Chapter 21 Creating a healthy work environment and worker wellbeing

Anthony Montgomery[1] & Olga Lainidi[2]

1. Northumbria University, Newcastle, UK

2. University of Leeds, Leeds, UK

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Abstract

Modern healthcare is characterised by increasing levels of job burnout, anxiety and depression among healthcare workers. Moreover, COVID-19 has exacerbated an already difficult situation resulting in extra problems concerning retention and a resistance to return to workplace. The accumulated evidence on employee well-being indicates that only 'whole organization' approaches have the potential to successfully address this significant public health challenge. Unfortunately, the inability to create healthy workplaces is rooted in the significant lack of experience in genuine interdisciplinary collaboration between the relevant scientific fields (i.e., public health, architecture, occupational health, ergonomics, nutrition, etc.). In this chapter, we outline the main developments in the research topic, evaluate the theoretical and practical value of research to date, identify the gaps in the field, delineate the next steps for human resource management, and chart the way forward in the field.

Keywords: worker well-being, healthy workplaces, burnout, quality of care, patient safety

INTRODUCTION

Hospitals are organizations under considerable stress. This is not surprising when one considers that healthcare professionals are expected to handle structural changes and technical developments, are required to be accessible, provide holistic patient-centered and patient-managed care, develop their own evidence-based competence and achieve an appropriate balance between their work and private life (Montgomery et al, 2013). Put simply, staff well-being moderates the relationship between organizational health and the quality of health care delivered (Cox and Leiter 1992; Teoh and Hassard, 2020). Hospitals are populated by a range of professionals, both medical and non-medical, and the stressors/strains experienced by healthcare professionals are a combination of patient-driven demands and the organizational factors specific to the hospital environment. The hospital environment will be the main focus throughout this chapter, but allied healthcare organizations will also be reviewed when examples and evidence are warranted.

The accumulated evidence indicates that healthcare professionals, especially in developed countries, are reporting higher rates of sickness absence, burnout, and distress compared to other sectors (Edwards and Burnard, 2003; Lee et al, 2012; Ruotsalainen et al, 2008). Healthcare worker well-being, patient outcomes and organizational change are symbiotically linked (Montgomery and Maslach, 2019), meaning that protecting and improving the well-being of healthcare professionals is crucial to the delivery of care and patient outcomes. For example, there is call to move from the triple aim (improving patient experience, patient outcomes, and efficiency) to a `quadruple aim', with the inclusion of improving healthcare staff well-being (Bodenheimer and Sinsky, 2014).

Creating healthy work environments in hospitals and allied healthcare organizations involves us moving the focus away from a physician-centric approach towards one that asks what can be done for the modern healthcare setting to support all workers in healthcare to thrive. The latest OECD report on *Skills for the Future Health Workforce* notes that the landscape of health services delivery needs to undergo a

significant transformation, from specialist and disease-centered care delivery systems toward value-based and people-centered models of care (Maeda and Socha-Dietrich, 2021). This is a response to the challenges presented by ageing populations with multiple chronic conditions and complex care needs as well as the changing expectations of patients, their carers, and communities, which will mean a greater emphasis on involving patients through shared patient-provider decision-making about care (Prince et al, 2015). This movement towards people-centred care will demand greater attention to broader aspects of patient care that extend well beyond bio-medical conditions and require attention to psycho-social conditions and other aspects of patients' lives (OECD, 2019). Thus, we have the possibility of a continuing mismatch between the skills of healthcare professionals and the changing demands of healthcare delivery that requires specific interpersonal skills, such as patient-centred communication and inter-professional collaboration, and will give rise to higher rates of worker attrition (Levi et al., 2004) and new ethically challenging issues (Ulrich et al., 2010). Thus, increasing rates of burnout, anxiety and depression seem more likely going forward.

WHAT ARE THE MAIN THEMES IN THE RESEARCH ON THIS TOPIC

Healthcare professionals are under increasing pressure to continuously improve the quality of care in environments that are not naturally designed to contribute positively to either the health of their employees or to the recipients of care (Montgomery and Maslach, 2019). Expecting health professionals to deliver safe, efficient and patient-centered care, while they are getting more and more burnt-out, is not only ineffective but also costly and dangerous (Panagopoulou, Montgomery and Tsiga, 2015).

