

# Gender Dynamics, Work Stress, and Burnout Among Health-Care Workers

Ibrahim Abdul Jaleel Yamani<sup>1</sup>, Izzeldeen Abdullah Alnaimi<sup>2</sup>, Ahed J. Alkhatib<sup>3</sup>

<sup>1</sup>Imam Mohammad Ibn Saud Islamic University (IMSIU)

<sup>2</sup>Imam Mohammad Ibn Saud Islamic University (IMSIU)

<sup>3</sup>Jordan University of Science & Technology

**Abstract:** The ways in which gender shapes our lives are an important cause of work stress and burnout among health-care workers, but this cause is not yet clearly examined in the research literature. This paper investigates how the experiences of burnout differ between health care professions, including the occupational roles and demands of workplace culture and scheduling. Burnout is explained as a multidimensional phenomenon in the workplace, emotional exhaustion, depersonalization and reduced personal accomplishment. Women in health care and particularly nursing, allied health and lower-tier occupations often have greater workload demands, lower scheduling control, unequal domestic load and exposure to gendered inequities. All of these factors lead to emotional exhaustion. Men can have burnout through depersonalization, role conflict, and professional detachment. The manuscript also highlights the need for an intersectional analysis of gender along the axes of occupation, hierarchy, professional identity, race, age, and organizational culture. Staff the right number of employees, hold a flexible timetable, encourage inclusive leadership, mentor others, offer employee assistance programs, measure tools that are gender sensitive, and institutionalize anti-discriminatory policies and personal empowerment initiatives for career advancement. The understanding of burnout should go beyond individual coping and recognize the sociomedical nature and organizational structuring and gendering of health-care work. Tackling gendered stressors will protect worker wellbeing, boost retention and bolster quality and safety of patient care

**Keywords:** Gender dynamics; Burnout; Work stress; Health-care workers; Occupational health

## Introduction

The concept of the gendered organization has emerged from a review of gender theory as a theoretical perspective relevant to the ongoing development of health-care organizations, and continues to inform research on health-care services (1). Gender therefore intersects with other social categories such as occupation, hierarchy, and professional identity that are inextricably linked to institutional and organizational arrangements (2). These other social categories reflect different conceptions of work that thereby mediate individuals' experience of work stress and burnout (3). Burnout is the psychological distress manifest in three dimensions: exhaustion, depersonalization, and reduced personal accomplishment (2). The required definition of burnout adopted in this study is therefore grounded in these three distinct yet interrelated categories (4).

### 2. Conceptual Framework

Gender dynamics significantly influence the stress exposure of health-care workers. An intersectional framework for studying gender therefore provides value (2). Gender dynamics shape social expectations regarding professionals' work roles, competencies, and availability (5). Such expectations generate stressors, risk factors, and burnout challenges; identifying gendered dynamics enables preventive interventions (6). The influence of gender also varies across professional categories; characterizing these roles yields a framework specific to health care (7).



Gender constitutes a social category wherein individuals are assigned differentiated characteristics and behaviors based on their physical anatomy or biological sex (8). Gender orientation interacts with social hierarchies and occupational categories, shaping control over events and career development (9). The health-care sector has a particularly intricate history of gender relations, as long-standing expectations continue to shape professional definitions, recruitment, advancement

opportunities, and ultimately retention (10). Gender-specific experience and cultural norms affect work-life interference and engagement with supervisory authorities (11).

Burnout is defined as a prolonged response to chronic work-related stress, comprising three components: exhaustion, cynicism (or disengagement), and diminished professional efficacy (12). The health-care sector is particularly prone to this phenomenon, with corresponding effects on employee health, productivity, service quality, and retention (13). The growing proportion of the workforce afflicted by burnout induces negative consequences for individual well-being and the delivery of adequate health-care services (14). Stressors shape the type of work conducted, the individuals encountered, the demands placed on staff, and the fulfilment of essential obligations; these elements address diverse phases in the progression of burnout (15).

