



JNK

JURNAL NERS DAN KEBIDANAN
(JOURNAL OF NERS AND MIDWIFERY)

<https://ojs.phb.ac.id/index.php/jnk>



Nurse-Physician Collaboration in Mitigating Workload-Induced Burnout and Turnover Intention: A Scoping Review of Adaptive Risk Pathways

^{CA}Muhammad Hafidh Taquiuddin¹, Ati Surya Mediawati¹, Hana Rizmadewi Agustina¹,
Muhammad Afiif Aziz¹, Windu Santoso², Sri Sudarsih², Reni Afriana¹, Vica Cahya
Ningrum²

¹Universitas Padjadjaran, Indonesia

²Universitas Bina Sehat PPNI, Indonesia

^{CA}Corresponding Author muhammad18287@mail.unpad.ac.id

Article Information

History Article:

Received, 11/06/2026

Accepted, 12/08/2026

Published, 15/08/2026

Keyword:

Workload, Turnover Intention,
Nurse-Physician Collaboration,
Hospital, Interprofessional
Teamwork

Abstract

Burnout and turnover intention threaten hospital workforce stability and patient safety. Workload is an established contributor, but how nurse-physician collaboration may interrupt this pathway across hospital contexts remains unclear. This scoping review followed Joanna Briggs Institute methodology, the Population-Concept-Context framework, and PRISMA-ScR guidance. PubMed, Scopus, and EBSCOhost were searched from database inception to 19 May 2026, with eligibility restricted to English-language peer-reviewed empirical studies published in 2022–2026. Of 576 records identified, seven studies were included after screening. The data were charted and interpreted using the Roy Adaptation Model. The seven studies (N = 51,711) identified staffing shortages, high patient acuity, time pressure, administrative and electronic health record burden, and crisis-related disruption. Collaboration involved relational coordination, shared goals, mutual respect, shared decision-making, mentorship, and peer support. Supportive collaboration was associated with job satisfaction, well-being, and intention to stay, whereas weak or unsupported collaboration coincided with burnout, moral injury, fatigue, and turnover intention. Collaboration may reduce uncertainty, distribute clinical responsibility, and strengthen collective coping; however, its protective value depends on staffing adequacy, responsive leadership, and work-system support. Nurse-physician collaboration may mitigate adverse workforce outcomes but cannot substitute for safe staffing and organizational support. Hospitals should integrate workload reduction with structured interprofessional communication, shared governance, mentoring, and peer support. Longitudinal and intervention studies are needed to test mediation and moderation effects.

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✉Correspondence Address:

Universitas Padjadjaran – Central Java, Indonesia

Email: muhammad18287@mail.unpad.ac.id

DOI: <https://doi.org/10.26699/jnk.v13i2.ART.p218-231>

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P-ISSN: 2355-052X

E-ISSN: 2548-3811

INTRODUCTION

Burnout and turnover intention among hospital clinicians threaten workforce stability, care quality, and patient safety ([Arnoux-Nicolas et al., 2016](#); [Lee et al., 2026](#); [Liu et al., 2023](#); [Moisoglou et al., 2025](#); [Safitri & Hartartiyanto, 2024](#)). Workload is multidimensional and includes inadequate staffing, high patient acuity, long or mandatory shifts, time pressure, administrative tasks, and electronic health record (EHR) documentation ([Al-Dajani et al., 2023](#); [Bakhoun et al., 2021](#); [Febrianti et al., 2024](#); [Park et al., 2024](#); [Schwabe et al., 2025](#)). These demands have been associated with emotional exhaustion, job dissatisfaction, and intention to leave among nurses and physicians ([Aiken et al., 2025](#); [Bae, 2024](#); [Gesner et al., 2022](#); [Moy et al., 2021](#)). Accordingly, adverse workforce outcomes should be interpreted as organizational as well as individual problems.

Nurse–physician collaboration may provide a team-level buffer by improving information exchange, role clarity, mutual respect, shared decision-making, and collective responsibility ([Al-Bustanji et al., 2024](#); [Dahlawi et al., 2023](#); [Elhouda Mohamed Awad et al., 2024](#); [Sarmadi et al., 2025](#)). Relational coordination has been associated with job satisfaction and intent to stay among nurses and physicians ([Falatah, 2017](#); [Gittell et al., 2018](#)) while interprofessional teamwork and nurse–physician collaboration have been linked to burnout and turnover intention through job satisfaction and organizational commitment ([S. Al Sabei et al., 2023](#); [Kwon et al., 2019](#); [Miri et al., 2026](#); [Siabi et al., 2025](#); [Yilmaz et al., 2023a](#)). Within the Roy Adaptation Model, workload can be viewed as a focal and contextual stimulus, collaboration as an interprofessional coping process, and burnout or turnover intention as maladaptive responses when coping resources are insufficient ([Roy et al., 2009](#)).