Burnout and poor well-being are often used interchangeably, but we have to be careful in conflating them together, as the two have different causes, symptoms, and potentially differing consequences (Hall et al, 2016). Burnout is considered mainly as an occupational phenomenon (see Table 1 for Key Facts about Burnout), while poor well-being is broader and is often characterized by symptoms or diagnoses of mental illnesses (e.g. depression), high levels of stress, and/or a reduced quality of life. However, the nexus between the two is highlighted by recent research showing that, for example, social stressors at work influence marital behaviors at home (Plutt et al, 2021).

Worker well-being is broader and more varied than burnout, but in the present chapter we will be mindful of this difference and discuss burnout as a springboard to a wider discussion of employee well-being, quality of care and organizational culture in healthcare (Panagopoulou and Montgomery, 2019).

There is a symbiotic relationship between healthcare workers' well-being and patient outcomes. Burnout is driven by small, burdensome, chronic events that erode the spirit of healthcare professionals – even more when it comes to frontline nurse or staff in Emergency Rooms. Burnout is associated with risky health behaviors (e.g. physical inactivity, alcohol misuse) that have been implicated as factors contributing to medical errors and inadequate patient safety, as well as to healthcare professionals' lack of health promotion activities directed toward patients (Alexandrova-Karamanova et al, 2016). Creating a healthy work environment in healthcare begins with genuine interdisciplinary collaboration by the relevant scientific fields (i.e., public health, architecture, occupational health, ergonomics, nutrition, etc.,) on building healthy workplaces (Montgomery & Lainidi, 2023).

More specifically, this section will review three themes that are of crucial importance to creating healthy workplaces in healthcare; (1) the way that health workers engage in performance protection strategies to mitigate the impact of stress and burnout, (2) the persistent focus on individual strategies and the avoidance of a wider organizational approach to well-being, and (3) the fact that many behaviors that contribute positively to quality of care (e.g., procedural and emotional caring) are likely to go under the radar.

An under-researched area in the literature is the way that healthcare professionals maintain performance during stressful conditions. For example, there is some evidence that even when staff lack mental or physical energy (Demerouti, Bakker and Leiter, 2014) they use "performance protection" strategies to maintain high priority clinical tasks and neglect low priority secondary tasks (such as reassuring patients) (Hockey, 1993). Moreover, there is evidence that employees with burnout are able to perform tasks adequately, applying high-effort strategies while they experience much strain during task performance (Van Dam et al, 2013). Within healthcare, the clearest example of this phenomenon is the existence and frequent use of 'work arounds', whereby staff develop creative solutions to resource and/or staff shortages (Lemaire et al, 2014). Thus, it appears that healthcare staff 'keep going' and the negative effects are felt at a later time. Congruently, with between 55 and 98 per cent

of nurses reporting that necessary patient care work remains undone in the end of their shift due to lack of time and resources (Jones, Hamilton and Murry, 2015), it becomes clear that during a typical workday, both nurses and doctors might often experience psychological distress due to the need to ration care. There is a psychological toll that comes with having to ration resources, transfer patients out of area owing to bed pressures, suspend vital services and see waiting lists grow longer (Beale, 2021). The gap between what our healthcare workers need in order to enable their optimal performance and the reality of what they actually do to maintain quality of care is significant – as is evidenced by increasing levels of burnout. Self-care equals safe care, but it is not happening as burnout and the associated mental health problems are not dealt with until a tipping point is reached. Thus, the challenge is to understand this dysfunctional picture of healthcare professionals having to ration care while reporting increasing levels of burnout.

Initiatives to tackle burnout are focused on individuals rather than taking a systems approach to the problem (Montgomery et al., 2019). We need effective strategies for preventing and ameliorating burnout within healthcare settings. The most common responses have put the responsibility on healthcare professionals to take better care of themselves, become more resilient, and cope with stressors on their own – an approach that calls on health workers to be a 'stronger canary in the coalmine' rather than one that changes working conditions. Moreover, viewing burnout as a disease has hindered efforts to examine workplace values, and the narrow focus on the exhaustion component of burnout has added confusion rather clarity. Meta-analysis in the field of burnout interventions for physicians points to the fact that there is a need for organisational solutions that address the factors that drive and maintain burnout (Panagioti et al., 2017). The support and resources provided by the organization in which healthcare professionals work has both direct and indirect effects on patient care. For example, there is good evidence that better nurse-to-patient ratios are associated with shorter hospital stays, lower failure-to-rescue rates, and lower mortality rates (Lang et al, 2004), and predict better nurse and patient-rated care outcomes (Aiken et al, 2012). Organizational factors such as spending on temporary staff and low bed occupancy rates are negatively correlated with measures of patient experience (Sizmur and Raleigh, 2018), while a strong safety culture is associated with fewer reported errors (Kagan and Barnoy, 2013), fewer adverse events reported (Mardon et al, 2010),

and lower readmission rates (Hansen, Williams, and Singer, 2011). Not surprisingly, healthcare workers' well-being can function as a mediator in the organisational factors—patient care relationship (Montgomery et al, 2011; Teoh and Hasard, 2020).

