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How COVID-19 changed frontline healthcare workers' experiences: A narrative inquiry into the impact of chronic burnout on a surgical physician assistant's wellness

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Abstract

Burnout is an occupational phenomenon resulting from unmanaged chronic workplace stress. Since COVID-19 started, burnout among healthcare workers has worsened and become a public health crisis. Wellness is about leading a physically, mentally, and spiritually healthy lifestyle to achieve one's full potential through positive affirmations. Its multiple dimensions include (1) physical, (2) emotional, (3) intellectual, (4) occupational, (5) social, and (6) spiritual. Extant empirical literature lacked regarding surgical physician assistants and how chronic burnout affected their wellness. This longitudinal narrative inquiry thus aimed to explore the perceived impact of a surgical physician assistant's chronic burnout during the COVID-19 pandemic on her physical, mental, and emotional wellness through her lived work experiences from the onset to the major surges of COVID-19 positive cases (2020, 2021, 2022). The study participant provided the researcher with her self-recorded personal journals of lived work experiences. The researcher organized and re-presented the narratives, applied thematic analyses to identify key dimensions from the narratives, and grouped them into positive-effect and negative-effect dimensions. Three positive-effect dimensions were (1) resilience and healthcare leadership competencies, (2) work support system, and (3) family-and-friend support system. Six negative-effect dimensions were (1) lack of federal leadership and coordination, (2) unhealthy work conditions, (3) caring for the critically ill, (4) inequity in work-location arrangements, (5) frustrated and angry patients and families, and (6) increased workload. Healthcare policymakers and industry leaders must pay immediate attention to the Quintuple Aim's 4th and 5th aims to address healthcare workers' burnout and wellness, and inequity within the healthcare workforce.

Keywords

Burnout, wellness, surgical physician assistant, workforce experiences, narrative inquiry

Introduction

Currently, more than 60,000 active surgeons provide patient care across the United States, while nearly 40,000 active surgical physician assistants work in operating rooms across the nation.¹⁻² A surgical team may comprise a surgeon, an anesthesiologist, a certified registered nurse anesthetist, a surgical physician assistant, an operating room nurse, surgical technologists, and at times residents or medical students.³ Approximately for every three surgeons in the United States, two surgical physician assistants work alongside them providing care for surgical patients.

The International Classification of Diseases' 11th Revision (ICD11) includes burnout as an occupational phenomenon, not as an illness or a health condition.⁴ According to the World Health Organization, not successfully managed chronic workplace stress can result in the burnout syndrome, including "feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to

one's job; and reduced professional efficacy."⁴ Since the onset of the COVID-19, burnout among healthcare workers has worsened, and the prevalence of burnout has become a public health crisis.⁵

Dr. Halbert L. Dunn introduced the concept of wellness in the 1950s.⁶ According to the National Wellness Institute (NWI), wellness "is a conscious, self-directed, and evolving process of achieving one's full potential"; "encompasses lifestyle, mental and spiritual well-being, and the environment"; "is positive, affirming, and contributes to living a long and healthy life"; and "is multicultural and holistic, involving multiple dimensions."⁶ Specifically, these multiple dimensions include (1) physical, (2) emotional, (3) intellectual, (4) occupational, (5) social, and (6) spiritual. Accordingly, surgical physician assistants' wellness is also multidimensional, involving their overall physical, mental, and emotional health.⁷ Furthermore, wellness of the healthcare workforce is also the 4th aim of the Quadruple Aim idea introduced in 2014. In response to the recorded and reported burnout among healthcare clinicians and staff, Bodenheimer and Sinsky called for

adding a 4th aim to the existing triple aims, which are to improve patient experience, improve population health, and reduce care costs.⁸ The 4th aim of the Quadruple Aim idea is to address clinician burnout and improve the work life of healthcare workforce.⁸

