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"I Don't Take Orders from You": How Families and Travel Nurses Impact Healthcare Employee Burnout

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ABSTRACT
Intensive care unit (ICU) employees experience specific organizational communication challenges that can increase their stress and burnout while decreasing their overall wellness. Twelve structured interviews and ten hours of observation with ICU employees were conducted to explore perceptions of increased stress and burnout. Multiple factors contributing to negative impacts on workplace wellness and burnout have been identified in previous communication literature, including work overload, time constraints, lack of management support, and role stressors. The findings of this study extended research on two additional organizational stressors linked to communication—patient families and travel nurses. Interactions with patient families since the COVID-19 pandemic have challenged ICU employees, with family members demonstrating overbearing and controlling tendencies as well as persistent questioning of ICU employees. The presence of travel nurses during COVID-19 were identified as a second stressor, with travel nurses' inexperience in the ICU units creating communication challenges. Pay discrepancies between travel nurses and ICU employees also contributed to perceptions of injustice. The identification of patient families and travel nurses as two significant organizational stressors expands previous organizational research beyond the identification of job characteristics to illustrate how communicative practices contribute to emotional exhaustion in organizations.

KEYWORDS: Burnout, covid-19, intensive care workers, organization stress, workplace wellness

The COVID-19 pandemic created numerous challenges and consequences related to physical and mental health for various types of employees (Tighe & McKiernan, 2025; Zuniga, 2025). For healthcare workers, COVID-19 created specific factors that increased stress (Fakunle & Hernandez Delgado, 2026). Indeed, most healthcare workers faced issues such as increased depression, insomnia, and anxiety along with a lack of resources to handle the additional stress (Abt et al., 2024). As a result of these emotional burdens, the stress healthcare workers felt during the COVID-19 pandemic has in some cases increased their stress overall and eventually led individuals to experience workplace burnout.

Stress, including experiences related to patient and patient family interactions, is often accepted as a normal part of a healthcare workplace (Ptacek & Apker, 2021). Previous research on

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healthcare organizations have also identified multiple sources of enduring job stressors within healthcare organizations, including identification of both patient-related and team-related communication stressors (Ptacek & Apker, 2021). Patient-related communication stressors identified in healthcare organizations can include the need for health care workers to manage patient expectations (Perez et al., 2015), experiences with patient aggression (Lanctôt & Guay, 2014), and decisions surrounding medication prescriptions and reconciliation (Jamison et al., 2014; Nazi, 2013). Researchers have broadly identified sources of healthcare worker stress related to managing interpersonal relationships with patients and their family members, as well as stress that results from required emotion displays and management of authentic emotions (Consiglio, 2014a). Notably, research has found health care professionals are at a higher risk of patient aggression compared to other occupations (Lanctôt & Guay, 2014), with nurses experiencing daily incivility on the job that directly impacts their overall wellbeing (Campana & Hammoud, 2015). Furthermore, team-related communication stressors in healthcare organizations include incivility from colleagues (D'ambra & Andrews, 2014; Spiri et al., 2016), risk of workplace violence (Liu et al., 2019), institution or colleague support challenges (Chemali et al., 2022; Liu et al., 2019) and communication overload (Barrett et al., 2021). When patient or team-related organizational stressors increase, health care workers can reach a long-term point of stress that can evolve into workplace burnout (Ptacek & Apker, 2021).

Workplace burnout, which emerges from chronic long-term stress, is defined by negative physical, emotional, and mental workplace experiences (Ptacek & Apker, 2021). Prior to the COVID-19 pandemic, burnout was affecting nearly half of all nurses, physicians, and clinicians (Shanafelt et al., 2015). Since the pandemic, concerns have continued to rise regarding a growing trend of increased healthcare worker burnout (Leo et al., 2021). Burnout is a three-dimensional concept that involves 1) emotional exhaustion, 2) depersonalization or a negative response to clients/patients, and 3) a reduced feeling of personal accomplishment (Maslach, 2003; Tracy, 2009). Furthermore, burnout includes six categories that help understand its causes better and move employees from burnout to engagement. These categories are (a) workload, (b) control, (c) reward, (d) community, (e) fairness, and (f) values (Maslach & Leither, 1997; Wicke & Nelson, 2021). Moreover, because burnout is a common experience for healthcare workers it can create effects that impact both the individual experiencing burnout as well as their patient's care.

