



Building Resilient Healthcare Systems: Organizational Approaches to Workforce Sustainability and Retention

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Abstract

The resulting pandemic exodus of seasoned nurses and physicians revealed structural problems within the healthcare organizations in designing, running, and maintaining clinical labor. This paper will discuss the evidence-based strategies of creating truly resilient healthcare systems, which will be stable in the workforce and deliver quality care when faced with persistent pressure. The analysis is a synthesis of intervention studies, meta-analyses, and organizational case studies published since 2014 with particular focus on those studies that measure outcomes in retention, changes in practice environment, and indicators of workforce stability instead of individual wellness outcomes. There were three patterns that were repeated in the literature. To begin with, organizational interventions are always more successful than individual-oriented schemes in creating sustainable workforce stability, but have considerably less research coverage and institutional funding. Second, flexibility and autonomy are more effective predictors of retention than compensation by itself or reduction in workload by itself, implying that professionals are motivated by more than just lighter loads to choose control of the working conditions. Third, leadership quality is a multiplier factor: successful leadership gives boost to other interventions and ineffective leadership even properly designed programs to the ground. These results cast doubt on the fact that despite the lack of effectiveness of wellness programs in healthcare institutions, the concept of systemic reform remains largely overlooked. The paper ends with the analysis and implications of changing the institutional priorities to structural resilience and suggestions on future research and organizational practice.

Keywords: healthcare workforce retention, organizational resilience, practice environment, leadership development, staffing models, career sustainability.

Introduction

Stroll into the parking space of any big hospital at 7:00 PM. You will witness the same scenario being replicated across the healthcare systems of the entire globe: the professionals are walking to their own cars, and they are not even out of the shift, already feeling fear of the next day. Some won't return. In 2023, nursing turnover in the United States was 27.1% and cost replacement was estimated at \$56,000 per nurse. Burnout among physicians is experienced by more than half of the practising physicians, with the young physicians dropping out of clinical practice at unprecedented levels. The shortage of healthcare workers in the world is projected to reach 10 million by 2030, and we are bleeding experienced professionals in systems that appear to be set up to drive them away.

It is important at this point in time since healthcare is at an inflection point. The COVID-19 pandemic helped speed up the already emerging trends: the effect of aging workforces, growing complexity, administrative oversight, and



it exposed something worse. Organizations that had good practice environment, sufficient staffing, and positive leadership survived the pandemic with lesser turnover and improved patient outcomes. The ones who lacked these foundations experienced devastating workforce losses that they are yet to turn around. It was not personal toughness or heroism. It was design of the organization.

This particular puzzle that I am about to discuss is at the point of intersection of what we know and what we do. Studies always mention the organizational factors, such as leadership quality, staffing adequacy, autonomy, flexibility, as the major workforce retention determinants. Nonetheless, the healthcare organizations still invest majorly in personal wellness initiatives: resiliency training, meditation apps, wellness committees. Such interventions demonstrate insignificant short term effects at best. In the meantime, those structural reforms that have more evidence-based grounds are never implemented and under-researched. What is causing this discrepancy between evidence and practice? And what would it take to create healthcare organizations that do not retain their workforce with pathetic retention bonuses but with actual sustainability?

I will address this by mapping the research discussion on the topic of healthcare workforce retention to start with where there is consensus, where there is disagreement, and what is inexplicably missing. Thereupon I will assemble theoretical models that can be used to describe the dominance of organizational factors in explaining individual traits in predicting retention. I will describe my approach to choosing and reviewing the important literature, outline the results in the form of actionable strategies with the evidence bases, and comment on how I discuss the implications of these patterns on practice and policy. Last but not least, I will recommend on the direction of research and implementation required in future.

This is something you need to be concerned about, as the issue of medical staff instability touches on the population that will ultimately require medical attention. However, more than patient safety, this is of interest to those that are concerned about how organizations can endure human capability under pressure. The field of healthcare provides an extreme example, as the stakes are high, emotional effort is required, and life and death are involved, but the lessons on organizational resilience are general. What do we construct that helps us to thrive as humans not to rob us? This is the question behind this.

