Why Burnout Persists: Applying Systems Thinking to Structural Conflicts and Unexamined Assumptions in Healthcare

John Sambrook*

November 10, 2025

Abstract

Healthcare burnout affects more than half of US physicians and nurses, costs billions annually, and directly impacts patient safety—yet persists despite decades of intervention. Multiple factors contribute to burnout, including staffing shortages, electronic health record documentation burden, inadequate compensation, lack of autonomy, leadership failures, and work-life balance challenges. This article focuses on a specific but critical subset of these factors: the psychological trauma, moral injury, and structural conflicts that arise from system constraints on care delivery. Through a systems thinking lens, we expose foundational conflicts and unexamined assumptions that make these particular drivers of burnout structurally inevitable. Healthcare organizations rigorously protect workers from physical hazards like radiation through dose limits and engineering controls, while expecting providers to absorb unlimited psychological trauma throughout their careers. This asymmetry reflects the absence of frameworks to identify and resolve inherent conflicts. Drawing on research showing organizational interventions significantly outperform individual resilience training, this article proposes that healthcare systems adopt occupational health principles for psychological hazards and apply rigorous conflict analysis to resolve—not merely manage—these structural conflicts.

1 Introduction: A Problem We Know How to Solve, Yet Don't

More than 50% of US physicians report substantial burnout symptoms.[1] Among nurses, the rates reach 56%.[2] The problem costs the US healthcare system between $1-2 billion annually in physician turnover alone.[3] Burnout correlates with increased medical errors, reduced patient satisfaction, and compromised quality of care.[4]

These facts are not new. The National Academy of Medicine labeled clinician burnout a "public health crisis" in 2019.[5] Countless interventions have been deployed: mindfulness programs, resilience training, wellness initiatives, organizational restructuring efforts. Yet the crisis deepens.

*Founder, Common Sense Systems, Inc. john@common-sense.com — common-sense.com

[1]Shanafelt TD, et al. Changes in burnout and satisfaction with work-life integration in physicians and the general US working population between 2011 and 2020. *Mayo Clinic Proceedings* 2022; 97(3):491-506.

[2]Prasad K, et al. Prevalence and correlates of stress and burnout among US healthcare workers during the COVID-19 pandemic. *EClinicalMedicine* 2021; 35:100879.

[3]Han S, et al. Estimating the attributable cost of physician burnout in the United States. *Annals of Internal Medicine* 2019; 170(11):784-790.

[4]Salyers MP, et al. The relationship between professional burnout and quality and safety in healthcare. *International Journal for Quality in Health Care* 2017; 29(5):621-628.

[5]National Academies of Sciences, Engineering, and Medicine. *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being.* Washington, DC: The National Academies Press; 2019.

Why does burnout persist?

2 Scope and Focus of This Analysis

Healthcare burnout is a multifaceted problem with numerous contributing factors. Research identifies staffing shortages as the top contributor (cited by 56% of physicians and 65% of nurses), followed by excessive bureaucratic tasks and documentation burden (54% of physicians), chaotic work environments (28-39%), lack of control over workload (39% of physicians), and after-hours work demands (45% of physicians).[6] Electronic health record (EHR) documentation burden alone is cited by 86.9% of clinicians as their most prominent EHR concern, with physicians spending up to twice as much time with EHRs as with patients.[7]

Additional critical factors include:

- Inadequate compensation and pay inequity
- Poor leadership quality and lack of organizational support
- Insufficient autonomy and control over work
- Poor interpersonal relationships and team dynamics
- Lack of professional recognition
- Work-life imbalance and inflexible scheduling

This article does not attempt to comprehensively address all these factors. Instead, we focus on a specific but under-analyzed subset: the psychological trauma, moral injury, and structural conflicts that arise when system constraints prevent healthcare workers from delivering care consistent with their professional values. We examine these factors through a systems thinking lens, using Theory of Constraints methodology to expose the foundational conflicts and unexamined assumptions that make burnout structurally inevitable in current healthcare delivery models.

This focused approach is deliberate. While factors like EHR burden, compensation, and scheduling are well-documented and increasingly addressed through targeted interventions, the systemic treatment of psychological trauma as an occupational hazard requiring organizational protection—analogous to protection from physical hazards—remains largely unexplored. Similarly, the application of rigorous conflict analysis to resolve the structural dilemmas inherent in healthcare delivery represents a novel analytical approach not commonly found in burnout literature.

Our argument is not that these factors we focus on are more important than others, but rather that they are amenable to a specific analytical framework (systems thinking and conflict resolution) that healthcare has not yet systematically applied. The absence of this framework helps explain why burnout persists even when organizations address other contributing factors.