Inter-personal care is neglected when healthcare staff are time pressured (Conroy et al, 2012). Neglected care, owing to time constraints and burnout (Humphries et al, 2014), can result in the following patient needs being missed; listening to patients and their concerns, responding to specific patient requests, and requests for education from patient and/or family members. The development of these behaviours can be found in early educational experiences, with a large US study across seven medical schools providing an important insight into the genesis of professional behaviour, whereby cheating/dishonest academic behaviours were rare (reported by 10%), but unprofessional conduct related to patient care was more acceptable (reported by up to 43%) (Dyrbye et al, 2010). From the patient perspective, these sub-optimal working conditions are experienced as fragmented care that does not meet their needs, and these shortcomings especially affect individuals with multiple long-term conditions and complex care needs (Ryan et al, 2016). Health systems need to get better at collecting the experience of wide communities of patients and carers and to use this information to inform their decision-making (Richards, 2019). Quality in healthcare is too heavily focused on process issues (e.g., length of stay, biomedical indicators) and little is known about the meaningful that patients attach to different elements of care (Bolger et al, 2015), which in turn means that patients' experiences of care are not taken into account. In particular, there is a need to collect information from those who have the worst outcomes, rather than the 'typical' patient (i.e., white, educated, middle class) which the system is skewed towards and inquiries into the failings of care over time (e.g., the Francis Report as in Francis, 2010, 2013;) have found that during the particular periods under investigation, the first indicators of neglected care were related to patient experience (e.g., neglect of the aforementioned patient requests) The perspective of patients and carers has the potential to be an indicator of organisational well-being, in terms of the organisational problems and burnout among healthcare staff (Montgomery, 2020).

Table 1 Key Facts about Burnout

How do we define Burnout?
Based on an extensive body of international research, in May 2019 the World Health Organization made the following statement: Burn-out is included in the 11th Revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon. It is not classified as a medical condition. Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: • 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.
How is Burnout Measured?
A number of survey instruments exist, but the most widely used is the Maslach Burnout Inventory (MBI). It has been considered the standard tool for research in this field, and has been translated and validated in many languages. Historically, the MBI-Human Services Survey (MBI-HSS) was developed, followed by the MBI-Educators Survey (MBI-ES), and then the MBI-General Survey (MBI-GS). The MBI-GS was developed for use with people in any type of occupation. In all versions, the MBI yields three scores for each respondent: exhaustion, cynicism, and professional efficacy.
Best Practice for Using the MBI
Research has revealed how to bring together all three MBI dimensions in a comprehensive and meaningful way (Maslach & Leiter, 2016). The new scoring procedure for the three dimensions generates five profiles of people's work experience: • Burnout: negative scores on exhaustion, cynicism, and professional efficacy • Overextended: strong negative score on exhaustion only • Ineffective: strong negative score on professional efficacy only • Disengaged: strong negative score on cynicism only • Engagement: strong positive scores on exhaustion, cynicism, and professional efficacy Evidence suggests that only 10% to 15% of employees fit the true burnout profile, whereas the engagement profile appears twice as often, at around 30% (Maslach & Leiter, 2020). However, organizations should not use the MBI in isolation. They should combine its findings with those of other tools to determine the likely causes of the five profiles. Sources: Leiter & Maslach (2016); Maslach & Leiter (2020)

HOW HAS THIS RESEARCH STREAM AND EMPHASIS DEVELOPED?

The concept of employee well-being has attracted considerable attention in research since the 1980s in the fields of Industrial Relations/Human Resource Management (IR/HRM) and organisational behaviour (OB). However, IR has tended to focus on the structural and policy issues (meso level), while OB has tended to approach well-being at the individual (micro level). The different fields appear to operate in parallel rather than complementing each other (e.g., Wilkinson, Barry and Morrison, 2020). To further complicate the picture, the literature in occupational health indicates the domination of individual-oriented strategies and measurements, meaning that the occupational individual working conditions and the organizational context in which they are created have been mainly studied separately (Barley and Kunda 2001). Thus, the field is characterised by approaches that either examine the modifiable risk factors that reduce well-being and/or look at the environmental (i.e., cultural, structural) factors that contribute towards a healthy work environment. In the following section, we, we will review the most influential models in the field of employee well-being that have influenced our approach to healthy work environments.

