

# WORKLOAD AND BURNOUT AMONG HEALTHCARE WORKERS: THE ROLE OF WORK-FAMILY CONFLICT AS A MEDIATOR AND HUMAN RESOURCE MANAGEMENT RESOURCES AS BUFFERS: A SYSTEMATIC REVIEW

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## Abstract

This systematic review examines the relationship between workload and burnout among healthcare workers, with work-family conflict (WFC) as a mediating mechanism and HRM resources as buffering factors. Following PRISMA guidelines, English-language studies published between 2015 and 2026 were screened, and 23 articles met the inclusion criteria. Of these, 21 reported a positive association between high workload and burnout, especially emotional exhaustion. Among 16 studies assessing WFC, 14 identified it as a mediator. Additionally, 18 studies found that organizational support, supportive leadership, family-friendly policies, adequate staffing, and positive work climates reduced burnout. Burnout thus reflects interacting work demands, family conflict, and organizational resources

**Keywords:** Burnout; Work family conflict; Workload; Human resource management; Healthcare workers

## INTRODUCTION

(World Health Organization, 2019) in the 11th edition of *the International Classification of Diseases* (ICD-11) classifies burnout as an occupational phenomenon rather than a medical condition, defined as a syndrome resulting from prolonged, unmanaged workplace stress. Burnout is characterized by three main dimensions: *feelings of energy depletion or exhaustion, increased mental distance or feelings of negativism and cynicism, and reduced professional efficacy* (World Health Organization, 2019). These dimensions are operationalized in various instruments, the most widely used of which is *the Maslach Burnout Inventory (MBI) m*, which measures *emotional exhaustion, depersonalization, and reduced personal accomplishment* (Maslach et al., 2001).

The prevalence of *burnout* among healthcare workers globally under normal conditions ranges from 32–34%, whereas during the COVID-19 pandemic it rose to 52–66%. This situation makes it one of the greatest threats to the stability of healthcare workers, their well-being, and the quality and sustainability of healthcare services (Ghahramani et al., 2021; Rotenstein et al., 2018). This phenomenon is explained by the *Job Demands-Resources (JD-R)* model (Bakker & Demerouti, 2007) and the *Conservation of Resources (COR)* theory (Hobfoll, 1989). Both frameworks explain the imbalance between work demands and available resources and trigger *resource depletion*, which leads to *burnout*. Clinicians work under constant pressure, with heavy workloads, long working hours, night shifts, and an imbalanced patient-to-staff ratio. This stress is further exacerbated by excessive emotional and administrative burdens, which also predict the onset of emotional exhaustion, depersonalization, intention to quit, and a decline in quality of life (Kowalczyk et al., 2020; Li et al., 2021; Wang et al., 2023; Wong et al., 2024). *Burnout* in healthcare is not merely a psychological condition but an organized phenomenon closely linked to job design and resource allocation.

From a Human Resource Management (HRM) perspective, burnout is viewed as a critical issue in retaining staff to maintain institutional performance and service quality. Within the Job Demands-Resources (JD-R) framework, it is explained that excessive job demands not only deplete psychological resources but also trigger counterproductive motivational processes when organizational resources are inadequate, particularly leading to weakened commitment and work engagement (Bakker & Demerouti, 2007). Burnout predicts turnover intention,

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absenteeism, and service continuity, which directly impact staff stability and organizational performance (Bogaert et al., 2018; Mthembu et al., 2025a; Scheepers, Van Den Broek, et al., 2023) . Burnout also leads to reduced empathy, impaired effectiveness, and presenteeism, causing healthcare workers to not perform at their optimal capacity—a situation exacerbated by family pressures and excessive workloads (Bogaert et al., 2018; Van Bogaert, Peremans, et al., 2017; S. M. Zwakhalen et al., 2018). Burnout is increasingly recognized as part of HRM issues requiring appropriate interventions.

The core argument of this review lies in the relationship between workload and burnout, often mediated by Work-Family Conflict (WFC) a form of role conflict where work and family demands clash (Greenhaus & Beutell, 1985). WFC manifests through two primary mechanisms: time-based conflict, where time spent on work reduces time available for family, and strain-based conflict, which occurs when fatigue and tension from work spill over into family roles (Greenhaus & Beutell, 1985) . The COR framework explains that WFC accelerates the depletion of psychological resources because individuals simultaneously face multiple demands, thereby limiting their capacity for recovery (Hobfoll, 1989). WFC also exacerbates emotional exhaustion, which serves as the closest link between excessive workload and fatigue (Pian et al., 2019a; Scheepers, Van Den Broek, et al., 2023; S. M. Zwakhalen et al., 2018). WFC is not merely an effect of high work demands but a mechanism that explains how working conditions transform into chronic psychological stress.