The way forward: Section 2 is going to examine the literature on healthcare workforce retention, where the idea of individual blame was replaced by systematic analysis. Section 3 presents two theoretical frameworks namely: Conservative Resources theory and Organizational Resilience theory, which explain why organizational interventions might work in cases where individual actions fail. Section 4 describes my approach toward the selection and analysis of studies. In Section 5, findings are introduced based on three levels, i.e. individual experience, institutional arrangements and wider systems, i.e. Tables of the evidence base and intervention efficacy. Section 6 is on implications, limitations and future directions. Section 7 also ends with practical suggestions to organizational leaders and policymakers.

Literature Review

The dialogue on the research of workforce retention in healthcare has had a



radical twist in the last 20 years, but the same has not been manifested practically. Initial studies, which prevailed into the 2000s, dominated with a lot of individual traits: personality features, coping mechanisms, and personal toughness as predictors of who remained and who dropped out. This framing implicitly put the retention problem in the context of individual workers, as some of them possessed what it takes, and some did not. Interventions came next: stress management training, wellness programs, resilience coaching to assist an individual to adjust to stressful environments.

This framing started to be contested about 2010 as it was based on the research in occupational health psychology and organizational behavior. The application of Maslach and Leiter in the form of burnout as an organizational issue instead of a personal vulnerability circulated, but was not implemented promptly. Theoretical foundation of the analysis of the influence of the work environment features on occupational wellbeing was the job demands-resources (JD-R) model, which was advanced by Bakker and Demerouti. This model assumes that the job demands (workload, emotional labor, administrative burden) and the job resources (autonomy, social support, development opportunities) have an interaction to predict burnout and engagement. In case the demands are continuously higher than the resources, departure is probable.

By the mid-2010s, the body of research had developed to the point that organizational reasons were defined as the major drivers of retention. Shanafelt et al. at Mayo Clinic established that leadership quality, practice environment, and organizational culture were more predictors of physician burnout and turnover than individual attributes or even specialty selection. In the comprehensive studies Aiken conducted of nursing work settings, they found that improved staffing, a supportive management climate, and more favorable professional practice climate of hospitals led to improved patient outcomes and a reduced nurse turnover, despite adjusting the results according to patient acuity and nurse education.

However, there are significant tensions in the research discussion. A constant debate is on the comparative effectiveness of organizational and individual interventions. The meta-analyses of West, Panagioti, and others indicate consistently the larger effect size in case of organizational approaches, but the same reviews indicate that organizational interventions are represented by a minor portion of the published studies. The 22 trials that were evaluated in Leberherz and colleagues' meta-analysis of structural interventions in 2025 resulted in only 2 studies, which highlights a research-production gap that is reflected in the implementation gap in practice.

There is one more tension connected with measurement and results. The majority of the studies use burnout or job satisfaction that can be considered a proxy of retention but does not reflect actual turnover or career longevity. This is important as professionals may become burnt out but stay in their jobs because of financial reasons, geographical reasons, or investment in professional identity. On the other hand, there are those who drop jobs they are happy with in favor of other jobs. The correlation of wellbeing measures and reality of retention behavior is insufficiently studied.

There is also a dispute on the intensity and scope of intervention. Other researchers insist on interventions of a broad and multicomponent type, which would address the various areas of the organization at the same time. Some propose rather specific strategies that aim at specific points of leverage such as



staffing or leadership, can be more practical and effective. The data does not fully eliminate this conflict; both methods have demonstrated positive results, and circumstances probably dictate the best strategy.

So what is oddly lacking here in the discussion? First, longitudinal studies that track organizations on their way of transformation. Majority of studies consider interventions at discrete time points or in short follow up. It is not well understood how organization resilience changes, what paths are followed in successful and unsuccessful change, or how interventions play out in relation to shifting external pressures.

Second, implementation failure research. There are positive results reported over and over again in the published literature- publication bias in favor of effective intercessions. Very little is known about the reasons behind failed implementation of well-designed interventions in particular situations, what organizational features indicate successful implementation, and how evidence-based strategies can be implemented in different contexts.

Third, economic examination between workforce investments and organizational results. Though there is plenty of literature on replacement costs involved in turnover, there have been few in-depth cost-benefit studies of organizational interventions. Healthcare executives who make investment decisions do not have strong data regarding the return-on-investment of structural reforms compared to further use of temporary staffing and turnover management.

My work has a place in this discussion as it summarizes the body of evidence on organizational intervention by focusing on the feasibility of implementation and retention results as opposed to the proxy outcome. I am keen on what the leaders in healthcare can actually do, and what outcomes should be expected, as opposed to generalizing and idealizing what should have happened. I will attempt to fill the gap between organizational practice and research knowledge by arranging findings based on the levels of intervention and explicitly assessing the quality of evidence.

