



Medical Residents' Burnout: Operational Implications in a Philippine Tertiary Hospital

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Abstract

Burnout remains a critical concern among medical residents in tertiary hospitals in the Philippines. This exploratory descriptive qualitative study used a phenomenological approach, employing in-depth interviews with 8 residents to explore contributors to burnout and coping mechanisms. Thematic analysis, validated through member checking and peer debriefing, revealed organizational influences shaping resident well-being: scheduling and task assignment, sufficient staffing levels, support from senior physicians, quality of team collaboration, a safe environment for open communication, and availability of counseling support. Burnout was primarily linked to work overload, poor work-life balance, mental and emotional strain, and strained relationships. Residents recommended strategies such as structured workload management, fostering healthier work-life integration, accessing psychological and emotional support, and seeking professional counseling. This study highlights specific workflow stressors in the Philippine tertiary hospitals – high patient volumes, extended duty hours, and complex clinical workflows – and translates them into actionable operational points for management. These findings underscore the need for both individual and institutional interventions to promote resident well-being, improve hospital operations, and strengthen healthcare system resilience.

Keywords: *Burnout, Medical Residents, Coping Strategies, Residency Training, Philippine Tertiary Hospital, Well-Being*

INTRODUCTION

Burnout is a pervasive occupational health concern among healthcare workers who face heavy workloads and emotionally demanding responsibilities. The [American Psychological Association \(2023\)](#) defines burnout as a work-related condition resulting from prolonged, unmanaged stress, characterized by emotional exhaustion, depersonalization, and diminished professional efficacy. During residency, burnout undermines learning, confidence, patient safety, and quality of care.

International studies indicate that burnout among residents arises from structural, interpersonal, and personal factors. Existing research indicates that burnout among resident physicians arises from several interacting factors. Structural job demands, such as extended duty hours and high patient loads, increase the risk of burnout ([Shanafelt et al., 2019](#)). The interpersonal climate within residency training, including hierarchical supervision and relationships with consultants and peers, also contributes to stress ([Nurikhwan et al., 2022](#)). Additionally, personal coping resources, such as resilience and spirituality, influence how residents manage occupational stress and maintain professional engagement ([Bordbar et al., 2025](#)).

However, scholars note that burnout has been conceptualized and measured in different ways across studies, and the absence of a fully unified definition complicates its measurement and interpretation ([De Hert, 2020](#)). This definitional and measurement variability reinforces the need

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to examine how residents experience and understand burnout, particularly within the context of their everyday training environments.

In the Philippines, residency training in tertiary hospitals is often characterized by extended duty hours, high patient volumes, and limited staffing, which intensify the demands on resident physicians. Residents commonly handle long duty rotations while managing multiple patients and clinical responsibilities, making them particularly vulnerable to burnout. While previous research has identified workload pressures and workplace relationships as contributing factors (Corpuz et al., 2024; Alibudbud, 2022; Turalde et al., 2022; Ang & Soriano-Estrella, 2021), it remains unclear how residents experience key stressors such as work overload, poor work–life balance, mental and emotional strain, and strained professional relationships within residency training.

Based on the researchers' knowledge, there is no study yet in the local setting on how medical residents in the Department of Internal Medicine personally experience and cope with burnout. Addressing this gap, the present study provides an in-depth phenomenological account of residents' lived experiences and coping mechanisms within a tertiary hospital setting.

This study, which examines medical residents' burnout and its operational implications in a Philippine tertiary hospital, contributes to the theoretical understanding of burnout by extending the Job Demands–Resources (JD-R) model by identifying context-specific job demands and coping resources within residency training in Philippine tertiary hospitals.

Practically, the findings translate residents' experiences into actionable insights for hospital operations, including improved workload distribution, strengthened team communication, supportive supervisory practices, adequate recovery time, and accessible mental health services. These insights may guide hospital administrators and policymakers in developing strategies that promote resident well-being and improve operational efficiency in tertiary healthcare institutions.

This study, therefore, aims to:

1. Identify the key factors contributing to burnout among medical residents in a tertiary hospital in the Philippines.
2. Explore the coping mechanisms used by residents to manage burnout.

In view of the above research objectives, the following research questions were aligned to the JD-R model:

1. What job demands and resource constraints are experienced as contributors to burnout?
2. What personal and institutional coping mechanisms/ resources are used or desired to mitigate burnout and support performance?

LITERATURE REVIEW

In line with the study's objectives, this literature review covers the following key areas: the theoretical framework; core burnout theory and its measurement; factors contributing to burnout; and coping mechanisms used by medical residents in a tertiary hospital setting. Together, these areas provide the foundation for understanding burnout and its management in the context of medical training.

Job Demands-Resources (JD-R) Model

This study is anchored in the JD-R model, which conceptualizes burnout as the result of an imbalance between job demands (e.g., heavy workload, extended duty hours, and emotional strain) and job resources (e.g., social support, autonomy, and institutional wellness programs). When job demands outweigh available resources, individuals are more likely to experience emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (Maslach & Leiter, 2021). In the context of tertiary hospital residency training, where patient loads, case complexity, and administrative responsibilities are exceptionally high, the JD-R model provides a

comprehensive framework for understanding how environmental and organizational factors contribute to resident burnout.