Various empirical studies have reinforced the mediating role of WFC in the pathway linking workload to burnout. Increased WFC is associated with higher daily fatigue, a stronger intention to quit, and lower vitality (Blanco-Donoso et al., 2021; Scheepers, Van Den Broek, et al., 2023) . Studies in hospitals and primary care settings have found that WFC leads to emotional exhaustion, reduced job satisfaction, and turnover intention, (Asiedu et al., 2018a; Dilmaghani et al., 2022; Wen, Xu, et al., 2023; Wen et al., 2024; Yan et al., 2023a) . Emotional burnout and WFC worsen health, sleep disturbances, and increase resignations (Bogaert et al., 2018; Bruyneel et al., 2025; Cerela-Boltunova & Millere, 2025; Monroe, Loresto, Horton-Deutsch, et al., 2021; Van Bogaert, Van Heusden, et al., 2017). Several studies confirm that workload contributes to WFC while also serving as a trigger for burnout, which can impact healthcare workers' retention and performance.

However, the pathways of WFC are not uniform but are shaped by several key moderators and buffers. Sleep disturbances, social support, decision-making autonomy, and supervisor support act as factors that weaken or strengthen the relationship between WFC and burnout in healthcare settings (Bellanti, Lo Buglio, et al., 2021; S. Han & Kwak, 2022; X. Wang et al., 2023; Yeh et al., 2020; H. Zhang et al., 2020; Y. Zhang et al., 2023). During the COVID-19 pandemic, WFC and burnout were exacerbated by escalating workloads, fear, uncertainty, and the blurring of boundaries between work and home life, leading to significantly higher psychological strain compared to normal conditions (Afulani et al., 2021; Appelbom et al., 2024a; Bellanti, Lo Buglio, et al., 2021; Cotel, Golu, Pantea Stoiian, et al., 2021; Golu et al., 2022) . Burnout should be understood as a dynamic phenomenon shaped by the interaction between demands and the availability of protective resources, rather than as a static condition.

The importance of HRM becomes increasingly relevant when HR practices support families and there is broader organizational support that leads to a reduction in work-family conflict and burnout. Large-scale studies in hospital and primary care settings have found that lower burnout rates are associated with organizational readiness, recognition, and organizational support, as well as a family-friendly work environment (Afulani et al., 2021; Liu et al., 2025; Martin et al., 2021; Zhou et al., 2022). Family-friendly work scheduling, leave policies, childcare support, and operational readiness can reduce work-related disruptions in the household. WFC is not merely a personal issue but can fundamentally be addressed through organizational arrangements.

Clinical supervision and team support can mitigate WFC, reducing the risk of burnout and staff turnover (Haruna et al., 2022; Martin et al., 2021; Oetoyo, 2022) . Supportive supervisors, fair scheduling, role clarity, recognition, and emotional regulation can help healthcare workers manage the demands of work and family life. Recent research also indicates that relying on a single strategy is insufficient; rather, it is necessary to integrate structural support—such as staff assignments and schedules with relational support, such as team climate and leadership quality (Dūdiņa & Martinsone, 2025) .

WFC and burnout are also associated with job type, gender, caregiving status, and exposure to extreme work conditions, with the direction and strength of these effects varying across work contexts. Healthcare workers including nurses, doctors, and ICU staff often exhibit burnout, with higher rates observed among doctors (Pang et al., 2022; Zhou et al., 2022) . Female healthcare workers and younger staff more frequently report higher levels of WFC and burnout due to role overlap and limited control, although this is not entirely consistent across all contexts and populations (Dillon et al., 2022; Pan et al., 2022; Zhou et al., 2022). The inconsistency of these findings suggests the possibility of contextual moderators that have not yet been fully mapped in the literature, thereby

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opening opportunities for more integrated analysis (Afulani et al., 2021; Appelbom et al., 2024; Cotel, Golu, Pantea Stoian, et al., 2021; Golu et al., 2022). Thus, this raises several questions regarding how to address the existing gaps, namely:

## LITERATURE REVIEW

Burnout has become a critical issue in the healthcare sector, particularly due to increasing job demands and complex work environments. According to Maslach et al. (2001), burnout is a psychological syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment, resulting from prolonged exposure to occupational stressors. The World Health Organization (2019) further classifies burnout as an occupational phenomenon, emphasizing its relevance in organizational and workforce management contexts. One of the primary factors contributing to burnout is workload. High workload reflects excessive job demands that require sustained physical and psychological effort, which can lead to fatigue and stress. Previous studies indicate that excessive workload is significantly associated with higher levels of burnout among healthcare workers (Ghahramani et al., 2021; Kowalczyk et al., 2020). Within the framework of the Job Demands-Resources (JD-R) model, workload is categorized as a job demand that can trigger strain when not balanced with adequate resources (Zhou et al., 2022).

In addition to workload, work-family conflict (WFC) plays a crucial mediating role in the development of burnout. Greenhaus and Beutell (1985) define WFC as a form of inter-role conflict in which the demands of work and family are mutually incompatible. When healthcare workers experience high workload, the pressure often extends beyond the workplace, disrupting family responsibilities and personal life. Empirical studies have shown that WFC significantly contributes to emotional exhaustion and overall burnout (Wen et al., 2023; Zhang et al., 2020). This indicates that WFC acts as a psychosocial mechanism that amplifies the negative effects of job demands. Furthermore, organizational support and human resource management (HRM) practices serve as important buffering factors against burnout. The Conservation of Resources (COR) theory proposed by Hobfoll (1989) suggests that individuals strive to obtain, retain, and protect valuable resources. In the workplace context, resources such as supervisory support, flexible work arrangements, and adequate staffing can reduce stress and mitigate burnout. Studies have demonstrated that supportive leadership and organizational interventions can significantly lower burnout levels among healthcare professionals (Martin et al., 2021; Härkänen et al., 2023).

Social support is also identified as a key protective factor. Emotional and professional support from supervisors and colleagues can help individuals cope with stress and maintain psychological well-being. Research shows that healthcare workers who receive strong social support experience lower levels of burnout and better job satisfaction (Haruna et al., 2022; Monroe et al., 2021). This highlights the importance of fostering a supportive work environment to enhance employee resilience. In the context of healthcare settings, burnout is also influenced by various contextual and demographic factors such as profession, gender, work unit, and crisis situations like the COVID-19 pandemic. Studies conducted during the pandemic reveal a significant increase in burnout levels due to heightened workload, uncertainty, and emotional pressure (Pang et al., 2022; Rotenstein et al., 2018). These findings suggest that burnout is not only an individual issue but also a systemic organizational challenge.

Despite the extensive research on burnout, most studies rely on cross-sectional designs and self-reported data, which limit the ability to establish causal relationships. Therefore, future research is encouraged to adopt longitudinal and multi-level approaches to better understand the dynamic relationships between workload, work-family conflict, organizational resources, and burnout. Overall, the existing literature consistently demonstrates that workload is a major predictor of burnout, with work-family conflict acting as a mediating mechanism and organizational support serving as a moderating factor. This theoretical and empirical foundation provides a strong basis for examining burnout among healthcare workers and highlights the importance of strategic interventions in managing workforce well-being.