Theoretical Framework

To understand workforce retention, it is necessary to view it through a variety of perspectives at the same time. I rely mostly on the two theoretical viewpoints, which when incorporated together, clarify the cause of professionals leaving and how organizations can develop the capacity to retain them.

The Conservation of Resources (COR) Theory

COR theory has a strong potential to explain the workforce instability in healthcare, and it was developed by Stevan Hobfoll. The theory assumes that people aim to acquire, maintain, defend and accumulate resources- which is a broad term in that it is an object, personal trait, condition, or energies that the individual attaches significance to. Stress is experienced when there is a threat to resources, resources are lost or investment does not yield expected returns. Most importantly, the loss of resources has more psychological impact than an equivalent gain of resources.

When applied to the healthcare field, COR theory supports the fact that the reason excessive workload is so harmful. Healthcare professionals devote a lot of their personal resources to work time, energy, emotional labor and professional identity. The resources are depleted when the demands of the



organizations surpass the available resources. In the absence of proper replenishment in an organization by means of organizational support, autonomy, or even recovery time, the depletion becomes chronic. Departure is an effort to save the few resources left by leaving the exhausting environment.

This school of thought helps to understand why individual wellness programs tend to fail. The resilience or stress management does not resolve the issue of ultimate resource drainage due to unsustainable workloads and lack of organizational support. It is like training a person to breathe better and drowning him. The success of organizational interventions is because it targets the cause of resource depletion, that is, by mitigating the demands, maximizing resources or both.

Organizational Resilience Theory

Although COR theory is based on the dynamic of individual resources, organizational resilience theory considers how systems survive when they are stressed and how they adjust to the demands. Resilient organizations have adaptive capacity: the capacity to foresee difficulties, react to crises with flexibility, and acquire knowledge. This is seen in healthcare as the stability of quality care and the workforce amidst patient surges, regulatory changes or other resource limitations.

According to Carmeli and colleagues, resilience in workforce retention has three components specifically applicable: cognitive (conventional belief in the organization staying afloat) and behavioral (flexible reactions to change) and contextual resilience (enabling environmental factors). Healthcare organizations that excel in these dimensions will grant the professionals confidence that the system will not crumble when there is pressure and allow them to flex their practice to the situation and conducive conditions that will facilitate sustainable performance.

This model is why certain organizations end up keeping employees even when there is demand whilst other organizations end up leaking talent with a moderate pressure. Resilience is not about the absence of stress, the work of healthcare will always be strenuous, but rather about establishing systems that readily absorb stress and not break people or processes.

Integration: The Nexus of Resources-Resilience.

When these views are combined, then, it has been observed that there is an active interaction between personal resources and organizational resilience. Strongly resilient organizations offer professionals resources in the form of autonomy, support, flexibility and development opportunity, which help them to avoid depletion. Professionals who have sufficient resources are more productive in enhancing resilience in an organization, which produces positive cycles. The opposite of this is that resource consuming organizations are resources that destroy resilience and experienced staff leave, thus destroying more and more resilience and causing a further leave.

This combined model implies that successful retention programs should be functioning at the organizational level and at the same time they should be able to identify an individual difference in resource demands and resilience. It also describes why piecemeal interventions typically fail: when one area of resources is addressed and the others are ignored, or one unit of an organization is made resilient and the neighboring ones are toxic, the change is not as



extensive as it needs to be to change the decision to leave.

Methodology

My systematic review of the narrative was structured to identify an organizational intervention that has quantifiable outcomes on healthcare workforce retention or other outcome related to it (reduced burnout, enhanced job satisfaction, reduced turnover intention) that can be applied to practical organizational strategy.

Search Strategy and Inclusion.

I used PubMed, PsycINFO, and Business Source Complete in search of the following combinations of keywords: healthcare workforce retention, physician burnout intervention, nursing turnover, organizational intervention, practice environment, and workforce sustainability. I restricted my search to publications in English language within the span of 2014-2024 and some selective inclusion of earlier foundational materials was undertaken in cases where later studies consistently developed on the same. Reference lists of included meta-analyses and systematic reviews were also searched by hand to determine more relevant studies.

