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Experiences of Burnout among Health Systems' Employees: A Mixed-Methods Study

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Abstract

Burnout is a prevalent issue in healthcare. However, investigations into experiences of burnout among mainly administrative health systems' personnel have not been conducted. Therefore, the purpose of this study is to evaluate burnout experiences among health systems' personnel in administrative positions. This is a mixed-methods study measuring burnout using an 18-ques- tion burnout scale and by conducting 23 semi-structured interviews. Mean responses and a correlation analysis of the survey results were conducted. Interview transcripts were coded using ATLAS.ti 22. The quantitative results show low burnout scores. However, the interviews show that all administrative personnel had experienced burnout or stress, particularly during the COVID-19 pandemic. The COVID-19 pandemic, workload, and volatility drove burnout. Recognizing employees, promoting a strong work/life balance, and self-care practices may alleviate burnout. Similar to nurses and physicians, administrative health systems' personnel are susceptible to burnout. Therefore, health systems' leaders should cultivate strategies to mitigate and prevent burnout among administrative personnel. This research focuses on experiences of burnout among health systems' employees who do not medically treat patients as part of their daily work. Additionally, this study uses interviews to obtain a context for survey results, unlike previous studies. Leaders should recognize not only clinicians but also administrative employees for their work to alleviate burnout. Additionally, leaders should promote work/life balance, especially among remote workers and attempt to reduce workload to mitigate burnout.

Keywords

Burnout, Health Systems, Administrative Employees, COVID-19 Pandemic, United States

1. Introduction

Burnout is a prevalent issue in health systems. For example, nearly 50% of health systems' pharmacists in Lebanon, U.S. military health system's staff, and nurses in Uganda reported feeling burned out (Abilmona et al., 2023; Udho & Kabunga, 2022; Wilk et al., 2023). Approximately 31% of Canadian physicians in rural areas reported burnout symptoms (Hansen et al., 2021).

Burnout is defined as a state of depletion (Schabram & Heng, 2022). Maslach splits burnout into three dimensions: emotional exhaustion (EE), which is the sensation of being depleted, weakened, and less energetic; cynicism/depersonalization, which is negative or inappropriate attitudes toward clients, irritability, the loss of idealism, and isolation from others; and inefficiency, characterized as diminished productivity or capability, low morale, and the inability to deal with challenging situations (Maslach, 2017). There are several contributors to burnout, including a high chronic workload, lack of recognition, low social support characterized by lack of trust and incivility (Kurosaka & Payton, 2020; Maslach, 2017). Several researchers have studied burnout among nurses and physicians (Clough et al., 2019; Ghannam et al., 2020; Paul et al., 2018). However, no research studies burnout among non-nurses and non-physicians use mixed-methods of a survey and interviews. Therefore, this study examines experiences of burnout among mainly health systems' administrative employees, who are defined as health systems' employees who work in non-clinical areas, such as in the finance department. They do not medically treat patients as part of their daily work—that is, they are non-patient-facing. Examples of administrative employees include administrative assistants, financial analysts, and directors of marketing. Moreover, they include employees in leadership roles, such as managers and directors, and individual contributors, such as marketing associates and data analysts. Administrative employees comprise nearly half of the health systems' workforce; their work significantly affects hospital performance (*U.S.* Bureau of Labor Statistics, n.d.). This research is novel because it is one of the first to study burnout among administrative employees in health systems using a survey and semi-structured interviews to determine drivers and the context of burnout for administrative health systems' employees.

2. Literature Review

2.1. Assessing Burnout

Several instruments are available to assess burnout. One of the most widely used instruments is the Maslach Burnout Inventory (MBI), which scores burnout based on the dimensions of EE, depersonalization, and efficiency (Maslach et al., 1996). Another instrument is the Oldenburg Burnout Inventory (OLBI); similar to the MBI, the OLBI splits burnout scores into the EE and depersonalization dimensions (Halbesleben & Demerouti, 2005). To reduce bias, the OLBI uses both positively and negatively worded questions, unlike the MBI. However, because the MBI and its abbreviated versions have been widely validated among

different audiences, including healthcare personnel, an abbreviated version of the MBI was used to assess burnout (Kovner et al., 2007).

2.2. Burnout in Health Systems

Hansen et al. (2021) found that most physicians practicing in northern Canada were burned out. Contributing factors included workload, lack of staff, and lack of leadership support (Hansen et al., 2021). Maslach (2017) agrees that the aforementioned factors contribute to burnout. Hansen et al. also found that social support mitigates burnout, as Maslach corroborates.