In the Philippines, where healthcare systems are frequently over-extended and cultural expectations emphasize endurance, the JD-R model serves as a useful framework for understanding burnout as both an individual and systemic issue. Empirical evidence suggests that limited institutional support and poorly structured duty schedules heighten the risk of burnout (Lawlor et al., 2022). In contrast, duty-hour restructuring has been linked to improved well-being and reduced emotional exhaustion (Heppe et al., 2024). Guided by the JD-R framework, this study used exploratory theory-driven propositions rather than formal hypotheses, consistent with its qualitative design. It is expected that high job demands and limited job resources would appear in residents' narratives of exhaustion, depersonalization, and reduced well-being. In contrast, relational and institutional resources would emerge as protective coping themes.

In this study, common aspects of residency training were mapped into job demands and job resources to make the JD-R framework more explicit. Job demands include long duty hours, heavy patient loads, administrative workload, emotional labor, and hierarchical conflict. In contrast, job resources include supervisory support, autonomy, adequate staffing, peer support, wellness services, and recovery time. This mapping guided the interview prompts and thematic coding of residents' experiences, consistent with the application of the JD-R model in healthcare and occupational burnout research (Bakker & Demerouti, 2023; Lesener et al., 2020).

Core Burnout Theory and Measurement

Maslach and colleagues widely conceptualize burnout as a multidimensional construct comprising emotional exhaustion, depersonalization, and diminished personal accomplishment. Emotional exhaustion refers to feeling drained by work demands, while depersonalization involves a detached or cynical attitude toward patients or colleagues.

On the other hand, reduced personal accomplishment reflects a decline in professional competence and achievement. These dimensions are commonly measured using instruments such as the Maslach Burnout Inventory, which is widely used in healthcare research to assess burnout among physicians and medical residents (Brady et al., 2020; Alberti et al., 2023; Kinman, 2025). Together, these dimensions provide a conceptual basis for understanding burnout in demanding healthcare environments.

Factors Contributing to Burnout

In the context of the highly demanding healthcare environments, prior studies reveal the following factors contributing to burnout of medical professionals: work overload; poor work-life balance; mental and emotional stress; strained professional relationships; and organizational and management factors.

Work Overload

Work overload is a major contributor to burnout among medical residents. Excessive workload and long duty hours are major contributors. In Nepal, 42.4% of residents reported burnout, particularly among those working more than 80 hours per week (Shahi et al., 2022), while in Palestine, over 80% experienced moderate-to-severe burnout (Shawahna et al., 2022). Within the JD-R model, excessive workload represents a job demand that drains energy and increases the risk of emotional exhaustion when adequate institutional support is lacking (Bakker & Demerouti, 2023; Lesener et al., 2020).

Poor Work–Life Balance

Poor work–life balance is another factor associated with burnout during residency training. According to the JD-R model, insufficient recovery time reduces personal resources needed to cope with high job demands, increasing vulnerability to burnout (Bakker & Demerouti, 2023).

Mental and Emotional Stress

Mental and emotional stress also contributes significantly to burnout among residents. Personal and demographic characteristics influence burnout, with younger and female residents showing greater vulnerability to emotional exhaustion and stress (Muteshi et al., 2024; Salihu et al., 2023). Exposure to high-pressure clinical situations, emotionally challenging patient interactions, and critical decision-making can lead to psychological strain over time. In the JD-R framework, sustained emotional demands without adequate psychological support accelerate the depletion of personal resources and contribute to burnout (Lesener et al., 2020; Panagioti et al., 2021).

Strained Professional Relationships

Strained relationships within the workplace can further intensify burnout. Interactions with consultants, supervisors, and co-residents influence the overall training environment. Supportive mentorship can strengthen resilience, whereas conflict or hierarchical tensions may increase emotional stress. In the JD-R model, positive workplace relationships function as resources that buffer the effects of demanding work conditions (Bakker & Demerouti, 2023; Panagioti et al., 2021).

Organizational and Management Factors

Organizational and management practices also play a critical role in shaping burnout experiences among medical residents. Leadership support, psychological safety, and positive teamwork climates contribute to healthier work environments by encouraging open communication and collaboration among healthcare professionals. Effective staffing models and fair workload distribution can reduce excessive job demands, while well-implemented duty-hour policies help ensure adequate rest and recovery time for residents.

Within the JD-R framework, these organizational factors function as institutional resources that help buffer the effects of demanding work conditions (Bakker & Demerouti, 2023; Li et al., 2024; Nagle et al., 2024; Norful et al., 2024). Strengthening these management practices can therefore improve both physician well-being and operational efficiency within tertiary hospital systems (Shanafelt et al., 2020).

Coping Mechanisms to Burnout

Medical residents employ several coping mechanisms to manage burnout in demanding clinical environments. Individual strategies such as building supportive peer relationships, getting adequate sleep, and engaging in stress-relief activities help reduce emotional exhaustion and depersonalization (Shahi et al., 2022; Shi et al., 2022). Organizational interventions such as duty schedule adjustments (Heppe et al., 2024) and structured wellness programs (Tan-Lim et al., 2022) have been shown to improve resident well-being and reduce fatigue.

In addition, professional counseling provides structured support to help residents develop coping strategies and maintain mental well-being. Within the JD-R framework, these strategies function as important resources that help buffer the effects of heavy workloads and emotional strain, promoting resilience among medical residents (Bakker & Demerouti, 2023; Panagioti et al., 2021; West et al., 2020).