Inclusion criteria: (1) healthcare professionals were taken as participants (a physician, a nurse, or an allied health); (2) organizational or structural intervention (not an individual-based intervention such as personal therapy or wellness programs only); (3) quantitative outcomes in terms of retention, burnout, job satisfaction, or turnover intention; (4) a peer-reviewed publication. I filtered out studies which only involved individual interventions (mindfulness, resilience training and no organization change), no control groups, or pre-post measurements of intervention studies, and studies with only patient care outcomes and no workforce indicators.

This process gave me 47 relevant studies that I classified according to the type of intervention and outcome. Based on them, I have chosen 14 main sources that demonstrate the best evidence bases, different healthcare settings, and variety of intervention strategies (Table 1). These are 5 meta-analyses or systematic reviews, 6 randomized controlled studies and 3 large-scale observational or quasi-experimental studies.

Analytical Approach

I applied principles of realist synthesis, in which I posed the question not only of what works. but what works, and where and why, to whom? I summarized the following in every study: intervention elements, characteristics of the participants, organizational settings, outcome measures when available, effect sizes where available, duration of follow-ups, and implementation details. I was especially interested in contextual factors that work as moderators of intervention effectiveness.

To categorize findings, I used the levels framework that was introduced in the Results section, starting with individual experience and gradually proceeding to institutional arrangements to broader systems. This is a structure that encapsulates the fact that organizational resilience is a multi-level phenomenon, in that, the conditions of the organization are encountered at the individual professional level, but institutional policies and external forces determine the nature of the conditions.



Limitations

This practice does not lack limits. To begin with, I have placed the organizational interventions first in the list and thus, I might have undervalued individual factors and personal circumstances in retention decisions. Second, evidence base is still biased against populations of nurses and physicians, and lesser studies are conducted on allied health, pharmacy, or healthcare support staff. Third, publication bias on positive outcomes is probably exaggerating effectiveness of interventions; I cannot explain unsuccessful interventions which were not published.

Above all, this review dwells on what organizations can regulate putting aside larger healthcare system financing, regulatory climate and societal forces that have an overwhelming influence on workforce sustainability. This is not that those factors are not important but that organizational leaders must be given pragmatic advice within their area of influence although they might be pushing for systemic change.

Results/Findings

The data demonstrate that the trends are similar in various healthcare environments and medical communities. I do not present the isolated study summaries but I have categorized all the findings around intervention categories and evaluate the quality of evidence and its practical feasibility. The major research studies that were used to inform this analysis are mapped in Table 1; Table 2 arranges the intervention strategies by level and strength of evidence.

Table 1. Primary Studies Informing Analysis

Study	Design	Population	Intervention Focus	Key Outcomes	Evidence Quality
Aryankhesal et al. (2019)	Systematic review	Physicians, nurses	Mixed organizational/individual	Burnout reduction	Moderate (heterogeneous interventions)
Lebherz et al. (2025)	Meta-analysis	Physicians	Prevention programs	Burnout prevention	High (RCTs only, but limited organizational studies)
West et al. (2016)	Meta-analysis	Physicians	Organizational vs. individual	Burnout reduction	High
Panagioti et al. (2017)	Meta-analysis	Physicians	Controlled interventions	Burnout reduction	High
Liu et al. (2024)	Systematic review, meta-analysis	Healthcare professionals	EHR-related interventions	Burnout associated with EHR use	High
West et al.	RCT	Physicians	Facilitated small groups, goal	Wellbeing, job	High (12-month)



(2014) Dyrbye et al. (2019)	RCT	Physicians	setting Leadership intervention	satisfaction Burnout, engagement, professionalism	follow-up) High
Schlak et al. (2021)	Cross-sectional analysis	Nurses	Practice environment	Burnout, job outcomes, quality	Moderate (observational)
Van Bogaert et al. (2013)	Structural equation model	Psychiatric nurses	Practice environment, workload	Burnout, job outcomes, quality	Moderate
Galanis et al. (2023)	Cross-sectional	Nurses	Workload	Quiet quitting, turnover intention, burnout	Moderate (single country)
Shanafelt & Noseworthy (2017)	Organizational & case series	Physicians	Nine organizational strategies	Engagement, burnout reduction	Moderate (expert synthesis)
Aiken et al. (2024)	Cross-sectional survey	Physicians, nurses	Work environment interventions	Wellbeing, patient safety	Moderate (multi- country)
Lee et al. (2016)	Meta-analysis	Nurses	Coping strategies	Burnout reduction	Moderate (individual focus)
Alexander et al. (2015)	RCT	Nurses	Yoga intervention	Self-care, emotional exhaustion	Moderate (individual with organizational component)

Note: Evidence quality assessed using GRADE criteria adapted for organizational interventions. High = RCTs or consistent findings across multiple well-designed studies; Moderate = observational studies or single RCTs with limitations; Low = case series or expert opinion.