### **3. Gender and Occupational Roles in Health Care**

Occupational roles in the health-care system demonstrate important gendered characteristics (16). Health-care occupations in several countries are predominantly female, include some predominantly male roles, and exhibit diversities in the degree of femininity and masculinity associated with specific roles (17). Gendered occupational roles typically encompass a description of the main duties performed; a hierarchy indicating suprahierarchical and infra-hierarchical relationships, arrangements of coupled roles, and the path followed for entering and advancing in the gendered role; and an indication of the relative degree of masculinity or femininity associated with the role as well as the classification of the role as gender-congruent, gender-ascribed, or gender-neutral (18). These characteristics establish the ways in which gender is constructed and interacted with throughout an individual's work life at their workplace and become an important consideration when examining the role of gender in health-care settings (16).

The situation in health care varies substantially according to the system of different countries and regions, and it is primarily based on the classification of health-care professions (19). Within the health-care professions, classification schemes which differentiate groups of professions based on educational requirements are often employed, and these groupings also show clear patterns of gender representation (20). Consequently, understanding the gender characteristics associated with health-care professions is an essential prerequisite for investigating gender differences in health-care settings (21). Some of the broad areas of overlap in education and training between professional categories are relevant to examining the main duties, specific work settings, and gendered expectations associated with distinct health-care professions (22).

### **4. Stressors Linked to Work Environment**

Gendered health-care roles create distinct occupational environments, each marked by particular stressors that contribute differently to burnout risk across genders (23). Gender disparities in workload and the ability to influence scheduling have been linked to differing degrees of perceived controllability, an important mediator between workload, coping resources, and exhaustion (1). Women frequently face higher demands and less scheduling flexibility, particularly in nursing, where they constitute the majority (16). Gendered expectations shape interpersonal interactions, including the likelihood of harassment or discrimination and the availability of support or collaboration (24). Women in health care routinely encounter discrimination irrespective of their position, but such challenges are typically more pronounced and detrimental in lower-tier occupations (25). Gender and professional identity considerably influence perceptions of safety and access to resources, such as adequate staffing, up-to-date equipment, and institutional responsiveness to concerns (26).

The work environment encompasses additional components commonly overlooked in stress frameworks but characterized by notable gender-linked contrasts (27). The variables listed above are only a subset of potential hazards identified by Lee et al. (16) and cognate categories adopted by Prasad et al. (1).

#### **4.1. Workload and Scheduling Demands**

Occupational health scholars and practitioners commonly define burnout as a prolonged response to chronic interpersonal stressors on the job (28). It is characterized by a state of physical, emotional, and mental exhaustion that manifests in three classic symptoms: emotional exhaustion, cynicism, and reduced professional efficacy (29). Interest in the phenomenon has surged over recent decades (30). Consequently, the conceptualization of burnout has flourished and expanded to encompass a plethora of important dimensions (31). Attention to burnout has mounted, especially since the WHO included burnout in the International Classification of Diseases (ICD-11) as an occupational phenomenon (32).

#### **4.2. Interpersonal Dynamics and Workplace Culture**

Interpersonal interactions and workplace culture constitute a significant source of stress in health-care settings, particularly among women and those in non-physician roles (16). Gendered discrimination and harassment continue to be present in the work culture of many health-care organizations, generating a distinctly unwelcoming environment for women. Stress due to these experiences may be compounded by a lack of adequate and reliable peer relationships, teamwork, and social support (33).

Gender-based treatment inequities permeate the entire career experience of women in health-care occupations (17). Women not only engage in proportionately greater amounts of unpaid domestic labor, but they are also subjected to more substantial scrutiny for their work motivation and accomplishment (34). Simultaneous pressures to perform well in multiple areas motivate many women to seek professional advancement that aligns with their career aspirations (35). In addition to increased pressure, the work-home interface becomes complicated and stressful for female health-care employees when domestic responsibilities coincide with professional duties (1). Among those perceived as health-care leaders, women and individuals from racially minoritized groups are less likely than their counterparts to receive professional endorsement from colleagues (36).

#### **4.3. Safety, Resources, and Support Mechanisms**

Organizational extremes compromise both employee safety and productivity (31). A lack of essential resources such as equipment, staffing, and time contributes to environmental and psychological hazard exposure (32). Health-care facilities frequently fall short of providing adequate resources (32). Policies that ensure hospital staffing is commensurate with the extent and demand for services protect both patients and health care providers (33). Many health-care professionals witness colleagues cut corners to cope with the demands of their jobs, knowing that these activities pose potential hazards to themselves and their patients (34). Organizational systems also fail to provide sufficient back-up for duty assignments (1).

