

The pathway from mental health, leaves of absence, and return to work of health professionals: Gender and leadership matter

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Abstract

Health professions are ranked among the most stressful occupations and have a much higher likelihood of absenteeism from work. In this article, we present findings from four health professional case studies in our Healthy Professional Worker partnership, involving surveys with 1,860 respondents and 163 interviews with nurses, physicians, midwives, and dentists conducted between December 2020 and April 2021. We found that the pathway from mental health experiences through to the decision to take a leave of absence and return to work differed between the health professions and that both gender and leadership matter greatly. There is a need to de-stigmatize mental health issues and encourage greater awareness and support from supervisors and colleagues. Leadership can play an important role in mitigating mental health issues, and as such investment in both leadership training and mentorship are important first steps in acting upon our research findings.

Introduction

Health professions are ranked among the most stressful occupations,^{1–4} and health professionals experience burnout,^{5–7} anxiety,^{8–10} depression,^{11–13} Post-Traumatic Stress Disorder (PTSD),^{14–16} and substance use at rates higher than the general population.^{17,18} These challenges are tied, in part, to the organization of work within the healthcare settings: irregular and inflexible work schedules, shift work, and required overtime.^{1,4,19} These experiences are compounded by the emotionally demanding nature of this work; caring for patients and families through immensely challenging and stressful times (diagnosis, treatment, and palliation) can lead to compassion fatigue and moral distress.²⁰ These workers often experience conflict at work, high levels of cognitive and physical fatigue and illness,^{21,22} workplace injury or violence, and subsequent PTSD.²³ Due to these intersecting factors, health workers are one and a half times more likely to be off work due to illness or disability than workers in other sectors of the Canadian economy.²⁴

These trends have only been exacerbated by the COVID-19 pandemic. Health workers occupy a unique position in the COVID-19 pandemic response.²⁵ As the backbone of health systems, they have been key frontline responders to the crisis and have faced and continue to face great risk of infection.^{26,27} Findings from a 2021 Statistics Canada/CIHI survey suggest that seven in ten healthcare workers report worsening mental health linked to stressful working conditions.²⁸ The unique epidemiology and infectiousness of COVID-19 contributes to demand on the health workforce of unprecedented volume and acuity, while at the same time diminishing health worker supply. Frontline health workers have faced increased job demands,^{29,30} complex and quickly evolving working environments, and riskier working conditions, all while navigating chronic staffing shortages that preceded COVID-19.³¹

The pandemic has put additional stress on workers in the health sector, leading to elevated levels of psychological distress³², ranging from anxiety and depression to PTSD.^{33–37} Risk of contamination, availability of appropriate personal protective equipment, and worker safety have been common concerns/stressors for workers in the healthcare sector during the current pandemic.^{38,39} Although “these concerns manifested as individual distress, they also intersect with and are reflective of concerns relating to healthcare institutions’ policies, communication practices, and politics.”³⁸ Statistics Canada⁴⁰ reported that vacancies in healthcare and social assistance increased by nearly 60% from the second quarter of 2019 to the second quarter of 2021, the largest increase in any sector of the economy. Given the challenging working conditions and inherently stressful nature of healthcare, it is important to understand the factors that facilitate or hinder their psychological health and safety.

The behaviours and leadership styles of supervisors and managers are important influences on frontline health worker mental health.^{41,42} Transformational leadership behaviours (communicating a vision, motivating the group toward higher goals, encouraging creative thinking, and being considerate of individual employees), for instance, have been found to be negatively associated with stress and burnout, and positively associated with self-rated psychosocial well-being.^{43–46} Transformational leadership behaviours can also decrease staff absenteeism,⁴⁷ turnover intention,^{48,49} and enhance staff retention⁵⁰—concerns currently of paramount importance as

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record numbers of health professionals in Canada are leaving their respective professions. Literature also suggests that the reduction in absenteeism and improved retention applies to health workers at all career stages, ranging from novice to senior,^{51,52} which is significant as health worker attrition is seen across the career trajectory.

The COVID-19 pandemic has highlighted the importance of leadership in responding to crisis. Some researchers have proposed or reviewed leadership models and frameworks that could be effective in different contexts (including healthcare) during the pandemic.⁵³⁻⁵⁷ For instance, the LEADS leadership capabilities framework identifies the characteristics of good leaders (ie, lead self, engage others, achieve results, develop coalitions, and champion system transformation) but may require adaptation to context.⁵⁸

Purpose

This study is part of a larger *Healthy Professional Worker* project that examines mental health, leaves of absence and return to work experiences of professional workers. In this paper, we present findings from four health professional case studies—Nursing, Medicine, Midwifery, and Dentistry—from surveys and interviews conducted between November 2020 and July 2021.