RESEARCH METHOD

This study employed an exploratory, descriptive, qualitative, phenomenological design to

examine the lived experiences of medical residents experiencing burnout at a tertiary hospital in the Philippines. Phenomenological research design is the most appropriate approach because it focuses on the meanings and essence of lived experience (Adeniran & Tayo-Ladega, 2024), allowing deeper insights into how residents interpret and cope with the demands of a high-pressure organizational setting. Credibility of the findings was strengthened through member checking and peer debriefing.

All eight residents from the Department of Internal Medicine of the subject hospital were included, representing a census of the eligible population. Participants were Year Level 1–3 residents with at least six months of training who self-identified as having experienced burnout, defined as persistent exhaustion or diminished sense of accomplishment. Adequacy was supported by information power and saturation logic: the group was homogeneous, the study aim was focused, and interviews were conducted in sufficient depth to capture meaningful insights.

The semi-structured interview guide for data collection was developed by the researchers following an extensive review of literature on medical residents' burnout and coping mechanisms (Dyrbye & Shanafelt, 2016; Shanafelt et al., 2019), ensuring alignment with the study's objectives. The instrument's clarity and relevance were evaluated using Taherdoost's (2016) Research Instrument Validation Criteria. Two experts, a social worker and an educator, independently reviewed the tool and rated it Very Satisfactory for both clarity and relevance.

Guided by this validated instrument, semi-structured interviews were conducted from September 15 to 18, 2025, each participant lasting 30 to 45 minutes. Ethical approval was obtained from the Chief of Clinic, and informed consent was obtained from all participants before the interviews. Interviews were conducted privately on hospital premises, audio-recorded with permission, transcribed verbatim, and anonymized using coded identifiers (e.g., D1).

To ensure credibility and trustworthiness, data triangulation was employed by comparing multiple resident perspectives and validating emerging themes against existing literature. The data were analyzed using Braun and Clarke's (2006) six-phase thematic analysis (Figure 1), a structured yet flexible framework that includes familiarization, initial coding, searching for themes, reviewing themes, defining and naming themes, and producing the report. This systematic process ensured theoretical transparency, reflexivity, and methodological rigor throughout the study (Ahmed et al., 2025).

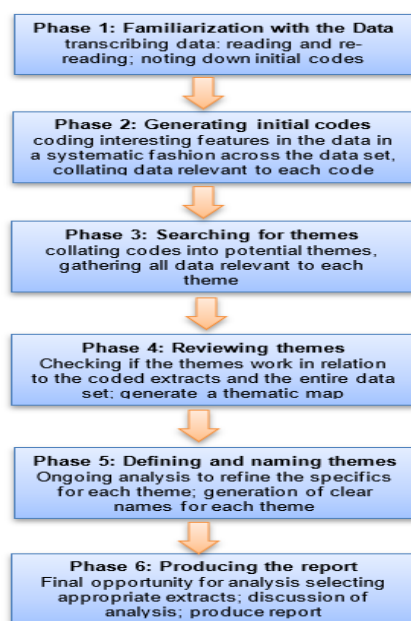


Figure 1. Braun and Clarke's thematic analysis step framework

To ensure the integrity of the findings, this study adheres to the criteria for trustworthiness in qualitative research: credibility, dependability, confirmability, and transferability (Tavakol & Sandars, 2025). After the initial thematic analysis, the researcher returned to the participants (D1–D8) to present the emerging themes and supporting quotes. The participants' validation ensured that the findings accurately represented their lived experiences of burnout. The coding process and theme development were reviewed by three external colleagues (one educator, one government employee, and one healthcare professional). These sessions served to challenge the researchers' assumptions and refine the thematic labels.

A detailed coding log was maintained, documenting every step from the raw transcriptions to the final thematic map. This allows future researchers to trace how specific data points led to the conclusions. As one of the researchers operates within a healthcare/academic context, a reflexivity journal was kept to identify personal biases regarding the Philippine residency system. This ensured that the themes were grounded strictly in the participants' narratives rather than the researcher's preconceptions.

The study provides a detailed account of the tertiary hospital setting (e.g., patient volumes of 100+ per shift, specific duty cycles). This thick description allows other hospital administrators to determine the applicability of this study's findings to their own institutional contexts. The study utilized data source triangulation (Vivek et al., 2023) by interviewing residents across three different year levels (Year Levels I, II, and III) and diverse rotations (ER, Ward, ICU, and OPD). This captured a 360-degree view of the residency workflow stressors.

This study used Braun and Clarke's Six-Phase Thematic Analysis rather than Interpretative Phenomenological Analysis (IPA) because the primary aim was to describe common patterns (themes) across the entire group of residents, rather than focusing solely on the idiosyncratic psychological nuances of a single individual. A hybrid coding approach was used for deductive coding, with the Job Demands-Resources (JD-R) model serving as a sensitizing framework to categorize initial data into demands (e.g., workload) and resources (e.g., peer support).

New codes, such as nature immersion and hospital-induced anxiety, were allowed to emerge organically from the raw data to capture context-specific nuances of the Philippine setting. Transcripts were coded line by line by the primary researcher. A second coder independently reviewed a subset (25%) of the transcripts to verify the application of codes. Any discrepancies in coding or theme naming were resolved through consensus-based discussion among researchers until 100% agreement was reached, ensuring the stability of the thematic framework.