The literature remains fragmented in three specific ways: many studies examine nurses or physicians separately; workload, collaboration, burnout, and turnover are often analyzed as isolated constructs; and few studies explicitly test collaboration as a buffer, mediator, or moderator within a shared hospital pathway. A scoping review was therefore selected rather than a systematic review because the evidence spans quantitative and qualitative designs, heterogeneous clinical settings, and varied outcome measures, and the objective was to map concepts and mechanisms rather than estimate a pooled intervention effect. This review aimed to map workload-related stressors, collaborative coping mechanisms, workforce responses, and mitigation strategies among nurses and physicians in hospital settings.

METHODS

This scoping review followed Joanna Briggs Institute guidance and was reported in accordance with the PRISMA Extension for Scoping Reviews ([Tricco et al., 2018](#)). The Population–Concept–Context framework comprised registered nurses and physicians, workload and interprofessional collaboration in relation to burnout or turnover intention, and hospital-based clinical settings. The Roy Adaptation Model guided interpretation. No protocol was prospectively registered; this is acknowledged as a limitation. PubMed, Scopus, and EBSCOhost were searched from database inception to 19 May 2026. Controlled vocabulary and free-text terms covered nurse–physician relations, interprofessional collaboration, workload, burnout, occupational stress, turnover intention, retention, coping, adaptation, hospitals, and acute care. Eligibility was restricted to articles published from 2022 through 2026. Complete database-specific search strings are provided in Supplementary File 1.

Table 1. Database-Specific Search Strategies

Data Base	String/Keywords
PubMed	("Physician-Nurse Relations"[Mesh] OR "Interprofessional Relations"[Mesh] OR "Patient Care Team"[Mesh] OR "nurse-physician"[Title/Abstract] OR "doctor-nurse"[Title/Abstract] OR (nurse*[Title/Abstract] AND physician*[Title/Abstract])) AND ("Workload"[Mesh] OR "Burnout, Professional"[Mesh] OR "Occupational Stress"[Mesh] OR workload*[Title/Abstract] OR burnout [Title/Abstract] OR "job stress"[Title/Abstract] OR "emotional exhaustion"[Title/Abstract]) AND ("Personnel Turnover"[Mesh] OR "turnover intention*[Title/Abstract] OR "intent to leave"[Title/Abstract] OR retention [Title/Abstract] OR "staff retention"[Title/Abstract] OR "Adaptation, Psychological"[Mesh] OR coping [Title/Abstract] OR adapt*[Title/Abstract]) AND ("Hospitals"[Mesh] OR hospital*[Title/Abstract] OR "acute care"[Title/Abstract])
Scopus	TITLE-ABS-KEY (("nurse-physician" OR "doctor-nurse" OR "physician-nurse" OR "interprofessional relation*" OR "interprofessional collaboration" OR (nurse* AND (physician* OR doctor*)))) AND TITLE-ABS-KEY (workload* OR burnout OR "occupational stress" OR "job stress" OR "emotional exhaustion") AND TITLE-ABS-KEY ("turnover intention*" OR "intent to leave" OR "intention to leave" OR retention OR "staff retention" OR coping OR adapt*) AND TITLE-ABS-KEY (hospital* OR "acute care" OR "medical center*" OR "medical centre*")
EBSCOhost	((MH "Physician-Nurse Relations" OR MH "Interprofessional Relations" OR TI "nurse-physician" OR AB "nurse-physician" OR TI "doctor-nurse" OR AB "doctor-nurse" OR ((TI nurse* OR AB nurse*) AND (TI physician* OR AB physician* OR TI doctor* OR AB doctor*)))) AND ((MH "Workload" OR MH "Burnout, Professional" OR MH "Stress, Occupational" OR TI workload* OR AB workload* OR TI burnout OR AB burnout OR TI "occupational stress" OR AB "occupational stress" OR TI "emotional exhaustion" OR AB "emotional exhaustion")) AND ((MH "Personnel Turnover" OR MH "Retention" OR MH "Adaptation, Psychological" OR MH "Coping" OR TI "turnover intention*" OR AB "turnover intention*" OR TI "intent to leave" OR AB "intent to leave" OR TI retention OR AB retention OR TI adapt* OR AB adapt*)) AND ((MH "Hospitals+" OR TI hospital* OR AB hospital* OR TI "acute care" OR AB "acute care" OR TI "medical center*" OR AB "medical center*"))

The eligibility criteria was English-language, full-text, peer-reviewed primary empirical studies were included when nurses and physicians were both represented in hospital practice and the study examined (1) a workload-related stressor, (2) nurse–physician collaboration or a closely related team construct, and (3) burnout, emotional exhaustion, job dissatisfaction, moral injury, turnover intention, intent to stay, or retention. Monodisciplinary studies

without interprofessional analysis, non-hospital settings, student or non-clinical populations, secondary research, editorials, conference abstracts, and grey literature were excluded.