3 The Asymmetry That Reveals the Assumptions

Consider two categories of occupational hazards in healthcare: ionizing radiation and bloodborne pathogens. For both, healthcare organizations maintain elaborate protection systems mandated by

[6] KLAS Arch Collaborative. Understanding and addressing trends in physician and nurse burnout 2024. 2024.

[7] Arndt BG, et al. Tethered to the EHR: Primary care physician workload assessment using EHR event log data and time-motion observations. *Annals of Family Medicine* 2017; 15(5):419-426.

federal regulation.

3.1 How Healthcare Protects Against Physical Hazards

The Occupational Safety and Health Administration (OSHA) requires employers to protect workers from ionizing radiation exposure through comprehensive programs.[8] Occupational dose limits are strictly enforced: 5 rem (50 mSv) per year for whole-body exposure, with lower limits for specific organs.[9] But regulation doesn't stop at limits—it requires monitoring, engineering controls, and systematic application of the ALARA principle (As Low As Reasonably Achievable).[10]

When workers approach just 10% of annual dose limits, organizations must investigate and implement corrective measures.[11] Workers receive personal dosimeters; exposure records are maintained for decades; facilities employ radiation safety officers; and pregnant workers receive enhanced protections with a maximum gestational dose of 0.5 rem.[12]

Similarly, the Bloodborne Pathogens Standard (29 CFR 1910.1030) requires exposure control plans, engineering controls (sharps disposal systems, safety devices), work practice controls, personal protective equipment, hepatitis B vaccination programs, and post-exposure protocols.[13] The system assumes that exposure to bloodborne pathogens poses unacceptable risk and that the *organization bears primary responsibility* for minimizing that exposure.

3.2 How Healthcare Fails to Protect Against Psychological Hazards

Now consider psychological trauma and moral injury—occupational hazards that contribute significantly to burnout. Healthcare workers routinely witness suffering, deliver devastating news to families, make life-or-death decisions under uncertainty, watch patients die despite their best efforts, and experience what researchers call "moral injury": the distress that results when system constraints prevent them from providing care consistent with their professional values.[14] Research shows that 76.61% of healthcare workers reported feeling betrayed by their healthcare organization during COVID-19, with witnessing potentially morally injurious events increasing burnout risk significantly.[15]

Unlike radiation or bloodborne pathogens, there are no:

- Dose limits for exposure to traumatic events
- Personal monitoring systems to track cumulative psychological exposure
- Engineering controls to reduce unnecessary exposure to moral distress
- Mandatory processing resources (analogous to post-exposure prophylaxis)

[8] 29 CFR 1910.1096 - Ionizing Radiation standard.

[9] 10 CFR 835.202 - Occupational dose limits for general employees.

[10] ALARA requires that "every reasonable effort must be made to keep the dose to workers and the public as far below the required limits as possible." NRC Regulatory Guide 8.29.

[11] Radiation Protection Programs typically set ALARA investigation levels at 10% (Level I) and 30% (Level II) of quarterly limits to trigger review and intervention.

[12] 10 CFR 835.206 - Maximum dose equivalent to embryo/fetus of 0.5 rem (5 mSv) during entire pregnancy.

[13] OSHA Bloodborne Pathogens Standard, 29 CFR 1910.1030, revised by Needlestick Safety and Prevention Act of 2000.

[14] Dean W, Talbot S. Moral injury in health care: a unified definition and its relationship to burnout. *Federal Practitioner* 2024; 41(4):104-107.

[15] Usset TJ, et al. Burnout and turnover risks for healthcare workers in the United States: downstream effects from moral injury exposure. *Scientific Reports* 2024; 14(1):24915.

- Investigation triggers when exposure exceeds safe thresholds
- Protected time offline when maximum safe exposure is reached

Instead, the implicit assumption is that healthcare workers can absorb unlimited psychological trauma over the course of a career, processing it through personal resilience and individual coping mechanisms. When they cannot—when burnout emerges—the system responds primarily with individual-level interventions: resilience training, mindfulness programs, stress management courses.

This asymmetry is not accidental. It reflects a set of deeply embedded, rarely examined assumptions about the nature of healthcare work and the capacities of healthcare workers.

4 The Unexamined Assumptions That Perpetuate Burnout

4.1 Assumption 1: Psychological Trauma Is Fundamentally Different from Physical Hazards

The distinction healthcare organizations draw between radiation exposure (carefully limited and monitored) and traumatic event exposure (unlimited and unmonitored) rests on an unstated assumption: that psychological hazards are categorically different from physical ones in ways that justify different protection standards.