Methods

An interdisciplinary mixed methods approach was undertaken to accommodate the complexity of intersectional, contextualized experiences along the pathway from mental health through to leaves of absence and return to work.

Case studies

The professions we focus on represent a mix of gender composition and work context features that the literature suggests are important to mental health. Dentistry and Medicine are traditionally masculine professions that are feminizing,^{59,60} whereas Nursing and Midwifery are traditionally feminine professions. Work contexts range from unionized salaried positions, with both regular and irregular schedules, to independent public sector contractors in solo or group practices, to owners of clinics in the private sector.

Worker surveys

Between the end of November 2020 and early May 2021, a bilingual (French-English) on-line, self-administered survey employing crowdsourcing recruitment via our partner organizations, direct e-mail and social media was undertaken. The survey design included cross-cutting questions asked of all case studies, particularly focusing on the mental health, leave of absence, and return to work pathway, but also including a component which assessed mental health, distress, presenteeism, and burnout during as compared to prior to the pandemic. In the context of this study, mental health issues include mental or psychological stress or

distress, burnout, anxiety, depression, other mood disorders, substance use or dependence, PTSD or serious thoughts of suicide. For each case study, an additional set of customized questions specific to the unique work circumstances of the profession were included. An initial profession-specific question filtered participants to the appropriate questionnaire which employed a skip-logic invisible to the participants, resulting in a survey taking approximately 20 minutes to complete.

A total of 1,860 (1,569 who identified as women and 291 as men) surveys that yielded at least a 90% completion score for the four case study professions were retained for analysis. Reported here are descriptive analyses of the survey data including frequency cross-tabulations where appropriate tests of significance were undertaken at a $P < .05$ significance threshold.

Worker interviews

Concurrent with the surveys, a total of 163 (132 who identified as women and 36 as men) in-depth interviews were conducted either by phone or by Zoom, in French or English between January and July 2021. Recruitment for the interviews was undertaken directly through the same crowdsourcing approach as for the survey and indirectly where survey participants volunteered to undertake a follow-up interview after they completed the survey. A set of screening questions were sent to participants to ensure representation by gender, region, work setting, leave of absence experiences, and other criteria important to the individual case studies. Two team members conducted the interviews, with one member being the primary interviewer and the other member taking notes and interjecting to probe in more depth into specific issues. All interviews were audio recorded, transcribed with Otter.AI, reviewed and analyzed using NVIVO software. A combined *a priori* coding scheme that reflects both a set of standardized codes that cut across cases and case specific codes that were both developed *a priori* and have emerged through the coding process were applied to interview segments. To supplement the survey data, select quotes are included in the paper.

Findings

Background of survey respondents and interview participants

Table 1 provides an overview of the survey respondents by province. The largest number of responses came from the provinces of Ontario and Quebec with Nova Scotia, British Columbia, and Alberta figuring prominently.

Also important for our consideration is the breakdown by gender identity where respondents who identify as women predominate, even in those professions where the gender breakdown is more balanced (Table 2). There were a total of 231 respondents who identify as Black, Indigenous, or health professionals of colour.

Pathway from mental health, leaves of absence to return to work

Our primary research objective was to understand the pathway from the experience of mental health issues to the decision to contemplate or take a leave of absence and return to work. Figure 1 depicts the proportion of our survey respondents that embarked on this pathway, including steps in between, such as making changes to their work and considering taking a leave, even if one was not taken.

Overall, 62% of professional workers who responded to our survey report having any experience of mental ill-health at any time during work or training. This may seem high but respondents who have lived or living experience with mental health issues are likely self-selected to participate in a study focused on this topic and our definition was quite broad. Of those, 60% made changes to work in response to their mental health issue; 53% contemplated taking a leave but only 29% took a leave of absence from work due to their mental health experiences. The vast majority of those who took a leave (73%) returned to work.

Although caution should be exercised in comparing across professions because our respondents do not constitute a representative sample of the professional groups, some interesting differences are notable. In comparison to professional workers overall:

- (1) Respondents from Dentistry are significantly less likely to report having ever suffered from a mental health

issue, whereas respondents from Midwifery and Nursing are significantly more likely.

