Occupational Stress Management Among Canadian Healthcare Professionals

Adeola Oyewole, MD

ABSTRACT

Background: Occupational stress for healthcare workers in Canada is an increasing problem, compounded by staffing shortages, administrative tasks, and the long-term effects of the COVID-19 pandemic. Chronic exposure to stressors leads to burnout, emotional exhaustion, and a diminishment of quality of care.

Purpose: The purpose of this review is to explore the prevalence, causes, and coping mechanisms of occupational stress in Canadian healthcare workers and to discuss barriers to the successful implementation of interventions.

Methods: A literature review of peer-reviewed publications from databases including PubMed, CINAHL, PsycINFO, and Scopus was undertaken for studies between 2010 and 2024. Thematic analysis was employed to integrate information on indicators of stress, coping strategies, and systemic issues.

Key Findings: Stress and burnout are pervasive throughout healthcare occupations, particularly for emergency staff and nurses. Overload, emotional labor, lack of organizational support, and administrative burden are prominent stressors. While individual-level coping strategies like mindfulness and peer support are standard, organizational and policy-level responses are underutilized due to stigma, time, and cultural inappropriateness.

Conclusions: Occupational stress is a systemic issue calling for far-reaching, proactive measures. Its reduction demands a cultural transformation to psychologically safe, culturally competent workplaces grounded in inclusive policy and leadership engagement. This review supports the need for comprehensive, sustainable stress management interventions in Canadian healthcare.

Keywords
Occupational stress, healthcare professionals, Canada, burnout, coping strategies, mental well-being

Introduction

Healthcare workers are some of the most stressed professionals in the world. In Canada, stress levels have gone up because of staff shortages, more people needing care, and significant health challenges like the COVID-19 pandemic. These problems don't just affect the health of doctors, nurses, and other healthcare professionals; they also put patients at risk, slow down the system, and make it harder for hospitals and clinics to operate efficiently [1,4]. Job stress happens when healthcare workers are asked to do more than they can handle.

If not properly managed, this stress can lead to burnout, mistakes, and long-term health problems. Long workdays, excessive workloads, moral discomfort, administrative responsibilities, and continuous exposure to emotionally stressful conditions are the leading causes of the high burnout rates among Canadian healthcare workers [6,7,9]. Studies show that stress-related illnesses that impact healthcare workers include anxiety, depression, substance abuse, cardiovascular issues, and cognitive impairment. The factors above increase turnover and negatively impact work performance. [4,16]

Effective stress management is essential for promoting clinician well-being and ensuring the optimal functioning of the healthcare system. They encompass individual interventions like mindfulness and resilience training, organizational policies like flexible working, leadership support, and psychological services [5,10,14]. Notwithstanding this, research indicates low utilization of institutional resources, with the bulk of this being

due to stigma, time concerns, and unawareness. This study examines the findings of past research on the prevalence of work-related stress among healthcare workers in Canada, its origins, and the management strategies employed. It aims to:

- Highlight the leading causes and warning signs of stress in Canadian healthcare environments.
- Explore different ways healthcare workers try to cope with stress and how well these approaches apply.
- Discuss the challenges that make it hard to put these stress-relief methods into practice or keep them going over time.

Scope of the Review

This literature review incorporates a total of 48 studies published between January 2010 and December 2024, which explore the topic of occupational stress in Canadian healthcare professionals. The highlights of this work are mainly empirical studies, systematic reviews, and meta-analyses, while the types of research methods include quantitative, qualitative, and mixed-methods studies. This study included various healthcare professionals, such as nurses, doctors, therapists, mental health staff, and workers in different settings, including hospitals, clinics, and rural areas.

