BENEATH & BEYOND BURNOUT – SOLVING FOR CAUSES

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All authors shared in the development of concepts and content of this manuscript and have given final approval to the manuscript. There are no conflicts of interest, and no external funding was received. The manuscript word count is 4,390.

Keywords: burnout, trauma, moral injury, well-being, workforce, positive leadership

Introduction

While it may be comforting to believe that the chaos and challenges of the last few years are safely in the rear-view mirror as the COVID-19 pandemic recedes, unfortunately a new and more difficult chapter began for the healthcare workforce. The exhaustion, stress, trauma, and moral injury underlying what manifests as burnout remains unrelenting for many healthcare

workers, perpetuating a cycle of suffering and difficulty achieving caregiving aspirations that is poised to accelerate. This cycle leads to medical errors, disengagement, and potentially strained relationships between the workforce and health systems, causing talented, experienced healthcare professionals to leave their institutions or their chosen careers altogether.

The lack of meaningful impact on burnout, despite efforts to pull every conventional lever for improvement, clearly indicates that we must look at the systemic issues causing stress, trauma, and moral injury that underlie the more overt symptoms of burnout and attrition most health systems now monitor. Healthcare may be in a perfect storm, but an opportunity to evolve our systems of care delivery is in front of us. With awareness and leadership informed by what we know about drivers of burnout, we can re-design healthcare delivery with the goal of zero harm, not only to patients but to all who work within healthcare systems.

It is not just clinical professionals and staff who are caught in the vise of personal commitment to a job-well-done and the pressures they encounter. Health system leaders, too, suffer moral injury as they are caught between financial/market realities, the very real needs of the people they employ and the communities they serve. They are key contributors to, and victims of, the system design that causes injury. Fortunately, they can do something about it.

Our objective is to explore strategies that focus on understanding and responding to the drivers of burnout impacting staff and organizational performance. We advocate moving past problem solving, which can feel like whack-a-mole with little sustainable progress. Shifting and solving for cause demands a more holistic perspective and preventative approaches that are more systemic.[1]

To illustrate specific points, throughout this paper we will repeatedly share, in italics, the experiences of one of our authors to remind everyone of what it was like for individuals during the pandemic.

Experiencing the unexpected: *Before COVID, in November 2019 US healthcare systems experienced unusual delays in the supply chain; new equipment to replace non-functional*

equipment was not attainable for weeks at a time. This was a problem that would shortly become much worse. By January 2020, it was clear there was something going on in the world that would affect hospitals' ability to provide care to patients. Healthcare personnel nationally and internationally were communicating to share any acquired knowledge. By March 2020, the healthcare community began strategizing how to continue performing emergent surgical procedures, care for critically ill patients in ICUs, provide care for extremely sick medicine patients, let alone continue to perform elective but much needed surgical procedures. As time went on, patients stopped coming to the Emergency Departments for fear of getting COVID-19; even those who really needed care for conditions such as myocardial infarctions, congestive heart failure, and many others. When they finally did come to the hospital, they frequently had reached the point of no return.

Staff were in a panic in the beginning of the pandemic. Registered Nurses, patient care assistants, housekeepers, security, dietary techs, and staff from every other service were frightened to come to work because of family members with co-morbidities; and because they feared for their own and their loved ones' lives. After the first 2 weeks of COVID overwhelming the health system, as the staff left the hospital, there were church groups in the parking lot singing in support of their efforts.

Experiencing fear & isolation: *There was fear of death for individual healthcare professionals, as well as fear that, because of their frontline work, the virus would be spread to loved ones. The need to isolate from friends and family left them without a vitally important support system that could have helped mitigate the traumatic stress in routine times. It can be further traumatizing to be alone with one's trauma. And healthcare professionals are not formally taught how to deal with the emotions that were arising from this unprecedented disaster.*

Examining the Relationship between Trauma and Burnout

The physical or mental collapse caused by overwork or stress that exceeds an individual's ability to cope produces burnout; which is a serious problem. When these additional stresses

occur for an individual already suffering from trauma, burnout is much worse and recovery more difficult.

There are many definitions for trauma, but the commonality is being overwhelmed by experiencing too much of something that is distressing, coupled with not enough of something that is supporting or resourcing. Shock, developmental, and transgenerational trauma change the brain's pathways and perception of threat; and stress hormone activity keeps physiologic systems in fight, flight, freeze, or collapse *as though trauma is happening in present time—even if the primary trauma experience has ceased*. This occurs in brain areas below conscious awareness but continues long after the inciting event or events have subsided until the trauma is recognized and resolved.[2]

Healthcare professionals have been overwhelmed by accumulating work-related stress, vicarious trauma, and secondary traumatic stress. Additionally, challenging early life events have significant downstream effects as shown in The Adverse Childhood Experiences (ACEs) studies, conducted by Dr. Vincent Felitti.[3] And some healthcare professionals have had their own buried early life trauma re-triggered by events associated with the pandemic. These individuals may be at increased risk of subsequently developing Post Traumatic Stress Disorder (PTSD) during times like these.