But what is the basis for this distinction? Both can cause lasting harm. Both accumulate over time. Both have dose-response relationships. Both impair functioning. The primary difference is that psychological harm is less visible and harder to measure—but difficulty of measurement is not a principled reason to abandon the obligation to protect.

Research on moral injury among Veterans Affairs healthcare workers during COVID-19 found that 39% were at risk for moral injury, with perceived lack of management support, short-staffing, and high work-family conflict as key predictors.[16] These are organizational factors, not individual deficiencies. Yet the response emphasizes individual adaptation.

4.2 Assumption 2: Healthcare Work Requires Self-Sacrifice

There exists a powerful cultural narrative that frames healthcare work as inherently requiring unlimited self-sacrifice. This narrative elevates the "self-sacrificing superhero" provider who works through exhaustion, absorbs endless trauma, and puts patients before self and family.

This framing is counterproductive. As one study notes, "The difference between burnout and moral injury is important because using different terminology reframes the problem and the solutions. Burnout suggests that the problem resides within the individual, who is in some way deficient."[17] When leadership celebrates self-sacrifice, it obscures systemic problems and shifts responsibility to individuals.

Healthcare organizations would never celebrate workers who routinely exceeded radiation dose limits as "dedicated professionals" demonstrating "commitment to patients." Leadership would

[16] Connelly CD, et al. Moral injury and mental health in healthcare workers. *BMC Health Services Research* 2023; 23:1245.

[17] Dean W, Talbot S. Reframing clinician distress: moral injury not burnout. *Federal Practitioner* 2019; 36(9):400-402.

recognize the system failure that made excess exposure necessary. The same principle should apply to psychological hazards.

4.3 Assumption 3: Individual Resilience Can Compensate for Systemic Dysfunction

Perhaps the most pernicious assumption is that individual-level interventions can adequately address what is fundamentally an organizational problem.

A 2024 study analyzing data from 46,336 workers across 233 organizations found no significant differences in well-being outcomes between participants and non-participants in individual-level interventions including resilience training, stress management, and mindfulness programs.[18] The authors concluded: "These findings challenge the hypothesis that individual-level interventions significantly improve workers' well-being...urging a reconsideration of workplace strategies."[19]

By contrast, a meta-analysis examining organizational interventions found significant effects in reducing exhaustion when interventions targeted structural changes such as workload, schedule, and job control.[20] Another systematic review concluded that "organization-directed interventions for reducing physician burnout were most effective but rare," providing "evidence-based support for viewing burnout as a problem of the whole healthcare organization, rather than individuals."[21]

Yet the overwhelming majority of interventions remain individual-focused, not because people don't care about systems, but because the field hasn't provided practical frameworks for recognizing when problems stem from systemic conflicts versus individual factors. Like a mechanic working with only a few tools, people naturally use what they have—"individual resilience" training programs feel concrete and implementable, while organizational redesign tools feel abstract and out of reach.

This pattern reflects a deeper conflict that organizations face when responding to burnout:

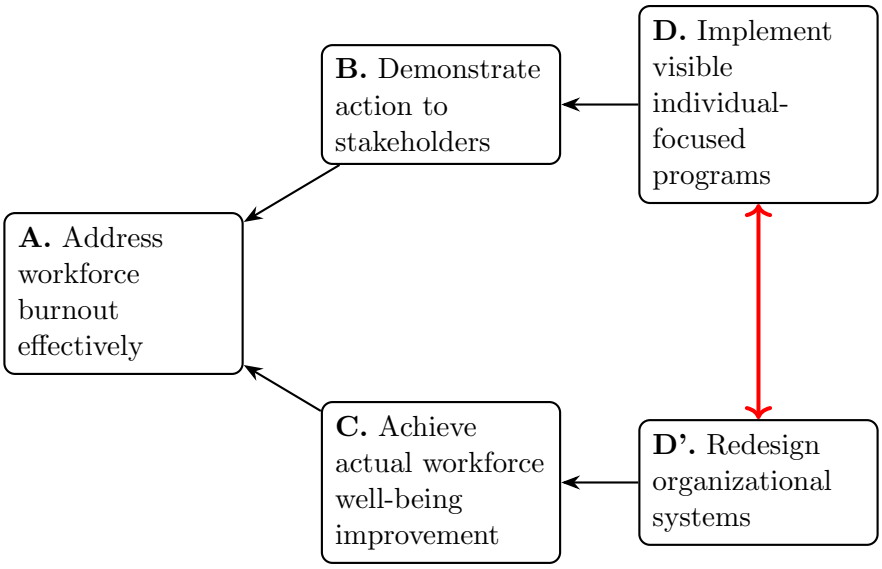
To address burnout effectively (A), organizations need both to demonstrate action to stakeholders—boards, staff, and the public (B)—and to achieve actual improvement in workforce well-being (C). Demonstrating action is readily satisfied by implementing visible individual-focused programs like resilience training (D), while achieving real improvement requires the harder work of redesigning organizational systems (D'). These approaches conflict when budget and change management constraints make quick visible programs more attractive than slower systemic change.