The inclusion criteria are as follows:

- Academic articles in the English language
- Sample population of medical doctors in Canada
- Studies on occupational stress, burnout, coping, or mental health
- Articles with reporting of data on causality, symptoms, or interventions in managing

Exclusion criteria included:

- Non-Canadian or global studies without Canada-specific data
- Research focused on non-healthcare occupations.
- Editorials, opinion pieces, and non-peer-reviewed grey literature (except for government reports like CIHI and PHAC for context)

Literature was searched using research databases, including PubMed, CINAHL, Scopus, and PsycINFO, with a complement of relevant governmental reports of Canada. A thematic analysis framework with an integrative design across studies of mixed population and study design was used in this review.

Methods: Literature Review Approach

The method used to conduct this study is a structured literature review. The study provides a review of relevant peer-reviewed literature on the occupational stress of Canadian healthcare workers and interventions to improve the management of stress.

Search Strategy and Data Source

The literature search includes studies that have appeared since January 2010 until December 2024.

Inclusion and Exclusion Criteria

Inclusion criteria were:

- Questionnaires concerning professional pressure among Canadian healthcare professionals (nurses, doctors, allied healthcare professionals).
- Empirical reports, reviews, or meta-analyses of data.
- English language and peer-reviewed journals

Exclusion criteria were:

- Studies outside the Canadian context.
- Non-healthcare occupational groups.
- Non-peer-reviewed opinion pieces or editorials.

Data Extraction and Analysis

Primary data extraction included: authorship, year of research, research population, career group, stress measures (e.g., Perceived Stress Scale, Maslach Burnout Inventory), nature of interventions, outcome, and limitations. Thematic (qualitative) extraction was used in identifying patterns and themes of recurring patterns in sources of pressure, indicators of pressure, and pressure management. Quantitative and qualitative data were merged.

Ethical Approval

Because no human subjects have been used in this study, no approval was required. Ethics of academic integrity as well as literature synthesis have been upheld in this work.

Results

Incorporating Personal Clinical Observations Prevalence and Symptoms of Stress

The studies constantly demonstrate elevated levels of burnout and pressure in healthcare workers in Canada. In one CIHI (2023) report, 60% of the nurses, as well as 47% of the physicians confess feeling overwhelmed on an everyday basis. Emotional exhaustion, depersonalization, as well as reduced personal work accomplishment are the main sources of Work-based Stress prevalent among healthcare workers, particularly among emergency workers as well as nurses [1,2]. Principal Workplace Sources of Anxiety among Health Professionals in Canada Occupational stress among Canadian healthcare workers is caused by an intricate combination of organizational, system, and personal factors.

The findings of this review are further supported by real-world clinical observations in Canadian mental

health practice. Two healthcare professionals - a psychologist and a mental health therapist have expressed ongoing distress arising from repeated emotional confrontations with high-needs patients in outpatient settings. One of these professionals reported experiencing emotional outbursts from a client without adequate team-based support or managerial intervention. Being left to deal with such an emergency alone meant that they felt isolated, overburdened, and devalued, even while undertaking pivotal frontline duties. Over time, such events generated heightened anxiety, emotional exhaustion, and compromised ability to undertake trivial clinical tasks confidently.

These direct accounts and others such as these highlight the essential value of organizational responsiveness to minimizing occupational stress. When healthcare professionals feel unsupported and unheard by management, the result is erosion of trust, compromised clinical judgment, and a risk of burnout. This pattern, which can be identified here, in which emotional labour is devalued , and bureaucratic inertia prevails, depicts the organizational failure to place value on psychological safety. Leveraging support protocols, team debriefing, and leadership responsibility as part of clinical practice is not optional; it is essential to keeping workforce well-being and patient care quality intact.
The literature identifies the leading causes as follows:

1. Overload of Work and Staff Shortages
High staff-to-patient ratios, long shifts, and overtime are chronic stressors. The Canadian healthcare system is struggling with resource constraints and workforce shortages, especially in rural and remote regions. Nurses and support workers often work double shifts to cover absences, contributing to fatigue and burnout [1].

2. Emotional Labour and Compassion Fatigue
Healthcare workers regularly experience emotionally demanding situations; providing care to dying patients, comforting bereaved families, and being exposed to trauma. Such prolonged emotional labor may trigger compassion fatigue, especially in emergency, oncology, intensive care, and psychiatric units [2,3].