FINDINGS AND DISCUSSION

This section presents the findings directly relevant to the study's objectives, focusing on the profile of medical residents, themes related to factors contributing to burnout, and the strategies they employ to cope with the condition.

Profile of the Participants

The study involved all medical residents undergoing training in the Department of Internal Medicine at the subject tertiary hospital. A total of eight residents participated, representing the entire population of interest. Table 1 presents the profiles of eight medical residents, including their gender, year of residency, average weekly duty hours, area of rotation, and corresponding duties and responsibilities.

Table 1. Profile of the Participants

Code	Gender	Current Year Level in Residency	Ave. Duty Hrs/Week	Primary Role in Residency Training
D1	Female	Year Level III (YL III)	60	Oversees and manages common and complex cases in Internal Medicine, emergencies, and subspecialty conditions; Handles surgical and Obstetrics and Gynecology (OB-Gyne) referrals; Performs pre-op risk assessments; Supervises junior residents; Assigned to Intensive Care Unit (ICU); Handles administrative work as Chief Resident
D2	Male	Year Level II (YL II)	60	Manages common Internal Medicine and emergency cases, subspecialty conditions in both outpatient and inpatient settings, and referrals from Surgery and OB-Gyne.
D3	Male	YL II	60	Manages common Internal Medicine and emergency cases, subspecialty conditions in both outpatient and inpatient settings, and referrals from Surgery and OB-Gyne.
D4	Male	Year Level I (YL I)	60	Manages common Internal Medicine cases in both outpatient and inpatient settings; Assigned to the Ward and Outpatient Department (OPD)
D5	Female	YL I	60	Manages common Internal Medicine cases in both outpatient and inpatient settings; Assigned to the Ward and OPD.
D6	Male	YL III	60	Oversees and manages common and complex cases in Internal Medicine, emergencies, and subspecialty conditions; Handles surgical and OB-Gyne referrals; Performs pre-op risk assessments; Supervises junior residents; Assigned to the ICU.
D7	Male	YL II	60	Manages common Internal Medicine and emergency cases, subspecialty conditions in both outpatient and inpatient settings, and referrals from Surgery and OB-Gyne.
D8	Female	YL II	60	Manages common Internal Medicine and emergency cases, subspecialty conditions in both outpatient and inpatient settings, and referrals from Surgery and OB-Gyne.

Interviewing residents from different year levels and rotations (ICU, ER, wards, OPD) enhanced the study's rigor by enabling cross-verification of experiences across training contexts. This diversity revealed how burnout varies with seniority, clinical exposure, and training stage.

Mojahed et al. (2024) found that early-stage residents, particularly first-year trainees, are more prone to emotional exhaustion than their senior counterparts. Including eight residents with varied assignments and duty schedules yielded a heterogeneous sample that reflected the multifaceted nature of residency training.

Factors Contributing to Burnout

Burnout often develops from prolonged exposure to workplace stressors. Table 2 presents the thematic framework for factors contributing to burnout among medical residents in a tertiary hospital in the Philippines.

Table 2. Factors Contributing to Burnout

Themes	Subthemes
Work Overload	High patient load; Understaffing and imbalance work distribution; Long working hours with inadequate rest
Poor Work-life Balance	Neglecting personal well-being, sleep deprivation, and social isolation, struggling to manage responsibilities.
Mental and emotional stress	Pressures from training requirements; Mental exhaustion; Hospital-induced anxiety; Feelings of isolation and inadequacy
Strained Relationship	Workplace tension; Personal relationship struggles

Work Overload

Work overload emerged as a central driver of burnout, reflecting both structural demands (high patient volumes, extended duty hours) and organizational inefficiencies (unequal task distribution, limited recovery opportunities). The following residents clearly described these factors:

“At the ER, what used to be 15 to 30 patients has now become 90 or even 100. Now, it can reach 100 to 120 patients in 24 hours” – D2,

“Managing both OPD and ward duties was overwhelming. On pre-duty days, if I am unable to finish OPD promptly, I make rounds at night and go home by 10 pm. Likewise, prioritizing critical ward cases left OPD staff frustrated, as the department handled 70–90 patients daily at the OPD” – D5.

“I felt pressured to start rounds as early as 4 a.m., finish by 7 a.m., then head to the OPD by 8 a.m. while still worrying about ward patients. Twenty-four hours never felt enough, and we could not focus.” – D4.

“We are only two doctors on duty, so we take turns. – D7

In the ER, residents like D2, a YL II resident, shouldered the staggering burden of 100-120 patients in a single 24-hour shift. While his clinical knowledge in emergency medicine is already extensive, the sheer volume of cases far exceeds what any resident can reasonably manage, turning expertise into exhaustion and highlighting the unsustainable demands placed on frontline physicians. On the other hand, D4 and D5, both YL I residents, were thrust into managing OPD and ward duties, handling an exhausting 35–45 patients in just seven hours, barely eight minutes per patient, creating intense time pressure and mental strain. D7 reported similar burdens, with only two residents covering 24-hour ER and ward duties.

With their clinical knowledge still confined to simple cases, the mismatch between their limited training and the overwhelming patient load underscores the unsustainable demands placed

upon them. These accounts highlight excessive patient loads and inadequate staffing, consistent with findings that excessive workload and extended hours contribute to burnout (Da Cruz Gouveia et al., 2023). Persistent staffing shortages and uneven work distribution further intensify burnout and hinder equitable care (Estreller et al., 2025; Parial et al., 2024).