The inclusion criteria in his scoping review included studies involving registered nurses and physicians who provided direct patient care within hospital-based clinical settings. Studies were considered eligible when nurses and physicians

were examined either interdependently, comparatively, or as part of an integrated interprofessional team. Studies that included additional healthcare professionals were also included, provided that nurses and physicians were clearly represented and the findings were relevant to interprofessional hospital practice. The concept of interest focused on workload-related stressors and at least one relevant outcome, including burnout, emotional exhaustion, job dissatisfaction, moral distress, turnover intention, intention to stay, retention, or career withdrawal. In addition, eligible studies needed to examine nurse–physician collaboration or related constructs such as interprofessional teamwork, relational coordination, collaborative coping, collaborative culture, shared decision-making, or team-based mitigation strategies. The context was limited to hospital-based clinical environments, including acute care wards, intensive care units, emergency departments, adult medical-surgical units, military treatment hospitals, and specialized hospital centers. Only primary empirical studies using quantitative, qualitative, or mixed-methods designs were included. Furthermore, studies were restricted to full-text articles published in English between 2022 and 2026.

The exclusion criteria of the studies were used when the study focused exclusively on a single professional group without addressing interprofessional or collaborative dynamics between nurses and physicians. Studies involving healthcare students, administrative personnel, volunteers, patients, or informal caregivers were also excluded. Research that did not explicitly link workload-related stressors to burnout, turnover intention, or related workforce outcomes was not considered eligible. Studies that only examined general occupational stress without a clear connection to workload or without incorporating collaborative or team-based dimensions were also excluded. In addition, studies conducted outside hospital-based settings, such as primary care clinics, community health centers, long-term care facilities, home care services, or pre-hospital emergency systems, were excluded. Finally, secondary

literature such as systematic reviews, scoping reviews, meta-analyses, theoretical papers, editorials, commentaries, conference abstracts without full text, and grey literature were not included in this review.

The study Selection was applied by managing and deduplicating in Mendeley Reference Manager; no dedicated screening platform was used. Two reviewers independently screened titles, abstracts, and full texts, and a third reviewer resolved disagreements that remained after discussion. Two reviewers charted study characteristics, workload stressors, collaborative mechanisms, workforce outcomes, and recommendations; a third reviewer checked the extracted data for consistency.

Data charting was conducted using a structured charting form developed in accordance with the review question, the PCC framework, and the Roy Adaptation Model. Two reviewers independently extracted data from the included studies, and the extracted information was checked by a third reviewer to ensure consistency and accuracy. Any discrepancies in data interpretation were resolved through discussion until consensus was reached. The charting form consisted of two main tables. [Table 2](#) captured the general characteristics of the included studies, including author(s), year, country, clinical setting, study aim, study design, population and sample size, response rate, and validated instruments. [Table 3](#) charted the core conceptual elements relevant to this review, including workload-related stressors, nurse–physician collaboration mechanisms, adaptive or maladaptive responses related to burnout and turnover, and recommended mitigation strategies. The Roy Adaptation Model was used to guide the organization of these data, with workload-related stressors interpreted as focal and contextual stimuli, nurse–physician collaboration as an interprofessional coping mechanism, and burnout, moral injury, job dissatisfaction, turnover intention, or intent to stay as adaptive or maladaptive responses. This approach allowed the review to map how collaborative mechanisms may function as adaptive pathways in mitigating workload-induced burnout and turnover-related outcomes among nurses and physicians in hospital settings.

The findings were summarized descriptively and narratively. Workload-related factors were mapped as focal or contextual stimuli, collaboration as an interprofessional coping process, and workforce outcomes as adaptive or maladaptive responses. Because the studies were heterogeneous in design, measures, and context, no meta-analysis was undertaken. Ethical approval was not required because this study used data from previously published studies and did not involve direct contact with human participants.

RESULTS

Study Selection

The initial literature search across three electronic databases yielded 576 records: PubMed (n = 93), Scopus (n = 245), and EBSCOhost (n = 238). Before screening, 232 duplicate records were identified and removed. A further 239 records were removed before title and abstract screening based on predefined database limits and preliminary

eligibility filters, including non-empirical document types such as reviews (n = 43) and records outside the review scope (n = 196). Consequently, 105 records proceeded to title and abstract screening.