[18] Hupfeld M, Grommes K. Individual and organizational interventions to reduce burnout. *Industrial Relations Journal* 2024; 55(2):178-195.

[19] Ibid.

[20] Guseva Canu I, et al. Organizational interventions and occupational burnout: a meta-analysis. *Scandinavian Journal of Work, Environment & Health* 2023; 49(7):462-472.

[21] Panagioti M, et al. Controlled interventions to reduce burnout in physicians. *JAMA Internal Medicine* 2017; 177(2):195-205.



4.4 Assumption 4: Current Workload and Expectations Are Fixed Constraints

Organizations often treat workload, staffing ratios, productivity expectations, and administrative burden as fixed external constraints rather than as design variables that can be adjusted. This assumption forecloses solutions before they are considered.

Research consistently identifies work overload as a primary driver of burnout. When work overload is present, healthcare workers have 2.2 to 2.9 times the risk of experiencing burnout.[22] Yet the response is rarely to question whether current productivity expectations are sustainable, but rather to help workers cope with unsustainable demands.

One study noted: "Approaches to workload reduction in medicine are haphazard, largely concentrated in trainees and differ from other industries where exhausted workers (e.g., airline pilots) are not allowed to work and workload is closely monitored."[23] The Federal Aviation Administration strictly limits pilot duty hours and mandates rest periods, recognizing that exhaustion compromises safety. Healthcare has no equivalent systematic approach to measuring and limiting workload.

5 Why These Assumptions Persist: The Absence of Systems Thinking Tools

The assumptions outlined above are not merely incorrect beliefs held by individuals. They are embedded in organizational structures, policies, compensation systems, regulatory frameworks, and cultural norms. They persist not because healthcare leaders are unaware of burnout, but because the field lacks the analytical frameworks to expose the foundational conflicts these assumptions create and perpetuate.

[22] Reith TP, et al. Work overload and intent to leave among health care professionals. *Journal of General Internal Medicine* 2023; 38(5):1247-1254.

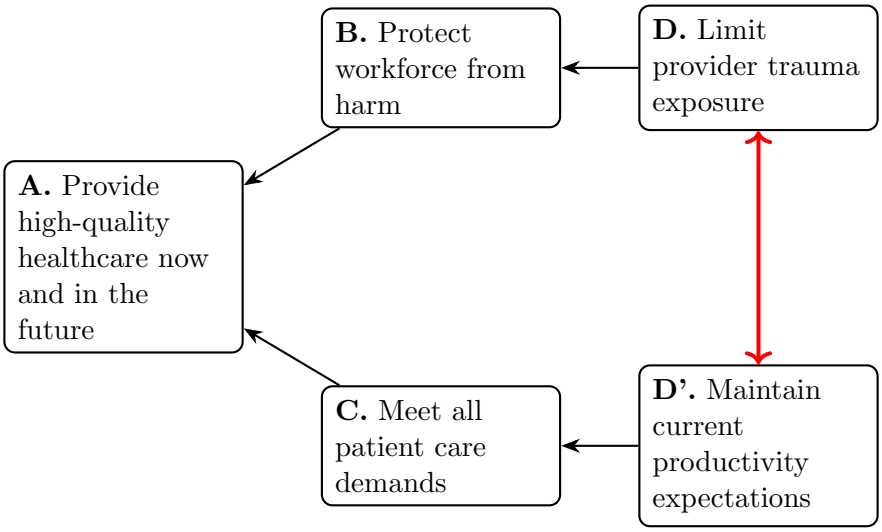
[23] Ibid.

5.1 The Theory of Constraints Perspective

Theory of Constraints (TOC) methodology provides tools specifically designed to expose and resolve conflicts that make problems chronic. The central insight is that intractable problems persist because of unresolved conflicts between legitimate needs or requirements—conflicts that force impossible choices.

In TOC terms, burnout stemming from moral injury and psychological trauma is not caused by any single factor, but by the conflicts embedded in how healthcare delivery has been structured. The Evaporating Cloud tool[24] systematically exposes these conflicts.

Consider the fundamental conflict driving this aspect of healthcare burnout:



The conflict structure reveals the dilemma: To provide high-quality healthcare now and in the future (A), organizations must both protect the workforce from harm (B) and meet all patient care demands (C). Protecting the workforce requires limiting provider trauma exposure (D), while meeting care demands under current assumptions requires maintaining current productivity expectations (D'). These two actions directly conflict.