Past empirical research generally paid little attention to surgical physician assistants and particularly to their burnout and wellness. As a result, the extant empirical literature lacked in the understanding of whether surgical physician assistants' chronic burnout for three years during the pandemic had lasting impact on their physical, mental, and emotional wellness. Therefore, this longitudinal narrative inquiry was necessary and timely important because it might help fill some empirical gaps and provide some insights for improving health policies and healthcare managerial practices. Specifically, this longitudinal narrative inquiry aimed to explore the perceived impact of a surgical physician assistant's chronic burnout during the COVID-19 pandemic on her physical, mental, and emotional wellness through her lived work experiences from the onset to the major surges of COVID-19 positive cases, during 2020, 2021, and 2022. It sought to answer one research question: what is the perceived impact of a surgical physician assistant's chronic burnout during the COVID-19 pandemic on her physical, mental, and emotional wellness? Study findings may be informative to health policymakers and healthcare practitioners, professional credentialing and advocacy organizations, and governing body and executive leaders of healthcare organizations that employ surgical physician assistants.

Methods

This section will address the qualitative method used in this inquiry. First, it will explain the narrative inquiry approach and its applicability to this study. Second, it will describe the data collection and data analysis procedures. Finally, it will discuss the limitations related to applying the narrative inquiry approach.

Narrative Inquiry

The narrative inquiry approach is conducive for recording an individual's or a small group's lived experiences or perspectives, usually through journalizing or recorded interviews that are subsequently organized into narratives in a chronological order.⁹ These narratives could also reveal the world in which the individual lived.¹⁰ Researchers typically take four steps when applying the narrative inquiry approach: choosing a problem or phenomenon, selecting one participant or a small group of participants, collecting detailed textual data in narratives, and telling the story of that participant or small group of participants in a chronological order.¹¹ Therefore, such a qualitative inquiry approach can facilitate a deep exploration of participants' lived experiences and result in

better understanding of the problem or phenomenon under study.

Data Collection and Data Analyses

Relative to data collection, the study participant in this narrative inquiry recorded her own accounts of events as a surgical physician assistant providing frontline patient care from the onset of the COVID-19 to several major surges of COVID-19 positive cases, over three years: from January of 2020 through 2022. These narratives were in the form of personal journals. Some of the narratives were reports of the study participant's own lived experiences with her work life, while others were her personal reflections. The researcher collected the self-recorded narratives from the participant.

Relative to data analyses, first, the researcher organized the collected narratives into a sequential and meaningful way, and then re-presented the pronoun of the narratives from "I" to "Jane".¹² Second, she applied the thematic analysis method to identify key dimensions that emerged from the organized narratives.¹³ Finally, she organized the key dimensions into two groups: Group 1 represented positive effects on the participant's wellness, and Group 2 represented negative effects on the participant's wellness.

Limitations of Applying the Narrative Inquiry Method

This narrative inquiry presents three main limitations. First, the study participant's personal, professional, and academic background could affect her worldview, which could affect how she perceived her lived experiences.¹² As a result, the self-reported narratives could reflect her personal, professional, and academic biases. Second, the researcher's personal, professional, and academic background could also affect her worldview and thus influence how she interpreted the narratives during data analyses.¹² Finally, the findings of this narrative inquiry may reflect the collective biases, views, and stances of the study participant and researcher.¹⁰

Results

Jane had worked as a surgical physician assistant for 15 years. In the last 10 years, she had worked in the surgical department of an acute care hospital in California. She had been a lead PA-C in surgical services, performing procedures and providing preoperative and postoperative consultations and education. She had also been proctoring 1st and 3rd year family practice residents, and 2nd year surgical residents. She served on Enhanced Colorectal Bundle (ECRB, used preoperatively) committee for colon procedures, on Breast Cancer Team, and as a committee member and provider for Preoperative Optimization Program, Surgical Peer Review Committee, and Quality Review Committee. Prior to becoming a surgical physician

assistant, Jane practiced as a physician assistant in primary care, and in obstetrics and gynecology.