3. Administrative and Bureaucratic Demands
Clinicians complain that too much documentation, performance measurement, and regulatory compliance take away from patient care. Such bureaucratic tasks create cognitive overload and diminish autonomy, resulting in a feeling of inefficacy [4].

4. Lack of Organizational Support
Lack of supportive leadership, ineffective communication channels, and lack of recognition are some of the leading causes of workplace dissatisfaction. Most professionals feel unappreciated and lonely, particularly those who are in lower-level or part-time jobs [5].

5. Work-Life Imbalance
Irregular shifts, night work, and the unpredictability of clinical demands can cause issues in maintaining personal relationships and sleep patterns. This imbalance undermines mental health, especially among female practitioners juggling caregiving roles at home [6].

6. Interpersonal Conflict and Bullying
Tensions among colleagues, hierarchical pressures from supervisors, and workplace incivility—including lateral violence among nurses—exacerbate stress levels. Junior staff and racialized healthcare workers are particularly vulnerable [7].

7. Exposure to Violence and Ethical Dilemmas
Frontline healthcare workers, especially in emergency departments and psychiatric wards, face verbal or physical aggression from patients. They also confront moral distress when institutional constraints prevent them from delivering the standard of care they believe is right [8,9].

Stress Management and Coping Skills
To cope with these stressors, the literature identifies a wide range of coping mechanisms and stress management practices, which can be broadly categorized as individual, organizational, and policy measures.

1. Personal coping strategies
These are independently chosen activities healthcare staff do to manage stress:
• Meditation and Mindfulness: Regular mindfulness exercises such as deep breathing, body scan, and guided meditation have been observed to reduce the amount of anxiety as well as improve the regulation of emotions [10].
• Exercise: Exercise, yoga, and physical activity have been related to lower levels of cortisol, together with improved mental resilience [11].
• Spirituality and Meaning making: Religious or spiritual activities are sources of strength for the majority of practitioners, especially those with immigrant or Indigenous origins. Connecting

meaningful work with related personal values provides purpose as well as motivation [12].
•Support System: Work mentoring, peer relationships, and family support reduce the effect of chronic strain. But they are most effective together with systemic support as well as with available interventions.

2. Organizational Intervention

Health care institutions have initiated specific evidence-based interventions in handling work pressure:
• Employee Assistance Programs (EAPs): Professional, confidential counselling for work as well as personal issues.
• Resilience Training Workshops: Cognitive-behavioural strategy-based training programs, emotion regulation training, and mindfulness training.
•Appropriate Practice of Leadership and Debriefing: Leadership development in trauma-informed care and frequent team-based debriefing of meaningful events prevent moral distress and promote psychological safety [13].
• Flexibility in Work Schedule and Redesign of Workload: Changes in shift patterns, along with work allocation, have assisted in improving work-life balance. But utilization of such care is most typically restricted due to stigma, time, and uncertainty regarding efficacy.

3. Systemic and Policy-Level Strategies

Increasing numbers of authorities and ministers know they need structural reform:
•Workforce Policies and Funding Increases: Increased funding in workforce recruitment, particularly in disadvantaged areas, decreases overload as well as absenteeism.
• Psychological Safety Standards: Implementation of standards such as the National Standard for Psychological Health and Safety in the Workplace (CSA Z1003-13) provides an institutional standard for mental health [14].
•Education and Licensing Reforms: Incorporation of stress.
Less than 28% of workers had presented at institution-management in the medical curriculum, as well as continuing professional development, infuses resilience at the beginning of training based stress facilities because they feared stigma, confidentiality issues, as well as time wastage [12].