Many facilities could address staffing challenges through the prudent allocation of additional resources (35). Similarly, health systems without employee assistance programs, mentoring, coaching, or similar support mechanisms often see an associated rise in work-related hazards (36). Clear communication about available resources, leave policies, mental health supports, and coping strategies can both mitigate dilemmas and create a greater sense of recognition when workers know that their health systems acknowledge and address their needs (37). These considerations are especially relevant to lower-wage and marginalized employee groups who often feel most neglected (38).

#### **5. Pathways to Burnout Across Genders**

Health-care workers may experience burnout differently based on their gender. In general, health-care workers transcend emotional exhaustion after their professional duties encounter obstacles common to their career (7). These stressors inhibit accomplishment feeling or generate expected career dissatisfaction, as workers must exceed expectations to enjoy advancement opportunities (39). Regarding gendered differences, even in post-pandemic times, women experience significantly higher emotional exhaustion than men, while men's workforce remains prone to feelings of depersonalization. Such feelings dynamically interrelate and propagate between the groups (40).

As workloads increase, corresponding emotional exhaustion symptoms escalate, at times forcing

personnel into conflicting clienteles, inadequate administrative support, and insufficient acceptance by co-equals (19). Consequently, practices such as widespread promotion and dispersed on-call assignments remain yet to obtain agreement from the professional circles involved (16). Gender prescribes which pathway health-care workers traverse, shaping both perceived professional standing and connection to anticipated promotion (41). Throughout these configurations determining organization involvement, forwarding an inclusive culture within health-care cooperation—positioned well beyond acknowledgment or the mere establishment of equality, yet instead incorporating endurance, adaptability, and interpersonal interexchange—might secure another viable approach (42).

### **5.1. Emotional Exhaustion and Detachment**

Burnout among health-care workers comprises three components: emotional exhaustion, depersonalization, and low personal accomplishment (43). Emotional exhaustion, defined as feelings of being drained by work, has been identified as the most crucial driver of the burnout process, as it stimulates the second and third components (43). Exposure to excessive workload and scheduling pressures—particularly when combined with inadequate supervisory support—occurs in parallel with limited availability of coping resources (44). This is especially serious in health-care environments, where turnover intentions associated with burnout increase despite low actual transition to other specialties (45). Administrative tasks constitute one of the highest sources of workload, as it necessitates time away from patients (46). Perceptions of having a great deal of administrative workload and insufficient time to complete it have close ties to emotional exhaustion (47).

Anticipating the presence of weekends off as a significant reward of entering health care professions, both within and outside the discipline, marks another pronounced similarity across health-care occupational categories (48). Perceptions of working non-stop for a considerable time without having a weekend off emerge among physicians and allied medical staff whenever a burden of on-call duties enters their working environment, heightening emotional-exhaustion concerns (49).

### **5.2. Depersonalization and Role Conflict**

Burnout constitutes a debilitating syndrome of workplace stress that originates from poorly managed occupational stressors (50). The most widely cited definition considers burnout to comprise three dimensions: emotional exhaustion, depersonalization, and lack of personal accomplishment (51). Emotional exhaustion is a general feeling of fatigue that arises from failed efforts to address work-related emotional demands. It can affect both overtly human-service and more technical jobs that involve the constant adjustment to complex inputs (50). Similarly, a study investigating the mental burden of a young physiotherapist suggests that patients pose multiple demands, requiring greater effort and eluding satisfaction, especially among young or inexperienced practitioners (52). These aspects highlighted an emotional dimension during the process (16). In the context of healthcare, depersonalization denotes the withdrawal of personal care toward a specific patient because of receiving too many patients at critical levels (53). Depersonalization tends to be more serious among male health care workers, and is likely observed among their professions (54). Healthcare workers strive to meet the multiple demands of ageing patients, thus contributing to the conflicting role-load and leading to burnout emotionally, mentally, and physically (7).

### **5.3. Personal Accomplishment and Career Trajectories**

Individual perceptions of personal accomplishment are critical to understanding burnout—especially when coupled with career advancement prospects (55). A modest yet statistically significant and directionally consistent gender difference appears to exist in health care settings (56). Among both nurses and allied professionals, respondents held predominantly positive views on career advancement, which did not appear to be accompanied by excessive expectation (57). Counterintuitively, physicians reported the least positive feelings regarding aspects of personal accomplishment—namely, perceived opportunities for advancement, satisfaction with career path and job, and career goals (58). Male physicians expressed the most favourable views overall and were less likely to describe themselves as stuck or trapped (16). Gendered career advancement possibilities may help explain such difficulties, given that women comprised approximately 40 percent of allied health and nursing respondents, yet only 19 percent of physicians (59). For both sexes, dissatisfaction with career progression, an impression of being trapped, and consideration of leaving the profession were

all significantly related to burnout (7).