From COVID-19's onset in early 2020 to subsequent surges of positive cases over the next three years, Jane was a frontline healthcare worker caring for COVID-19 patients and her usual surgical patients. The following section presents her self-reported lived experiences in 2020, 2021, and 2022 in a chronological order.

2020, January-February: COVID-19 Onset

Jane remembered the palpable tension within her hospital, where she worked as a surgical physician assistant at the beginning of 2020. Although stress was a somewhat normal part of working in surgery, the tension within her organization and increased visible stress seen among her colleagues were not part of the everyday work environment. However, constant daily updates and hourly reminders about the virus known as COVID-19 or COVID for short, and its effects on the respiratory system leading to ARDS (Acute Respiratory Distress Syndrome), caused even the most stoic colleague to cringe, because of the awareness that an ARDS patient has a poorer prognosis requiring mechanical ventilation.

2020, March-April: First Surges of COVID-19 Positive Cases

In early March of 2020, hospital administration moved into the surgical department's conference room, setting up a command center to quickly develop surge plans for what was referred to as the Apocalypse. The tension mounted within the hospital because of the potential for shortages in ventilators, staff, and supplies, which was already being observed in parts of the world. Admittedly, Jane never thought she would entirely abandon her infectious disease training, because she and her colleagues were reusing personal protective equipment (PPE) and other disposable supplies as a result of PPE shortage. At that time, she and her colleagues were coming up with plans about how to extend the use of PPE and sterilize their N95 masks. Their plans included placing used PPE in paper bags, baking PPE in low oven at home, and keeping masks in sunlight after writing their names on masks in permanent marker. As the surgical stocks of PPE were taken and locked up, using plastic disposable shower caps for hair and shoe coverings became the realistic alternative. Then came the tents.

On March 17, the tents became the gateway to the hospital for patients and staff through different entrances. Screening temperatures were taken daily, and color-coded stickers were placed ID badges to wear as proof of screening, which changed daily. This was also Jane's first day working in the tents. She was deployed without any knowledge of what was yet to come and relieved a visibly stressed and shaken physician. The physician hurriedly said to her, "I'm glad you are here, I'm leaving..." Jane asked

what she was supposed to do in the tents, and the physician replied "I don't know. We are figuring it out as we go." Then the physician promptly left the tent. Jane was wearing two pairs of operating room scrubs, disposable operating room jacket, a plastic surgical gown, goggles brought from home, an N95 mask covered by an outer mask, disposable hair covering, and double gloves. Jane then proceeded to see the ill patients. She quickly triaged them, and ordered sputum tests as appropriate, then referred them to the appropriate departments such as urgent care or emergency department. Like something out of an old historical documentary which Jane had only seen on T.V., she did this for every patient, one after another. She kept thinking to herself: "Is there no end?"

The first patient whom Jane tested was an ill-appearing, older person in obvious acute respiratory distress. She quickly referred the patient to the emergency room. The patient tested positive for COVID, subsequently developed ARDS, and was placed on a ventilator. This was her first confirmed positive patient at the hospital. After this she triaged and tested a variety of COVID positive patients, including young pregnant patients, physicians, and nurse colleagues who all required ventilators.

The tents had opened the door to a whole new reality. Employees across her hospital, some Jane once admired, were now scared, and refused to see ill patients out of fear and yet others had unknowingly stepped up into leadership roles to treat the ill. The strength of the unsung leaders provided comfort and needed calmness for the staff and patients throughout the hospital.

April 2020 continued with daily surge changes, deployments, and updates to testing guidelines. The tents had become more streamlined, but their inside temperature had reached 120 degrees when Jane was wearing 4-5 layers, including a N95 mask and an outer mask, goggles, and the addition of a face shield. Sweating through her layers, dehydrated, and irritable, Jane was performing nasal swabs on her sick colleagues, friends, and droves of patients; and wondering if they would be the next ones to be vented. This was something she often thought quietly to herself while working in the tents because she needed to remain calm, appear strong, comfort the sick, and remain a leader.