Healthcare professionals who have experienced traumatic stress during the pandemic may appear to be functioning largely as they did before the pandemic. However, many are experiencing regular PTSD symptoms that look and feel more like they did at the height of the pandemic: anxiety, depression, insomnia, inability to concentrate, substance use, loss of interest in things that previously brought joy, or many other symptoms of distress. And they may be unaware of the source of these changes or what to do about them, thus causing further distress.[4] Physician burnout has increased from the early days of the pandemic to late 2021 and early 2023, even though many aspects of clinical care have eased.[5]

Experiencing trauma firsthand: *Every single day there were tears, struggles, CRNAs being used as nurses, buddies to assist with increasing nurse-to-patient ratios, and lots of hugs. As time went on you could see the strain the staff were enduring. Many were asking for prescriptions for sleeping pills, consuming alcohol, or overeating, and some were exercising or working in flower beds. But very few were seeking counseling or any form of evidence-based, trauma-informed therapies. There were feelings of betrayal by the organization for not providing appropriate support at times.*

Experiencing Lack of Resources & Support. *Shortages of supplies and PPE left them feeling isolated and as though the organization did not "have their back." There was disbelief that at times leadership was "calling it in" rather than providing the necessary support by being physically present; and were therefore indirectly asking that the clinical professionals put themselves in harm's way in a manner that other leadership did not. The lack of trust negatively impacted teamwork, engagement, innovation, and ultimately, patient care, thereby causing more trauma to an already stressed patient population. Trauma impacts relationships, and traumatized people can traumatize others inadvertently.*

The role of moral injury is a relatively recent addition to the causal family of burnout and trauma. Moral injury is defined as "the strong cognitive and emotional response that can occur following events that violate a person's moral or ethical code," where "potentially morally injurious events include a person's own or other people's acts of omission or commission, or betrayal by a trusted person in a high-stakes situation"—a frequent experience for healthcare workers during the pandemic.[5]

For all, and especially those individuals already dealing with post-traumatic impacts, the moral injury experienced after the onset of COVID-19 heightens the pain. While PTSD is associated with fear of a threat to life, moral injury is a psychosocial, spiritual wound felt in response to violations of one's beliefs or values. The very real actions driven by the pandemic resulted in multiple instances of moral injury. A common example during the pandemic is the emotional toll

taken by the volume of death, particularly the unexpected mortality experienced in younger age groups. Healthcare professionals who are trained to save lives and generally do, often internalize this degree of loss of life resulting in feelings of helplessness, distress, guilt, and inadequacy over the lack of control when interventions did not change the course of the illness, despite providing exceptionally good care.[6],[7] Feelings of sorrow, regret, shame, a deep sense of betrayal, alienation, and isolation may manifest. It hits at the core of self-perception. Suddenly the person in the mirror is unfamiliar.[8]

Experiencing Moral Injury in Daily Work: *The need for care was monumental, but the bandwidth and resources for that specific kind of care were finite, leading to excessive clinician to patient ratios with all the related downstream impacts. There was the vulnerability of constant process change, disruption of teams with people placed in circumstances of providing care outside their level of expertise in what was exceedingly challenging physical and emotional work. The overwhelming need meant that they could not always maintain previous standards of care delivery, despite their best efforts and due to circumstances far beyond their control.*

Those on the frontlines of care who are struggling are at risk of long-term suffering and more persistent burnout if nothing changes. While COVID-19 is no longer dominating lives as it did in 2020 and 2021, burnout persists and appears to be getting much worse. The most recent survey of 29 specialties, with data collected from 13,069 respondents, was conducted in the last half of 2021, and showed six specialties reporting burnout at 50% or higher. Burnout increased by 5% from 2020 to 2021 for both men and women. When asked if they were experiencing more, the same, or less burnout than during the COVID-19 quarantine, 50% of men and 60% of women said more. The survey also examined burnout in other professions: Nurse burnout registered at 64%, with the next most impacted profession – police officers – at 59%. A quote from one respondent is indicative of how many feel: “I’m grumpy and unpleasant to be around. I don’t care about anyone anymore; I don’t care about my hobbies anymore.”[9]