## **6. Protective Factors and Resilience**

Work stress, burnout, and the related construct of resilience in the workplace are approached with a focus on personal factors and coping strategies at the individual level (60). In long hours, tight deadlines, anxiety for patients, and workplace politics, work stress has been inevitable and ascribed to continued inner struggle while performing well for others' benefits by projecting the image of being instrumental and caring. Institutional or occupational stressors are less treated (61). The prevalence, covariates, and consequences of emotional exhaustion among healthcare workers further reinforce the debilitating impact of overexposure to workplace demands (62). The increased workload following the departure of colleagues is exacerbating the strain due to stress and subsequently (62). Regarding health care, by location and employee type, job strain and emotional exhaustion have been found to be significantly positively correlated, predisposing to burnout (63). Educational or training preparation for such job strain is of little help (64).

In the analysis of ways to enhance resilience, social connectivity and support outside work, supplementary occupation, possibilities to decline additional work, sound sleep, work being a shackle or saviour, mapping connections between coping strategies with amplifying or stress-relieving effects, comfort and discomfort zones, and active time-off are pinpointed (65). Further investigation is warranted on the resonating process of positive and negative occurrences not only in the present but also in retrospection before fatigue emerges (65).

### **6.1. Organizational Interventions and Policy Measures**

Health-care workers face significant levels of stress and burnout, with detrimental consequences for professional well-being, retention, and patient care (66). Systematic reviews highlight several risk factors among health-care workers, including high workload and time pressure; lack of control and participation; role conflict; work-home interaction; work relationships; and insufficient rewards (67). Moreover, the degree of exposure to such factors is influenced by gender (68). It is therefore crucial to select and prioritize the interventions and strategies that align best with specific contexts and the particular needs of respective workers and organizations (66).

A range of organizational interventions and policy measures can directly reduce exposure to stressors or enhance equity in stressor experience across genders (69). Achieving or reinforcing balanced staffing levels, ensuring appropriate and flexible scheduling arrangements, and fostering an inclusive, respectful workplace culture can all meaningfully mitigate gendered stress exposures for health-care workers (70).

Measures designed to alleviate the burden of work individuals already face can also help promote career development and restore a healthier balance between work and other life pursuits (71). Such adjustments include granting additional time and transparency for key and often-stressful tasks (e.g., performance appraisal, salary negotiation) and increasing the flexibility or availability of opportunities to engage in broadly recognized professional development activities (72).

### **6.2. Individual Coping Strategies and Training**

During the COVID-19 pandemic, health-care workers faced unprecedented stress related to increased workload and risk of infection (73). Health professionals used a variety of coping strategies during this period, with problem solving, desiderative thinking, and social support being the most frequent (74). Women relied more on emotional expression and social support. Utilization of coping strategies varied by work environment and demographic characteristics (75). Health-care workers reported high incidences of stress-related symptoms, including sleep disorders, anxiety, and depressive symptoms, and a large majority also indicated a need for additional training to deal with future crises (76). The pandemic highlighted the importance of social support, particularly for medical trainees and nursing staff (77). Although some coping strategies were employed to a considerable extent, others, such as social withdrawal, problem avoidance, and self-criticism, were rarely utilized (78). The study reinforced the idea that adequate coping, including seeking help from others, facilitates better sleep quality, reduces anxiety and depression, and alleviates burnout (73).

### **6.3. Social Support, Mentorship, and Equity Initiatives**

Burnout among health-care workers has risen sharply, especially since the COVID-19 pandemic, with profound implications for employees, patients, and organizations (40). Preventive interventions are needed, particularly for women and those in marginalized groups (79). Below, several strategies aimed at reducing exposure to workplace stressors, enhancing resilience, and supporting advancement within health care organizations are described (80).