During this stage of the pandemic, Jane received much support from family, friends, and the public. When leaving work, at times people were standing outside her hospital with signs of appreciation for the tireless work healthcare workers were doing. Certain stores were opening early for seniors, the immunocompromised, and healthcare workers. These early store hours helped healthcare workers tremendously, especially with reduced store hours during shutdowns.

2020, May-June: Drive-Through Care, Telecare, and Surgical Patient Care

In May 2020, Jane was told that she would be swabbing symptomatic patients via a drive-through in the back parking lot of the hospital. She was one of a handful of the hospital's employees who began providing drive-through care. At first, she had no place to sit or protection from the elements while still wearing full COVID gear, including shower cap coverings and the same N95 mask that she had been using daily. This situation went on for a few weeks, while Jane had trained other staff how to perform nasal swabs accurately and swiftly. After many real time discussions with administrators regarding the lack of protection from sun and rain and the lack of chairs, the drive-through operation was then moved into the parking structure, which included the addition of a chair and a portable sink to occasionally wash her hands. Once the drive-through testing site was up and running efficiently, the hospital's command center decided that Jane would best be utilized in other areas.

As the hospital began running out of resources such as ventilators, elective surgical cases were cancelled. With the hospital operating at capacity, Jane began providing telecare visits for COVID positive patients who were isolating at home. In addition, she provided telecare visits for her surgical patients. Within her hospital, the surgical department in which she was a surgical physician assistant was among the few departments that continued to function almost normally because of surgical emergencies and cancer patients.

In addition, Jane was also deployed to the hospitalist service to take care of the inpatient COVID positive patients. This deployment led to her taking care of the critically ill, which included her having a conversation with an ill patient then witnessing them decompensate requiring ventilator within minutes to hours, knowing many of these patients would not recover. Jane would never forget after witnessing the impact of COVID and the prolonged intubation including those patients requiring prone positioning and those patients with almost mummified skin because of prolonged prone positioning.

2020, July-December: More Surges of COVID-19 Positive Cases, Some Normalcy, and Emerging Burnout among Surgical Physician Assistants

Jane began to feel numb as 2020 progressed coupled with the surges of COVID positive cases. She realized she became distant from her clinician and non-clinician colleagues working from home because they could not understand what she was experiencing. She realized quickly that surgical specialties were often in charge of creating and implementing various strategies, while caring for the ill. She realized many providers were able to work from home providing phone care, while she was working

long hours in dreadful conditions, stressed out all day long. She had not repaired the relationships with her clinician and non-clinician colleagues as strained by the COVID, perhaps because she was still somewhat feeling numb. However, she was grateful to her department colleagues because they found a way to vent and discuss their concerns with one another.

In mid-2020, her surgical department began resuming some elective, non-emergent surgeries, such as those with symptomatic complaints. Patients could complete their preoperative visits via phone, which was her hospital's new approach resulting from COVID, and obtain a COVID test at her hospital's drive-through testing station. She believed this process and early adoption of resuming elective surgeries had helped significantly with the backlog of surgical cases. Toward the end of 2020 and early 2021, Jane observed a shift in her hospital's culture and outlook. Following a year-long battle of chronic stressors during the COVID in 2020, Jane saw a clear sign of burnout and frustration among the hospital workforce.

Meanwhile, as the pandemic continued, the public's support for frontline healthcare workers drifted off, while the public's frustration grew from the local governments' stay-at-home orders and mask mandates and the federal government's lack of support and clear communication. Despite this situation, Jane continued to provide surgical and non-surgical care to those in need, while experiencing increased stress, compassion fatigue, and exhaustion, which led to burnout. The public also seemed to increasingly underappreciate Jane and other healthcare workers.