For example, healthcare workers can have their own care and safety impacted when they are burned out (Leo et al., 2021). As mentioned, healthcare workers have a much higher level of stress than the general population and during the COVID-19 pandemic these levels increased. Indeed, a meta-analysis reported that healthcare workers during COVID-19 had levels of anxiety (24.94%), depression (24.83%), and sleep disorders (44.03%) (Marvaldi et al., 2021). Additionally, some healthcare may also hide their health issues rather than seek care when they need help which can create further challenges with stress management (Brower, 2021).

Another effect of burnout is the potential impact on patient care through medical errors and less attention to patient safety (Salyers et al., 2017). As Leo et al. (2021) explain, when healthcare workers engage in more risks and potentially provide less quality care, they may simultaneously experience additional distress as well. Finally, burnout can create economic issues if employees leave organizations and need to be replaced or create reduced levels of effort placed into work for employees who do not leave (Leo et al., 2021). During COVID-19, one type of healthcare worker who experienced higher levels of burnout were intensive care unit (ICU) employees (Kok et al., 2021; Miller et al., 2021).

In critical care hospital settings, such as ICUs, burnout has been shown to create myriad organizational challenges including decreased employee well-being and higher levels of turnover (Schlak et al., 2021). Indeed, several studies have found that ICU workers have experienced higher

levels of burnout since the COVID-19 pandemic—particularly respiratory therapists (RTs) and nurses (Kok et al., 2021; Miller et al., 2021). COVID-19 intensified demands on ICU employees and organizational stressors because of the unpredictability of the disease and the dangerous respiratory symptoms (Labrague et al., 2020). In communication research, scholars have recently determined ICU workers can feel overloaded due to navigating a lack of resources and staff—especially due to COVID-19 (Barrett et al., 2023)—as well as requirements to improve patient care while learning new technologies (Ford et al., 2022). Additional studies have suggested further reasons for ICU employee burnout, including employee density, emotion management requirements, increased workloads, and the practice of hiring travel nurses to backfill employee gaps.

First, there is a "high density" of critical care employees (Papazian et al., 2023). This can create challenges with communication and understanding when multiple employees are trying to enact various work roles at the same time. Second, ICU employees must handle intense emotional situations where patients are often facing life-threatening illnesses (Moreland & Apker, 2016). This required emotion management can include instances where ICU employees may be forced to manage their authentic emotions that are incongruent with their job requirements in a given time or context (Consiglio, 2014a). For example, ICU employees frequently see patients that are very ill and therefore they must manage their own emotions and, in some cases, help families grieve while suppressing their own felt grief (Papazian et al., 2023). Third, ICU employees may experience increased workload and interpersonal conflicts with other employees (Papazian et al., 2018). This increased workload and pressure in ICUs has been identified as a common problem in the health sector that is contributing to poor overall relationships amongst ICU nurses (Mahvar et al., 2022). In turn, this stress experienced by ICU nurses impacts the quality of care experienced by patients (Martins et al., 2014).

Fourth, while hiring travel nurses has been a common practice for many years, the number of travel nurses that were hired increased significantly during COVID-19 (Spector et al., 2024). Research has shown that travel nurses may add additional burden to full-time ICU employees stress (Azoulay et al., 2009). Thus, travel nurses in the ICU could be another potential cause of ICU employee burnout. Finally, patient families can create stress for ICU employees based on perceptions of "good care" (Alshery, 2022, p. 8). In one study, it was found that families often perceive good care in a holistic sense while healthcare workers tend to view good care through a biomedical lens (VanDenKerkhof et al., 2017). Additionally, other research has found that conflict between patients' families and workers is common when there are ethic or cultural differences present (Boateng & Brown, 2022).

Particularly relevant to this study are organizational stressors that are related to burnout in the work of ICU employees, including nurses and respiratory therapists (RTs), and how these employees perceive these stressors impact their work. To that end, this study poses the following research question:

RQ: What organizational stressors do nurses and RTs perceive as contributing to their burnout in a post-COVID-19 ICU?