Dopelt et al. (2021) found that burnout was prevalent among non-nurses and non-physicians in a health system (Dopelt et al., 2021). However, they did not specify the titles of the non-nurses and non-physicians, such as whether they were administrative or patient-facing personnel. To supplement their survey results, they conducted 10 interviews with nurses, physicians, and medical technologists. Interestingly, their themes did not align with Hansen et al.'s themes, despite the interviews occurring during the novel coronavirus pandemic. However, the themes of patient orientation and caring for patients were shared among both studies. In their study of burnout among physicians and nurses, Lu et al. (2022) found similar themes as Dopelt et al. and Hansen et al., one of which included loneliness.

Unlike the previous studies, Sangal et al. (2021) studied burnout among frontline emergency department (ED) workers in a multisite health system in the northeastern United States (Sangal et al., 2021). They studied employees including environmental services staff, administrative nurses, and security officers, in contrast to Lu et al., Dopelt et al., and Hansen et al. They found that a lack of communication contributes to burnout, which is not a theme that emerged in the aforementioned studies.

In contrast to the previous studies, Prasad et al. (2021) studied burnout among multiple disciplines of workers who comprise 80% of the healthcare workforce, not only physicians and nurses (Kinder, 2020; Prasad et al., 2021). However, they studied healthcare workers only during the early phase of the COVID-19 pandemic, between May 2020 and October 2020. The authors found correlations between workload, ethnicity, and anxiety with burnout. However, their study does not demonstrate whether workload, ethnicity, and anxiety cause burnout. Hansen et al. found that workload contributes to physician burnout; however, it is unclear whether their finding holds true for other disciplines.

The aforementioned research does not study burnout among health systems' administrative employees. Therefore, a mixed-methods study was used to assess experiences with and drivers of burnout among them.

The research questions are:

RQ1. What are the experiences of health systems' employees with burnout?

RQ2. What are the drivers of burnout among health systems employees?

RQ3. What could alleviate burnout and stress in health systems' employees?

3. Research Methodology

3.1. Study Design, Setting, and Participants

This is a mixed-methods study. To reduce selection bias, trade organizations, such as hospital associations and the American College of Healthcare Executives, were solicited to distribute the survey to members. Additionally, individuals of influence (e.g., hospital administrators) were contacted to distribute the survey to their network and health systems. A survey link was distributed through social media, such as LinkedIn. Responses were collected from February 2022 to October 2022. The survey was hosted on JotForm.com. Participants provided informed consent prior to the survey. All health systems' employees were invited to participate.

In the qualitative phase, participants were recruited via the American College of Healthcare Executives, a trade organization of healthcare professionals, and by contacting employees who worked in health systems located on the east coast of the United States. Interviews were conducted from October 2022 to January 2023 via Microsoft Teams or phone. The interviews were transcribed and recorded, and the recordings and transcriptions were uploaded into ATLAS.ti 22, a qualitative analysis software. Interviews were conducted until data saturation was reached, for a total of 23 interviews from 23 individuals. Data saturation was determined to have been reached when no new information or themes were obtained (Guest et al., 2020). Verbal and written informed consent were obtained prior to the interviews. The mixed-methods study was approved by Harrisburg University of Science and Technology's Institutional Review Board (IRB# 20221026).

3.2. Measures

In the quantitative phase of the study, a survey from Kovner et al. (2007) that was derived from the 22-item Maslach Burnout Inventory for General Use (MBI-GS) was distributed to health systems' employees (Kovner et al., 2007; Maslach et al., 1996). The MBI-GS measures burnout via a Likert scale that measures items from 0 (never) to 6 (every day). Demographics questions (e.g., the respondents' departments, position titles) were added. A total of 67 responses were received.

In the qualitative phase, a semi-structured interview guide (**Table 1**) was created based on the Oldenburg Burnout Inventory (Robert et al., 2011; Shumba et al., 2017). Each interview lasted approximately 30-minute to 1 hour. If further clarification was required, then probing questions were asked. The data collection method was validated using a pilot interview. The interviews were validated using triangulation from research studies and the survey data (Creswell, 2018). Furthermore, the interviewer conducted member-checking in which clarifying questions were asked to verify that interpretation of each interviewee's response was correct. Reliability was ensured by reviewing and correcting the transcriptions, defining the codes, continually comparing data with the codes, and writing memos about the codes and their definitions.

Table 1. Interview guide.