2021-2022: Continued Surges of COVID-19 Positive Cases and Increased Burnout among Remaining Surgical Physician Assistants because of the Great Resignation

For Jane, working during the COVID-19 pandemic in 2021 and 2022 was challenging for different reasons. She saw many of her hospital's great nursing and support staff leave healthcare for jobs in other industries. She also witnessed a surge of physicians and surgeons retiring early because of the stress and burnout related to the COVID. As the world was recovering from COVID with intermittent surges, healthcare was attempting to revert to its life before COVID. This had resulted in burnout and what seemed like mild PTSD for frontline healthcare workers. Trained as a surgical physician assistant but playing many roles during the onset and through subsequent surges of COVID positive cases, Jane had become very exhausted but felt very proud because she was one of the few healthcare workers who remained on the frontline throughout 2020, 2021, and 2022.

As patients returned to scheduled and routine office visits, they showed frustration and anger toward healthcare

workers. Mostly of the anger resulted from long wait times such as a surgical backlog for elective cases of 3-5 months, lack of resources, and staffing shortages. Patients seemed to have already forgotten that healthcare workers had been working nonstop throughout COVID. Patients and hospital administrators seemed to have forgotten that healthcare workers had worked under tremendous pressure for three years while witnessing death and destruction, had not recovered physically, mentally, or emotionally, and had been doing the best they could.

Jane continued to wear masks including N95 masks for patient care, although without her full COVID gear. Although COVID positive cases at her hospital were declining, Jane continued to be numb and go about her daily routines of providing patient care. She knew that she was not alone in her experience and all frontline healthcare workers had similar stories. The prolonged pandemic had changed healthcare organizations and their workforce forever, and the pandemic will not completely disappear. Jane was hopeful that COVID had inspired some individuals to choose healthcare as a new or continued profession and prompted other individuals to become healthcare leaders of the future.

2020, 2021, and 2022: Support of Family, Friends, and Work Colleagues

Jane grew up in a family of writers. Her parents were newspaper editors and publishers. At an early age, Jane learned from her parents the importance of hard work and developed a strong sense of responsibility. Now retired, her parents continued to be Jane's strong supporters and cheer leaders. Jane's daily calls with her parents provided empathetic conversations, and their active listening to the hardships that she endured during the pandemic helped improve her emotional and mental wellness. Discussing work situations and surges with friends working in healthcare in different counties or states provided additional support and open communication needed to remain grounded and focused on the tasks and goals during the pandemic. Throughout the pandemic Jane and her colleagues at the surgical department often came together throughout the day to discuss their frustrations, sadness, experiences, and areas of hope. Such frequent, informal huddles improved Jane's emotional and mental wellness. The support and empathy that Jane received from her family, friends, and close colleagues were her main reason to continue providing quality care to her surgical and non-surgical patients, without succumbing to the Great Resignation.

Key Findings

Nine key themes emerged from Jane's self-reported narratives. Specifically, three themes represented important dimensions that had positive impact on the surgical physician assistant's physical, mental, and emotional wellness, whereas six themes represented important

dimensions that had negative impact on the surgical physician assistant's physical, mental, and emotional wellness. The forthcoming section will provide a description and discussion for each of the three positive dimensions and each of the six negative dimensions.

Discussion

Dimensions of Positive Impact on the Surgical Physician Assistant's Physical, Mental, and Emotional Wellness

Three important dimensions had positive impact on the surgical physician assistant's physical, mental, and emotional wellness. These three dimensions were (1) resilience and healthcare leadership competencies, (2) work support system, and (3) family-and-friend support system.

Resilience and healthcare leadership competencies

The first positive dimension was Jane's innate resilience and calm demeanors in times of chaos, as well as her healthcare leadership competencies developed through her many years of professional and academic training. Jane's physical, mental, emotional, and social resilience has enabled her to work through her physical exhaustion, mental stress, emotional pain, and social isolation and bounce back from the challenging events of her work life. Examples of the key healthcare leadership competencies that she possessed include accountability, achievement orientation, information seeking, analytical thinking, organizational awareness, interpersonal understanding, collaboration, and communication in writing and speaking. For example, in the early months of the COVID-19 pandemic, employees across Jane's hospital, including some whom she admired before, became scared in fear of their own safety and refused to see ill patients. During these critical times of urgent needs, Jane stepped up into the leadership roles to treat the ill, because of her leadership competencies in accountability, organizational awareness, and interpersonal understanding. The strength of the unsung leaders like Jane provided comfort and much needed calmness for the staff and patients throughout the hospital.