- (2) Respondents from Dentistry were significantly less likely to contemplate a leave, whereas respondents from Nursing were significantly more likely to contemplate a leave.
- (3) Respondents from Nursing were significantly more likely to report taking a leave of absence from work, whereas respondents from Dentistry, Medicine, and Midwifery were significantly less likely to have taken a leave.

Notably, the differences we found along this pathway by gender identity were in the experience of mental health issues (reported by 65% of respondents who identified as women in comparison to 45% of respondents who identified as men); the consideration of taking a leave (54% among women and 40% among men); and actually, taking a leave (29% among women and 20% among men). There were no significant differences in the rates of return to work, largely due to small sample sizes.

Across all professional respondents, the main reason why mental health leaves were not taken was that they felt that the mental health issue they were experiencing was not severe enough to warrant a leave; the only exception was for respondents from Medicine for whom the most likely response was because of the stigma that disclosure of a mental health issue at work would entail (Figure 2). Stigma and concern about the professional impact of taking a mental health leave from work was a close second for all professional respondents except those from Dentistry. Financial barriers to taking a leave were noted in the top three most frequent responses from Dentistry, Midwifery, and Nursing respondents.

Table 1. HPW survey respondents by province^a.

Province	Dentistry	Medicine	Midwifery	Nursing	Total
BC	63	29	30	77	199
AB	11	33	12	91	147
SK	0	14	0	40	54
MB	7	7	9	37	60
ON	217	120	111	185	633
QC	13	41	11	210	275
NB	0	0	0	106	106
PE	0	0	0	12	12
NS	27	9	0	108	144
NL	0	17	0	20	37
NT/NU/YT	0	0	0	0	0
Missing	44	33	19	120	216

^aSome of the zeros in the table are suppressed data representing less than 5 respondents.

“What pushed me to take that leave of absence was I wasn’t able to, I didn’t feel like I could take care of myself outside of work anymore. I felt as though I had given everything I had to, to thrive and work in this environment, that when I went home, I was done, exhausted.” Nursing Participant

“I think just the reluctance to talk about it for fear if word gets out it may affect their practice ... So I think the barrier would be still the stigma surrounding this whole issue, this whole area of illness.” Dentistry Stakeholder

The factor that facilitated the taking of a leave of absence from work for mental health issues was most likely to be financial support or coverage while on leave, with supportive colleagues, supervisors, and family also

Table 2. Participants by case study and data collection method^a.

	Professional worker surveys	Professional worker interviews
Dentistry	397 (194 women/185 men)	36: 18 women/18 men
Medicine ^b	310 (258 women/46 men)	29: 24 women/5 men
Midwifery ^b	202 (188 women/0 men)	44: almost all women
Nursing	1,013 (929 women/60 men)	54: 46 women/8 men

^aThe total numbers may not add up given we allowed participants to leave the question blank, to identify as non-binary or to self-describe.

^bThe Medicine and Midwifery cases included trainee participants in the survey and interviews.