Methodology

Participants included twelve ICU employees (5 nurses and 7 RTs) who worked at a large Southeastern university hospital in the United States. Participants were recruited via an email sent by two gatekeepers (i.e., nursing manager and respiratory therapist supervisor), and data was collected during the first six months of 2022. Additionally, the first author conducted ten hours of shadowing in the ICU to better understand the workplace environment. Participants included nine

women and three men, their average age was 40 years old, and they worked at the hospital for a range of 3-20 years (N=8.8). All participants self-identified as white.

Procedures

Interested participants emailed the first author to find a day and time that was convenient for them to be interviewed. Semi-structured audio recorded interviews—with about 23 questions and probes—were conducted on Zoom. Participants had the option to turn off their videos during the interview if they preferred. However, all participants chose to keep their cameras on. At the beginning of the interview, all participants selected a pseudonym. Interviews ranged in length from 28-58 minutes (M=44.7) and were transcribed by a third-party automated service called temi.com. After transcription, the authors listened to the audio files while correcting the transcripts for errors. The final corrected transcripts resulted in 215 single-spaced pages of data.

Data Analysis

First, we read all the transcripts and open-coded the data looking for first-level descriptive codes (Tracy, 2024). Second, a codebook was created based on the initial first-level codes. During the creation of the codebook, we noticed that several codes fit within the dimensions and stressors that had been discussed in past research related to burnout. After creating a codebook, we went back through the data to conduct second-level theoretical coding (Tracy, 2024). During this time, we created codes that were related to theoretical work on burnout and examined how the data extended past theoretical work. Coding resulted in the identification of two new organizational stressors that were discussed by the participants which we examine in the results below. To ensure qualitative data analysis rigor as recommended by Creswell & Creswell (2017), these findings were member checked by an ICU nurse with over 30 years of ICU unit experience.

Ethical Considerations

This study was reviewed and approved by the sponsoring university's Institutional Review Board (protocol # 74377). The authors ensured that they always followed all the procedures in the IRB protocol. Participants were allowed to skip any interview questions they did not want to answer, and they could discontinue the interview early if needed. The authors also strove to protect participant confidentiality by using pseudonyms and keeping data on password protected computers.

Results: Workplace Wellness Experiences of ICU Workers

Consistent with past research (Tracy, 2009), nurses and RTs in the present study identified work overload, time constraint, lack of management support, and role stressors as impacting their level of burnout. However, the participants also detailed two additional organizational stressors that we focus on here:

- patient families and
- travel nurses

Patient Families

Participants explained how interactions with patient families since COVID-19 have impacted their emotional exhaustion. When asked if he has conflict with patient family members, Kyle (RT) described them as one of the most challenging aspects of his job. He stated:

> Most of the time the families are great. But it is an extra set of eyes that doesn't necessarily understand what's going on. And it can be really challenging to do your job. So, they [family] start asking questions about, you know, "Is this gonna happen? Is this gonna happen?" We're like, "Well, I've only had this patient for like 20 minutes and I've got 20 other patients. I'm not the person to ask." But then you feel bad telling a family member, "I don't know what's going on with your family member."

In this example, we see how the emotional complexities of wanting to help and be sympathetic was often coupled with feelings of frustration about the actual power and control to communicate medical information. ICU participants in this study often filled a role of serving as an *intermediary* or *buffer* (Scarduzio & Tracy, 2015) between physicians and family members, where they were required to engage in surface acting and hide their true feelings, instead performing in ways that countered their own felt frustration or anger. This cultivated emotional dissonance, where ICU unit employees were confronted with managing authentic feelings such as frustration with appropriate emotion displays, leading to additional stress. Emotional dissonance is one of the most stressful elements of service professional's work (Consiglio, 2014b), and thus these ongoing emotional buffering events in the ICU in some part appear to contribute to the emotional fatigue experienced by ICU employees.