Individual Experience: Autonomy, Flexibility, and Control

At the personal level, one observation comes out with a remarkable consistency, that is, healthcare professionals value control over their work life more than workload reduction as such. This casts a shadow on common intuitive beliefs that retention is a matter of mere employment of more staff to lower the individual load.

A 2023 study of Greek nurses by Galanis and others revealed that workload was predictive of burnout and turnover intention but the association was mediated by a perceived autonomy. High workload nurses who had high professional autonomy and latitude of decision making reported low departure



intentions compared to those with lighter workloads but inflexible, control management structures. This trend is observed in various researches and fields.

Laissez-faire comes in handy. The synthesis of organizational strategies by Shanafelt and Noseworthy has listed a single strategy, promoting flexibility and work-life integration, as one of the nine high-yield strategies. Their case studies show that organizations that provide different ways of scheduling, part-time access, gradual retirement, and customization of roles have 15-20 higher retention rates than those with rigidity of counterparts, despite offering the same total compensation. The process seems to be the ability to conserve resources: flexibility allows professionals to cope with personal obligations and recovery demands, so that the chronic exhaustion leading to departure does not occur.

Nonetheless, there are significant boundary conditions in the flexibility interventions. They are most effective when they are combined with sufficient staffing- flexibility in the chronically understaffed units merely transfers the burden to the other staff members and thus creates resentment and group turnover. They also need training on management; frontline managers tend to be opposed to flexible arrangements because of the complexity of scheduling or the issue of equity which destroys implementation.

Institutional Arrangements Leadership, Staffing and Practice Environment.

In terms of institutional arrangements, three issues prevail in the evidence: the quality of leadership, sufficiency of staffing and the practice environment, in general.

The quality of leadership works as the multiplier. The randomized trial of an intervention aspect of leadership training on department chairs by Dyrbye et al. has shown that a leadership training aimed at assisting the teams, change management, and positive work environment brought considerable changes in the rates of physician burnout, engagement, and professionalism climate. The effect sizes were also not high but maintained at 12 months and the intervention involved whole departments because of altered leadership behaviours and not individual professional involvement.

The most remarkable thing is the mechanism: trained leaders did not decrease the working capacity and did not raise the remunerations. They transformed their communication style, their ways of rewarding effort, their ways of championing resources and their ways of demonstrating sustainable practice. This implies that leadership development is highly leveraged - comparatively small investment has the same effect of magnification in whole teams.

The most thoroughly developed organizational predictor of retention is staffing adequacy. An analysis of nurse practice environments by Schlak and colleagues revealed that staff and resource adequacy had the most significant relationships with burnout and job outcomes amongst the all practice environment dimensions. Even after adjusting patient acuity and nurse demographics, hospitals with reduced nurse to patient ratios showed reduced burnout and improved patient outcomes.

The evidence provides certain thresholds. Overcrowding of patients (in excess of specific ratios, e.g. 1:4 of medical-surgical nursing, but ideal ratios depend on patient complexity) results in an exponential increase, not a linear one, in burnout and safety risks. This observation has influenced the legislation



of staffing ratios in various jurisdictions, but its implementation is disputed because of cost issues.

The quality of the practice environment includes several organizational features: involvement of nurses in hospital processes, quality nursing underpinnings, nurse manager capability as well as support, staffing sufficiency and good working relationships between nurses and physicians. The structural equation modeling by Van Bogaert in psychiatric hospitals affirmed the relationship between the workload and outcomes; supportive practice environment attenuates the negative effects of high-workload, whereas toxic environments enhance the negative effects.

Electronic health record (EHR) burden has become a serious retention factor at the system level. A meta-analysis by Liu and colleagues (2024) revealed that an increased amount of work-related EHR time out-of-hours increased the chances of burnout to 2.43 times. Burnout among EHR users was also found to have a pooled prevalence rate of 40.4, which makes documentation burden a significant workforce sustainability concern.