Following title and abstract screening, 30 records were excluded because they did not align with the review objectives. Full-text reports were sought for the remaining 75 articles; however, 2 reports could not be retrieved. The remaining 73 full-text articles were assessed for eligibility using the predefined Population, Concept, and Context criteria. Of these, 66 articles were excluded for the following reasons: monodisciplinary samples without interprofessional evaluation (n = 25), lack of focus on collaborative adaptation in mitigating workload-related stress (n = 37), and non-hospital settings (n = 4). Ultimately, 7 primary empirical studies met the inclusion criteria and were included in the final synthesis. The complete study selection process is presented in [Figure 1](#).

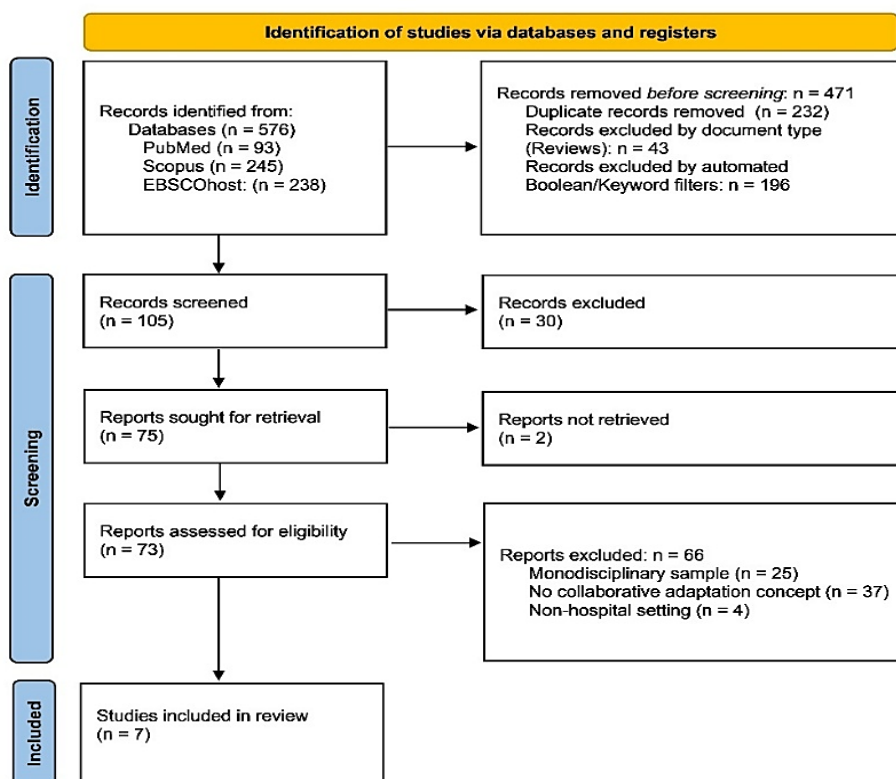


Figure1.Prisma Flow Diagram

Characteristics of Included Studies

The seven studies were published between 2022 and 2025 and represented hospital systems in Europe, the United States, and India. Five used cross-sectional designs and two used qualitative approaches. Together they included 51,711 participants: 37,610 nurses, 14,067 physicians, and 34 other or unclassified personnel. Settings included

acute general hospitals, medical–surgical units, intensive care, emergency departments, a military treatment facility, and a temporary COVID-19 intensive care unit. Essential study characteristics are summarized in [Table 2](#); response rates and measurement instruments were moved to Supplementary [Table 2](#).

Table 2. Essential Characteristics of Included Studies

Study	Country and setting	Design and sample	Primary focus
Aiken et al., 2024	Six European countries; acute general hospitals	Cross-sectional survey; N = 8,830 (6,643 nurses; 2,187 physicians)	Clinician well-being, staffing, work environment, and intervention priorities
Aiken et al., 2023	United States; 60 Magnet hospitals	Multicenter cross-sectional survey; N = 21,050 (15,738 nurses; 5,312 physicians)	Well-being, turnover, patient safety, and modifiable work conditions
Aiken et al., 2025	Europe and United States; 105 hospitals	Cross-sectional study; N = 21,396 (14,913 nurses; 6,483 physicians)	Staffing, teamwork, physician well-being, and intention to leave
D'Silva et al., 2024	India; tertiary-hospital emergency department	Prospective cross-sectional study; N = 82	Organizational culture, teamwork, stress, and job satisfaction
Guessoum et al., 2022	France; temporary COVID-19 intensive care unit	Qualitative phenomenological study; N = 15 (8 nurses; 7 physicians)	Team coping and psychological effects during crisis deployment
House et al., 2023	United States; military treatment facility	Exploratory cross-sectional study; N = 289	Relational coordination, job satisfaction, and intent to stay
Snyder et al., 2025	United States; acute-care settings	Qualitative focus groups; N = 49 (25 nurses; 24 physicians)	Burnout and reasons for leaving direct patient care

Table note: N, sample size.