The work support system

The second positive dimension was Jane's work support system. Her colleagues at the hospital's surgical department supported one another during the severe shortages of PPE by brainstorming ways to sterilize PPE for reuses and make their own PPE using personal materials at home. When they felt burned out and frustrated, Jane and her department colleagues were also able to discuss their concerns and then find ways to cope with their challenging situations. Their daily huddles, often multiple times a day, provided them with a brief but much needed physical and mental time-off from their direct patient care duties and emotional support for one another. Jane's work support system helped her ease the burnout

level slightly and her decision to continue working as a frontline care provider during the pandemic.

The family-and-friend support system

Finally, the third positive dimension was Jane's family-and-friend support system. Jane's parents were both writers and retired newspaper editors. They instilled in Jane a deep sense of duty and inspired Jane to always strive for excellence from very early on. Their daily check-in calls with Jane during the onset and subsequent surges of COVID-19 positive cases were critical to help Jane stay focused on positive aspects of her patient care work and find some joy in her work. Furthermore, Jane's friends who were frontline healthcare workers in different counties or states provided her new perspectives on work conditions of frontline healthcare workers and additional moral support. Her frank and personal conversations with these friends regarding their work situations and experiences with surges of COVID-19 positive cases were much needed for her to remain grounded and focused on her work during the pandemic.

Dimensions of Negative Impact on the Surgical Physician Assistant's Physical, Mental, and Emotional Wellness

Six important dimensions had a negative impact on the surgical physician assistant's physical, mental, and emotional wellness. The six dimensions were (1) lack of federal leadership and coordination, (2) unhealthy work conditions, (3) caring for the critically ill, (4) inequity in work location arrangements, (5) frustrated and angry patients and families, and (6) increased workload because of the Great Resignation.

Lack of federal leadership and coordination as sources of burnout

The first negative dimension was the complete lack of leadership and coordination at the federal government level in the distributions of PPE, resulting in a near breakdown of the PPE supply chain in January through June of 2020. When Jane and her colleagues were brainstorming ways and then taking actions to extend the normal usable life of their scarce PPE supply and use personal materials to make their own PPE, they could have been taking care of their patients had the federal government demonstrated some level of leadership competence and coordinated the PPE distributions competently. The tremendous amount of time and energy spent in getting the necessary PPE to protect themselves while working as frontline care providers resulted in a high level of constant stress and anxiety that are ingredients of burnout, which could have been prevented.

Unhealthy work conditions as sources of burnout

The second negative dimension was Jane's unhealthy work conditions during the onset and early surges of COVID-19 positive cases. She often had no advance knowledge of

which frontline position of patient care she would be deployed to and no knowledge regarding the position's responsibilities. It was a chronic stressor to figure out her responsibilities quickly without any directions. The frontlines were like battle fields. Jane had to think and act quickly all the time. For example, when her hospital set up screening tents in the walkway of the facility buildings, she had to triage the ill patients quickly, one by one, almost nonstop, while wearing two pairs of operating room scrubs, a disposable operating room jacket, a plastic surgical gown, goggles brought from home, an N95 mask covered by an outer mask, disposable hair covering, and double gloves. She was still in such COVID-19 gear when the temperature inside the tents reached 120 degrees. Her work conditions were stressful and unhealthy and at times chaotic.

Caring for critically ill patients as a source of burnout

The third negative dimension was the physical demand, emotional exhaustion, and mental stress resulting from Jane's caring for the critically ill COVID-19 patients. Her emotional burden was particularly intensified when these patients were young pregnant women and her clinician colleagues (e.g., physicians and nurses) at the hospital. Tensions were mounting high in Jane's hospital, because the shortage in ventilators, ventilator operators, and supplies resulted in clinicians like her fighting for these resources in order to treat their critically ill patients. Such shortages lasted for months, and fighting for resources needed to treat the critically ill was time consuming, frustrating, and exhausting, leading to physical, mental, and emotional stress.