Summary of Findings

Literature repeatedly documents a high prevalence of work-centred occupational pressure among Canada's healthcare workers, with the highest burdens among emergency specialists, nurses, and mental health workers. Heavy workloads, work demands on emotions, bureaucratic workloads, lack of organizational support, and workplace aggression have been found at the highest levels of pressure. These sources of pressure have been linked with a state of feeling drained of emotions, burnout, nervousness, and reduced work output. Since various personal managing strategies, for example, mindful lifestyles, physical exercise, and social support have been observed, they always find themselves in disrepair with further organizational as well as systematic changes.

Organizational interventions such as work timetables with flexibility, employee assistance programs, as well as resilience training, can be found but unexploited due to stigma, time, and the absence of culture-specific aid. Furthermore, this review points out that experiencing pressure in addition to using aid services is not proportionate, with marginally positioned groups having distinct obstacles. In general, this work tilts towards using concurrent, equity- informed strategies across levels of pressure at both the organizational and policy levels, as well as at the individual level.

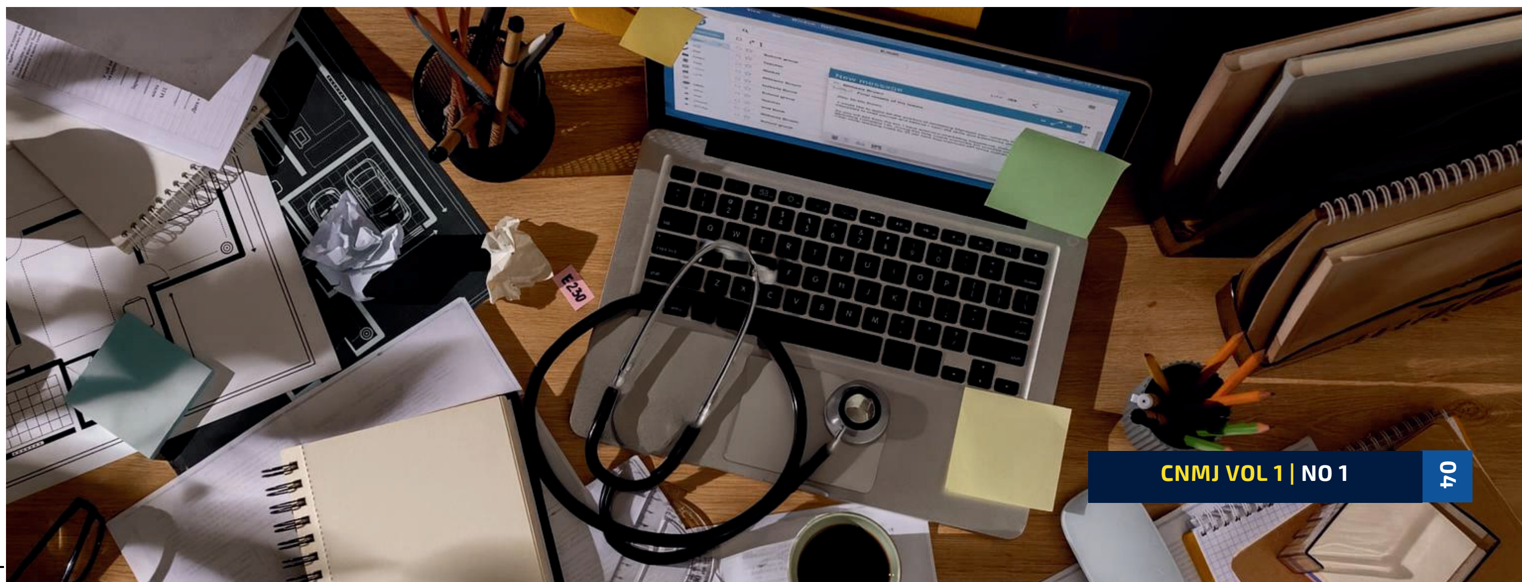

Table 1: Common Sources of Occupational Stress Among Canadian Healthcare Professionals			
Stress Source	**Description**	**Groups Most Affected**	**References**
Work Overload & Staffing Shortages	Long shifts, high patient loads, inadequate staffing	Nurses, rural/remote workers	[1]
Emotional Labor & Compassion Fatigue	Frequent exposure to trauma, suffering, and death	Emergency, oncology, mental health	[2], [3]
Administrative Burdens	Excessive documentation, limited autonomy	Physicians, allied health	[4]
Lack of Organizational Support	Inadequate leadership response, poor	Part-time, junior staff	[5]
Work-Life Imbalance	Irregular hours, family strain	Female professionals, caregivers	[6]
Interpersonal Conflict & Bullying	Workplace incivility, racism, lateral violence	New grads, racialized workers	[7]
Violence & Ethical Dilemmas	Verbal/physical aggression, moral distress	Emergency, psychiatric units	[8], [9]

Table 2: Summary of Coping and Management Strategies				
Strategy Type	**Examples**	**Effectiveness**	**Barriers to Use**	**References**
Individual	Mindfulness, exercise, spirituality, peer support	Moderately effective short-term	Time, stigma, inconsistent access	[10]–[12]
Organizational	EAPs, resilience workshops, trauma-informed leadership, flexible schedules	Varies by implementation quality	Low awareness, skepticism, time constraints	[13]
Policy/Systemic	Staffing investments, psychological safety standards, training reforms	Promising long-term impact	Uneven uptake, lack of enforcement	[14], [15]
Culturally Inclusive	Tailored supports for Indigenous, immigrant, racialized staff	Under-researched, potentially strong	Cultural mismatch, mistrust	[16]

Discussion