## METHOD

### 1. Review Design

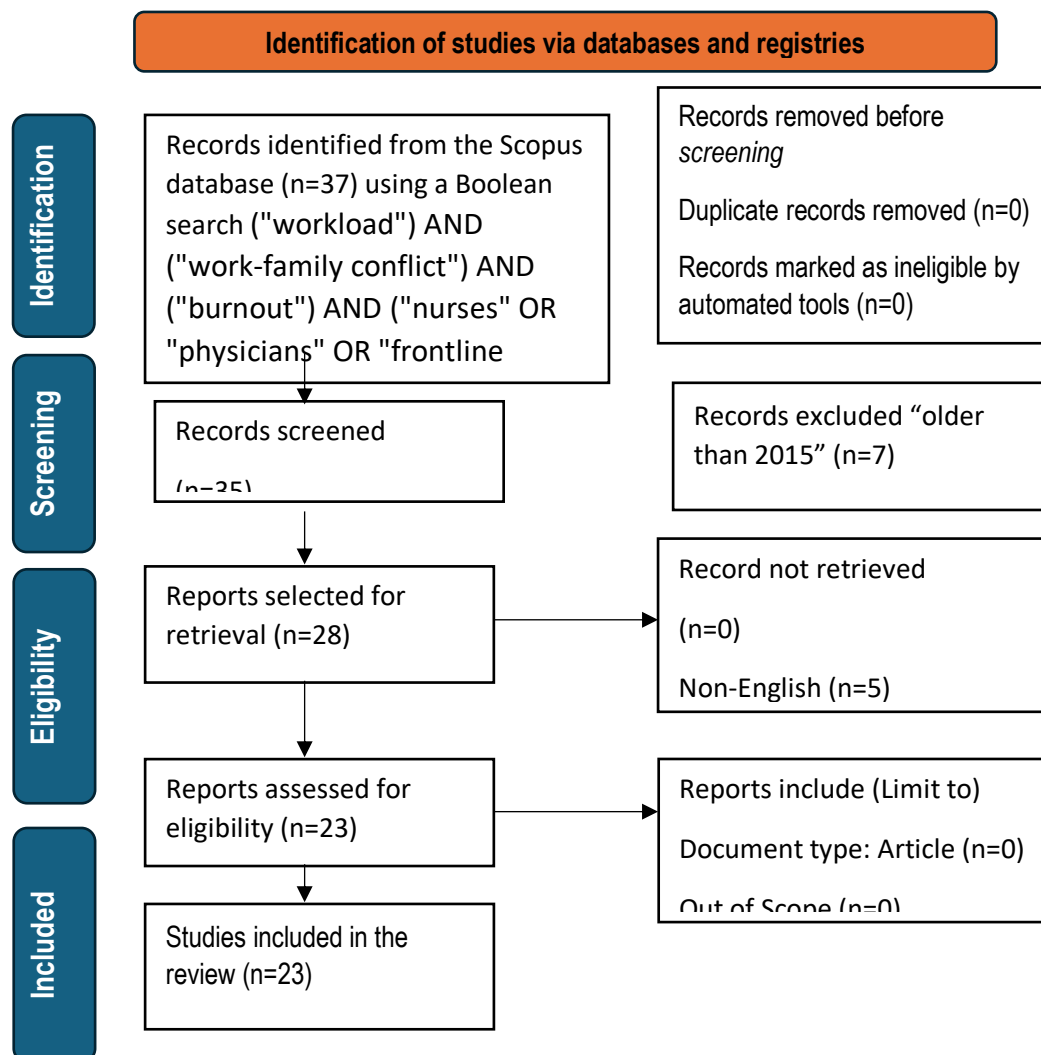
This review is designed as a *systematic review* that synthesizes studies across various designs in a transparent and reproducible manner in accordance with *multilevel* research questions (quantitative, qualitative, and *mixed-methods* studies). The review adheres to the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) guidelines, which require documentation of eligibility criteria, search procedures, study selection, data extraction, quality assessment, and synthesis strategies to ensure transparency and reproducibility (Page et al., 2021).

**2. Search Strategy**

Data were sourced from multidisciplinary biomedical and social science literature covering research in health management, occupational health, psychology, and nursing science. The databases used included PubMed/MEDLINE, Embase, CINAHL, PsycINFO, Scopus, and Web of Science, with publication years ranging from 2015 to 2026. To enhance the comprehensiveness of the literature and minimize bias, other relevant sources were also considered, such as: the Cochrane Library, the ProQuest database (Agyemang et al., 2023; Aust et al., 2024; De La Fuente-Solana et al., 2020; Härkänen et al., 2023; Zareei et al., 2022) . The Boolean search string used was: ("workload") AND ("work-family conflict") AND ("burnout") AND ("nurses" OR "physicians" OR "frontline healthcare workers"). The search strategy was developed using the *Population, Phenomenon of Interest, Context, Outcome, Study Design* (PICOS) framework (Schardt et al., 2007) as a guide. Additional relevant articles were identified through reference checking and included from the full-text review stage onwards.

**3. Screening, Selection, and Data Extraction Process**

The screening process involved removing documents identified as duplicates (based on title and abstract) and filtering to ensure the inclusion of relevant studies. Eligible articles were then selected based on inclusion and exclusion criteria by two independent reviewers. Data extraction was performed using a structured template to explore the characteristics of each study, including study design, sample characteristics, health services, instruments, key variables (workload, work-family conflict, burnout), and main findings. The selection flow is shown in (Figure 1).