Some residents recounted instances in which co-residents failed to fulfill their assigned responsibilities, leading to the redistribution of tasks and increased pressure on others to compensate. They stated the following:

"Tasks must be completed rather than passed on to others. Each year level should be held accountable for the responsibilities assigned to them." – D5.

"Implementing proper task delegation helps reduce the burden on each individual, with responsibilities distributed according to year level." – D4.

Some residents reported being assigned responsibilities beyond their year-level expectations, leading to feelings of being overwhelmed and undervalued. D4 and D5 observed that uneven task distribution intensified workload and emotional fatigue, creating workplace tension. Participants emphasized the importance of structured and fair task delegation aligned with training levels. Corpuz et al. (2024) noted that equitable task distribution reduces burnout, while Kelly et al. (2020) linked uneven workload to emotional strain.

The prolonged working hours are another contributor to burnout. These prolonged working hours with limited rest and recovery have resulted in compounded exhaustion and an increased risk of burnout (Luceño-Moreno et al., 2025). Some residents narrated the following:

"We had 24-hour duty every three days, and I often got home by 10 p.m. after managing critical cases and follow-ups." – D4

"On pre-duty days, unfinished OPD consultations delay ward rounds, and I often do not get home until 10 p.m." – D5

"Every three-day duty is intense, requiring preparation for 24 hours without sleep." – D7

Residents reported 24-hour duties every three days, resulting in continuous fatigue, sleep deprivation, and physical exhaustion. Even after these shifts, they often stayed late for follow-ups and critical cases, heightening emotional exhaustion and burnout (Freedy et al., 2022). The combination of high patient load, understaffing, and uneven task distribution, along with long hours and inadequate rest, placed persistent pressure on them. These conditions adversely affected their well-being and increased the risk of burnout.

Addressing these issues through improved staffing, equitable workload allocation, and sufficient recovery time is vital for a healthier, more sustainable training environment. Within the JD-R framework, these stressors represent excessive job demands that are insufficiently balanced by job resources such as fair scheduling, adequate staffing, and protected rest. Addressing these influencers through duty-hour redesign, equitable workload allocation, and staffing reinforcement offers actionable pathways for management to reduce resident burnout in tertiary hospitals, as noted by Freedy et al. (2022).

Poor Work-life Balance

Poor work-life balance was identified as a major contributor to burnout, reflecting how professional demands crowd out opportunities for rest, self-care, and social connection. Within the JD-R framework, these stressors represent excessive job demands (extended duty hours, competing responsibilities) that are insufficiently offset by job resources such as flexible scheduling,

supportive policies, and protected time for recovery. For management, this highlights the need to design interventions that safeguard residents' personal well-being – such as structured rest periods, family-friendly scheduling, and a peer support system – to reduce chronic stress and fatigue.

This deterioration of balance is reflected in residents' own words:

"They appeared physically unkempt, suggesting a decline in personal care." – D4

"I used to go to the gym occasionally, but now I do not feel like it anymore." – D3

"Before residency, I slept regularly, but residency ruined my sleep. Constant sleep deprivation affected my health, with no time to recover between pre-duty days." – D8.

"The sleep schedule is reduced to just one to two hours. If that continues every day, you just end up always feeling tired." - D3.

"I am always tired." -D7

"I have missed many events and celebrations that I used to attend." – D5

"As for friends, I do not really have a social life." – D8

"It was hard to get out of bed in the morning. You feel like you are just dragging yourself to the hospital."- D4

"At home, responsibilities pile up, so juggling tasks becomes unavoidable." - D2

Residents reported that burnout eroded self-care and personal well-being. D4 observed peers showing burnout through poor self-care, while D3 lost motivation for physical activity, signs that residency undermines self-maintenance and leads to emotional exhaustion. [Mincarone et al. \(2024\)](#) linked burnout to low physical activity, as healthcare workers feel too drained to exercise. D8 said residency "ruined" her sleep, D3 slept only "one to two hours," and D7 said, "I am always tired," showing chronic sleep deprivation that worsens mental health ([Di Giampaolo et al., 2024](#); [Surawattanasakul et al., 2024](#)). Social isolation and competing home demands further deepened fatigue and burnout.

Collectively, these narratives show that neglecting personal well-being, ongoing sleep deprivation, social isolation, and difficulty managing responsibilities contribute significantly to burnout among medical residents. Residents described a decline in self-care, diminished motivation for leisure activities, chronic fatigue, strained relationships, and challenges in fulfilling both clinical and family obligations. Within the JD-R framework, these persistent demands led to emotional exhaustion, diminished resilience, and a constant sense of being overwhelmed. This is supported by [Kelly et al. \(2020\)](#), who found that residents experiencing burnout were more likely to report poor work-life balance.

Mental and Emotional Stress

Mental and emotional stress emerged as a major factor in resident burnout, driven by the dual demands of clinical service and academic requirements. These pressures were evident in the following statements:

"Workload is intense, handling ER patients while preparing urgent reports often leads to burnout." – D3

"Additional tasks like research and weekly reports, including presentations, significantly contribute to burnout." – D7

"I experienced being on my own. I struggled to cope with being alone, with higher demands and expectations...no matter how much I try to help them and do my best, it is still lacking because of the hospital's limitations or the patients' lack of resources."- D6.