5.2 The Assumptions That Sustain the Conflict

The Evaporating Cloud tool systematically exposes assumptions underlying each connection in the conflict structure. When these assumptions are articulated explicitly, they become available for challenge.

Assumptions connecting D (limit exposure) to B (protect well-being):

- Current levels of traumatic exposure exceed safe limits
- Reducing exposure requires reducing workload or enhancing support
- Individual resilience is insufficient to process current exposure levels

Assumptions connecting D' (maintain workload) to C (meet care demands):

[24]The Evaporating Cloud (also called the Conflict Cloud) is a TOC thinking process tool that diagrams the logic underlying a conflict, making explicit the assumptions that sustain it and enabling systematic challenge of those assumptions.

- Current staffing and resources are fixed constraints
- Productivity targets are necessary for financial viability
- Reducing workload would compromise patient access or quality
- No significant inefficiencies exist that could be eliminated

Assumptions that create the conflict between D and D':

- Healthcare workers can absorb unlimited psychological trauma
- Individual adaptation is less costly than system redesign
- The cost of burnout is less than the cost of system change
- Current workload distribution across the workforce is optimal

When articulated explicitly, several of these assumptions become immediately questionable. Healthcare workers demonstrably cannot absorb unlimited trauma—the burnout epidemic proves this. The cost of burnout likely exceeds the cost of prevention.[25] Significant inefficiencies exist in documentation burden, administrative tasks, and workflow design.

But without tools to systematically expose and challenge these assumptions, they remain implicit and unexamined, perpetuating the conflict that generates burnout.

6 What a Systems Approach Would Look Like: Treating Psychological Trauma as an Occupational Hazard

If healthcare organizations applied the same occupational health framework to psychological hazards that they apply to physical hazards, several practices would become standard.

6.1 Exposure Monitoring and Dose Limits

Just as radiation workers wear dosimeters, healthcare organizations could systematically track exposure to psychologically traumatic events. This is not about measuring "resilience" or "coping"—it's about measuring exposure. Relevant exposures might include:

- Patient deaths, especially unexpected or traumatic
- Delivering devastating news to families
- Involvement in serious medical errors or adverse events
- Witnessing suffering that cannot be alleviated
- Situations where system constraints prevent optimal care (moral injury events)

Organizations could establish evidence-based thresholds—analogous to ALARA levels—that trigger review and intervention. When a provider's cumulative exposure over a period reaches a defined level, mandatory actions might include:

- Immediate supervisor discussion and assessment

[25] Conservative estimates place the cost of physician burnout alone at $4.6 billion annually when including turnover and reduced clinical hours.

- Access to structured psychological processing (analogous to post-exposure prophylaxis)
- Temporary reduction in high-trauma exposure
- Investigation of whether exposure was preventable through system changes

When exposure reaches upper limits, providers might be temporarily reassigned to lower-trauma roles or provided protected leave to process accumulated experiences—just as radiation workers who approach dose limits are removed from radiation areas.

6.2 Engineering Controls to Reduce Unnecessary Exposure

The hierarchy of controls in occupational health prioritizes engineering controls (eliminating or reducing the hazard at its source) over personal protective equipment or administrative controls. Applied to psychological hazards, this means:

- Workflow redesign to eliminate unnecessary administrative burden and documentation that distracts from meaningful patient care
- Team-based care models that distribute high-stress decision-making and provide built-in support
- Structured handoff protocols that transfer not just clinical information but emotional burden
- Debriefing and processing systems built into the workday, not added to personal time
- Predictable scheduling that allows workers to recover between high-intensity periods
- Organizational authority to address system constraints that generate moral injury rather than expecting individuals to cope with unchangeable realities

6.3 Organizational Accountability and Measurement

Organizations track healthcare-associated infections, medication errors, and patient falls with rigorous measurement systems that drive accountability. The same should apply to workforce well-being.

Meaningful organizational accountability would include:

- Regular, systematic measurement of burnout, moral distress, and workforce well-being using validated instruments
- Public reporting of workforce well-being metrics as part of organizational quality dashboards
- Leadership accountability with executive compensation tied to workforce well-being metrics[26]
- Investigation protocols when workforce well-being metrics exceed concerning thresholds
- Resources and authority provided to Wellness Officers equivalent to what is provided to Patient Safety Officers

[26]Dean W, Talbot S. *Federal Practitioner* 2019: "If we link patient satisfaction with clinician compensation, why not link clinician satisfaction with executive compensation?"

7 Applying Conflict Resolution to System Design

Beyond treating psychological trauma as an occupational hazard requiring protection, a true systems approach requires exposing and resolving the foundational conflicts that generate burnout from moral injury and system constraints.