The two most influential Stress models in occupational health are the job demands control (JD-C) model (Karasek and Theorell 1990) and Job-Demand Resources (JD-R) model (Bakker and Demerouti, 2007), and both are based on the theoretical assumption that organizations have an impact on job design and worker well-being. The JDC model takes its starting point from a workplace that is organized based on Tayloristic principles, with the job rather than the profession being the analytical unit. According to the model, healthy work is achieved when the degree of job control is higher than the degree of job demands; this 'active' profile is associated with learning and motivation. The JDC model was subsequently expanded to include social support to form the job demand–control–support model (Johnson and Hall, 1988). The JDR model, which extended the JDC model, makes it possible for researchers to choose what factors are to be tested as job demands and resources in their analyses, and the JDR model states more clearly that organizational factors are important for health. The model suggests two processes, the health impairment process whereby excessive demands may lead to exhaustion and health problems, and the

motivational process whereby job resources may lead to increased work engagement and performance (Bakker and Demerouti, 2007). Both models have enjoyed considerable popularity as is evidenced by their frequent citation within the field of worker health (de Lange et al, 2003; Nahrgang, Morgeson, and Hofmann, 2011).

Thus, both the JD-C and JD-R approaches provide a model of healthy work that assumes that there are health risk factors that are both identifiable and changeable, and we can improve employees' health by addressing these risks (at both the individual and organizational level). Both the JD-C and JD-R models have a rational perspective on organizations, in that organizations are viewed as deliberately designed systems that can be redesigned. However, both models have been criticized for not adequately addressing the organizational level factors (e.g., inequality and power dynamics) that deplete healthcare workers' well-being (Bolin and Olofsdotter, 2019). Moreover, in a study evaluating work stress among eight hospitals in the European Union, Pisljar et al (2011) found that both work control and job/time autonomy were not associated with the health of hospital employees. Pisljar et al (2011) conclude that interventions to prevent work stress must look more closely at interventions that will help all hospital employees cope with their growing workload, longer hours and unsocial schedules. Equally, Egan et al. (2007) in a review of organization-level interventions that aimed specifically to increase employee control found some evidence to support the demand-control-support model, but control did not protect employees from generally poor working conditions. Moreover, while we accept that organizations are influenced by the social context of working conditions, relatively little effort has been made to assess this within the field of work and health. For example, in terms of the JDC model, it would be interesting to examine whether the health effects of active jobs differ across occupational levels and among varying types of organizations, and how such differences are maintained by organizational processes.

The lessons from the aforementioned JDC and JDR models have been integrated within the growing field of positive psychology (Seligman, and Csikszentmihalyi, 2000). Positive psychology heralds a shift from a pathogenic perspective focusing on risk factors and diseases towards a salutogenic one, looking at the positive resources that can promote well-being within organizations. Positive psychology is about helping individuals to explore their natural qualities and the goals that are intrinsically motivating them and about helping organizations bring out the best

in each of their workers (Van Woerkom, Bakker and Leiter, 2021). However, there is still a lack of clarity as to whether the focus should be on the individual or the organization, or both. For example, job crafting interventions (rooted in the JDR theory) have been associated with higher levels of work engagement (Bakker and Demerouti, 2017; Tims and Bakker, 2010), but the theory with its emphasis on optimizing the balance between job demands and job resources to increase person-job fit places the onus on the individual. A meta-analysis on positive psychology interventions at work found no significant effect of positive psychology interventions on either performance (e.g., personal accomplishment) or negative performance (e.g., supervisor and/or coworker incivility, turnover intent, absenteeism) (Donaldson, Lee and Donaldson, 2019), but did find moderate support for the impact on well-being outcomes. Overall, the authors of the meta-analysis conclude that the lack of association with performance indicators suggests that positive psychology theory alone may not serve as the most predictive moderator of work outcomes. The aforementioned approaches revolve around the ability of the individual to cope with the demands of the workplace and utilize job resources when appropriate. They obviously don't ignore the environment of the workplace but there is an inherent pragmatic assumption that job redesign is individually located and driven.