"After going on duty at the ER for 24 hours...I get tired just by talking to patients...it drains my stamina." – D8.

"It is really the time you spend in the hospital that's draining ...because it is like you have anxiety whenever you are here." – D7.

"Reports and presentations contribute to burnout as well, causing mental exhaustion." – D8.

The pressure to meet training obligations – including reports, exams, and research – significantly intensified stress. For example, D3 described preparing urgent reports while still on ER duty, illustrating the strain of balancing academic and clinical responsibilities. Similarly, D7 and D8 emphasized how weekly reports and research tasks led to mental exhaustion, showing how academic expectations erode emotional resilience when layered onto clinical work.

These experiences highlight how job demands – academic workload, performance pressure, and clinical intensity – overwhelm residents, while job resources such as mentoring, peer support, and structured feedback remain insufficient. Emotional strain manifests as anxiety, exhaustion, and feelings of inadequacy, consistent with prior findings (Doe et al., 2024; Feng & Narayanan, 2024; Tarrash et al., 2022), which emphasized that chronic stress and institutional pressures are central to burnout. Within the JD-R framework, this imbalance underscores the need for organizational interventions that reduce academic overload and strengthen supportive resources to protect residents' psychological well-being.

Strained Relationship

Strained interpersonal relationships were consistently described as emotionally draining and isolating, compounding the effects of workload and clinical demands. Residents reported poor communication, minimal support, and unresolved workplace conflicts, which exacerbated emotional exhaustion.

"Burnout mostly stems from issues with co-residents. I even considered resigning as chief resident because of exhaustion from their behavior—they no longer talk to me or stay in the office when I am around." – D1.

"My relationship with my partner suffered because I kept postponing activities, always saying I would check my schedule first." – D6.

For example, D1 and D6 highlighted how strained peer relationships, social withdrawal, and feelings of rejection contribute to stress and burnout. These findings align with Corpuz et al. (2024), who identified interpersonal tensions as major stressors among medical trainees, and with Aghaei et al. (2022), who emphasized the role of poor communication and conflict in deepening burnout.

Within the JD-R framework, strained relationships constitute job demands (e.g., relational strain, team breakdown) that erode residents' resilience. The absence of strong job resources – such as supportive peer networks, mentoring, and healthy communication channels – further intensifies feelings of isolation and inadequacy. This echoes broader evidence (Doe et al., 2024; Feng & Narayanan, 2024; Tarrash et al., 2022) that emotional exhaustion is not only workload-driven but also relationally mediated. For management, this underscores the importance of fostering a positive teamwork climate, strengthening supervisory support, and building accessible social support systems to mitigate burnout.

Taken together, these themes show that burnout among medical residents arises when escalating job demands – work overload, poor work-life balance, mental and emotional stress, and strained relationships – consistently outweighs available personal and institutional resources. Consistent with the JD-R model, prolonged demands erode resilience by limiting opportunities for

rest, support, and recovery (Bakker et al., 2023).

This imbalance not only undermines resident well-being but also compromises hospital operational efficiency, patient safety, and clinical judgment, as highlighted by Reith (2018). Effective coping mechanisms and organizational interventions are therefore essential to balance demands and resources (Briones et al., 2025), safeguard physician health, and sustain both patient outcomes and institutional performance.

Coping Mechanisms to Reduce Burnout

Medical residency is an intensely demanding period marked by heavy clinical workloads, academic pressures, emotional challenges, and often strained interpersonal relationships, all of which contribute to burnout. To address this issue, it is essential to understand and implement effective coping strategies. Table 3 presents these coping mechanisms.

Table 3. Coping Mechanisms

Themes	Subthemes
Workload Management	Additional Manpower, Scheduling reforms, Mentorship, and consultants
Promoting Good Work-life Balance	Self-care and reflections; Social interaction; Nature immersion
Psychological and Emotional Support	Reframing and resilience; Finding purpose and meaning
Professional Counselling	Supportive space for emotional well-being; Strengthening coping and stress management skills

Workload Management

Residents emphasized workload management as a critical coping mechanism, highlighting the need for additional workforce, structured scheduling, and accessible mentorship. The following are their specific suggestions:

"Hire more residents." -D3

"Additional residents or additional manpower." - D1

"More plantilla positions, so there are more of us, and the work or workload can be spread out among the residents."- D7

"I plan to organize my schedule and create a to-do list."- D4

"Implementing proper task delegation helps reduce the burden on each individual, with responsibilities distributed according to year level."- D4.

"Consultants being more hands-on" - D1

"It really helps that we have consultants we can approach whenever we have problems in the workplace."- D8.

Calls to recruit more residents underscore the importance of adequate staffing to ensure equitable task distribution. Scheduling reforms – such as structuring duties by year level and protecting recovery time – were seen as essential to prevent exhaustion. Equally, mentorship and approachable consultants provided guidance that reduced uncertainty and emotional strain. Within the JD-R framework, these strategies represent job resources that directly counterbalance excessive demands.

By strengthening staffing, redesigning schedules, and embedding supervisory support,

institutions can reduce the risk of burnout and enhance resilience. These findings align with [Baes et al. \(2025\)](#) and [Bailey et al. \(2022\)](#), who noted that supportive supervision and balanced staffing are protective factors against burnout, reinforcing the organizational responsibility to embed workload management into hospital operations.