By promoting equity, social support structures, mentorship programs, and informal networks can help foster a sense of belonging at work and facilitate career advancement (81). The establishment of in-house staffing agencies to facilitate relocation between departments and the formal recognition of informal supportive behaviour, for example through awards, can further contribute to such cultures and networks (1).

### **7. Methodological Considerations in Studying Gender, Stress, and Burnout**

Gender shapes professional roles in health-care settings with implications for job stress and burnout (82). Roles are defined in terms of tasks, workplace dynamics, and pathways for advancement, with considerable variation across occupational categories such as nursing, medicine, and allied health (83). Gender dimensions influence job nature and overall career trajectory, framing access to positions perceived as advanced and critical for broader tenure (7). Gendered expectations guide role boundaries, defining responsibilities and associated models adopted under stress (84). Gender shapes supervisory arrangements and associated discourse, authority, and client interaction (16). Role segmentation among allied health professionals, whereby supervision is predominantly lateral rather than through engagement with an authority figure minimising boundary transgression, experiences variable segmentation between institutions (85).

Health-care professionals face a range of workplace stressors (86). Workload and scheduling factors emerge as significant determinants of job stress and broadly reflect institutional commitment, adequacy of staffing, and attention to employee welfare (87). Demands imposed by shift patterns, requirements for overtime or on-call, overall degree of perceived control over workload, and organisation of work in a manner that can be disrupted by external pressures constitute key features (88). Interpersonal dynamics among colleagues constitute a further major source of stress (88). Workplace culture encompasses aspects such as acceptance, discrimination, and harassment, while colleague collaboration and availability of broader social support act as important moderating factors (89). The design and condition of the physical environment, availability or inadequacy of resources and equipment, staffing levels, and range of supportive mechanisms such as personnel accessible for consultation constitute relevant variables (90).

#### **7.1. Measurement Approaches and Biases**

Measurement approaches, instruments, and potential biases are critical for studying gender, work stress, and burnout among health-care workers (91). Many health-care stress and burnout assessments, particularly the newly developed instruments, have not been validated for gender-sensitive or intersectional measurement (2). Standardized gender-sensitive measures tailored for specific health-care occupations would enhance the assessment of gender differences in stress exposure and burnout risk (92).

Assessments for systematic workload and shift-work scheduling variation, which have been linked to stress exposure and burnout risk, are also infrequently included in health-care surveys (93). Simple and clear markers of exposure for multiple high-priority national health-care workplace stressors would further clarify the analysis of exposure–burnout relationships across genders (94).

#### **7.2. Study Designs and Ethical Considerations**

Longitudinal designs capture the time-course of pre-pandemic-pandemic transitions and reveal the interplay between burnout and anxiety (95). Exposure-response relationships help identify at-risk segments of the workforce (95). Careful sampling ensures the representation of smaller subgroups (96). Gender-sensitive instruments address possible variations in the expression and experience of constructs across groups (97). At the same time, the sensitive nature of some issues (e.g., sexuality,

discrimination, harassment) necessitates strict confidentiality mechanisms to encourage openness in responses and the full disclosure of experiences (98). These ethical considerations are particularly salient when studying vulnerable populations, such as health-care workers exposed to the cumulative effects of the pandemic and COVID-19 (98).

## **8. Implications for Practice and Leadership**

Burnout is a state of somatic, emotional, and cognitive distress arising from persistent, chronic stress on the job (1). A consensus has emerged around the multifactorial nature of work-related stress and the role of people's working environments in creating or mitigating it (14). For health-care workers, stress obviously arises from the occupations they engage in and the demands associated with them (99). Different dimensions of workers' environments—such as organizational culture, managerial support, job control, and work-life balance—have been effectively studied across a range of sectors, leading to some priority factors for preventative interventions (100). Stress is also widely acknowledged as a precursor to burnout and is, in turn, influenced by individual characteristics (2).

Gender inequity and discrimination have long been the subject of extensive research, particularly the unequal treatment of women and the barriers they encounter in developing their careers (101). With the increasing entry of women into the labour market and especially into the health-care sector, researchers have now started to explore how the work of men and women differs across a wide range of activities, the patterning of opportunities for advancement, and the potential implications for stress and burnout (102). Gender-sensitive structural models accentuate the manner in which ongoing role patterns and the articulation of socially constructed differences within the broader culture shape individual experiences (103). Gender, like other dimensions of diversity, also interacts with other social characteristics to enrich individual understanding and alter experience (104).