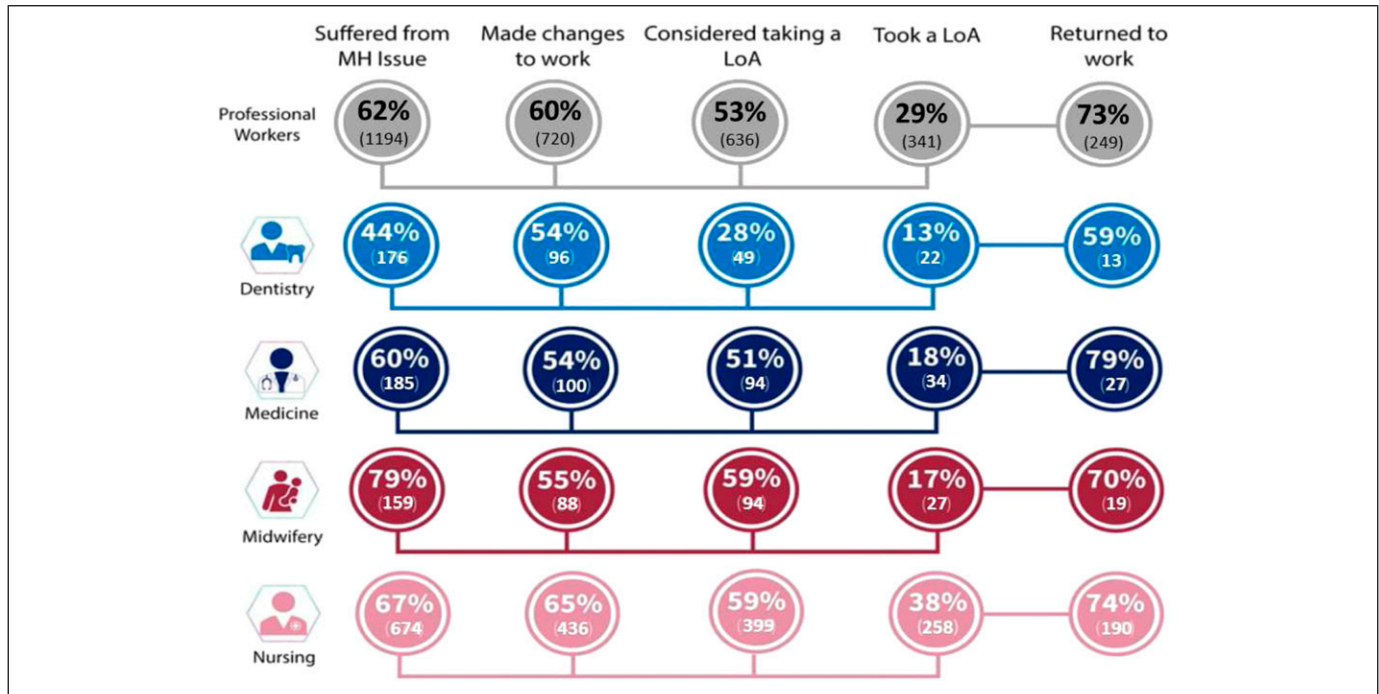


Figure 1. Experiences of mental health and the pathway to leaves of absence and return to work, by profession.

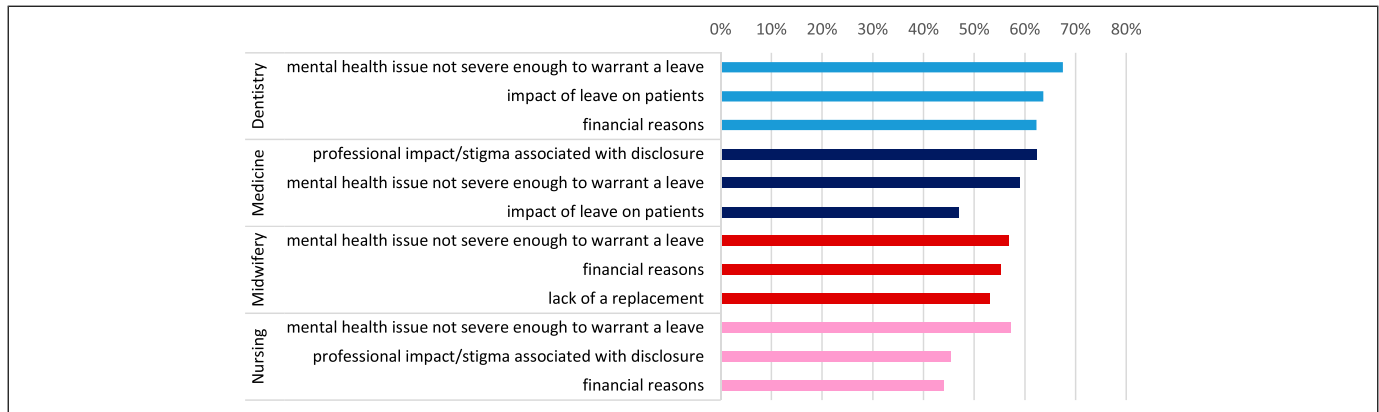


Figure 2. Top three reasons mental health leaves were not taken, by profession, percentage of respondents.

figuring prominently (Figure 3). Similarly, the barriers experienced when taking a leave most often cited by participants were unsupportive supervisors, colleagues, and union representatives and a lack of financial coverage while on leave (Figure 4).

Having supportive colleagues and supervisors figured prominently in facilitating return to work after a leave of absence due to mental health issues. Similarly, unsupportive supervisors and a lack of workplace accommodations, policies, and programs were barriers (Figure 5).