Topics/Dimensions	Questions
Demographics/ Background	Tell me about yourself. What department do you work in? How long have you been working in healthcare? How long have you been working in your current health system? What motivated you to start working in healthcare?
Experiences with burnout	Describe an experience you've had with burnout or stress. How did you feel? Was your burnout gradual?
Disengagement	Do you sometimes do your work mechanically, such as by not paying attention during meetings or while interacting with others? If so, in what circumstances does this usually happen?
Exhaustion	How do you feel at the end of a work day? Can you tolerate the pressure of your work every day? If so, how do you cope? How do you feel during the work day—energized, tired, in-between?
Drivers of burnout	What causes your burnout or stress: workload; pressures from leadership, patients, and your employees; lack of resources to complete your work; or something else?
Alleviating burnout	How do you cope with stress? How are your health systems' leaders alleviating burnout? What efforts are your leaders currently making to alleviate burnout that aren't working? What advice/solutions would you give your leaders about alleviating burnout?
End of interview	Is there anything you would like to add?

3.3. Analysis

The survey results were analyzed using R, a statistical analysis software. Means and the standard deviations of each response was calculated. Additionally, a correlation analysis on the question responses was completed.

The interview transcriptions were analyzed line-by-line using ATLAS.ti 22 by the first author. The first author discovered codes emergently in which the transcriptions were read and then codes were created according to the transcriptions. The codes were refined iteratively based on the themes discovered in the interviews. Themes were found based on common tenets of the interviews and similar responses that were categorized into common subjects.

4. Results

4.1. Quantitative Phase

Tables 2-6 show survey participants' demographics. Most respondents worked as administrators, assistant administrators, or supervisors (n = 18) and in an

Table 2. Survey respondents' departments.

Department	Number of Respondents
Administration	20
Board of Directors	4
Community Health	3
Diagnostic Imaging/Radiology	1
ED	4
Inpatient Psychiatry	1
Inpatient Surgery	2
Lab Services	1
Med/surg	2
OR/PACU	1
Pharmacy	1
Quality and Patient Safety	4
Step down/Transitional	1
Analytics	4
Case Management/Social Work	1
Finance	1
Graduate Medical Education	1
Information Technology	2
Marketing/Business Development	2
Operations	1
Strategy	5
Patient Experience	1
Radiation Oncology	2
Refused to Answer	3

Table 3. Survey respondents' positions.

Position Title	Number of Respondents
Administrator/Assistant Administrator/Supervisor	18
Board Member	3
Consultant	4
Case Manager	1
Clerical	1
IT Support	2
Medical Assistant	12

Continued

Medical Doctor (MD)	10
Patient Coordinator/Access Representative	3
Chaplain	1
Physician Chief/Chair	1
Project Manager	1
Registered Nurse	7
Residency Coordinator	1
Other	2

Table 4. Survey respondents' hospital size.

Bed Size	Number of Respondents
6 - 24 beds	6
25 - 49 beds	1
50 - 99 beds	3
100 - 199 beds	7
200 - 299 beds	3
300 - 399 beds	5
400 - 499 beds	8
500 beds or more	34

Table 5. Survey respondents' health systems' geographic location.

Location	Number of Respondents
Rural	26
Urban	41

Table 6. Survey respondents' health system type.

Type	Number of Respondents
Federal	2
For-profit	20
Non-profit	45

administrative department (n = 20). The majority worked in health systems with 500 beds or more (n = 34). Furthermore, most worked in nonprofit health systems (n = 45) located in urban settings (n = 41). Because each question was required to answer, there is no missing data to address.

As demonstrated in Table 7, the survey results show a lack of burnout symptoms among respondents. For example, regarding the EE dimension, several

Table 7. Question response means.

Survey Item	Mean
When I go home after work, I feel emotionally drained.	3.22
I understand patients' feelings.	4.34
I understand visitors' feelings.	4.25
Knowing what I know now, I would take my current job all over again.	3.84
My job interferes with my home-life.	2.75
My job keeps me from spending the amount of time I would like with my family.	2.81
I often get irritated by little annoyances.	2.54
I suffer from anxiety.	2.63
My mood often goes up and down.	2.57
There are days when I'm "on edge" all the time.	2.72
I feel fatigued when I get up in the morning.	2.96
I feel like I'm at my wits' end.	2.40
I feel stimulated when I work with my colleagues.	3.70
I deal very effectively with the problems of patients and/or co-workers.	4.08
I treat some patients and/or co-workers like they're impersonal objects.	1.64
In my work, I'm very relaxed when dealing with emotional problems.	3.33
I've become more callous toward people since starting my current job.	2.39
I feel exhilarated after working with or talking to patients.	3.30

respondents did not feel emotionally drained after work (mean = 3.22). Additionally, respondents did not feel fatigued when waking in the morning (mean = 2.96) or as though they were at their wits' end (mean = 2.40).

