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Medical doctors taking the lead: transforming workplaces towards sustainable employability

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CHAPTER 7

Summary

This chapter summarises the main findings of the separate studies described in this dissertation and links them to its three central aims:

AIM 1: Identifying whether Psychosocial Safety Climate (PSC) and which job demands and job resources determine medical doctors' Sustainable Employability (SE) and act as drivers of change within SE-focused organisational-level workplace interventions;

AIM 2: Evaluating the effectiveness of organisational-level workplace interventions in improving medical doctors' SE;

AIM 3: Identifying the process factors that facilitate or hinder the effectiveness of SE-focused organisational-level workplace interventions among medical doctors.

To address these aims, we applied a two-pronged strategy:

(1) Synthesising existing evidence on implemented and evaluated organisational-level workplace interventions targeting SE among medical doctors (Chapter 2);

(2) Generating new evidence by implementing and evaluating a new organisational-level workplace intervention ourselves, including a Participatory Action Research (PAR) approach, among groups of Dutch medical doctors (Chapters 3, 4, 5, and 6).

Synthesising existing evidence

In **Chapter 2** we conducted a narrative systematic review to evaluate the effectiveness of organisational-level workplace interventions aimed at improving SE among medical doctors (AIM 2). We included interventions targeting burnout, work engagement, and/or job satisfaction. We also examined whether these studies assessed changes in job factors that function as drivers of change in SE indicators (AIM 1), and whether they evaluated process factors that facilitate or hinder intervention effectiveness (AIM 3). Across the included studies focusing on burnout, 69% reported reductions in at least one burnout symptom. Furthermore, 70% of the included studies focusing on job satisfaction found increased job satisfaction. These findings indicated that organisational-level workplace interventions can be effective in improving medical doctors' SE indicators (AIM 2). However, no studies assessed intervention effects on work engagement, leaving open the question whether such interventions can be effective in improving medical doctors' work engagement (AIM 2). Almost none of the studies explicitly examined changes in job factors as mechanisms driving SE improvements (AIM 1). However, 69% did report intervention effects on job factors and SE outcomes separately, suggesting that workload and job demands-, work efficiency and workflow-, income and non-financial incentives or rewards-, and opportunities for professional development-related job factors may be key drivers of change (AIM 1). Similarly, almost no studies explicitly assessed process factors

influencing intervention effectiveness (AIM 3). Still, 48% reported process factors without linking them to intervention outcomes, indicating that positive mental models toward the intervention may enhance intervention effectiveness, whereas poor adherence to the intervention may hinder it (AIM 3).

Generating new evidence

In **Chapter 3**, we outlined the protocol for the central study in this dissertation, which evaluated the effectiveness of a newly developed organisational-level workplace intervention aimed at improving SE indicators among Dutch medical doctor groups (AIM 2). The intervention was based on the Job Demands-Resources (JD-R) model and incorporated Participatory Action Research (PAR), positioning medical doctors as the primary drivers of change. Medical doctor groups developed, implemented, and evaluated organisational changes aimed at increasing PSC, reducing job demands, and/or increasing job resources. Process facilitators supported the medical doctor groups, with support gradually decreasing across the three intervention phases: phase one (8 months), phase two (6 months), and phase three (10 months). Four measurement points were included to assess intervention effectiveness over time: baseline, mid-intervention one (after 8 months), mid-intervention two (after 14 months), and post-intervention (after 24 months). In addition to assessing intervention effects on SE indicators (i.e., burnout, work engagement, job satisfaction, turnover intention, occupational self-efficacy, positive perceived impact on health and well-being) (AIM 2), the protocol specified that we would examine whether improvements in PSC, job demands, and job resources functioned as mechanisms driving SE improvements (AIM 1). Finally, we described plans to evaluate whether intervention effects on PSC, job demands, job resources, and SE indicators would be stronger in medical doctor groups with more favourable implementation processes: the influence of process factors on intervention effectiveness (AIM 3).