7.1 Challenge Invalid Assumptions

Organizations, when equipped with the right analytical tools, can systematically examine the assumptions embedded in their operating models:

- Is current workload actually fixed? Or have organizations simply accepted historical patterns without rigorous analysis of what is necessary versus what is habitual?
- Are productivity targets optimized? Or are they artifacts of payment models and competitive pressures that could be challenged?
- Have organizations eliminated all unnecessary work? Initiatives like "Getting Rid of Stupid Stuff" (GROSS)[27] have shown that significant amounts of required work provides no actual value
- Are organizations measuring the right things? Quality metrics and documentation requirements may impose burden without improving outcomes
- Is the distribution of work optimal? Could tasks be redistributed, delegated, or eliminated?

7.2 Find the Assumptions That, If Broken, Resolve the Conflict

In TOC methodology, resolving a conflict requires identifying assumptions that, if invalidated or changed, dissolve the conflict. For the burnout conflict related to psychological trauma and moral injury, several assumptions are candidates:

Assumption: "Healthcare workers can absorb unlimited psychological trauma"

Breaking this assumption—explicitly acknowledging that psychological exposure, like radiation exposure, has limits—fundamentally reframes the problem. It shifts the question from "How do organizations help workers cope with whatever they're exposed to?" to "How do organizations limit exposure to safe, sustainable levels?"

Assumption: "Current staffing and resource levels are fixed constraints"

Treating this as variable rather than fixed opens solution space: What if organizations staffed adequately? What if they hired more support staff to reduce clinician administrative burden? What if they used technology to genuinely reduce work rather than add documentation requirements? The cost of these investments must be compared to the true cost of burnout, not assumed to be prohibitive.

Assumption: "Individual adaptation is cheaper than system redesign"

This assumption collapses when healthcare leadership calculates the actual cost of burnout-driven turnover, reduced productivity, increased errors, and compromised quality. Research suggests that

[27] Ashton M. Getting rid of stupid stuff. *New England Journal of Medicine* 2018; 379:1789-1791.

the cost of replacing a single physician ranges from $500,000 to $1 million.[28] System redesign becomes economically rational when compared against these costs.

7.3 Design Solutions That Satisfy Both Conflicting Requirements

The goal is not to choose between worker well-being and patient care, but to find approaches that genuinely support both. Examples might include:

- Team-based care models that provide better patient continuity while distributing high-stress exposure across team members
- Realistic scheduling that acknowledges recovery time as essential, not optional, improving both worker well-being and clinical quality
- Technology deployment focused on genuinely reducing burden (e.g., ambient clinical documentation) rather than adding requirements
- Task redistribution moving administrative and low-complexity tasks to appropriate roles, freeing clinicians for work that uses their training
- Quality metric redesign focused on meaningful outcomes rather than process compliance, reducing gaming behavior and moral distress

7.4 The Economic Case for System Redesign

Architecture-level evaluation of burnout interventions requires clear cost-benefit analysis. Consider these established cost factors:

Costs of the status quo (burnout):

- Physician turnover: $500,000-$1,000,000 per physician replaced
- Reduced clinical hours: $7,600 per physician per 0.1 FTE reduction
- Medical errors: Burned-out physicians make significantly more errors
- Patient satisfaction: Lower scores correlate with burnout, affecting reimbursement
- Total estimated cost: $4.6 billion annually for physicians alone

Costs of system redesign:

- Additional staffing and support personnel
- Process improvement initiatives and workflow redesign
- Technology investments that genuinely reduce burden
- Protected time for processing and recovery
- Measurement and monitoring systems

When leadership compares these costs honestly, system redesign frequently becomes the economically rational choice. The question is not whether organizations can afford to redesign systems, but whether they can afford not to.

[28] Shanafelt TD, et al. The business case for investing in physician well-being. *JAMA Internal Medicine* 2017; 177(12):1826-1832.

8 Confronting the Cultural Narrative

Any serious effort to resolve burnout stemming from moral injury must gently reshape the cultural narrative of the self-sacrificing healthcare superhero. This narrative, while well-intentioned and serving important functions like motivating dedication and justifying necessary sacrifice, also creates unintended consequences when taken to extremes.

The superhero narrative, while well-intentioned, inadvertently:

- Obscures systemic problems by framing burnout as individual failure rather than system design dilemma
- Creates obstacles to legitimate boundary-setting by making it seem unprofessional to limit exposure to trauma
- Perpetuates patterns that unintentionally discourage the organizational changes needed

Healthcare leadership, with appropriate tools and frameworks, can help reshape the narrative: building on the legitimate inspiring aspects of dedication while adding new elements that recognize sustainable excellence, effective teamwork and mutual support, and continuous system improvement as hallmarks of true professionalism.