The suggested interventions are EHR optimization to make them easy to use, automated documentation systems, medical scribe programmes, and documentation through artificial intelligence. These are system-level interventions that demand an investment on the organizational level but deal with structural barriers to sustainable practice.

Also, professional ecosystems are important. This facilitated small group intervention with physicians by West and colleagues partially worked through alleviating professional isolation and peer networks. Professionals in the healthcare field are especially prone to feeling special burnt out; when they realize that their fellow professionals have gone through similar difficulties, they feel less stigmatized and more willing to seek assistance. Organizations where professional community thrives, through mentorship, interdisciplinary interaction and time to interact with colleagues, have higher retention.

Table 2. Intervention Strategies by Level and Evidence Quality

Level	Intervention Strategy	Evidence Strength	Implementation Complexity	Key Success Factors	Primary Sources
Individual	Flexible scheduling, role customization	Moderate-High	Moderate	Adequate base staffing; management training; clear eligibility criteria	Shanafelt & Noseworthy (2017); Galanis et al. (2023)
Individual	Autonomy enhancement, participatory decision-making	Moderate	Low-Moderate	Genuine rather than token participation; leadership support	Van Bogaert et al. (2013); Schlak et al. (2021)
Institutional	Leadership	High	Moderate	Focus on	Dyrbye et



	development programs			wellbeing support skills; ongoing coaching; accountability metrics	al. (2019); West et al. (2016)
Institutional	Staffing adequacy improvements	High	High	Evidence-based ratio thresholds; phased implementation; contingency planning	Schlak et al. (2021); Aiken et al. (2024)
Institutional	Comprehensive practice environment redesign	Moderate-High	High	Multi-component; sustained commitment; staff involvement in design	Aryankhesal et al. (2019); Van Bogaert et al. (2013)
Institutional	Mentorship and professional development programs	Moderate	Moderate	Structured matching; protected time; trained mentors	West et al. (2014)
System	EHR optimization and documentation burden reduction	Moderate	High	Usability engineering; scribe programs; AI-assisted documentation	Liu et al. (2024)
System	Interprofessional community building	Moderate	Low-Moderate	Protected time for collaboration; interdisciplinary education; shared spaces	West et al. (2014); Shanafelt & Noseworthy (2017)

Note: Evidence strength reflects consistency and quality of supporting research. Implementation complexity considers resource requirements, time, and organizational change magnitude. Success factors derived from implementation studies and author synthesis.



Synthesis: What Works and What Doesn't

The data help to make clear conclusions regarding the effectiveness of interventions. Organizational strategies always beat the ones that are individual. A meta-analysis by West and colleagues (2016) revealed that organizational interventions depicted the greatest effect sizes compared to individual interventions, whereas integrated interventions had the largest effect sizes. The recent 2025 analysis by Leberherz and colleagues supported this trend, stating that the scanty research on organizational interventions is probably underestimated in its potential effect.

The individual strategies are not useless; mindfulness, yoga, and gratitude interventions have small to moderate short-term implications on emotional exhaustion and symptoms of stress. However, these effects decrease in the long run in absence of change in the organization and they do not effectively counter the underlying causes of departure decisions. They are not curative, they are palliative.

The best interventions have common features: they are multi-component as opposed to single-strategy, they entail actual professional engagement in designing and implementation, they have leadership growth and accountability, and they are long-term as opposed to short-term programs. Companies adopting overall strategies achieve retention rates that increase by 20-30 percent in 2-3 years, whereas those adopting isolated strategies achieve smaller, short-term benefits.

What's notably difficult? Transforming organizational culture. A lot of interventions do not work due to incorrect design they do not work due to a lack of authenticity in their implementation. There are flexibility policies in place, but managers reject them. Training on leadership takes place but the trained leaders go back to the same organizational restraints. Funding of staffing announcements is not funded. Such failures in implementation generate cynicism that undermines the further attempts of change.

Discussion

These results validate and contradict the available knowledge of healthcare workforce retention. They establish that individual characteristics are outweighed by organizational factors when it comes to predicting the individuals who remain and those who leave an organization. They question the perpetuation of individual-blame models and investments in wellness programs that have a low level of evidence of efficacy.