This review confirms that workplace stress is an entrenched problem in Canadian healthcare. Very high levels of emotional exhaustion and burnout reflect global trends. Yet in Canada, it is compounded at an additional level by inherent systemic problems like the delivery of care in two languages, geographically based disparities, and the multiculturalism of patient populations.

Among its significant findings is the inappropriateness between the resources available and their use. Highly identified as such, exercise as well as mindfulness is usually made impossible with structural barriers. In addition, interventions mostly stay reactive instead of being preventive.

The research also documents increased interest in spirituality and meaning-making as a way of engaging with an understudied but promising area of intervention, especially among non-dominant Canadian settings.

Its strengths are highlighting Canadian-specific data, along with the inclusion of the latest literature since the first occurrence of COVID-19. Publication bias is likely with the underrepresentation of certain healthcare professions, like paramedics, as well as personal support workers. Future research must explore combined models of personal resilience with institutional and policy reform. Engagement of healthcare workers in the design phases of such interventions using a participatory approach can aid adoption as well as sustainability.

Despite growing consciousness regarding the psychiatric burden of healthcare work among providers, there is a persistent gap between research in practical approaches to pressure reduction activities and practice. Organizations become stuck in advancing towards reactive instead of proactive interventions. Implications reveal signs of value, albeit modest, of systems for training programmes in resilience along with mindfulness interventions unless organizational climate as well as workload frameworks concomitantly shift. As examples, hospital systems that are unable to eradicate bureaucratic red tape or increase workforce numbers will experience little long-term impact among providers, regardless of efforts towards committed measures of coping [15]. This implies systems thinking, wherein human resource policy, leadership development, and wellness programs become embedded in the strategic planning of healthcare systems.

Additionally, interventions to reduce stress must be ethnically sensitive and non-discriminatory. Medical professionals belonging to underprivileged groups, like racial minorities, immigrants, and professionals, typically bring other burdens of stress outside the workplace, such as discrimination and microaggressions. These professionals have been documented with minimal use of support services due to stigma or due to program planning irrelevance in a multicultural population [16]. Specifically targeted interventions that sensitized participants to intersectionality concerns and facilitated diverse groups with psychological safety were necessary. Future research must identify the issues surrounding how identity variables contribute to the pressures experienced and analyze the effectiveness of non-discriminatory models of intervention in Canadian healthcare settings.