Some of the rise in burnout can likely be attributed to the cumulative challenges faced by healthcare workers across multiple COVID-19 waves. However, the rate of increase is also due to trauma and moral injury and burnout experienced by healthcare professionals prior to the crisis of the pandemic. Healthcare organizations are not immune to this damage. They have also been traumatized and are struggling to regain a sense of normalcy. The eruption of articles in the past year attacking the moral failings of health systems – initially seen as heroic pillars of public health and social good as recently as 2020 – highlight a belief among many healthcare workers about corrosive focus on profit. This profit focus has infiltrated the most sacred aspect of the healing profession, the relationship between healthcare professional and patient, and the time it takes to build and nurture that healing relationship.[10],[11],,[12]

At an operational level, exhaustion, stress, and trauma translate into increased medical errors, recruitment and replacement costs, service closures due to lack of staff and other problems. Bringing in new staff, whether new graduates or travelers, creates additional challenges in teamwork, mentoring needs and process reliability. We owe all who served, at every level, a debt of gratitude for their selfless service in the face of a global pandemic, complicated at times with environmental disasters. To assume they will continue serving selflessly is folly.

If we simply proceed without wisely discovering the sources of burnout and systematically making substantive changes, we are willfully choosing to ignore the opportunity to reduce the harm our people experience, support our injured brethren, and improve system-wide performance as a result. Many of the systems through which healthcare is delivered today were never designed for the current environment but rather evolved from a different era or intervention to solve other challenges. We believe a fundamental paradigm shift is needed regarding what health systems look like and strive to accomplish today.

Journey to Healing in the Workplace

Our answer to the question of what leaders want their organizations to become is a Healing Ecosystem: a new paradigm where work and the workplace is a source of wellness, meaning

and purpose, connection and relationship, accomplishment, pride, and a sense of agency.[13] Value is produced by the people who perform the work, deliver the care, and keep the organization operating. When we think about organizations as ecosystems – complex networks of interconnected systems – we must think holistically rather than focusing on each work system independently.[13] Focusing strategically on creating a workplace that works for everyone is the best way to ensure long-term success. These are the characteristics to design for while adapting your operational model. In such an organization achieving the quadruple aim of improving patient experience, outcomes and clinician experience while reducing cost is within reach.

Every ecosystem has multiple components. We believe four are the most important in transitioning from today's healthcare workplace to a more desirable and healing future. They are Leadership, Structure, Climate, and Individuals/Teams that are focused – first and foremost – on producing healing for patients and for the workforce, as the fundamental organizational priority.

Leaders are the driving force in how an organization operates. As a leader, the first question to ask is "How do I lead?" A simple, yet profound question. Follow that with an interrogation of the factors you consider and prioritize in decision-making. Ask yourself if those considerations are consistent with building a sustainable, high-performance organization that attracts and retains high quality people.

When thinking about Structure, look beyond the buildings, space, equipment and technology to the policies, rules, and expectations that define how people do their work. Challenge how those elements support a work environment that respects and cares about both patients and the people dedicated to caring for them. Bricks and mortar, technology and policy were all put in place "once upon a time" by someone and can be re-imagined by leaders today.

The Climate of the organization – the emotional temperature people feel within the ecosystem and inside their own work area – is largely the outcome of how leaders lead and the structures they establish and maintain. Climate, opposed to culture, is experienced directly every day.

Finally, Individuals have their own traits, aspirations, experiences. Teams throughout the organization are made up of individuals and their behavior is largely a response to the explicit and implicit cues they receive from the Climate, Structure, & Leaders.[14]

Below are two stories that clearly describe this chain reaction and clarify the importance of re-thinking how we, as leaders, contribute to the burnout we deplore.

Experiencing cumulative moral injury: #1 *In the midst of all the turmoil & lack of support the staff felt, the CFO/CNO made the decision to change the medication dispensing machines in the middle of COVID, throughout all 3 hospitals. This decision was implemented despite them having been warned that the bandwidth was absent for the support needed for such a consequential system-wide endeavor. This was enough to make the staff lose their trust in what we do as a Leadership Team. They wanted to know we had their backside. By implementing the new Pyxis system, contravening the stated clinical concerns, we put major stress on an already stretched work force. It took endless hours to set up, reconstruct, and locate places for the Pyxis. Not only that, but the continuous delay in medications for the patients, and the education and training the staff had to do, was stretching their limits of remaining calm. When medications were not available the Pharmacy Director set up the Pyxis to tell them where to go to get the medication. It may have been one or two floors up or down or all the way to the ground floor where the Pharmacy is located. This went on for months!*