This reframing is not about reducing dedication to patients—it's about recognizing that sustainable, well-supported healthcare workers provide better care than exhausted, traumatized ones. Just as strict pilot duty-hour limits improved flight safety, acknowledging that clinician capacity has limits will improve patient safety.

9 The Path Forward: What Healthcare Leaders Must Do

9.1 Immediate Actions

Healthcare organizations can take several immediate steps without requiring massive system overhaul:

1. **Measure honestly.** Implement regular, validated measurement of workforce burnout, moral distress, and well-being. Make results transparent to leadership and boards.
2. **Build on existing efforts while expanding the toolkit.** Recognize that current individual resilience programs, while valuable, need to be complemented by organizational approaches. Start equipping leaders with the analytical tools to identify and resolve systemic conflicts that drive burnout.
3. **Launch "stupid stuff" initiatives.** Systematically identify and eliminate work that provides no value. Empower frontline staff to flag unnecessary requirements.
4. **Establish exposure tracking pilots.** In high-trauma areas (emergency departments, intensive care units, oncology), pilot systematic tracking of traumatic event exposure and test intervention thresholds.
5. **Create real processing capacity.** Provide structured, accessible, destigmatized resources for processing traumatic experiences. Build these into the workday, not personal time.

9.2 Medium-Term Structural Changes

1. **Redesign work.** Apply industrial engineering and process improvement methodologies to clinical workflow. Question every assumption about how work must be done.
2. **Implement team-based care.** Genuinely distribute responsibility and decision-making across teams, not as cost-cutting but as psychological load-sharing.
3. **Revise quality metrics.** Work with payers and regulators to eliminate or redesign metrics that generate moral distress without improving outcomes.
4. **Establish dose-based frameworks.** Develop evidence-based guidelines for safe levels of exposure to different types of psychological trauma. Create ALARA-equivalent programs.
5. **Tie executive compensation to workforce well-being.** Make leader accountability for workforce well-being as real as accountability for financial performance.

9.3 Long-Term System Transformation

1. **Advance organizational science.** Fund rigorous research on organizational interventions, measuring not just burnout scores but clinical outcomes, safety, quality, and cost.
2. **Develop industry standards.** Create healthcare-wide standards for psychological hazard protection, analogous to OSHA standards for physical hazards.
3. **Reform payment models.** Engage payers and policymakers to address payment structures that create impossible conflicts between financial viability and sustainable work.
4. **Transform education.** Prepare the next generation of healthcare leaders with systems thinking tools that enable them to expose and resolve structural conflicts.
5. **Change the narrative.** Actively replace the superhero narrative with one that celebrates sustainable excellence, mutual support, and functional systems.

10 Conclusion: From Managing Symptoms to Resolving Causes

Healthcare burnout is multifaceted, with numerous contributing factors including staffing shortages, EHR documentation burden, inadequate compensation, lack of autonomy, and poor leadership. This article has focused on a specific but critical subset: the psychological trauma, moral injury, and structural conflicts that arise when system constraints prevent healthcare workers from delivering care consistent with their values.

For these specific factors, the path forward is clear. The asymmetry between how healthcare organizations protect against physical hazards and how they fail to protect against psychological hazards reveals priorities. When organizations demand that radiation workers respect dose limits and provide elaborate systems to minimize exposure, they recognize organizational responsibility. When they expect healthcare workers to absorb unlimited psychological trauma and cope through personal resilience, they evade that responsibility.

Research demonstrates that organizational interventions targeting structural changes work better than individual resilience training for these factors. Treating occupational hazards systematically—with exposure limits, monitoring, engineering controls, and organizational accountability—protects

workers. Rigorous systems analysis can expose and resolve conflicts that seem intractable when left implicit.

These particular drivers of burnout persist not because people don't care or lack competence, but because healthcare hasn't yet equipped its leaders with the same rigorous, systems-level analysis and intervention approaches that are routinely applied to other occupational hazards. The tools exist. The knowledge exists. The economic case is clear. What remains is helping healthcare leaders discover and master these approaches—providing the analytical frameworks they need to recognize assumptions, understand narratives, calculate true costs, and redesign systems to protect workers from psychological trauma while meeting patient care needs.

Addressing burnout comprehensively will require parallel efforts on multiple fronts: improving EHR usability, ensuring adequate staffing and fair compensation, developing better leaders, providing autonomy and flexibility, and fostering supportive cultures. This article's contribution is to provide a specific analytical framework—systems thinking and conflict resolution—for addressing the subset of burnout drivers related to psychological trauma and moral injury, factors that have been under-analyzed despite their significant impact on healthcare worker well-being.