Most respondents did not report depersonalization toward others. For example, respondents agreed that they understood patients' and visitors' feelings (mean = 4.34 and 4.25 respectively). They also reported hardly ever treating or seeing patients as impersonal objects (mean = 1.64). However, most respondents felt neutral instead of exhilarated when talking to patients (mean = 3.30). Their jobs did not cause them to feel more callous toward others (mean = 2.39).

Most respondents reported a strong work/life balance; work hardly encroached on their home and personal lives (mean = 2.75) and time with family (mean = 2.81). Workloads may have been manageable for most respondents, which allowed them to maintain work/life balance.

Figure 1 is a matrix showing only statistically significant correlations between each of the survey responses. If the colors on the matrix are darker, then the correlations between each response are stronger. Red squares denote a negative correlation, and blue squares denote a positive correlation. As shown in Figure 1, the correlation analysis revealed a statistically significant negative relationship

between the burnout symptom of mood swings and taking one's job again knowing what one knows now. The burnout symptom of continually feeling "on-edge" was also negatively correlated with taking one's job again. Therefore, the more emotionally exhausted an employee is, the less likely he is to accept one's current job again knowing what he knows now. Becoming more callous toward others, which is an element of depersonalization, is negatively correlated with taking one's job again.

Other responses and burnout symptoms are positively correlated with one another. For example, the burnout symptoms of feeling emotionally drained after work and one's job interfering with home-life are positively correlated. Furthermore, feeling emotionally drained after work and suffering from anxiety are positively correlated. Respondents with one burnout symptom are more likely to have multiple burnout symptoms.

Standard deviations for each response ranged about 1 point for each response, as shown in Table 8. The responses are spread significantly, which might be due to the variety of respondents from different health systems and positions.

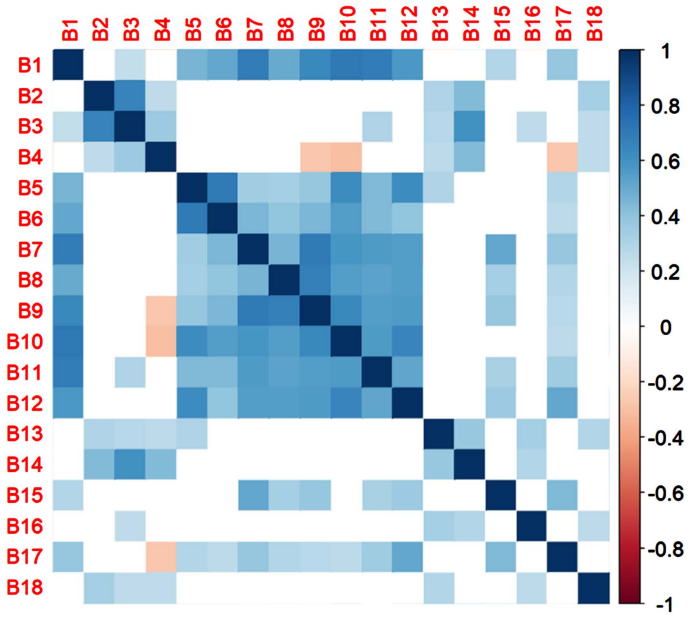

Figure 1. Correlation matrix of burnout responses. Key: B1: When I go home after work, I feel emotionally drained. B2: I understand my patients' feelings. B3: I understand visitors' feelings. B4: Knowing what I know now, I would take my current job all over again. B5: My job interferes with my home-life. B6: My job keeps me from spending the amount of time I would like with my family. B7: I often get irritated by little annoyances. B8: I suffer from anxiety. B9: My mood often goes up and down. B10: There are days when I'm "on edge" all the time. B11: I feel fatigued when I get up in the morning. B12: I feel like I'm at my wits' end. B13: I feel stimulated when I work with my colleagues. B14: I deal very effectively with the problems of my patients and/or co-workers. B15: I treat some of my patients and/or co-workers like they're impersonal objects. B16: In my work, I'm very relaxed when dealing with emotional problems. B17: I've become more callous toward people since starting my current job. B18: I feel exhilarated after working with or talking to patients.

Table 8. Standard deviations.