#2 *In August of 2021 we lost seven ICU COVID-19 patients all under the age of 45 between 6:30am & 12:30pm. What a day that was for all involved! The nursing staff throughout the hospital were literally having emotional meltdowns with the loss of each patient. So as the VP/CNO I stepped in to assist with the final codes on seven patients for whom the staff had provided care for weeks. I prepared their bodies for the family viewing and eventually for*

transfer to the morgue. The Critical Care staff at this point said, "I will not go back to the morgue and deal with the fact the lift does not work to get the patients up to the second level." I was told on the 9am morning call with the leadership team that the morgue lift had been fixed. I had to tell them in the utmost polite way that I would like for someone from Plant Operations and Security to come with me today because it is "not fixed!" It had been broken for months and staff were using their bodies to hoist the patients on the top. The moral injury was deep and gut wrenching. The nurses blamed themselves for the loss of lives daily and were lashing out about simple things that should have been fixed. As the VP/CNO I constantly reinforced the great job all of them were doing. I did not ask them to do anything I would not do myself.

How might an organization that saw itself as a Healing Ecosystem prevent the experiences described above? There are many small, but impactful, changes leaders can make that amount to progress on shifting the ecosystem toward healing. Applying what is known about treating and reducing trauma's long-term impact is just beginning in work settings – likely brought about by the systemic trauma experienced during the pandemic. The Great Resignation, "quiet quitting" and other issues are frequently in the news, causing leaders to rethink their workforce strategies. Much current focus is on burnout and the need to address "toxic culture" to boost employee retention.[15] Data on health care professionals leaving the industry, the rise in suicides exacerbate the situation for healthcare leaders – many of whom are still dealing with financial challenges.

A few analytic reports of limited size can be found that examined how trauma informed leaders act and tactics that could be employed.[16, 17] Reflection of lived experience and thoughtful design and implementation of micro-reactions – one unit or department at a time – provides lessons learned which may be customized and deployed. Our hope is that these lessons may be assessed systemically and broader, leader-owned strategies employed. A few tactics are clearly fundamental, at all levels.

Seeing employees first and foremost as people, individuals with their own stories and lives and not just as FTEs, is paramount. Even in times when leaders don't have all the answers and are afraid of the unknown, getting out in front, telling the truth as they know it can calm fears, even their own. Staff are smart – they know tough things are happening and can tell when truth is not being told. When leaders clearly communicate commitment to their people – not the amorphous staff, but the people – within the organization that they are with them; it makes a difference.

Leaders who aspire to make the workplace one of healing think through how they communicate with colleagues in all functions and at all levels. They assess how actions and decisions create an environment for sustainable success, and what their behaviors and interactions with others message to the organization. Leadership teams can practice active listening to each other – verifying what they heard – before moving on. Humans in general want to be heard, regardless of their role or station in an organization, listening is invaluable and is the only way to accomplish this.

Acknowledging the extraordinary effort staff expend to continue to provide the best possible care under trying conditions is important. People need to see that leadership has their backs. A coach may stay on the sidelines – but in a struggle for the soul of the organization the leader must be on the field. Further, leaders must take care of themselves. Leaders have suffered moral injury along with everyone else, trying to balance fiscal realities that make hard choices a daily occurrence. When leaders and staff are one team, all do better. These are things leaders can do.

As leaders strive to address the trauma being experienced individually by many, they struggle to develop new approaches to address the evolving challenges being presented. Increasingly leaders are being faced with adaptive challenges which are characteristically complex, long standing, with solutions not found within the existing system.

With trauma-informed leadership, leaders not only role model behaviors throughout the organization but use this perspective in decisions informing organizational structure. A greater

sensitivity to operations leads to making both short- and longer-term decisions that consider the effect on the people they lead and how they communicate and implement decisions. Openness to consider alternatives can begin to shift the structure in meaningful ways.[18] Complexity calls for adaptive leadership, shifting thinking to include multiple downstream impacts, not least of which is on the workforce. Ronald Heifetz in his seminal work on leadership describes the special skills leaders need to address these adaptive challenges in their work today.[19],[20]

Including balancing measures for both business and well-being in the organization's performance scorecard supports this approach. A decision to implement a major structural change – such as a Pyxis – when staff who must adapt to a new system are holding on by their fingernails would not be made as it was in the example above by trauma-informed leaders, who are seeking to heal rather than induce further trauma for their workforce through narrowly-constructed imperatives for operational change. Similarly, system and process weaknesses would be proactively identified and repaired so staff don't have to compensate for system failures.[18]

The perceived chasm between clinicians, whose first loyalty is to their patient, and administration – who are seen as being consumed by the business side of healthcare – [10][11][12] can be closed by choosing to partner more closely with clinical leaders. Working side-by-side, credibility of both will improve and the partnership sends an important message to all.