#### **4. Quality Assessment and Synthesis of Evidence**

Quality was determined based on the methodological design of each study, using the Joanna Briggs Institute (JBI) critical appraisal to assess the methodological quality of quantitative, qualitative, and mixed-methods studies (Cerela-Boltunova & Millere, 2025; Monroe, Loresto, Horton-Deutsch, et al., 2021; S. M. Zwakhalen et al., 2018). Following the review, a structured narrative synthesis was conducted on the following thematic areas: (1) job demands and workload as triggers of burnout, (2) work-family conflict as a mediating mechanism, (3) human resource (HR) resources as buffering factors, and (4) contextual contingencies and intervention implications.

### **RESULTS AND DISCUSSION**

#### **1. Study Characteristics**

Based on a literature review of 23 articles, the majority of studies used a cross-sectional design (n=18; 78%), followed by longitudinal or quasi-experimental designs (n=3; 13%), mixed-methods designs (n=1; 4%), and scoping reviews (n=1; 4%). The most commonly used instruments were the Maslach Burnout Inventory (MBI) (n=21; 91%) and the , while the other two studies used the Copenhagen Burnout Inventory (CBI) (n=1) and the Burnout Assessment Tool (BAT) (n=1). The studies originated from 13 countries, reflecting the geographical diversity of the research, with the largest contribution from China (n=5; 22%), followed by Belgium, the Netherlands, Romania, and Ghana (n=2) with 2 studies each, and the remainder with 1 study each from Latvia, the USA, Spain, Iran, South Korea, Taiwan, Sweden, Malaysia, and South Africa (n=1 each). The study sample included various healthcare professions, dominated by hospital nurses and primary care facility staff, followed by physicians and primary care staff. Several studies were specifically conducted during the COVID-19 pandemic (n=7; 30%).

#### **2. Study Quality Assessment**

Methodological quality assessment used the Joanna Briggs Institute (JBI) criteria for quantitative, qualitative, and mixed-method studies. Of the 23 included studies, 20 (87%) met  $\geq 70\%$  of the methodological quality criteria, indicating evidence of moderate to high quality. Three studies (13%) met 60–69% of the criteria, primarily due to sample size limitations and potential common method variance bias resulting from the use of self-report surveys in a cross-sectional design. No studies were excluded based on quality assessment but were still considered in the interpretation of findings.

#### **3. Workload as a Trigger for Burnout**

Overall, workload was found to be a fairly consistent trigger for *burnout* among healthcare workers. These studies report a relationship between high workload and increased *burnout*, particularly in the dimension of emotional exhaustion; (Bellanti, Buglio, et al., 2021; Cotel, Golu, Stoian, et al., 2021; Pang et al., 2022; Zhou et al., 2022). This pattern is found across various healthcare settings, including hospitals, intensive care units, emergency departments, primary care, and long-term care facilities {Citation} ( Bellanti, Buglio, et al., 2021; Cerela-Boltunova & Millere, 2025b; Scheepers, Broek, et al., 2023) . The factors most frequently associated with *burnout* are long working hours, irregular *shift* schedules, high patient-to-staff ratios, administrative burdens, and emotional demands in clinical work (Bellanti, Buglio, et al., 2021; Cotel, Golu, Stoian, et al., 2021; Van Bogaert, Peremans, et al., 2017; Wong et al., 2024) . Although the direction of the relationships in the reviews is relatively consistent, the strength of these relationships varies according to the type of profession, organizational context, and working conditions faced by healthcare workers (Pang et al., 2022, 2022b; Zhou et al., 2022)

#### **4. Work-Family Conflict as a Mediating Mechanism**

This review also found that *work-family conflict*(WFC) plays an important role in explaining the relationship between workload and *burnout*. A total of 16 studies examined WFC as a primary variable, and 14 of these studies supported the mediating or partial mediating role of WFC in this relationship (Blanco-Donoso et al., 2021; Asiedu et al., 2018; Dilmaghani et al., 2022 ; Z. Wen et al., 2023 ;Z. Wen et al., 2023; Z. Wen et al., 2024 ; Scheepers et al., 2023 ; Han & Kwak, 2022 ). In general, higher work-family conflict ( ) is associated with increased time-based and pressure-based conflicts between work and family roles, which ultimately contribute to emotional exhaustion, decreased vitality, reduced job satisfaction, and increased intention to leave the job (Blanco-Donoso et al., 2021; Asiedu et al., 2018 ; Dilmaghani et al., 2022 ; Z. Wen et al., 2023 ; Scheepers et al., 2023 ). This pattern is primarily found among healthcare workers who have long working hours, irregular shift schedules,

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and high emotional demands (Scheepers, Van Den Broek, et al., 2023; Yan et al., 2023). Therefore, WFC not only acts as an additional stressor but also as a psychosocial pathway explaining how excessive workload transforms into chronic work stress and *burnout* (S.-J. Han & Kwak, 2022; Scheepers, Van Den Broek, et al., 2023; Wen, JinTao, et al., 2023).