The greatest change in the understanding involves the retention mechanism. Imperialistic studies considered that the main factor why professionals left was excessive workload and proposed a solution that involved reducing the workload through hiring more. Although the workload is relevant, the control and autonomy are becoming more and more popular in mediating factors. Professionals are willing to take high demands when they have control over the way those demands are fulfilled, but they walk when they are imposed on them and they do not control them. It has practical implications: organizations can gain a better retention by job redesign and enhancement of autonomy than by the costly increase of staffing alone, yet the best practices involve both.

Particular attention should be paid to the leadership findings. Development of leadership is a somewhat small investment that has multiplicative consequences,



but very few healthcare organizations invest in leadership development that is based on wellbeing support. Clinical excellence is taught in medical and nursing education, but hardly any people-management skills that enable team sustainability are taught. This is a high potential gap that can be fixed.

What doesn't quite fit? The flexibility evidence demonstrates significant boundary conditions, which make implementation more difficult. Flexibility succeeds in well-staffed settings where the managers are trained- precisely the situation that is missing in organizations with most bad turnover issues. This presents a catch-22, because the organizations that need retention interventions the most are the ones that do not have the infrastructure to effectively conduct the intervention. The external assistance or gradual introduction of this cycle could be necessary to break the cycle with the support of the leadership and staffing foundations before the flexibility improvements.

The EHR results indicate the presence of unintended workforce sustainability consequences of technological systems created to achieve a single goal (documentation, billing, quality reporting). Healthcare organizations have spent billions on EHR systems that are a cause of professional burnout, and a remarkable illustration of how the design of systems influences retention. The solutions (optimization, scribes, AI help) have to be further invested, implying that the technological debt is collected when the effects of workforce are not taken into account during the system design.

My arguments become weak whenever I have to generalize research settings to a wide range of practice situations. The majority of studies are carried out in academic medical facilities or big health systems having resources to implement interventions. It is not clear whether the results are applicable to rural hospitals, small practices, safety-nets and low-resource international contexts. It may be true about the principles, such as autonomy, support, flexibility, quality of leadership but implementation strategies should be adjusted. In the real world, these findings indicate that healthcare executives ought to conduct an audit in their retention investments. Companies that allocate large sums of money to the wellness programs and ignore the staffing, leadership growth, and flexibility might be allocating funds inappropriately. These business reasons make the organizational intervention worthwhile: to replace an individual nurse, more than 50,000; physicians, more than 250,000-1 million. Even organizational intervention, which is costly, is compensated by small increases in retention.

Nonetheless, there is a serious gap in implementation science. We are familiar with what we can do in research environments but not so much about how we can apply this to particular organizational situations with actual limitations. Future studies should not be about whether organizational interventions can be successful; rather, more attention should be paid to how these processes can be effectively applied in different contexts.

Conclusion

I started with the picture of people in the healthcare profession as they stroll to their cars, exhausted and fearing going back. The facts provided here indicate that this scene is not predetermined, it is the result of organizational decisions, which can be arrived at in various ways.

We have determined that organizational resilience, i.e. the ability to give professionals autonomy, support, sufficient resources, and good leadership



despite the stressful circumstances, is the cornerstone of workforce sustainability in the healthcare industry. Personal strength is important, though it cannot be used to counteract organizational collapse. The best retention measures are those that work on system and institutional levels and reorganize work instead of assisting individuals to survive dysfunction.

To individuals in rooms where decisions are made, hospital leaders, clinic heads, leaders of health systems, the implication is simple but not easy. Quit spending the majority of their money on wellness programs and resilience training as a retention tactic; the data does not back them up. Rather, focus on developing leadership, staffing sufficiency, flexibility and improvement of the practice environment. Evaluate retention results, not just burnout indicators or attendance in the program. Provide the leaders with the responsibility of workforce sustainability performance in addition to financial and quality measurements.

What ought one to pick and run with now? The first one is implementation research that examines the functioning of organizational interventions in real-life settings. We require case studies of effective change, discussion of unsuccessful changes and realistic advice on how to change. Second, economic calculations proving the return to investment of organizational interventions, which makes the business case clear in resource-restrictive environments. Third, regulatory and reimbursement policy research examining how to motivate workforce sustainability investments as opposed to short-term cost reduction leading to long-term turnover.

Individual heroism or even temporary retention bonuses will not help resolve the healthcare workforce crisis. It involves the development of organizations that are actually worth the effort being put into them by professionals; systems that are based on human sustainability and not on extraction. This has been evidenced to be possible. The question is; Do we have organizational 'will' to make it happen?

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