Promoting Good Work-life Balance

A good work-life balance is essential for maintaining physical, emotional, and mental well-being, especially in high-stress environments like medical residency. It allows individuals to rest, recharge, and engage in meaningful activities outside of work, ultimately supporting better performance, resilience, and overall quality of life ([Muteshi et al., 2024](#); [Tan, 2024](#)). To manage burnout, residents shared a range of coping strategies, such as self-care and quiet time, social interaction, and spiritual and nature immersion. Here are their narratives:

"Sleeping more often. When I get home, I just sleep." - D1

"I often get sick, so sick leave really helps." - D8

"I watch Netflix or a movie in a controlled manner—maybe just for an hour." - D2

While these residents engage in personal hobbies and quiet time to recharge.

"I usually play video games. It helps relieve stress, but it is more like a band-aid solution." - D3.

"I used to spend time playing with my dogs, watching Netflix and movies, and going for jogs." - D5.

"My personal hobby really is playing games." - D6.

"For me, we have a lot of pets at home. Usually, I read novels. Fiction, fantasy novels." - D7

"Spending time with my cats. When I am stressed, I just stay in their room." - D1.

This time, D4 and D6 are immersed in nature and reflection

"I would go for long drives, especially along SCTEX, just to clear my mind." - D4

"When I feel the tension and anxieties building up, I drive to the beach, stand there, and listen to the sound of the waves." - D6

Social interaction and spending time with family helped these residents cope with burnout.

"Time with my family – that is what really helped me cope. We have family dates, like when we go out together on the days I am available." - D8.

"I would visit my family who live far away, and spend time with friends." - D4.

"My children at home are the ones who completely take away my stress and tiredness—one hundred percent." - D2.

Residents highlighted the importance of maintaining a good work-life balance as a coping mechanism, emphasizing self-care, social interaction, and nature or spiritual immersion. Self-care practices such as adequate sleep, passive leisure, and hobbies, as described by D1, D3, D5, D6, and D7, provided emotional grounding and recovery from exhaustion, consistent with findings that mindful self-care reduces burnout ([Guyker et al., 2024](#); [Koçak et al., 2024](#); [Sipos et al., 2024](#)).

Social and familial interactions, as described by D2, D4, and D8, provided emotional support and reduced isolation, consistent with evidence that strong social ties help preserve boundaries and manage stress ([Maresca et al., 2022](#); [Dashevsky, 2024](#)). Nature immersion and spirituality further promote emotional regulation and resilience, with residents D4 and D6 describing a sense of peace through prayer and outdoor activities, aligning with [Morrison et al. \(2024\)](#) and [Doolittle et al. \(2024\)](#).

Within the JD-R framework, these strategies represent job resources that replenish personal energy and counterbalance excessive demands. However, their effectiveness depends on institutional support – such as policies that protect rest time and encourage recovery – rather than on individual effort alone (Muteshi et al., 2024; Tan, 2024; Tarrash et al., 2022). Promoting work-life balance thus requires hospitals to create space for self-care, social connection, and restorative practices, ensuring residents can sustain resilience in high-demand environments.

Psychological and Emotional Support

Residents described psychological and emotional support strategies as vital to sustaining resilience amid demanding clinical training. Maintaining optimism, reframing negative thoughts, and finding meaning in their work helped them remain emotionally grounded and motivated despite stressors.

D4 emphasized the importance of reframing daily experiences:

“I also try to keep in mind that each day brings new learning opportunities—that has become my mindset.” – D4

For D7, motivation arose from practical reframing:

“I tell myself, ‘Alright, I need to go in because I need the money.’ This motivates me to return to the hospital.” – D7.

D2 and D3 found relief through informal emotional release, noting that talking with others helped them de-stress.

*“I just talk with the nurses—talking to other people. Sometimes I resort to stress eating.” – D3.
“I also talk to my colleagues, that is how you de-stress or vent out what happened... it feels like you unload the burden.” – D2.*

D6 found a deeper sense of meaning through spiritual engagement and service:

“I go to church. I join medical missions. It just feels different when you see patients outside. It lightens how you feel when you are out there attending to patients.” – D6.

These practices reflect cognitive and emotional resources that buffer against exhaustion and depersonalization. Within the JD-R framework, reframing and meaning-making serve as job resources that counterbalance high demands by enhancing adaptability and emotional stability. Evidence supports this: Lee et al. (2025) found that positive coping styles are linked to lower burnout, while Song et al. (2023) emphasized that meaning-making and reframing protect against emotional exhaustion. By fostering resilience and a sense of purpose, these strategies strengthen residents’ psychological capacity to withstand prolonged stress, underscoring the value of embedding emotional support and reflective practices in residency programs.

Professional Counselling

Although most residents had not yet accessed formal counseling, several emphasized its potential value for managing emotional stress and interpersonal challenges (Manzoor et al., 2022). As D1 suggested:

“An in-house psychiatrist for counseling is necessary.” – D1

Similarly, D3 noted,

“Having a counselor to talk to would also help.” – D3

while D8 shared,

“It would really help if we had a counselor we could approach whenever we have problems in relationships.” – D8.

Professional counseling was seen as a safe and confidential space to process distress, strengthen coping skills, and enhance resilience. These reflections highlight the importance of accessible, reliable, and trusted mental health support within institutions. Within the JD-R framework, counseling represents a job resource that directly counterbalances high demands by providing structured emotional support and skill-building.