An approach more attuned to locating ways to improve the job environment is the Areas of Worklife (AWL) model (Leiter and Maslach, 2004). The model identifies the six specific areas where there could be a mismatch between the workplace and the worker: workload, control, reward, community, fairness, and values. Research indicates that the six areas are valid within healthcare settings (Gregory, 2015; Leiter, Gascon and Martinez-Jarreta, 2010). From this perspective, employee well-being arises from workload problems combined with mismatches across the other five areas of worklife. The advantage of this approach for the demanding nature of healthcare is that a practice or department may be experiencing problems in multiple areas that may be outside the control of that team, but it makes practical sense to first work on the problems that people most care and are actually willing to do something about. Thus, focusing on the most likely to succeed areas can be a springboard to tackling the more difficult areas. In the UK NHS, organizations in which staff have set their own working patterns (affecting the areas of fairness and control) have shown improved recruitment and staff satisfaction (Royal College of Emergency Medicine et al., 2018). The six areas of the

AWL model play an influential role in helping new graduate nurses develop confidence in their ability to handle their new professional role, with authentic leadership playing an important role in creating these conditions (Laschinger et al, 2015). The six areas can reveal critical work conditions and serve as prevention factors for negative work-related outcomes.

WHERE HAS THIS RESEARCH ADDED THEORETICAL AND PRACTICAL VALUE?

The aforementioned JD-C, JD-R and AWL models have informed the development of interventions aimed at employee well-being. However, there has been a shift from a focus on measures to support individual coping towards a preventative approach to treating the workplace as a system that needs sustainable changes in the workplace to bolster well-being (Boorman, 2009; Brand et al, 2017; Poland et al, 2009). A good example of this is the CREW approach (Civility, Respect, and Engagement in the Workplace) which was designed to enhance working relationships among hospital employees (Leiter et al, 2011). The CREW approach provides the opportunity for employees to identify their own civility and relationship goals and agendas for improving these working relationships. The approach has been used successfully within nursing units (Laschinger et al, 2012), with the authors suggesting that CREW provided the context within which nurses could identify and seek out sources of structural empowerment at work, and by working on a regular basis with their colleagues on important worklife issues, nurses may have become more aware of the potential support and resources for solving problems in the workplace. The CREW approach is one that has the potential to have ripple effects in the organization. Workgroup interventions to improve workplace civility in social encounters among people in workgroups (Leiter et al, 2012; Leiter et al, 2011) contribute positively to both workgroup culture and more positive experiences for the individual. The CREW approach represents a movement towards a wider field of analysis and impact (i.e., the unit or department), and has influenced 'whole system' approaches, which are discussed in the next section.

Interventions targeting the whole organization in healthcare are rare, with the majority of studies examining units, departments or discrete samples. Brand et al., (2017), in a systematic review of whole-system healthy workplace interventions in

healthcare settings, found that while interventions were heterogeneous there was some evidence that they can improve the physical and mental staff health, and well-being and promote healthier behaviours. In their review, interventions were considered 'whole-system' if they targeted all staff within a healthcare setting (e.g. a whole hospital, health centre, or unit), were predominantly delivered as group rather than individual activities, and measured the impact on health behaviours or psychological well-being in healthcare professionals (outcomes chosen a-priori). It was noteworthy that in studies that included process evaluations, results suggested that time was one of the greatest barriers to employee participation in workplace health and well-being interventions. Moreover, there was lower participation in interventions with more pre-determined activities. Additionally, there is lack of comprehensive evaluation frameworks that can allow a meaningful and realistic evaluation of the outcomes of an intervention – even when it comes to smaller-scale interventions (e.g., one team), let alone at the organizational level. The most common practice is the use of "proxy measures" for success at an organizational level that are not actually measuring the consequential outcomes and practical implications that reflect the suggested goals of such trainings and interventions (Devine and Ash, 2022).

The emerging literature on creating healthy workplaces highlights an interesting tension between the use of methodologically best practice (e.g. randomized control trial) and the need for approaches that maximize ecological validity. In their review of positive psychology interventions (PPIs) Donaldson, Lee and Donaldson (2019) did not find any evidence that intervention delivery methods (i.e., whether interventions use online, group, or individual methods) moderated the relationship between PPIs and desirable work outcomes or undesirable work outcomes. Pre- and post-measurement designs with randomized controls are considered the 'gold standard' for evaluating interventions; however, there is also a need to consider process evaluations of organizational interventions (Nielsen and Abildgaard, 2013; Michel, O'Shea and Hoppe, 2015). According to Brand et al. (2017) realist reviews of the literature, in which context-mechanism-outcome configurations rather than whole interventions are the unit of analysis, can be useful in establishing what it is about whole-system interventions that works to improve health and well-being for healthcare workers, who for, under what circumstances, and in what way.