“Trying to accommodate everybody else and the resentment that comes from that. And I think it’s a time where resources are already stretched so midwives find that it’s easy to justify undue hardship.” Midwifery Stakeholder

“... you can’t get a locum here to save your life.” Medicine Participant

“... it’s just not financially feasible.” Medicine Participant

“I was really fearful to go back and, and see that, you know, the environment hadn’t changed, and everything is still the same ... I went back into the same toxic environment.” Nursing Participant

“... the first day is, is pretty brutal ... having a structure when you can go back progressively, is very important, because otherwise it’s very difficult mentally.” Medicine Participant

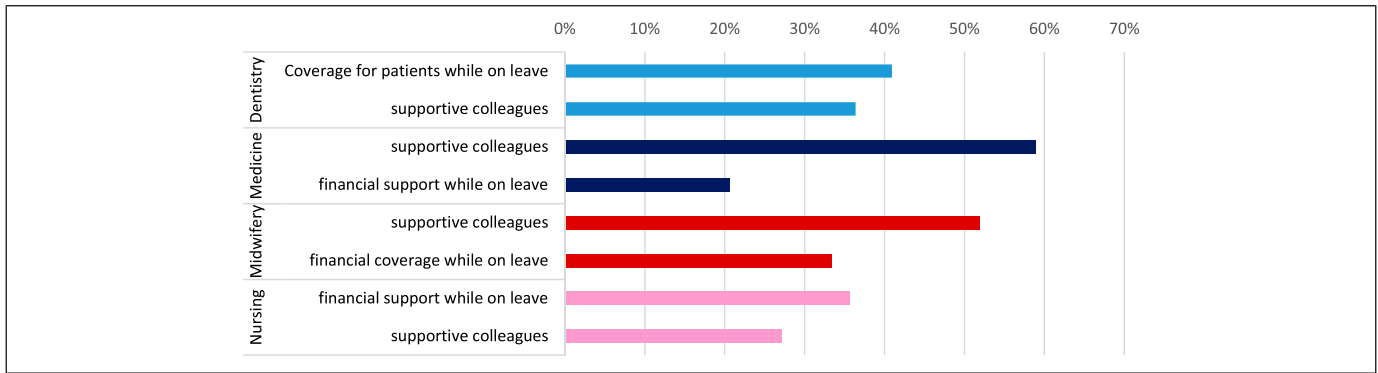


Figure 3. Top two facilitators to taking a leave of absence from work for mental health issues by profession, percentage of respondents.

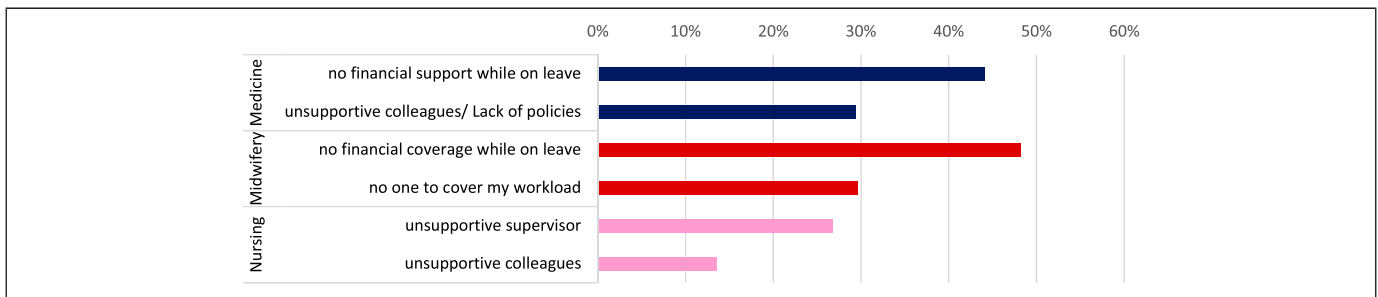


Figure 4. Top two barriers experienced when taking a leave of absence from work for mental health issues by profession*, Percentage of respondents. *There were insufficient data to report for Dentistry.