Shelly (nurse) shared similar feelings around the need to emotionally buffer, including the difficulty of trying to provide updates to family despite changing policies surrounding care and visitation. In one situation, a family member became "almost like aggressive and frustrated*"* because she did not know the visitation policy. Shelly explains how she *"*just tried to reassure [the family], 'Hey, I just need to double check. Things change so much. So, I honestly don't know.*'"* Shelly's conflict illustrates how family members expected her to be all-knowing, creating additional stress (Alshehry, 2022).

At the start of the pandemic when COVID-19 protocols removed family visitation, employees did not have these conflicts, which some staff members reflected on with a tone of nostalgia. For example, Kyle (RT) shared: "I think a lot of people that worked in the COVID unit, their favorite time was when we didn't have family members. 'Cause we got in, we did our job." The return of visitation after restrictions were lifted introduced stress that employees attributed to questioning family members. Amy (nurse) recalled bargaining with several visiting family members to wear masks:

> They did eventually wear the mask, but not appropriately. Like, they tried not to wear it. They kept pulling it to the side. They were just being obstinate, but they did put it on their face at least.

These examples show how the reintroduction of family visitation policies post-COVID-19 increased stressful family interactions for employees because of conflicts involving what types of care was needed or health practices (Alshehry, 2022). Others talked about how this struggle continues despite the end of the pandemic.

For example, employees discussed how families may attempt to interfere with patient care in emotionally exhausting ways. Britney (RT) shared that:

> "It's still an issue, you know. The family wants to speak for [the patient] or go against their wishes. I mean, it's wild. It's crazy."

She continued:

> "They can be overbearing to the point where it impedes their loved one's care. It makes us not even want to go in the room."

In a similar vein, Billy (RT) revealed:

> "It's harder with family being in there. It makes it way harder on us."

In both examples, participants describe feeling increased stress as part of dealing with family in patient rooms.

Participants also discussed how family members attempted to control what they were doing, which cultivated additional feelings of emotional exhaustion. For example, Lucy (RT) recalled:

> "Their family member was a doctor and was on the phone trying to tell us orders. And all I would say was like, 'I don't take orders from you. I take orders from the medicine team.'"

Corrinne (travel nurse) described a situation with a patient who was an organ donor that was difficult for her and her coworkers because it felt *"inhumane"* when they had to wait for family members to make decisions. In both cases, the participants faced challenges surrounding what they could and could not communicate with the patients' families (see Boateng & Brown, 2022).

Additionally, some employees revealed how persistent questioning from family members created additional stress. For example, Sally (RT) revealed one case where she felt caught in the middle between the doctor and family members. She said:

> "And she is asking me what I think. Well, I'm not able to tell her anything like that."

In another example, Corinne, who was the only travel nurse we interviewed, talked about a situation she faced with a new patient and family members that had no information about the routine procedure their sick loved one was about to undergo:

> "They were surprised after their family member was trached that they were not gonna be able to talk at first. That was like super emotional and took them aback."

These employee quotes revealed that they attributed their amplified stress directly to interactions or anticipation of interactions with family.

Travel Nurses

Another factor that impacted employees' burnout levels was their communication with travel nurses, who are defined as nurses working short-term contracts. The presence of travel nurses increased during COVID-19 and remains high due to ongoing nursing shortages (Wendlandt, 2022). Most employees vocalized multiple ways that travel nurses impacted their emotional well-being. For example, Billy (RT) explained:

> "That's a big complaint with everybody because like we just hired a bunch of travelers [sic] full time and they compensated them very well. We're the ones who've been here for a long time. It's kind of a slap in the face." Brittney (RT) detailed, "We got new nurses and then this travel thing started booming, and here we are." And Krystal (nurse) revealed, "We're not really doing anything to keep current staff. But we're hiring all these travel nurses. And they're saying that they don't have the money. But they have the money to hire all these travelers?"

Employees explain here how the hiring of travel nurses is frustrating, particularly related to issues of pay and fairness (see Spector et al., 2024). They communicated a sense of frustration

about mixed messages from management, lack of rewards for their efforts, and working with employees new to the organizational culture—an issue we turn to next.

