Burnout among US health care workers is an increasingly recognized problem. General Social Survey data suggest that almost one-half of US health care workers experienced symptoms of burnout often or very often in 2022, up from less than one-third in 2018. The Chief Medical Officer of the Centers for Disease Control and Prevention has said that “burnout among [health care] workers has reached crisis levels.”

In recent years, this burnout crisis has accelerated alongside the COVID-19 pandemic and broader workforce trends. The percentage of workers, both inside and outside health care, reporting often having sleep problems increased between 2018 and 2022 (from 21% to 27% for health workers, from 22% to 25% for other essential workers, and from 21% to 24% for all other workers). This suggests that although health care workers have faced unique challenges during this period, there are other changes that have affected our whole society since the start of the COVID-19 pandemic.

Overall, US health care workers are now more burned out than they were before the COVID-19 pandemic. A national study of burnout in physicians by Shanafelt et al found that 63% of physicians reported symptoms of burnout in 2021, 38% reported burnout symptoms in 2020, and 44% reported such symptoms in 2017. Burnout is a problem not only because of the suffering of our colleagues and their families, but also because of the repercussions for the health care system. For instance, clinicians who are burned out are more likely to consider leaving the practice of medicine. In a national survey by Sinsky et al in December 2020, 1 in 5 physicians and 2 in 5 nurses reported intending to leave medical practice within 2 years, and 1 in 3 health care workers reported intending to reduce their work hours. Both reduced work hours and clinician turnover due to burnout have substantial financial repercussions, with physician burnout alone thought to cost the US health care system an estimated $4.6 billion per year. With the growing concern over health care worker shortages, the burnout crisis for health care clinicians is already likely contributing to a lack of availability of care for patients.

In this context, rigorous study of how to reduce physician burnout is essential. Meredith et al examined the efficacy of a military-developed, evidence-based intervention to help individuals navigate highly stressful situations. Stress First Aid is an easily deployable framework for engaging in self-care and peer support through actionable coping skills, resilience building, and healing. Meredith et al conducted a cluster randomized clinical trial by comparing the effects of the intervention vs usual care on a number of well-being measures, including posttraumatic stress disorder (PTSD) and psychological distress, for health care workers during the COVID-19 pandemic. Their survey-based study involved polling health care workers during the pandemic about symptoms of general psychological distress and PTSD before and after they received intervention support vs usual care (ie, no targeted support interventions). Although they found no treatment effect across the general study population, they found a clinically and statistically significant reduction in self-reported symptoms of both general psychological distress (approximately 4-point reduction on a 0-24 score; $P = .01$) and PTSD (approximately 7-point reduction on a 0-80 score; $P = .04$) in young health care workers (<30 years old) in federally qualified health centers after intervention training.

These findings are notable for 2 primary reasons. First, from a research methods perspective, this is an example of a rigorous randomized clinical trial used to study psychological outcomes and burnout among health care workers. Given the importance of the burnout crisis, we need to have the most possible confidence about the efficacy of interventions. Clinical trials are ideal to identify the...
causal treatment effect of interventions. The results of such trials are, thus, especially attractive to policymakers and health care leadership. The fact that these authors were able to conduct their trial in health care settings through the COVID-19 crisis is particularly commendable. Second, their findings highlight that workplace interventions in health care have the potential to make meaningful reductions in burnout and potentially lead to more robust and resilient health care institutions.

By using peer-based support to navigate highly stressful circumstances, Meredith et al highlight the importance of collegiality and mutual support in a cataclysmic crisis. On the basis of the results of their study, this may be especially meaningful for young health care workers who have yet to develop the most personally meaningful coping strategies, clinical confidence, and workplace community and networks that a longer career in health care may afford. Furthermore, as Meredith et al suggest, peer-based skills acquired through programs may be especially important to teach early and nurture throughout the arc of an individual’s professional career.

More broadly, the results from their study suggest that strengthening peer-peer interactions in the workplace offers a potential target for reducing burnout in health care. Others have similarly found that workplace relationships can influence burnout. For instance, when Nigam et al examined General Social Survey data, they found that the odds of experiencing burnout among those who felt their supervisors helped them were 26% that of those who did not feel their supervisors helped. Similarly, the odds of experiencing burnout among those who reported trust in their management were 40% that of those who did not. These results suggest that if burnout is affected by workplace dynamics, whether peer-peer or between employees and supervisors, then focusing on these relationships and the improved workplace culture that can result is an important potential target for reducing health care burnout.

Together, these results highlight that continued worsening of the burnout crisis in health care is not inevitable. Although systemic changes are likely required to reverse the trend, the results from Meredith et al and others highlight the potential role of workplace-culture interventions in starting to move the needle. As the authors suggest, organizational leadership may want to consider devoting resources for peer-based support initiatives to build workplace relationships and mitigate burnout. As we think about ways to help a generation of health care workers heal from the pandemic and its aftermath, focusing on peer-peer dynamics and workplace culture as the targets of intervention may be especially effective in reinforcing strong institutions, engaged health care workers, and robust community and collegiality in health care.


