g. stress, fatigue, lack of motivation, sickness, poor attitude, depression, anger, sleeplessness, exhaustion) have a direct impact on patients/recipients of services?
 - a) Have you witnessed this? If so, please describe how this impacted the patient.
 7. Any additional questions or comments?

Author's Bio

Ebony Monique Webb, RN, Masters of Nonprofit Administration (MNA) Student Athlete.

Originally from Tasmania, Australia, Ebony moved to San Francisco in 2022 to study at the University of San Francisco whilst running on the college's cross country and track & field team. Ebony graduated with a Bachelor of Nursing from the University of Tasmania in 2021. She completed her first year and a half of practice as a Registered Nurse at the Royal Hobart Hospital as an operating room nurse. Prior to this she worked as a Pharmacy Assistant and Dispensary Tech for six years. Now a student completing a Masters of Nonprofit Administration (MNA), Ebony is passionate about using her education and experience to combine healthcare and social sector work. Ebony hopes to work with nonprofit organizations who provide health care services within the community, to advocate for equity and improve access for all individuals.