### **8.1. Workforce Planning and Scheduling Reforms**

Achieving safe staffing levels requires proactive workforce planning and scheduling reforms that recognize and respond to the complex interplay of demand, capacity, and work-timing patterns (105). Health-care organizations remain first responders in the ongoing, unprecedented global crisis that threatens the wellbeing of their employees, particularly women in health care (106). During periodic surges in demand, such as the COVID-19 pandemic, planning frameworks should be able to increase recruitment, training, or redeployment of new personnel and ensure ease of staff movement across roles, services, and parts of the organization (81). Existing, long-standing problems related to excessive workloads, unpredictable and inappropriate schedules, on-call demands, inability to book vacations as planned, discrimination, harassment, limited resources, and inadequate safety nets have intensified considerably as increased surges in demand and work-from-home surges continue to stress an already beleaguered workforce (105).

### **8.2. Cultivating Inclusive Organizational Cultures**

Organizational culture significantly shapes employee experience and well-being through norms, values, and practices defining acceptable behaviour and guiding decision-making (107). This culture, often reflected in the level of inclusivity fostered, may exert a strong influence on workplace burnout (108).

A commitment to equal participation, opportunity, and respect for all individuals, sector-leading practices surrounding equity, diversity and inclusion can help organizations attend to employee well-being, promote access to career-advancing opportunities, and meaningfully mitigate burnout (109). Various approaches exist to assess equity-related inclusion and belonging across workplaces, and feedback can be embraced as an opportunity to adapt and continuously cultivate an environment that actively strengthens well-being at each level of the organization (110).

### **8.3. Monitoring, Evaluation, and Continuous Improvement**

Monitoring, evaluation, and continuous improvement are essential for improving work-related well-being (2). Factors such as job satisfaction, stress, and burnout significantly impact healthcare professionals' mental health and work-life balance (111). Clinical supervision benefits female hospital nurses' well-being, while physician compensation, education debt, and work environment influence

burnout levels (112). Mentoring and management programs support female physicians and nurses in balancing career and family (113). Tools like the Copenhagen Burnout Inventory help assess burnout levels. Addressing these areas promotes organizational well-being and enhances the quality of healthcare delivery (114).

### **9. Policy Implications and Future Directions**

Expanding gender-equity governance frameworks in the health-care sector can offer particular dividends (115). Health-care organizations often rely on elaborate governance processes to assure clinical oversight and health-care quality but may overlook an equally critical focus on the organizational dimension that shapes the work experience of physicians, nurses, and other health-care workers (116). Empowering a much wider range of health-care professionals to participate in gender-equity decision-making, including enhancement of their role in evaluating and recommending organizational policies, practices, and behaviours, can strengthen the system and help connect care quality with broader conceptualizations of workplace wellness—in particular, burnout avoidance—among all genders (117). The potential for a gender-diverse workforce to enhance organizational performance has been widely documented, including clinical and safety dimensions (1).

Advancing occupational-health standards that address gender-specific issues, complemented by preventive frameworks that focus on work stress, burnout, and safety, can also deliver cross-cutting benefits. Including gender-specific dimensions in updated guidance on work-related stress, well-being, and occupational safety can elevate attention to the gendered implications of demand, control, social support, and commitment factors that contribute to work stress, burnout, and staff turnover—as well as the wider clinical implications of workplace-left stress in the health-care context (118). Providing explicit governmental direction on observable metrics relevant to burnout and the work environment can enhance subsequent targets among health equity and employee well-being initiatives (119).

The need for continued and further exploration of gender-related issues in health care remains pressing (120). Significant inter-occupational differences in the dynamics of occupational stress, burnout, and systemic-level responses, distinguished by substantial variations in the usual work context between nursing, frontline allied health support, and nonfrontline physician staff, indicates that further disentangling these complexities will improve understanding and action among their respective populations (2). The need for adequately financed data collection, measurement, and reporting on the subject—particular longitudinal information that permits within and across level-change exploration—also remains acute (121). Gender-disaggregated and corresponding-macro-information on all aspects of the health workforce and its connection to patient safety, satisfaction, and turnover will support progress towards effective plans, including the launch of separate physician investigations and a focus on the support trends that are connected to occupational stress and burnout among both genders (122).