Involving those who work within the system, especially clinicians, in decisions, communication and implementation planning will improve the quality of decisions and outcome. In addition, by understanding the contribution of trauma and moral injury to today's burnout crisis, attention can be given to incorporate elements that acknowledge and de-stigmatize individuals' feelings and needs for support. Including questions about attitudes towards well-being in new hire interviews, re-thinking performance reviews to focus on well-being and post-traumatic growth as much as grading employees and providing additional training to managers to help them markedly amplify positive feedback and recognize how trauma manifests can make a

significant difference. Tactics such as offering more money, a midday well-being lecture, access to a fitness center, etc., do not address and will not overcome the toxic work situations healthcare workers experience. Evidence-based and effective ways to address injured and burnt-out individuals, without stigma, and to prevent further damage are available.

These relatively simple modifications are not expensive and, in the aggregate and over time, will moderate the climate for those within the ecosystem of care – staff, patients and family alike. It will allow breathing room, reduce the stress-level and the moral injury that have been a part of too many interactions. Well-designed well-being initiatives that lead to de-toxification of the workplace and taken seriously by leadership create and sustain a climate supportive of the people who give and receive care. As the climate improves and people once again feel cared about and cared for, respected, appreciated, and connected to the organization and each other, trust returns. Trust in self, colleagues and the organization is foundational to engagement, returning joy to the workplace and a return to leaning into work rather than leaving it altogether.[21]

For those on the journey to high reliability, work towards 200% accountability – where staff are 100% accountable for their own best practices and 100% accountable for their colleagues' best practices – encouraging teamwork and looking out for each other.[22] Many organizations are working on implementing Just Culture, reducing blame, and building accountability. People respond to the signals they receive from their environment. When they feel leaders "see" and respect them, when systems and structures reflect an appreciation for them as individuals and offer appropriate support, they regain confidence and resilience.

While many in the healthcare workforce are asking for increased pay, significant research has shown that compensation is marginally correlated with job satisfaction and that most workers prefer greater meaning at work.[24] The quality revolution, begun nearly 35 years ago, taught us that work process design and improvement needed to be informed by those who did the work to achieve sustainable high performance and results. The tyranny of urgency often causes us to

act now on the immediate issue, frequently with ideas designed in the boardroom rather than in the workplace, rather than taking time to understand the ground from which they emerged. Many people believe healthcare is the most complicated industry in the world, and we are not doing much to make it simpler.[25] If workplace toxicity is tempered and it is clear efforts are being made towards a positive, caring, and supportive work environment staff can experience a liberating sense of security;[23] which can in turn mitigate the effects of trauma.

Final Thoughts

People who are burnt-out may want to perform at their previous high level, but they need significant help and, in some cases resuscitation or rescue, to be able to do so. Continuing to look at our organizations as functions, departments and hierarchies that produce X value at Y cost will continue to get the results we are now seeing: suboptimal performance with worsening workforce burnout and disengagement. Instead, applying a paradigm that starts shaping the organization in a different way can mean that those who work within it feel pride, ownership, and partnership in providing the very best care they can to the patients who depend on them. The suggestions above are ones that can be made by leaders' decisions, are for the most part not resource intensive. Rather, they involve changes of mindset, orientation, and assumptions about where we should focus over the coming decade, and they can make a big difference. Other needed actions are more substantive and require more investment. For example, providing system wide education about trauma and moral injury including effective ways to address both will help people understand their own situations and encourage them to get the help they need. This is important and will take considerable time. Engaging healthcare workers in helping to redesign structural elements to achieve both high performance and positive workplaces will deliver benefit for all.

GIGI IS GOING TO WORK ON SOMETHING LIKE THIS TO BE INSERTED BEFORE FRIDAY PM.

The preponderance of work in trauma to date has focused on war-related PTSD, ACEs … very little in the workplace and even less in healthcare settings. The smart thing to do is to honor the work that has been done in these areas and extrapolate the lessons learned and understand how to best apply those lessons in a professional environment to include with clinicians and staff… Those lessons have to do with honoring / respecting the experience and pain of those traumatized, taking the time to authentically hear their stories, etc… And while the work setting isn't therapy, we have (in the writing above) identified actions that can make a difference.

Leaders who understand the importance of trauma-informed leadership and attention to workforce thriving as a new way of achieving system excellence can and should raise these issues beyond their own organizations and work to create and fuel a movement to address the systemic issues within which today's healthcare industry struggles.

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