## 5. HR Resources as a Buffering Factor

Most of the studies reviewed indicate that organizational resources and human resource management practices (MSDM) serve as protective factors against *burnout*. A total of 18 studies highlighted the protective role of supervisor support, staff empowerment, organizational recognition, adequate staffing, work autonomy, family-friendly work arrangements, and a positive team climate. *Burnout* tends to be less prevalent among healthcare workers who perceive stronger institutional support and more supportive work designs (Afulani et al., 2021; Van Bogaert, Van Heusden, et al., 2017; J. Wang et al., 2023). Several intervention-based studies have also found that a reduction in *burnout* is more likely to occur when individual-focused strategies are combined with organizational support, rather than relying solely on personal coping mechanisms (Monroe, Loresto, Horton-Deutsch, et al., 2021a; S. Zwakhalen et al., 2018). These findings confirm that *burnout* among healthcare workers cannot be adequately understood as solely an individual issue but is also closely linked to work design, organizational policies, and the quality of managerial support (J. Wang et al., 2023; Yeh et al., 2020).

## 6. Contextual Variations in Findings

The review also showed that the relationship between workload, WFC, and *burnout* is shaped by various contextual factors. Variations in findings were reported based on profession, gender, caregiving status, clinical unit, exposure to crises or pandemics, sleep disturbances, as well as levels of supervisor support and social support (Appelbom et al., 2024; Mthembu et al., 2025; Pang et al., 2022; Yan et al., 2023; Zhou et al., 2022). Nurses, physicians, and staff in intensive care units or emergency departments are groups more vulnerable to *burnout* (Pang et al., 2022; Yan et al., 2023). In some contexts, female healthcare workers and younger healthcare workers more frequently report higher levels of WFC and *burnout*, particularly when facing caregiving responsibilities and heavy work demands simultaneously (Yan et al., 2023; Zhou et al., 2022). However, the influence of these contextual factors is not entirely consistent across all studies, indicating that the relationship between workload, WFC, and *burnout* is sensitive to organizational context and healthcare worker characteristics (Appelbom et al., 2024; Mthembu et al., 2025).

## Discussion

### 1. Workload as a Trigger for Burnout

Workload must be understood not merely as a characteristic of the job but as a structural mechanism that drives *burnout* among healthcare workers. High work pressure reflects an imbalance between job demands and the capacity of both the individual and the organization (Bellanti, Buglio, et al., 2021; Cotel, Golu, Stoian, et al., 2021; Pang et al., 2022; Van Bogaert, Peremans, et al., 2017; Zhou et al., 2022). Thus, *burnout* among healthcare workers cannot be adequately explained as a matter of personal resilience but must be understood as the result of demanding, repetitive, and continuous work designs that require both physical and emotional energy. Within the *Job Demands-Resources* framework (JD - R), it is explained that high job demands trigger health issues, particularly when not balanced by adequate job resources (Bakker & Demerouti, 2007). In healthcare, workload is not only about the volume of tasks but also includes time pressure, clinical uncertainty, administrative burdens, and the emotional intensity of care all of which can accelerate *burnout* (Monroe, Loresto, Horton-Deutsch, et al., 2021; Scheepers, Broek, et al., 2023). Therefore, reducing *burnout* requires organizational-level interventions through workload management and resource redistribution; individual coping training alone is insufficient.