Survey Item	SD
When I go home after work, I feel emotionally drained.	1.45
I understand patients' feelings.	0.86
I understand visitors' feelings.	1.03
Knowing what I know now, I would take my current job all over again.	1.27
My job interferes with my home-life.	1.33
My job keeps me from spending the amount of time I would like with my family.	1.43
I often get irritated by little annoyances.	1.34
I suffer from anxiety.	1.56
My mood often goes up and down.	1.35
There are days when I'm "on edge" all the time.	1.41
I feel fatigued when I get up in the morning.	1.42
I feel like I'm at my wits' end.	1.34
I feel stimulated when I work with my colleagues.	1.10
I deal very effectively with the problems of patients and/or co-workers.	0.89
I treat some patients and/or co-workers like they're impersonal objects.	1.10
In my work, I'm very relaxed when dealing with emotional problems.	1.22
I've become more callous toward people since starting my current job.	1.56
I feel exhilarated after working with or talking to patients.	1.28

4.2. Interviewees' Demographics and Interview Themes

Interviewees' departments and positions are shown in Table 9 and Table 10, respectively. Table 9 shows that interviewees worked in a variety of departments, such as physical therapy and community health. As shown in Table 10, most worked as leaders, i.e., manager-level and above (n = 17). Six participants were individual contributors.

4.2.1. Theme 1: The COVID-19 Pandemic Drives Burnout

Several interviewees expressed that the COVID-19 pandemic caused burnout and stress due to rapidly changing state and organizational guidelines, the uncertainty concerning the virus (e.g., what the virus was, its effects and mortality rate, and safety concerns for employees working in their health systems' offices), and an increased workload. Several interviewees were required to create daily reports that were sent to the state and national governments, which included weekends, and resulted in less time with friends and family. The daily reporting needs encroached on work/life balance. One business intelligence developer's workload increased during the pandemic. The developer expressed that the state continually added COVID-19- and non-COVID-19-related metrics. As a result,

Table 9. Interviewees' departments.

Department	Number of Respondents
Administration	4
Ambulatory Care	3
Community Health	3
Radiation Oncology	1
Maternal/Women's and Child Health	2
Philanthropy	1
Physical Therapy	1
Analytics	2
Marketing	1
Operations	1
Human Resources	1
Radiation Oncology	1
Quality and Patient Safety/Performance Improvement	2

Table 10. Interviewees' positions.

Position	Number of Respondents
Associate Director	1
COO	2
Divisional Director	1
Quality Coordinator	2
Vice-President of Ancillary Services	1
Administrative Assistant	2
Assistant Manager	1
Administrator	1
Director of Quality	1
Director of Ambulatory Services	1
Senior Director of Marketing	1
Business Intelligence Developer	1
Manager of Data Analytics	1
Vice-President of Human Resources	1
Manager/Director of Community Health	2
Director of Women's and Children's Health	1
Director of Nursing	1
Lean Specialist	1
Director of Operations	1

gathering data from different departments to report the metrics took more time. The developer eventually left the department, citing one reason as the daily reporting requirements causing stress and burnout.

When asked to describe a time when they experienced burnout, nearly all interviewees recounted situations during the COVID-19 pandemic. One human resources vice-president stated:

"*COVID is what I remember. I've been in HR for decades now, and COVID, by far, has been the most stressful event of my career, COVID, especially from a healthcare perspective… Everybody was pretty much on-call. We were meeting, literally, seven days a week, nonstop, early morning, late evening.*"

The vice-president's sentiments align with several interviewees who stated that the pandemic increased their workload and reduced the amount of time to spend with loved ones and pursue personal hobbies.

A director of quality summarized the experience of burnout during the pandemic:

"*I was driving home one day at, like, 8:00 o'clock at night…pitch-black on the* [*highway*]*… I had a long commute, and I got stopped for speeding, and the cop said to me…why are you out, blah, blah, blah. And I said Oh, I work for a hospital…I'm the COVID person. I'm allowed to be out. I have credentials. And I said, to be honest, getting a speeding ticket would be a lot less stressful than what I had to deal with at work. And he's like, oh, my God, I understand that. Please be safe. I didn't get the ticket. Thank God. But that's how stressful it was during that COVID time, that getting a speeding ticket was a lot more relaxing than being at work… They talk about the frontline healthcare people, but you also have the administrative side of healthcare that took the brunt of it also. And I think a lot of that has been overlooked.*"

Even though seeing patients was not part of their daily work, the interviewees experienced burnout. There were additional demands on their time and energy, as expressed by several interviewees whose workplaces called them at various hours about the pandemic. Furthermore, interviewees who worked remotely stated the difficulty in maintaining work/life balance. Since their workstation was at home, they could work at any time. Several worked past their scheduled hours. An associate director of foundation relations expressed feeling pressured to remain in the "Available" status in Microsoft Teams, which is an online collaboration platform. A manager of data analytics regularly worked late into the night. The pandemic-caused remote work resulted in less work/life balance and increased work, which drove interviewees' burnout.