For example, employees revealed how working with travel nurses created communicate challenges. Sally (RT) shared:

> I ask her about it, and she was like, "I don't know. I didn't even know they were gonna do it at the bedside." So that's miscommunication. I told her, "They're gonna do the trach." But she didn't know what she does. She's a travel nurse and she hadn't done it before here.

And Jason (RT) reiterated,

> "[It] got to the point where we were getting a lot of travelers that were finishing their new grad orientation as a traveler. So it was, interesting working with less experienced people."

In these examples, Sally and Jason reflect on the complexities of integrating new members into the organization. Sally's recollection of an interaction where the travel nurse did not know her role during a tracheotomy procedure is labeled as a *"miscommunication"*. Later, Sally revealed that:

> "I feel like there is some miscommunication with travelers because they maybe don't know all of our procedures and so forth."

The travel nurse's lack of knowledge created stress for Sally and Jason. These findings reflect previous research noting the importance of work experience in creating supportive interpersonal nursing relationships and more positive attitudes towards colleagues (Martins et al., 2014). Therefore, resolving these types of work experience conflicts in the ICU, which have been identified as a key stressor for nurses, can cultivate improved interpersonal relationships among nurses as well as quality of patient care (Studdert et al., 2003).

The data also highlighted that a lack of knowledge created threats to patient care. These threats, often described as rule violations, underscored the real stress that emerged for employees when travel nurses lacked knowledge and communicated in an abrasive manner when corrected. As Krystal (nurse) explained:

> "I was like okay; I'm not going to help you. If you're going to bite my head off every time that I say something . . . You can't just come in and do things the way you wanna do it . . . Cuz then it messes everything up."

Travel nurses *"messing things up"* included small and large issues linked to life threatening patient incidents. For example, Krystal explained:

> "The reason we do these baths on these days is so that everyone gets one. And it helps decrease their chance of getting an infection . . . you cannot change it just because that's what you wanna do."

In another example, Billy (RT) shared:

> "That shift changes his whole tube came out and we had a travel nurse who didn't know what she was doing. And luckily, we were able to get his trach back in and got him ventilated again. But oh my gosh, it was awful."

Similarly, Emily (RT) detailed:

> "Sometimes they mess with the ventilators or do things they're not supposed to be doing. That can be frustrating."

In these examples, we see that employee stress was impacted by the introduction of travel nurses to the work environment.

Implications and Discussion

In this study, we examined ICU nurse and RT perceptions of organizational stressors that impacted burnout. We identified two additional organizational stressors that have been amplified in the work of employees since the end of the COVID-19 pandemic: 1) patient families and 2) travel nurses. In the following paragraphs, we explore the implications and limitations of this research.

Past research has explored various challenges nurses face with patients and patients' families. These challenges typically have been found to center around types of care (Alshehry, 2022) and ethnic/cultural differences between employees and patients (Boateng & Brown, 2022). However, our study has extended this past research by exploring how specific COVID-19 practices creates challenges for ICU employees and patient families. During COVID-19 in the hospital we examined, ICU employees were able to provide care without family in patient rooms. But now since those restrictions have been lifted, employees have described increased communication challenges and conflict with patient's family members (Wendlandt et al., 2022). Several participants stated "dealing with family" as their least favorite part of their job, every participant provided at least one example of a communication challenge with a patient's family member(s), and many talked about how those challenges ultimately created more workplace stress. It is important for hospital administrators to understand how patient families can create stress for employees in the ICU and to continue to work with employees to develop the most appropriate policies to manage this challenge.

Another interesting finding we determined that extends past research in this area is that the participants in this study were also placed into the role of *intermediary* or *buffer* (Scarduzio & Tracy, 2015) between physicians and family members, which created additional emotional fatigue for ICU employees. In other words, many times family members asked ICU employees questions or expected them to perform behaviors that were actually the tasks of physicians. In these situations, the employees became frustrated because they felt stuck in the middle between physicians and patients' families. However, these employees were unable to express this frustration and instead would engage in either avoidance strategies or surface acting, which forced them to perform with patients and patient's families in ways that countered their felt frustration. In turn, the emotional dissonance created between managing authentic feelings of frustration with appropriate emotion displays created additional stress on ICU employees. Burnout researchers have identified the practice of surface acting and the creation of emotional dissonance as one of the most stressful elements of service professional's work (Consiglio, 2014b), indicating a need for health care workplaces to address these emotional buffering events contributing to ICU employee emotional fatigue.