Taking Action

This article outlines the systemic nature of burnout. If you're a healthcare leader tired of applying individual solutions to what is clearly an organizational conflict, let's talk.

I help organizations apply these exact tools to redesign their systems. Contact me for a 30-minute consultation to map your organization's core conflict.

Common Sense Systems, Inc.
www.common-sense.com
john@common-sense.com
Telephone: 425-979-2282

About the Author

John Sambrook is the founder of Common Sense Systems, established in 1996, specializing in healthcare systems architecture and organizational redesign. With 30+ years as a software consultant and systems architect, former executive experience in medical device QA/QC/regulatory affairs, and extensive expertise in Theory of Constraints methodology (including personal mentorship from Eli Goldratt), John helps healthcare leadership diagnose and redesign organizational systems to resolve hidden conflicts that perpetuate chronic problems.

References

[1] Shanafelt TD, West CP, Sinsky C, et al. Changes in burnout and satisfaction with work-life integration in physicians and the general US working population between 2011 and 2020. *Mayo Clinic Proceedings*. 2022;97(3):491-506.

[2] Prasad K, McLoughlin C, Stillman M, et al. Prevalence and correlates of stress and burnout among US healthcare workers during the COVID-19 pandemic: a national cross-sectional survey study. *EClinicalMedicine*. 2021;35:100879.

[3] Han S, Shanafelt TD, Sinsky CA, et al. Estimating the attributable cost of physician burnout in the United States. *Annals of Internal Medicine*. 2019;170(11):784-790.

[4] Salyers MP, Bonfils KA, Luther L, et al. The relationship between professional burnout and quality and safety in healthcare: a meta-analysis. *International Journal for Quality in Health Care*. 2017;29(5):621-628.

[5] National Academies of Sciences, Engineering, and Medicine. *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*. Washington, DC: The National Academies Press; 2019.

[6] KLAS Arch Collaborative. Understanding and addressing trends in physician and nurse burnout 2024. 2024.

[7] Arndt BG, Beasley JW, Watkinson MD, et al. Tethered to the EHR: Primary care physician workload assessment using EHR event log data and time-motion observations. *Annals of Family Medicine*. 2017;15(5):419-426.

[8] Occupational Safety and Health Administration. 29 CFR 1910.1096 - Ionizing Radiation. US Department of Labor.

[9] US Nuclear Regulatory Commission. 10 CFR 835 - Occupational Radiation Protection. Code of Federal Regulations.

[10] US Nuclear Regulatory Commission. Regulatory Guide 8.29: Instruction Concerning Risks from Occupational Radiation Exposure. 1981.

[11] Occupational Safety and Health Administration. 29 CFR 1910.1030 - Bloodborne Pathogens. US Department of Labor; 1991, revised 2001.

[12] Dean W, Talbot S, Fokuo JK, et al. Moral injury in health care: a unified definition and its relationship to burnout. *Federal Practitioner*. 2024;41(4):104-107.

[13] Usset TJ, Baker LD, Griffin BJ, et al. Burnout and turnover risks for healthcare workers in the United States: downstream effects from moral injury exposure. *Scientific Reports*. 2024;14(1):24915.

[14] Connelly CD, Marino K, Groh C, et al. Moral injury and mental health in healthcare workers are linked to organizational culture and modifiable workplace conditions. *Frontiers in Public Health*. 2023;11:1245036.

[15] Dean W, Talbot S. Reframing clinician distress: moral injury not burnout. *Federal Practitioner*. 2019;36(9):400-402.

[16] Hupfeld M, Grommes K. Rethinking workplace well-being: individual-level interventions found to be ineffective. *Industrial Relations Journal*. 2024;55(2):178-195.

[17] Guseva Canu I, Marca SC, Dell'Oro F, Beque M, Zurcher K, Plessow R. Organizational interventions and occupational burnout: a meta-analysis with focus on exhaustion. *Scandinavian Journal of Work, Environment & Health*. 2023;49(7):462-472.

[18] Panagioti M, Panagopoulou E, Bower P, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. *JAMA Internal Medicine*. 2017;177(2):195-205.

[19] Reith TP, Sinsky CA, Brewer J, et al. Work overload triples the risk of burnout in health care. *Journal of General Internal Medicine*. 2023;38(5):1247-1254.

[20] Ashton M. Getting rid of stupid stuff. *New England Journal of Medicine*. 2018;379:1789-1791.

[21] Shanafelt TD, Goh J, Sinsky CA. The business case for investing in physician well-being. *JAMA Internal Medicine*. 2017;177(12):1826-1832.