4.2.2. Theme 2: A High and Increased Workload Drives Stress and Burnout

A high or increased workload caused the interviewees' burnout. Several interviewees had high workloads before the pandemic, but their workloads increased during the pandemic. One manager of community health began to do tasks outside of the job description, such as patient experience-related work, which re-

sulted in stress. The manager explained:

"*The last year and a half* [*I was at the organization*], *it was the pandemic, and everybody was stressed out about the pandemic… There were lots of changes made to everyone's job. We all had to adapt and be flexible. So for about 8 months, I went to* [*another hospital in the health system*] *to do patient experience… I wouldn't say I was burned out, but I was stressed out… But the job that I was doing, not that I felt like I couldn't do the job. It was a little bit out of my realm… I was still communicating with patients, which was fine, but because with patient experience…people are complaining. Basically, you're hearing complaints… By the time I left* [*the hospital*] *after 8 months and went back to my old job, I'm a little burnt out… That was a little stressful because I was overwhelmed. It wasn't really something I wanted to do, but I knew I needed to do it for lots of reasons—because it was something that the organization asked me to do. It was also because financially and personally I wanted to continue to work, so I was a little stressed there.*"

When a data analytics manager's employees' positions were eliminated due to the economic impact of the pandemic, the manager's workload increased. The manager expressed difficulty in completing the eliminated employees' work during scheduled hours. The manager stated feeling pressured from executive leaders to complete the same amount of work without the additional personnel. A vice-president of ancillary services said that leaders regularly asked employees to work additional shifts to complete the work.

Some interviewees acknowledged that the increased workload decreased the quality of job performance. The data analytics manager admitted that the "best job" was not always completed because of the increased workload. An executive assistant did not finish tasks to the highest ability because of the increased workload that resulted from turnover:

"*Even my role, I think when I started…Corporate had 8 admins, and they also had an admin for the president at the hospital.* [*Now*] *I'm it… They whittled all those people down to me… I have the president's admin role, so… I'm like, I would love to do this the best way I can, but… there are days I'm like, no, I'm gonna throw it on and that's just what it is, guys. I would love to make a beautiful agenda for you… I don't have that kind of time.*"

In some instances, a high workload leads to turnover, especially if there is not sufficient leadership support or staff. Additional administrative staff could alleviate the workload and, thus, burnout. An administrative assistant stated:

"*The team that I work for… I had to leave that team and go over to one of the other teams because it was just too much. I replaced one of the workers, then someone replaced me and someone replaced her and she is now leaving. So that would say to me in leadership that we need to specifically look at this team. You cannot cookie cut every team in a department. Some need a little more handholding and a little more coddling, if you will, and that team needs additional support staff, and I fault leadership for that.*"

The data analytics manager and a director of the women's and children's service line began to search for another job when the workload increased. The data analytics manager eventually left the health system to work at an organization that was not a health system.

4.2.3. Theme 3: Volatility Drives Burnout

Several interviewees noted that changes, especially in leadership and non-managerial employees, cause perceptions of uncertainty and instability and, subsequently, stress. One director of the women's and children's service line stated that, during the pandemic, there were several leadership changes and a department restructuring. The restructuring and organizational policy changes from the pandemic increased workload, which caused burnout. A vice-president of human resources said that the pandemic-related policy changes resulted in stress. A manager of community health became stressed because of the volatility in the health system regarding leadership changes. The manager expressed disengagement, which is a symptom of burnout. A director of ambulatory clinical practice said that the uncertainty about the health system's financial stability, especially concerning a possible workforce reduction, caused stress. Employees were unsure whether their roles would be eliminated. The director was also did not know whether the right tasks were being prioritized, worried about work, and felt "unsettled" when attempting to explain the role to new supervisors. The interviewee had four supervisors in three years, which caused stress. Therefore, too much volatility in a health system can cause stress and, in some cases, burnout.

4.2.4. Theme 4: Individual Coping Strategies and Organizational Support for Alleviating Burnout

Interviewees used a variety of coping strategies for burnout. Many stated that social support helped them cope. One executive assistant walked with friends outside of work. Several interviewees spent time with family to alleviate burnout. For example, a quality coordinator stops working at a certain time every day to be with family. The director of ambulatory clinical practice bakes cookies with family. An administrative assistant talks to a spouse.

Interviewees meditated, practiced yoga, prayed, and exercised. A director of quality ran before work to cope with stress. An administrative assistant walked and prayed before and after work. Some interviewees used at-work recreational facilities, such as massage areas and break rooms.

Organizational support reduced burnout. A director in one health system's philanthropy department stated that leaders encouraged time away from work by allowing Fridays to be vacation days. Leaders recognizing their employees for high-quality work or metrics being met reduced stress and burnout. A director of maternal and child health stated that allowing time to "have fun at work" alleviates stress and burnout. A Lean specialist expressed that more recognition, such as celebrating birthdays and providing additional paid time away, would reduce burnout. The interviewees' responses show that, not only can individuals

mitigate burnout using a variety of ways, but organizations' leaders can help employees cope by providing formal programs, areas to remove oneself from work, and recognizing employees.