WHAT HAS BEEN OVERLOOKED OR INADEQUATELY ADDRESSED?

Events such as pandemics have shown us how brittle hospitals and healthcare delivery can be. However, even prior to the COVID-19 pandemic, the trends in healthcare delivery were pointing to diminishing resources and greater levels of burden for healthcare professionals. Thus, the need to create healthier work environments needs to be prioritized. Although considerable progress has been made in bringing worker well-being into the narrative, some areas have been inadequately addressed, and include; the ways in which our work and non-work lives interact; how we can better integrate individual and organizational approaches to creating healthy work environments, how we can disentangle the concepts of stress, burnout and well-being and the 'elephant' in the room - employee silence.

Work serves a crucial but complex role in our lives, in that it is a significant source of both fulfilment and frustration. Equally, our non-work roles (i.e., personal, family, community roles) have both positive and negative effects on individual and family well-being. Historically, we have viewed work and non-work domains as separate (e.g., Greenhaus and Beutell, 1985), but there has been a gradual recognition that both domains are symbiotic and 'bleed' into each other, as indicated by how, for example, social stressors at work can result in marital dissatisfaction (Plutt et al. 2021). The challenge is to understand how healthy work environments can adequately account for the fact that there will be crossovers in both domains, while respecting boundaries but not ignoring the fact that organizational life and non-work roles are interdependent. This question provides a steppingstone to a more serious issue regarding the way that variables such as gender and socio-economic factors are associated with worker well-being. For example, problems regarding unhealthy working conditions and high sick leave absenteeism have been found mainly in sectors and occupations gender-marked as female or numerically dominated by women (Biletta et al, 2018; Forsberg Kankkunen 2014; Vänje, 2015). The changing nature of work is also making more people increasingly vulnerable (Burke, 2019). Those working for a minimum wage, from contract to contract, working part-time, and potentially being terminated with no warning, experience more uncertainty, stress and poverty. Hospitals are composed of a variety of professionals and support staff, at all levels of hierarchy, which indicates that creating a healthier work environment means that the environment needs to be healthier for all. These trends have prompted researchers to call for reintegrating organizational

analysis into occupational health research to explore how inequality in working conditions and work-related health is related to changes in how organizations are organized and staffed (Bolin and Olofsdotter, 2019).

We have accumulated a significant evidence-base with regard to burnout interventions in healthcare (Dreison et a.l, 2016; Panagioti et al., 2017; West et al, 2016), which suggests that interventions are moderately effective. However, there is less agreement as to what constitutes a person-directed intervention versus an organization-direct one (O'Connor, Hall and Johnson, 2020), with an overlap between the two types. Policy and practice in the area of work stress and well-being have focused on jobs and job redesign but has evolved to ignore how workers interpret their work and how they act to shape their work (Daniels, 2011). In this regard, the distinction between healthcare professionals' safety perceptions versus behaviours is important (O'Connor, Hall and Johnson, 2020). As noted in the review of Hall et al. (2016), it could be that burnt-out healthcare professionals are more likely to perceive their practice as less safe, regardless of the actual safety behaviours, due to feelings of low personal accomplishment and exhaustion, while poor well-being (e.g. depression) may be more associated with at-risk behaviours - of actual involvement in patient safety incidents, as a consequence of some of the symptoms of poor mental health (e.g. memory and concentration issues, indecisiveness). We need more longitudinal research that can help disentangle the impact of different types of poor well-being and can shed light on how they compound and/or work in parallel.

Finally, there is considerable evidence that employee silence is common in healthcare. Silence in healthcare can include withholding patient safety concerns and covering up errors (Edmondson 2019; Henriksen and Dayton 2006; Tangirala & Ramanujam, 2008), ethical issues (Robertson and Long, 2018), discrimination issues (Premkumar et al. 2018), unprofessional behaviour (Grenny, 2009; Killeen and Bridges, 20118), neglected care (Bhattacharya & Sundari Ravindran, 2018), and lack of resources (Creese et al. 2021). The need for us to address employee silence in healthcare has been highlighted by a recent systematic review which concluded that speaking-up interventions in healthcare are largely ineffective, due to a global pervasiveness and dominance of professional cultures that are inimical to speaking-up interventions (Jones et al., 2021). Most importantly, if junior healthcare staff believe that certain forms of silence based on loyalty or "not breaking ranks" is expected of