Evidence supports this: [Manzoor et al. \(2022\)](#) noted that counseling helps address moral injury and emotional strain, while [Maresca et al. \(2022\)](#) emphasized its role in stress management, reframing, and emotional regulation. Integrating professional counseling into residency programs, therefore, offers a vital organizational strategy for burnout prevention, ensuring that residents are not left to rely solely on personal coping mechanisms.

Overall, the coping mechanisms described reflect residents’ deliberate efforts to reinforce both personal and institutional supports, much like strengthening the pillars of a structure under constant strain. The four key strategies—workload management, maintaining work-life balance, psychological and emotional support, and professional counseling—act as the pillars sustaining their resilience. Workload management, through staffing, improved scheduling, and mentorship, eases the heavy load residents carry ([Bes et al., 2023](#); [Cohen et al., 2023](#)).

Work-life balance, through self-care, social interaction, and nature immersion, serves as the residents’ breathing space, allowing them to recover from unrelenting stress ([Istiqomah & Putra, 2025](#)). Psychological and emotional support, such as nurturing a positive mindset and reframing challenges, helps them adapt and stay grounded ([Martín-Brufau et al., 2020](#)). Professional counseling offers a safe harbor where emotional burdens can be processed and coping tools refined ([Seo et al., 2021](#)).

Together, these strategies function like interconnected safety nets, each supporting the other to prevent collapse under strain. By reinforcing both personal and institutional resources, these measures not only mitigate burnout but also enhance hospital efficiency by reducing absenteeism and sustaining the quality of patient care ([Cohen et al., 2023](#)).

These coping mechanisms to reduce burnout will be significant in maintaining the operational efficiency of the subject hospital in its delivery of healthcare services. As further indicated by [Razai et al. \(2023\)](#), addressing healthcare burnout requires a multifaceted, sustained effort to create supportive, safe work environments. As emphasized by [De Ramos and Briones \(2024\)](#), continuous improvement is essential to uphold the organization’s commitment to quality service. Addressing burnout must therefore be viewed as a shared responsibility between medical residents and the institution to ensure resilience, safety, and excellence in care delivery.

CONCLUSIONS

Residency is one of the most rigorous and formative stages in a physician’s career. However, it is also a period of heightened vulnerability to burnout that affects both well-being and patient care. This study explored the lived experiences of medical residents in a tertiary hospital in the Philippines, revealing the multifaceted nature of burnout in clinical training. Key themes included excessive workload, poor work-life balance, mental and emotional strain, and strained relationships.

Residents also identified coping strategies such as managing workloads, promoting a good work-life balance, accessing psychological and emotional support, and seeking professional counseling. These mechanisms highlight residents’ ongoing efforts to maintain balance and

resilience amid the demanding realities of medical training while ensuring the hospital's operational efficiency in healthcare delivery.

The following conclusions are mapped to formulated research questions (RQ):

- RQ1 (Job demands): Residents faced unsustainable patient loads, long duty hours, and hierarchical pressures that heightened the risk of burnout. These demands were perceived as overwhelming, leading to psychological strain, diminished work-life balance, and feelings of inadequacy.
- RQ2 (Coping resources): Residents relied on peer support, counseling, and personal boundary-setting, though these strategies were often insufficient against systemic pressures.

Beyond individual adaptation, the study's findings both support and extend the JD-R model by prioritizing residents' well-being and supportive work environments. Interpreted through the JD-R model, burnout occurs when high job demands - such as extreme patient loads, overlapping training-academic responsibilities, and resource constraints - are not balanced by sufficient personal and institutional resources. Buffering resources identified include approachable consultants, peer support, and protected recovery time.

Theoretically, the study reinforces the JD-R model's view that strengthening job and personal resources can buffer stress and build resilience, while also extending the model by identifying residency-specific demands and resources. Practically, the study points to actionable steps for program directors and hospital administrators for the following concerns: 1. Establishing staffing/coverage targets and surge support mechanisms (floaters, ER/OPD reinforcement); 2. Implementing duty-hour and recovery-time safeguards; 3. Ensure transparent workload allocation by year level with accountability; 4. Providing structured mentorship and supervisor training; 5. Offering confidential counseling services and referral pathways; and 6. Conducting routine well-being check-ins and reporting mechanisms.

These measures aim to reduce patient flow delays, minimize the risk of errors, lower absenteeism and turnover intention, and strengthen the teamwork climate, while safeguarding resident well-being. More broadly, the study contributes to the future of work in healthcare by advocating for a sustainable training system and psychologically safe workplaces that nurture both competence and resilience.

LIMITATION & FURTHER RESEARCH

This study provides meaningful qualitative insights into medical residents' experiences with burnout; however, its small sample size from a single tertiary hospital limits generalizability. The reliance on self-reported interviews may introduce recall and social desirability biases, affecting response accuracy. Future research should adopt mixed-methods designs that integrate qualitative insights with validated quantitative tools, such as the Copenhagen Burnout Inventory (CBI) and the Maslach Burnout Inventory (MBI), to improve reliability and comparability.

Expanding to larger, more diverse, and multi-institutional samples using longitudinal approaches can better capture the development of burnout over time. Future studies should also assess interventions that promote resident well-being, such as workload reform, structured mentorship, wellness initiatives, and psychological support, to develop evidence-based strategies to strengthen resilience and create healthier training environments.

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