5. Discussion

The survey results show that respondents do not suffer from burnout symptoms, including leaders and individual contributors. For example, respondents were not emotionally exhausted. The results contrast with studies of patient-facing employees, such as hospital-based pharmacists, physicians, and nurses who showed moderate levels of EE (Aiken et al., 2002; Durham et al., 2018; Dyrbye et al., 2017; Kraus et al., 2021; Morgan Jones et al., 2017). However, the results of this study are aligned with Maunder et al.'s study showing low EE rates among non-clinical staff (e.g., non-nurses and non-physicians) (Maunder et al., 2022). In contrast to Maunder et al.'s study, this study focuses on primarily administrative staff, who included nurses and physicians working in non-patient-facing roles. The results show that non-patient-facing employees do not suffer from EE.

Furthermore, many respondents did not show depersonalization. If they incidentally saw patients or visitors, such as in the hallways, they did not treat patients or visitors as impersonal objects or behave callously. The survey results contrast with results among employees of a Ghanian hospital where non-clinical employees are likely to depersonalize patients and visitors (Konlan et al., 2022). Ghanian hospitals may have fewer personnel than health systems in the United States, which contributes to depersonalization and, thus, burnout (Asiedu et al., 2018; Odonkor & Frimpong, 2020). The survey results align with Maunder et al.'s study that showed a low burnout rate and, thus, depersonalization among non-clinical staff (Maunder et al., 2022). Cultural differences between Western and other countries, such as Eastern and African countries, may contribute to higher levels of depersonalization in Eastern and African countries in contrast to Western countries (Menon et al., 2022).

The correlation analysis results align with several studies that show a positive correlation between multiple burnout symptoms (Bianchi et al., 2020; Cox et al., 1993; Kahill, 1988). Therefore, if employees are suffering from one burnout symptom, then they are likely to suffer from several. The results align with studies that show that several burnout symptoms must be shown before a burnout is reached (Chambers & Frampton, 2022; Ran et al., 2020).

The interviews show that burnout is driven by several factors. One is the COVID-19 pandemic (de Medeiros et al., 2022; Sikaras et al., 2021). The uncertainty of the pandemic, particularly during the first wave, increased interviewees' stress. Several interviewees noted that knowing little about the virus, including long-term effects on their health systems' finances and staffing, and possibly becoming infected and infecting their loved ones, was causing stress and anxiety (Leung et al., 2022). Their fears of infection while at work are similar to the fears of nurses and physicians (Mattila et al., 2021; Sriharan et al., 2021). Furthermore,

the length of the pandemic was driving stress. The surges of the numerous variants, such as delta and omicron, resulted in several interviewees feeling as though the pandemic would not end. The prolonged nature of the pandemic; the continued amount of pressure from leadership, particularly concerning financial viability; and increased workload drove burnout. The results align with several studies that measured burnout of health systems' employees during the pandemic (Jones et al., 2021; Martins et al., 2022; Teo et al., 2021). However, the aforementioned studies are about mainly frontline staff, such as nurses and physicians, and not administrative staff. Therefore, this study shows that the pandemic affected administrative employees' stress and burnout.

Secondly, burnout is driven by a high workload (Kim et al., 2022; Lee et al., 2021). An administrator stated that focusing on one high-urgency task caused other work to "pile up", which led to burnout. A director of quality regularly worked outside of work hours to complete tasks, especially during the beginning of the pandemic. A high workload was associated with the pandemic; several interviewees stated that their workloads increased after the pandemic started. Understaffed departments increased workloads among leaders and individual contributors. Two administrative assistants stated that they did not have sufficient staff in their departments to complete the work. One of the administrative assistants stated that job performance decreased as a result; some work was unable to be completed in a high-quality manner or was not completed at all, which aligns with the results of several studies (Bahador et al., 2019; Balducci et al., 2021; Meilani et al., 2022). Leaders noted that they frequently stayed at work after their scheduled shifts. A high workload contributed to a lack of work/life balance. Interviewees noted the lack of work/life balance. One director of nursing stated that work/life balance does not exist, depending on one's life circumstances. For example, work may "take a backburner" while one pursues education. An analyst stated that, once the pandemic began and employees transitioned to remote work, some worked after their allotted number of hours because their work laptop was always available. The office and home were no longer physically separated. A manager of data analytics and associate director of foundation relations expressed similar sentiments. Not being able to mentally separate work from home as a remote worker drove burnout (Irawanto et al., 2021; Unal & Dulay, 2022). Some interviewees stated that they have a strong work/life balance or supervisors who encourage one. Interviewees also noted that they implemented work/life balance to cope with stress and burnout. Leadership support for work/life balance helped employees maintain it. Fan (2018) also found that leadership support mediated work/life balance (Fan, 2018).