them, they run the risk of underestimating its impact on their own well-being. Moreover, staff can carry this rumination home making recovery from work less effective (Madrid, Patterson and Leiva, 2015). During the COVID-19 pandemic, staff were instructed to keep silent about the lack of personal and protective equipment (PPE) equipment (Campbell, 2020; Dyer, 2020). Employee silence and voice is a complex issue and one that HRM needs to be proactive about. Staff remaining silent about genuine issues that need to be addressed have serious implications for employee well-being, patient safety and quality of care (Montgomery et al., 2022). Given the widespread nature of employee silence in the health sector, the complexity of medical healthcare provision and the augmented stress that characterizes healthcare professions, we should also consider that the extent to which employee silence that can be identified in the healthcare sector might also be a type of participative team climate, especially if we take into account all plausible motivations for being silent about medical errors and/or mental health issues faced by healthcare professionals or other problems in the sector. In this case, if speaking up is perceived as a threat to psychological safety on a team level, then the tendency to be silent—or speak up less—as an individual, could be an expression of a participative climate, that creates a false sense of psychological safety on the team level (Montgomery and Lainidi, 2023). This is indicative of a culture where workers feel the need to protect themselves from possible negative implications and have a low or no sense of control over the dysfunctional aspects of their jobs (e.g., for example, silence to protect the team from being blamed for a complication that resulted from lack of PPE). This also highlights the potential "dichotomy" between the team and the organization – feeling safe in the team does not equal feeling safe in the organization - adding to the need for interventions that target organizational barriers to employee well-being rather than only team- or individual-focused interventions.

WHAT ARE THE KEY IMPLICATIONS / NEXT STEPS FOR HUMAN RESOURCE MANAGEMENT THEORY, RESEARCH AND PRACTICE?

The challenge for human resource management (HRM) in healthcare is the degree to which it can positively contribute to the core demands within healthcare delivery, which include providing people-centred care; supporting hospitals to achieve better patient and population outcomes, higher productivity; and higher retention/job satisfaction

among the health care workforce. Fortunately, HRM has an important role to play in developing the transversal (core) skills that are becoming increasingly crucial for all front-line health workers. These transversal skills include interpersonal skills, such as person-centred communication, interprofessional teamwork, self-awareness and socio-cultural sensitivity, as well as analytical skills, such as adaptive problem solving to devise customised care for individual persons, system thinking, openness to continuous learning, and the ability to use digital technologies effectively (Maeda and Socha-Dietrich, 2021). Congruently, priority should therefore be given to developing an organizational culture that promotes constructive forms of interpersonal relationships and outwardly rejects any form of workplace mistreatment, especially because many social stressors are subtle and difficult to identify for those who are not the instigator or target (Plutt et al, 2021). Thus, staff well-being needs to be incorporated into the core demands within healthcare delivery as a 'key indicator' of success and organizational health, and not merely as the means to achieving organizational goals.

In terms of practical steps going forward both the WHO (2010) and NIOSH (2017) provide step-by-step guidelines for developing healthier work environments. The WHO approach puts particular emphasis on four factors that affect employee well-being; the physical work environment, the psycho-social work environment, personal health resources and community involvement. The fourth factor (community involvement) is noteworthy in that it recognises that employee health is profoundly affected by the physical and social environment of the broader community. Their model is a continual improvement model with eight sequential steps that should be underlined by leadership engagement and worker involvement. The NIOSH approach is driven by a holistic model for improving workforce safety, health, and well-being via the concept of Total Worker Health (TWH). TWH is an integrated approach that prioritizes safety while simultaneously engaging in other workplace efforts (e.g., healthy work design, employee training and development, injury and illness prevention efforts) to advance the overall well-being of workers. TWH is characterised by five elements; leadership commitment to worker safety and health at all levels of the organization, designing work to eliminate or reduce safety and health hazards, promoting and supporting worker engagement, ensuring confidentiality and privacy of workers, and integrating relevant systems to advance worker well-being. Both approaches represent useful checklists and the idea of achieving 'small wins' is emphasised in both. Ultimately, they represent

pictures of where an organization would like to be and provide relatively little directions on how to overcome the barriers and resistances to creating a healthy work environment. Health care is a unique environment, and hospitals operate at different levels appearing more like a number of micro-organizations rather than one whole entity.

The challenge of creating healthy work environments within healthcare needs to appreciate the unique way that professionals are educated and socialised. Health professionals are trained and equipped with specialised knowledge and skills for handling well-specified clinical functions, and these remain the primary focus of professional education institutions and regulatory bodies. In this sense, these professional and regulatory bodies are virtual components of the organization. Moreover, organizational research and discussions about hospitals are skewed towards the experience of doctors and nurses and can overlook the ancillary staff critical to healthcare delivery. Besides the agents that are primarily involved in the caring situation – caring professionals and patients/clients – there are secondary or external agents whose well-being needs to be addressed, such as; janitors in hospitals, administration staff, receptionists and catering staff.