Inequity in work location arrangements as a source of burnout

The fourth negative dimension was the inequity in work location arrangements. Jane's hospital asked some of her clinician and administrative staff colleagues to work from home during the early months of the pandemic. Some of her clinician colleagues at the hospital were able to work from the comfort and safety of their homes by providing telecare to patients, while nonessential administrators also tele-commuted from the comfort and safety of their homes. As a result, these work-from-home clinicians and administrators did not understand frontline healthcare workers' constant concerns for their own safety because of the continuous exposures to the COVID-19 virus, and some of them made decisions that were not considerate for frontline care providers like Jane. This inequity in work location arrangements resulted in tensions among the workforce at Jane's hospital and was a chronic stressor for Jane for months.

Frustrated and angry patients and their families as sources of burnout

The fifth negative dimension was frustrated and angry patients and their families because of long wait time for

medical appointments and surgeries as a result of staffing challenges. As COVID-19 positive cases declined, Jane's hospital began to resume some normal operations. Her surgical department also resumed some elective surgeries. Because there was a personnel shortage throughout her hospital, patients and their families often had to wait for a long time at each point of interaction with the hospital's clinical and nonclinical staff, including admission, consultation, treatment, discharge, and check out. Frustrated and angry patients and their families often treated frontline care providers like Jane rudely and blamed these healthcare workers for their long wait time. Frequent poor treatment by frustrated and angry patients and their families was a chronic stressor for Jane physically, mentally, and emotionally.

Increased workload because of the Great Resignation as a source of burnout

Finally, the sixth negative dimension was Jane's much increased and often unpredictable workload. At the onset and early surges of COVID-19 positive cases, some of Jane's colleagues left their hospital jobs in fear of their own safety because of exposures to the virus. Most of them left the healthcare industry entirely to seek employment in other industries. As the surges of COVID-19 positive cases continued at her hospital, more clinicians became burned out, and some of them just quit abruptly or quickly decided to take an early retirement. This Great Resignation left a huge staffing vacuum for her hospital. As a result, Jane often had to work overtime and sometimes double shifts. She felt proud of her work caring for surgical and non-surgical patients but also felt numb. The increased workload and frequent overtime had taken a huge toll on her physical, mental, and emotional health.

Policy and managerial Implications

Several implications on health policies and managerial practices emerged from Jane's experiences as a frontline healthcare worker during the COVID-19 pandemic over three years (2020, 2021, and 2022). This section will present three implications for health policies and three implications on healthcare managerial practices.

Implications for health policies

First, findings of this narrative inquiry affirmed the urgent need to call for the 4th aim of the Quadruple Aim idea. The 4th aim is to address clinician burnout and improve healthcare workforce's wellness.⁸ The COVID-19 pandemic in the last three years has resulted in chronic burnout of the healthcare workforce, particularly among the frontline healthcare workers. Therefore, health policymakers should address the prevailing clinician burnout immediately, and take necessary actions to prevent acute burnout from becoming chronic burnout in order to improve clinicians' physical, emotional, intellectual, occupational, social, and spiritual wellness.

Second, findings of this narrative inquiry also affirmed the urgent need to call for the 5th aim of the Quintuple Aim idea. The 5th aim is for advancing health equity.¹⁴ Health inequity is not only prevalent in the general population but also present among healthcare workers. This is because the socio-economic status of healthcare workers parallels that of the general population. During much of 2020, 2021, and 2022, some healthcare workers were able to stay safe and healthy by providing telecare from the comfort of their homes; some did not have any safe work space at home when they had to work from home; and some had to be at their frontline posts every day to care for the ill, sometimes critically ill, risking continuous exposures to the COVID-19 virus. Therefore, health policymakers should address the prevailing health inequity among healthcare workers in the healthcare industry itself.