Contribution of the Study

By identifying systemic pitfalls in practice related to stress management and integrating existing evidence on occupational stress among Canadian health care workers, the review contributes to both the practice and academic literature. It helps in establishing geographically as well as culturally acceptable interventions in Canada's unique healthcare system of rural-urban disparities, multilingual provision of duty, and cultural diversity. It highlights the discrepancy between available wellness resources and utilization, while observing how organizational trust, timeliness, and stigma hinder their potential.

The results have implications for healthcare administrators, policymakers, and educators in designing workforce support systems that are more sensitive, inclusive, and sustainable. Some examples of such actionable interventions include integrating measures of psychological safety in accreditation processes, such as stress management in health professional education programs, and engaging front-line workers in the co-design of wellness programs. By locating institutions as well as individualism at the center-stage, this work provides evidence of contributions towards reframing reactive burnout management as proactive stress prevention, thereby contributing to field-building in Canadian healthcare occupational health.

Conclusion

This article has recognized work-based intricacies of stress among Canadian healthcare professionals and identified key drivers like workload, emotional pressure, bureaucratic pressure, and structural disparities. Individual coping mechanisms, such as mindfulness and

maintenance of professional networks, are helpful, but organizational and policy reform is the basis of long-term pressure reduction. Safeguarding mentally healthier workplaces, promoting diverse wellness programs, and reducing bureaucratic pressure are the next steps. Health systems need to be proactive, culturally aware, evidence-informed, and equitable in handling stress. Future combined interventions need to test both long-term and equity effects. The internal voices of oppressed professionals must then come into focus to achieve a policy with widespread support. This is how Canada can invest in the mental health of its healthcare workforce in order to protect its healthcare system's quality, safety, and humanity.

References

1. Canadian Institute for Health Information. Health workforce in Canada. Ottawa: CIHI; 2021. Available from: https://www.cihi.ca
2. Figley CR. Compassion fatigue: Psychotherapists' chronic lack of self-care. J Clin Psychol. 2002;58(11):1433–41.
3. Sinclair S, Raffin-Bouchal S, Venturato L, Mijovic-Kondejewski J, Smith-MacDonald L. Compassion fatigue: A meta-narrative review of the healthcare literature. Int J Nurs Stud. 2017;69:9–24.
4. Wallace JE, Lemaire JB, Ghali WA. Physician wellness: a missing quality indicator. Lancet. 2009;374(9702):1714–21.
5. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. Mayo Clin Proc. 2017;92(1):129–46.
6. Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, Shanafelt TD. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014;89(3):443–51.
7. Laschinger HK, Grau AL, Finegan J, Wilk P. New graduate nurses' experiences of bullying and burnout in hospital settings. J Adv Nurs. 2010;66(12):2732–42.
8. Arnetz JE, Hamblin LE, Sudan S, Arnetz BB. Organizational determinants of workplace violence against hospital workers. J Occup Environ Med. 2018;60(8):693–9.
9. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. J Clin Ethics. 2009;20(4):330–42.
10. Gilmartin H, Goyal A, Hamati MC, Mann J, Saint S, Chopra V. Brief mindfulness practices for healthcare providers – a systematic literature review. Am J Med. 2017;130(10):1219.e1–1219.e17.
11. Gerber M, Holsboer-Trachsler E, Pühse U, Brand S. Exercise is medicine for patients with major depressive disorders: but only if the "pill" is taken! Neuropsychiatr Dis Treat. 2016;12:1977–81.
12. Koenig HG. Religion, spirituality, and health: the research and clinical implications. ISRN Psychiatry. 2012;2012:278730.
13. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet. 2016;388(10057):2272–81.
14. Mental Health Commission of Canada. National Standard of Canada for Psychological Health and Safety in the Workplace. Ottawa: CSA Group; 2013.
15. Panagioti M, Panagopoulou E, Bower P, Lewith G, Kontopantelis E, Chew-Graham C, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. JAMA Intern Med. 2017;177(2):195–205.
16. Williams DR, Mohammed SA. Racism and health I: pathways and scientific evidence. Am Behav Sci. 2013;57(8):1152–73.