In terms of theory and research, recent research indicates that organizational behavior and human resource management (OBHRM) research is at risk of becoming irrelevant. In a review of policy implications of OBHRM research, policy implications were underutilized suggesting that OBHRM risks becoming societally irrelevant (Aguinis, Jensen and Kraus, 2021). Additionally, a review of HRM research highlighted the limited focus that HRM academic journals place on practical implications, and where practical implications were offered, they were often obscure, implicit, and used unintelligible terms (Kourgiannou and Ridway, 2021). Finally, the study of behaviors is lacking in leadership and general organizational behaviour research, which is problematic (Banks, Woznyi and Mansfield, 2021). There is a significant lack of joined-up-thinking when it comes to integrating knowledge from across different domains and silos are likely to continue unless interdisciplinarity becomes the norm. At a very simple level, the research community needs to model this behavior if we want the practice community to follow suit.

The take home message from this chapter is that initiatives to create healthy work environments and improve worker well-being have to be realistic, pragmatic, easy-to-apply, congruent with usual practice, minimally invasive and sustainable. In this regard, the recent recommendations by Higham et al, (2021) concerning the use of embedded peer groups in the medical curriculum are an interesting starting point. Peer support has the potential to 'tick many boxes' in the well-being area of healthcare in that it has the potential to; increase psychological safety, improve individual resilience, reduce the impact of the hidden curriculum, improve employee voice and provide support to individuals at the most stressful aspects of their career (especially junior nurses and doctors). The recommendations by Higham et al, (2021) are specific to physicians, but there is no reason why such an approach could not have wider application in healthcare. Finally, peer support and mentoring have the potential to address the more difficult aspects of organizational behaviour in healthcare, meaning changing organizational culture and addressing interpersonal conflicts. Ultimately, transforming a difficult hospital work environment into a healthier work one is ambitious, but the gradual integration of peer support can create ripple effects for worker well-being.

THE DEVELOPMENT OF HEALTHY WORKPLACES

Modern healthcare is characterized by increasing levels of job burnout, anxiety and depression. Moreover, the COVID-19 pandemic has exacerbated an already difficult situation resulting in extra problems concerning retention and a resistance to return to workplace. The accumulated evidence on employee well-being indicates that only 'whole organization' approaches have the potential to successfully address this significant public health challenge. The inability to create healthy workplaces is rooted in three factors; (1) Real and genuine 'whole organization' approaches are rare and problematic to implement and evaluate due to the difficulty in involving all elements of the organization, (2) there is a significant lack of experience in genuine interdisciplinary collaboration by the relevant scientific fields (i.e., public health, architecture, occupational health, ergonomics, nutrition, etc.), (3) individual approaches to the problem have dominated in comparison to organizational approaches, with the latter considered complex and difficult to implement. In a nutshell, we know what is

needed but we have relatively little experience in genuine whole organization approaches.

The development of healthy workplaces should be a major goal for healthcare organizations. We argue that research should move from assessing only the burnt-out physician to assessing the 'on fire' environment of the healthcare setting, where collective burnout rates are high. What are the key stressors driven by the organization that put people at risk for burnout, and what changes could be made in the job setting to reduce their impact? We believe that creating healthy workplaces could both promote patient safety and enable HP resilience. In terms of benchmarking organizational issues prior to an intervention, measuring these attributes can provide a foundation on which to monitor the health of an organization and to select the appropriate tools to enable changes of work practices. Whole organization approaches, while difficult, represent the sustainable way forward. Interventions that result in limited success (e.g., reduced burnout among front-line staff) risk becoming the victim of their own success—meaning that healthcare organizations will be less motivated to engage in the long-term sustainable goal of healthy workplaces if they can extinguish some fires at the front-line (Montgomery & Lainidi, 2023). Involvement of patients and their families is also crucial to building healthy workplaces, which emphasizes further the need for interdisciplinary approaches given that there is no 'natural' avenue for human resources to engage with patients and the public.

Prevention, which is more desirable than treatment, will be enabled by a healthy workplace approach that includes the continuous assessment of burnout, and addresses the positive drivers of well-being. Finally, adopting a healthy workplace approach makes most sense if it is co-designed with input from the users of the health service.

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