In **Chapter 4**, we analysed the baseline data of the organisational-level workplace intervention to examine whether PSC, job demands, and job resources were related to medical doctors' SE indicators - burnout, work engagement, and job satisfaction (AIM 1). We were specifically interested in whether PSC functioned as a "cause of causes", meaning that it is indirectly related to SE indicators through job demands and job resources. We also examined whether PSC buffered the impact of job demands on SE indicators, and strengthened the impact of job resources on SE indicators. We found that almost all job demands were positively associated with burnout, and some were also related to work engagement and/or job satisfaction. Time pressure had the strongest relationships with all three SE indicators. Several job resources were negatively related to burnout, and positively to work engagement and job satisfaction. Opportunities for development had the

strongest relationships with all three SE indicators. PSC was related to various job resources and only to one job demand: social harassment. We found some support for PSC as a cause of causes, with indirect observed associations between PSC and SE indicators through staffing levels, social support from supervisor, opportunities for development, and social harassment. Finally, PSC moderated several relationships between job demands and resources and SE indicators; however the findings were reversed: under high PSC, unfavourable scores on social harassment, work procedures, and internal communication were related to more negative SE outcomes. Taken together, the findings suggested that key determinants of medical doctors SE were: PSC, particularly through job resources and social harassment; job demands, especially in relation to burnout; and job resources, which were related to all SE indicators. Among these job demands and resources, time pressure and opportunities for development emerged as the most important determinants of SE indicators (AIM 1).

In **Chapter 5**, we evaluated the effectiveness of the organisational-level workplace intervention on PSC, job demands, job resources, and SE indicators among medical doctors (AIM 2). We also examined job factors as drivers of change in SE improvements (AIM 1). We found that the intervention was effective in improving PSC and several job resources from baseline to post-intervention (after 24 months). The medical doctors also reported a small positive perceived impact of the intervention on their work situation at post-intervention. However, the intervention was less successful in reducing job demands and improving SE indicators. The medical doctors did report a small positive perceived impact of the intervention on their health and well-being at post-intervention (AIM 2). Decreases in job demands and increases in job resources from baseline to post-intervention emerged as drivers of change in SE improvements between baseline and post-intervention. Time pressure and opportunities for development were the most influential drivers of change, while PSC played a more limited role, except for PSC related to organisational participation, which was associated with improved job satisfaction (AIM 1). Thus, the organisational-level workplace intervention was particularly effective in improving PSC and job resources, and less effective in improving job demands and SE indicators (AIM 2). Time pressure and opportunities for development emerged as the most important drivers of change in SE (AIM 1).

In **Chapter 6**, we evaluated the process of the organisational-level workplace intervention (AIM 3). We examined whether intervention design and implementation processes (degree of implementation of changes, information provision, medical doctors' involvement, management support) and medical doctors' mental models (positive appraisals of intervention focus and approach, positive expectations), measured at mid-intervention

two (after 14 months), facilitated and/or hindered intervention effectiveness on job factors (PSC, job demands, job resources) and SE indicators. We also assessed whether the intervention context - timing of intervention start (early versus later) and organisational setting (municipal public health services, hospital departments, other non-hospital institutions) influenced intervention effectiveness. We found that more favourable perceptions of intervention design and implementation processes facilitated intervention effects on job factors, and to a lesser extent on SE indicators. Medical doctors' mental models appeared to play a smaller role in the intervention's effects. However, less positive appraisals of intervention focus and approach unexpectedly enhanced intervention effectiveness on some SE indicators and job resources. Finally, more positive intervention effects were observed among later intervention starters and hospital departments. Together, these findings indicated that more favourable perceptions of intervention design and implementation process factors, and less favourable perceptions of intervention's focus and approach at 14 months, as well as the later intervention start and hospital-based settings, were important in facilitating intervention effectiveness (AIM 3).