### 2. WFC as a Psychosocial Mechanism

WFC acts as a mediator but interprets work-family conflict as a psychosocial pathway that makes the impact of work stress more complex. When work demands extend into the family sphere, healthcare workers not only face work-related exhaustion but also lose the recovery space they should be able to find within the family or outside the workplace (Asiedu et al., 2018; Blanco-Donoso et al., 2021; Dilmaghani et al., 2022; Wen, JinTao, et al., 2023). WFC can be understood as a process explaining why the same workload leads to higher *burnout* levels when individuals also experience role pressure within the household. (JD-R) which views stress as occurring as a

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result of the loss of valuable resources, such as time, energy, and control). When healthcare workers face intense job demands alongside difficulties in fulfilling family responsibilities, the psychological resources available for recovery become increasingly limited (Pian et al., 2019; Scheepers, Broek, et al., 2023; S. Zwakhalen et al., 2018). Therefore, managing *burnout* cannot focus solely on the workplace but must also consider how organizations manage the impact of work on work-family balance.

### 3. The Role of HR Resources as a Support System

Human resource management practices (*MSDM*) serve not merely as a supplement but as a core component in mitigating the impact of work demands on *burnout*. A supportive work environment can break the chain or at least weaken the pathway through which workloads lead to work-family conflict and *burnout* (Afulani et al., 2021; Monroe, Loresto, Horton-Deutsch, et al., 2021; J. Wang et al., 2023; Yeh et al., 2020b; S. Zwakhalen et al., 2018). *Burnout* is not an inevitable outcome, as the impact of work demands is significantly influenced by the quality of support available within the organization.

Work resources such as supervisor support, organizational recognition, adequate staffing, autonomy, and family-friendly work policies serve as protective factors that can mitigate the negative impact of job demands (Bakker & Demerouti, 2007). Effective HRM interventions need to shift from a reactive to a preventive approach. Healthcare organizations are advised to establish a work system that not only responds to *burnout* after it occurs but also actively designs work conditions that prevent the depletion of healthcare workers' psychological resources at an earlier stage.

### 4. Contextual Contingencies and Variations in Vulnerability

The occurrence of WFC and *burnout* is not uniform across all groups of healthcare workers. *Burnout* is shaped by the interaction between work demands and the organizational social context in which healthcare workers operate (Appelbom et al., 2024; Mthembu et al., 2025; Pang et al., 2022; Yan et al., 2023). Therefore, the risk of *burnout* is significantly influenced by the characteristics of the job and the social responsibilities of healthcare workers. Healthcare workers in units with high work pressure, such as ICUs and emergency departments, experience higher work demands and emotional stress, while workers with caregiving responsibilities particularly women are more vulnerable to more severe work-family conflicts (Pang et al., 2022; Yan et al., 2023b; Zhou et al., 2022). The organizational context plays a significant role in either amplifying or mitigating the resulting vulnerabilities. Interventions within each organization should not be treated uniformly but tailored to the specific conditions of each organization, such as considering the characteristics of work units, professional groups, and the varying needs of healthcare workers.

### 5. Methodological and Practical Implications

The predominance of *cross-sectional* studies and the use of *self-report* instruments indicate that the relationships between variables in the reviewed literature are consistent and pattern-oriented but still have limitations in strongly confirming causal direction. Therefore, longitudinal studies, multilevel approaches, and intervention evaluations are needed to gain a deeper understanding of the relationships between workload, WFC, HRM resources, and *burnout*.

From a practical standpoint, *burnout* among healthcare workers should be treated as a strategic organizational issue, and organizations should prioritize workload management, adequate staffing, flexible scheduling, supervisory support, and policies that promote work-family balance as part of their employee retention strategies and efforts to improve the quality of healthcare services (Afulani et al., 2021; Martin et al., 2021; J. Wang et al., 2023; Van Bogaert, Van Heusden, et al., 2017). Thus, the contribution of this review is not only to demonstrate that workload is associated with *burnout* but also to confirm that specific psychosocial mechanisms can be mitigated through appropriate HRM interventions.

## CONCLUSION

From this review, we conclude that high workload serves as a trigger for *burnout* among healthcare workers, particularly in the dimension of emotional exhaustion, and this relationship is explained by *work-family conflict* (*WFC*) as a psychosocial mechanism that extends the impact of work demands into the family sphere, while organizational resources and human resource management practices (*MSDM*) act as buffering factors. This

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relationship is also influenced by contextual factors, including profession, gender, caregiving status, work unit, and crisis situations. Although most of the evidence comes from *cross-sectional* and *self-report* studies, these findings underscore that *burnout* must be positioned as a strategic issue in healthcare workforce management. Therefore, healthcare organizations need to prioritize workload management, adequate staffing, leadership support, and policies that support work-life balance.

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