Volatility increased stress and burnout, especially in leadership. Health systems who show poor change management by not communicating well with employees or being transparent may have contributed to employees' burnout (Beaulieu et al., 2023; Gwon et al., 2023; Sengul et al., 2021). Interviewees may have been afflicted with "change fatigue", in which employees feel exhausted, stressed, and burned out from frequent change (Brown et al., 2018). Several interviewees

noted that a high amount of leadership turnover caused stress. A director of ambulatory clinical practice stated that changing supervisors frequently caused anxiety, which is a burnout symptom (Maslach, 1982; Maslach et al., 1996).

Interviewees talked about several coping strategies and organizational attempts to alleviate burnout, such as recognition. One study shows that recognition reduces burnout in nurses; however, administrative personnel were not studied (Kelly & Lefton, 2017). Therefore, this study contributes to the literature by showing that administrative health systems' personnels' burnout is also alleviated when they are recognized. The interviewees' statements align with one study of healthcare workers that showed that employees who felt valued were less likely to feel stressed or burned out (Teo et al., 2021). Interviewees described formal recognition programs at their health systems, such as online recognition boards in which employees could publicly thank others. Other interviewees stated that coping strategies such as exercise and social support alleviated burnout. This theme aligns with other studies. However, this study adds to the literature by showing that these coping strategies alleviate health systems' administrative employees' burnout (Dominguez-Espinosa & Fontaine, 2023; García-Rivera et al., 2020; Pei et al., 2021; Turton & Francis, 2007).

6. Conclusion

This research shows the importance of recognizing and alleviating burnout among health systems' administrative employees, who are often overlooked in burnout research and by health systems' leaders. It is imperative that leaders focus on mitigating administrative employees' burnout by addressing root causes instead of focusing only on nurse and physician burnout. Doing so will increase engagement, and employees will be less likely to leave their health systems.

Additionally, this study shows that managers and directors have similar burnout symptoms as individual contributors. For example, both individual contributors and leaders felt pressured to work past their regularly scheduled hours, especially when working remotely, to complete their tasks. High workload may be a root cause of stress that should be addressed for all employees, and work/life balance should be encouraged. Leaders believed that they were recognizing employees effectively to mitigate burnout. However, individual contributors thought that their leaders could recognize them more. Leaders could see how individual contributors would like to be recognized to mitigate burnout. Addressing the root causes of burnout would alleviate these issues.

6.1. Limitations

Despite its contributions to the literature and the healthcare industry, this study has several limitations. One of the limitations is the lack of the results' generalizability to other health systems due to the interviews being limited to employees who work in health systems in the Mid-Atlantic area of the United States. Future studies should interview employees who work in health systems throughout the United States.

A second limitation is that some demographics information, such as race/ethnicity and age, were not collected to encourage survey responses and ensure anonymity. Future studies should include additional demographics questions since burnout has been shown to be correlated with race/ethnicity, age, sex, and other demographics (Beier et al., 2023; Fiorilli et al., 2022; Kunimura, 2022).

6.2. Contributions to the Literature

This research contributes to the literature in several ways. This is one of the first studies to focus on mainly administrative health systems' personnel. Second, this study pinpoints contributors to and mitigators of burnout. Survey instruments show only burnout scores. The results of this research provide depth to the survey results that previous studies have not reached, particularly among administrative health systems' employees.

6.3. Practical Implications

The results of this study show for which burnout symptoms leaders should be looking. The correlation analysis shows that, if employees are suffering from one burnout symptom, then they are likely to be suffering from at least one more; burnout symptoms are positively correlated with one another. Leaders should watch for and support employees who are showing burnout symptoms. Furthermore, this research helps leaders recognize reasons why administrative employees become burned out or stressed. Leaders can then address these issues, such as lack of recognition or a high chronic workload, to alleviate burnout and, thus, reduce the chance that employees will resign. Finally, this research shows that burnout must be acknowledged among not only nurses and physicians but also administrative employees. The survey results demonstrate that administrative employees may occasionally interact with patients; if an administrative employee treats a patient inappropriately due to depersonalization, then patient satisfaction scores may decrease. Leaders should engage administrative employees and address root causes of burnout, such as a negatively perceived organizational culture, to reduce depersonalization and increase engagement (Privitera, 2016).

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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