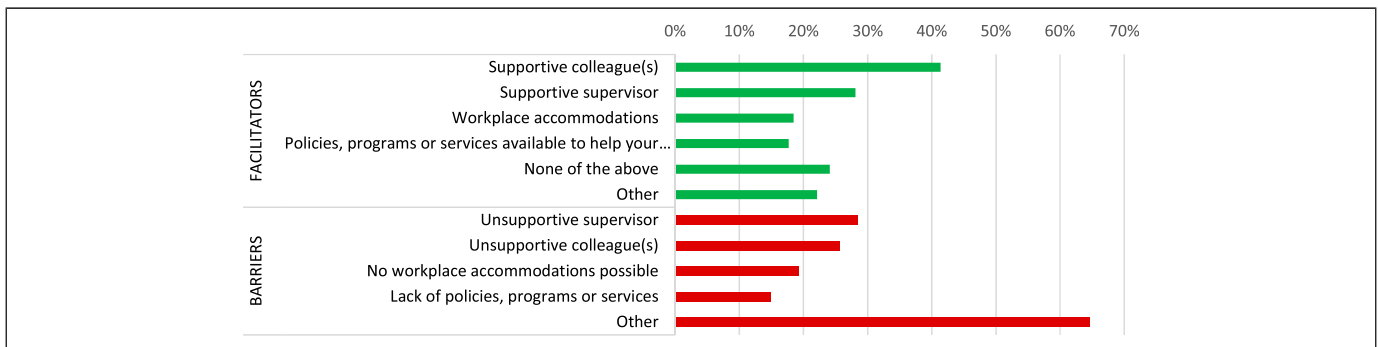


Figure 5. Facilitators and barriers identified by all health professional respondents who returned to work, percentage of respondents.

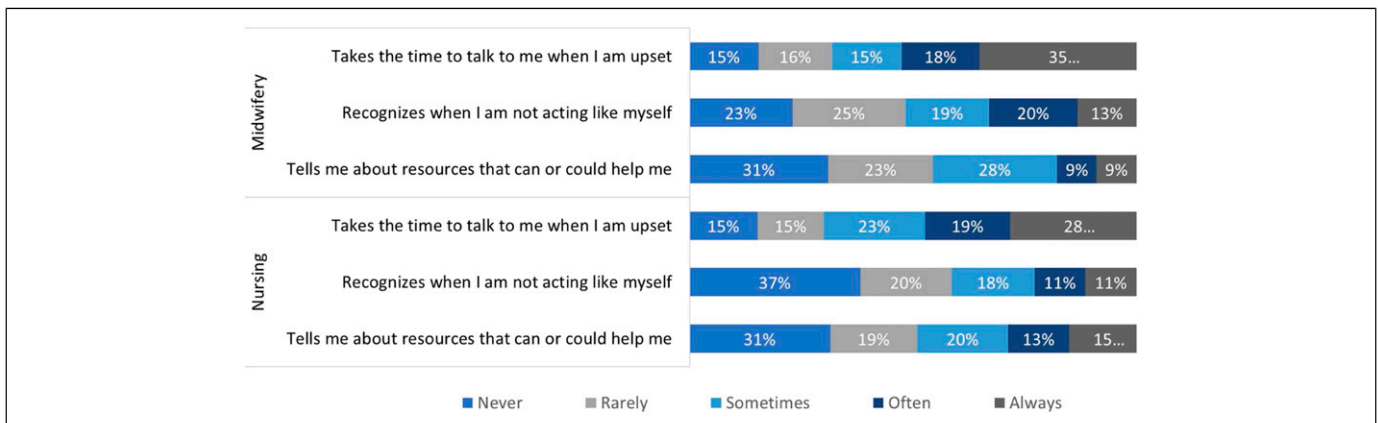


Figure 6. Mental health supports from supervisors by percentage of Midwifery and Nursing respondents.

Midwifery and Nursing respondents were queried specifically about support they receive from their supervisors (Figure 6). For both, they were more likely to report supervisors taking time to talk when they were upset than they were to tell them about resources that could help.

Discussion

Considering the significant mental health concerns that have arisen during the COVID-19 pandemic, these findings are of critical importance. Pandemic-focused research has revealed that supervisors have felt both ambiguity and at times under-prepared for certain roles in responding to the pandemic, including protecting worker psychological health and safety.⁶¹ Supervisors are instrumental in supporting work-life satisfaction, psychological health and well-being at work,⁴³⁻⁴⁶ and health worker retention^{49,50} and as such we encourage those at all levels of health supervision and leadership to reflect on how their positions can uniquely mediate the psychological health and well-being of the health workforce. We encourage supervisors, managers, and those in leadership roles to take an explicit profession- and gender-based approach that recognizes the influence of individual, work, and family circumstances on health worker mental health. We also encourage those in supervisory positions to reflect upon their leadership style because it has the potential to improve workforce mental health and health worker retention. Given that leadership can play an important role in mitigating mental health issues, investment in both leadership training and mentorship is an important first step in acting upon our research findings.

In sum, the findings from our research on the pathway from the experience of mental health through to subsequent decisions to take a leave of absence from work (*or not*) and then to return reveal some important concerns and opportunities for intervention. Across professions, there is a need to destigmatize mental health issues and encourage greater awareness and support from leaders, supervisors, and colleagues recognizing that both gender and leadership matter greatly. Our findings of how this pathway differed among the health professions suggests that it will be important to study these phenomena in other health professions so as to further explore how different work context influences workers' experiences of mental health.

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