Finally, American Academy of Physician Associates has been a champion for the physician associate/assistant profession. It makes public announcements from time to time to expand the public awareness of the profession. Such professional organizations should increase their advocacy to healthcare provider organizations that employ physician associates/assistants. Examples include advocacy for representation of physician associates/assistants in organizational governance and executive leadership teams.

Implications on healthcare managerial practices

First, reducing clinician burnout and improving clinician wellness should be a practice of healthcare organizations' human resource management. For example, healthcare organizations can practice evidence-based staffing by removing the burden of double shifts from clinicians and limiting their overtime duration and frequency. Healthcare organizations can also provide several mandatory 15-minute breaks for clinicians on each workday, and clinicians can take these breaks either alone or with colleagues. Findings of this narrative inquiry indicated that huddles among colleagues who could speak frankly with one another provided mutual emotional support and helped reduce their burnout. Furthermore, evidence-based designs of healthcare facilities can help provide a soothing work environment and reduce the amount of time care providers spend walking, thus help prevent or reduce the burnout of healthcare workers, and improve their physical, emotional, intellectual, occupational, social, and spiritual wellness. User-friendly designs of electronic health records can also help reduce clinicians' documentation time thus help prevent or reduce their burnout.

Second, retaining healthcare workers should be the practice of every healthcare leader. In 2021, the top concern of the hospital CEOs across the United States was personnel shortages.¹⁵ In 2022, the top concern of the hospital CEOs across the United States was workforce challenges, an expanded category that includes personnel shortages.¹⁶ For some CEOs of healthcare organizations in

the United States, 2022 was the toughest year in their long career in terms of staffing challenges. Releasing healthcare workers from work during their normal work hours to participate in programs of professional development or leadership competency development can help improve employee engagement and succession planning for positions from senior executives to frontline care providers and thus help employee retention.

Finally, governing bodies and executive leaders of healthcare organizations should devise a leadership pathway for physician associates/assistants. This pathway will parallel with that for the medical staff and nursing staff of a healthcare organization. Surgical physician assistants perform surgical procedures and provide preoperative and postoperative care for surgical patients. Given the prevailing severe personnel shortage and that there are two surgical physician assistants for every three surgeons, healthcare organizations may consider utilizing their surgical physician assistants more efficiently by elevating their professional prominence.

Conclusion

In conclusion, the frontline surgical physician assistant's chronic burnout was a result of several main stressors. The stressors were lack of federal leadership and coordination, unhealthy work conditions, caring for the critically ill COVID-19 patients, inequity in work location arrangements, frustrated and angry patients and their families, and increased workload because of the Great Resignation. Such prolonged burnout has negatively affected the frontline healthcare worker's physical, mental, and emotional wellness. Nevertheless, personal resilience and leadership competencies, work support system, and family-and-friend support system helped ease the burnout level. This narrative inquiry thus answered the research question.

Healthcare leaders must develop their own leadership competencies in order to identify signs of burnout among their workforce and then take necessary actions in a timely manner to care for the caregivers who deliver direct care to patients. Surgical physician assistants show clear signs of burnout and frustration after fighting a prolonged battle of chronic stressors during the COVID-19 pandemic, which are not over despite what many people want to believe. The healthcare workforce's burnout and frustration has intensified by the Great Resignation. During the COVID-19 pandemic, many clinicians quit their jobs, often abruptly. Surgical physician assistants had to play many roles and often step in to perform duties outside of their clinical and administrative training. As a result, surgical physician assistants have become exhausted physically and mentally, numbed emotionally, and isolated socially. The surgical physician assistants who were among the few non-absent healthcare workers on the frontline

throughout 2020, 2021, and 2022 feel proud of their work in taking care of surgical and non-surgical patients during times of critical need. It is therefore up to the national, state, and local healthcare leaders to do their part to keep these resilient frontline healthcare workers by paying immediate and close attention to reducing burnout and improving wellness of the healthcare workforce as well as reducing inequity within the healthcare workforce in addition to improving patient experience, improving population health, and reducing cost of care.

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