Additionally, participants highlighted perceptions of injustice related to travel nurses and their lack of knowledge regarding policies. The communication between travel nurses and other employees was discussed as creating additional workplace stress. Many participants identified miscommunications they had with travel nurses, and some participants detailed how they struggled to get on the same page with travel nurses, which has been previously noted by researchers as an ongoing communication problem (see Spector et al., 2024). As Spector and colleagues (2024) explain, research on travel nurses is limited, and research about the relationship between travel nurses and full-time employees is even further limited. Thus, this study provides a first investigation of some of the challenges facing the relationship between travel nurses and full-time ICU employees, answering an identified gap in health care literature that has become increasing more relevant as health care organizations expand the role of travel nurses to fill ongoing staffing gaps (Zhong et al., 2024).

Additionally, these findings reflected ICU unit participant's almost universal frustrations with the travel nurses' lack of ICU experience with the visiting organizational culture. Previous research has noted the importance of work experience in creating and cultivating overall supportive interpersonal nursing relationships and more positive attitudes towards colleagues (Martins et al., 2014). Therefore, resolving this work experience conflicts in the ICU may ultimately cultivate improved interpersonal relationships amongst all ICU nurses. Furthermore, positive interpersonal nursing relationships have been found to improve overall quality of patient care (Studdert et al., 2003). By resolving the ICU experience gap first identified within the COVID-19 ICU travel nurse cohort, more positive interpersonal relationships across all ICU employees can be cultivated, potentially leading to improved patient care. Future research should continue to explore how both current ICU employees and travel nurses can work together without creating conflict, and how short-term training or knowledge development programs focused on closing knowledge gaps of temporary employees may ultimately facilitate reduced stress and burnout for all ICU health care workers.

Ultimately, while the organizational stressors in past research on burnout are connected more directly to job characteristics, the two new stressors identified in this study directly relate to communication—including communication between family members and employees and communication between different types of ICU employees. These findings support ongoing efforts to address lingering stress and burnout that emerged from the COVID-19 pandemic within the field of medicine. Practitioners, including hospital administrators, are encouraged to incorporate the findings of this study in their efforts to decrease workplace stress and burnout, especially in ICU units.

This study is not without limitations. First, most of the participants were women. In fact, the three male participants were RTs, and no male nurses were included. While there are more female nurses than men, it is important to investigate the experiences of male nurses regarding these findings in future research. Second, the participants were all White and heterosexual. Thus, the sample was not diverse. Future research on ICU employee experience needs to see what specific aspects relate to job burnout for employees of more diverse backgrounds and if there are any other causes of job burnout unique to their experiences. Third, this study investigated the relationship between travel nurses and ICU full time employees, and how the challenges within this relationship related to workplace burnout. Future research should study the experiences of travel nurses and ICU employees by including both groups as participants to gather a more complete picture of the relationship between these groups.

In summary, this study investigated the perceptions of ICU employees related to their organizational stressors. Through in-depth interviews and observation, it was determined that participants named 1) communication with patient families and 2) travel nurses as two important causes of their stress and burnout. This study revealed that communication with patient families can create emotional challenges such as feeling like an intermediary or buffer between patients' families and physicians and experiencing emotional incongruence, or dissonance. Furthermore, this study highlighted the challenges that occurred between travel nurses and full time ICU employees—particularly related to the travel nurse lack of experience or misunderstanding of each specific workplace culture. Future research should continue to explore how these patient families and travel nurses add organizational stress and burnout to ICU employee work by investigating more diverse groups of workers.

Disclosure Statement

There is not financial interest or benefit that has arisen from the direct applications of this research.

Authors Contributions

Jennifer Scarduzio contributed to study design and conceptualization, data collection, data analysis, and writing of the manuscript. Amber Lynn Scott contributed to data collection, data analysis, and writing of the manuscript.

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Data Availability Statement

Data is available through contacting by emailing the first author at jennifer.scarduzio@uky.edu

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