#### **9.1. Gender Equity in Health-Care Leadership**

Research shows that women are well represented in the health-care workforce. In Canada, only 13.6% of all permanent health-care establishment positions were held by female workers in 1986, whereas this figure increased to 74.1% in 2020 (2). Despite significant improvement in gender equity in health-care jobs, the participation of women in leadership and decision-making roles remains low (123). According to the Canadian Institute for Health Information (CIHI), about 90% of physicians working in Canada during 2023 were male (41). Among the top leadership positions in health-care organizations, only 25% were occupied by women (124). Instilling gender equity in leadership and decision-making roles can contribute to the achievement of better organizational performance and a higher intent to remain in the health-care system (81).

Some strategies to promote the advancement of women in leadership and decision-making roles include mentoring programs, systematic review of recruitment and retention strategies, and exploring the incorporation of self-regulatory models (125). Health-care organizations should develop tangible goals and targets, measurement tools, accountability mechanisms, and equity-oriented practices (117). To ensure continuous improvement in gender equity, the progress of women into leadership and decision-making roles should also be monitored, evaluated, and reported regularly (126).

#### **9.2. Occupational Health Standards and Burnout Prevention**

## Gender Dynamics, Work Stress, and Burnout Among Health-Care Workers

Ensuring the physical and mental well-being of health-care workers is imperative for comprehensive quality improvement in the sector (127). Illness and distress affect health workers more than any other job category (128). In developing countries, health-care workers face excessive workloads and dangerous working conditions (129). Work-related stressors reduce job efficiency and effectiveness, resulting in suboptimal care for patients (130).

The burden of stress has intensified during the COVID pandemic, further complicating an already paramount global problem (131). The World Health Organization recognizes the rising incidence of worker burnout as a pressing occupational health issue (132). Amid the pandemic, countries such as the United States reported a marked increase in only one sector: health care (133). In the United States, burnout was acknowledged as an occupational phenomenon in the International Classification of Diseases in 2019 (134).

Burnout develops due to chronic job stress, leading to symptoms like apathy, cynicism, lack of empathy, and loss of purpose (16). Work-related stress factors include excessive workload, harassment, shift work, racism, staff reductions, and departmental shifts (135). In health care, young professionals report considerable stress regarding skill mastery, decision-making capacity, and work-family balance (68). Reported stress levels vary by occupation (136). Gender appears to affect the degree of stress associated with these factors and the corresponding allocation of attention (137). Female healthcare workers often experience gender discrimination, dissatisfaction, and higher dropout rates, especially those with lower training levels and single marital status (138).

### 9.3. Research Gaps and Priorities

Gender-related discrepancies dramatically influence stress and burnout among health workers (139). Yet this field remains under-explored, and fundamental gaps hinder progress (140). Research priorities include wider investigation, gender-sensitive data collection, and enhanced methodological rigour (141).

Health-care workers consistently report substantial stress and burnout. A national U.S. survey conducted during the COVID-19 pandemic found that stress and burnout levels among a range of job categories—including nursing assistants, medical assistants, housekeeping, and social work—were elevated compared to previous national data (142). Notably, female and staff identifying with racially minoritized populations experienced the greatest stress and burnout (1). Similarly, among a group of those surveyed directly after the pandemic lockdown, women reported higher levels of emotional exhaustion, depersonalization, and reduced personal accomplishment compared to men (68). Female health professionals therefore warrant heightened attention, especially given ongoing pandemic-related restrictions and increased ill-health concerns among this population (143).

### 10. Conclusion

Current findings reinforce the understanding of occupational health-care dynamics, aligning with broader societal efforts for equality and empowerment. These developments call for measures to enhance health-care systems and mitigate burnout while fostering literature on gender and stress in this context.

Within the field, gender roles traditionally define health-care worker positions and responsibilities. These roles differ across professional categories (e.g., physicians vs. nursing staff) and largely persist despite efforts to promote equity, with repercussions for exposure to burnout—a response still explored mainly from race and age perspectives.

In conclusion, health sectors worldwide grapple with employee stress and burnout, hindering quality and efficiency. Gender dynamics significantly influence both phenomena across countries; yet schooling remains scarce, particularly in mid-employment phases. Health-care executives and policy-makers can hence boost system performance by adjusting recruitment mandates, compensations, responsibilities, turn-overs, facility constructions, and services.

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