Table 3. Workload Stressors, Collaborative mechanism, Workforce outcome or interpretation

Study	Workload-related stressors	Collaborative mechanism	Workforce outcome or interpretation
Aiken et al., 2024	Understaffing, high patient ratios, documentation burden, increased complexity	Structural empowerment, clinician participation, collaborative nurse–physician relationships	Better staffing and work environments were associated with less burnout and lower intention to leave
Aiken et al., 2023	Chronic understaffing, chaotic work, EHR burden, low schedule control	Positive professional relationships and efficient unit teamwork	Poor environments and high burnout coincided with job dissatisfaction and turnover
Aiken et al., 2025	Excessive workload, low control, unresponsive administration, understaffing	Strong interdisciplinary teams and supportive care environments	Staffing and teamwork were associated with lower physician burnout and intention to leave
D'Silva et al., 2024	Variable volume, crowding, aggression, documentation burden	Clan-oriented culture, peer support, mentorship, shared responsibility	Lower stress and high satisfaction were reported, although emotional exhaustion persisted
Guessoum et al., 2022	Extreme COVID-19 ICU demand, changing protocols, infection control, ethical dilemmas	Team spirit, frequent briefing, informal debriefing, flexible leadership	Collaboration supported short-term coping but did not prevent fatigue and secondary trauma
House et al., 2023	Time pressure, task interdependence, administrative work	Frequent, timely, accurate, problem-solving communication with shared goals and respect	Relational coordination predicted job satisfaction and intent to stay
Snyder et al., 2025	Unsafe ratios, support-staff shortages, mandatory overtime, crisis conflict	Camaraderie and peer support; weak administrative support	Moral injury and physical exhaustion contributed to leaving direct care

Workload as Focal and Contextual Stimuli

Across the included studies, workload was mapped as a central stimulus within the adaptive risk pathway linking hospital work conditions, burnout-related outcomes, and turnover-related outcomes among nurses and physicians. From the perspective of the Roy Adaptation Model, workload can be interpreted as both a focal and contextual stimulus, in which immediate clinical demands interact with broader organizational conditions that shape clinicians' adaptive or maladaptive responses ([Roy et al., 2009](#)). As a focal stimulus, workload included unsafe staffing levels, high patient-to-

nurse ratios, excessive clinical demands, unpredictable patient volume, patient complexity, and time pressure in high-acuity hospital units. Staffing inadequacy and excessive workload were particularly emphasized in the Aiken-led studies ([Aiken et al., 2023, 2024](#)). Emergency department overcrowding and unpredictable patient volume were highlighted as workload-related stressors in emergency care settings ([D'Silva et al., 2024](#)). Unsafe nurse-to-patient ratios, shortage of support staff, and mandatory overtime were also identified as workload-related stressors among clinicians who

had left direct patient care careers ([Snyder et al., 2025](#)).

Workload also appeared as a contextual stimulus when intensified by organizational and administrative conditions, including clinical documentation demands, excessive time spent on electronic health records, bureaucratic burden, limited control over work schedules, unresponsive administration, infection control demands, and organizational disruption during the COVID-19 pandemic. Chaotic work environments and excessive EHR-related time were identified as relevant workload-related pressures in hospital practice ([Aiken et al., 2023](#)). Nurse staffing adequacy, clinical care environment, and clinician teamwork were also identified as modifiable hospital-level factors associated with physician well-being and job outcomes ([Aiken et al., 2025](#)). Extreme ICU workload during the COVID-19 crisis was compounded by rapidly changing protocols, limited disease knowledge, and ethical dilemmas in end-of-life care ([Guessoum et al., 2022](#)). Taken together, the included studies suggest that workload was not merely an individual occupational burden, but an organizational and interprofessional stressor embedded within hospital care systems, where adequate staffing, supportive clinical environments, and effective nurse–physician teamwork may buffer workload-related strain and support more adaptive responses.

Nurse-Physician Collaboration as Coping Mechanisms

Nurse–physician collaboration was mapped as an interprofessional coping mechanism through which clinicians responded collectively to workload-related stressors in hospital settings. From the perspective of the Roy Adaptation Model, collaboration can be interpreted as a coping process that supports adaptation when nurses and physicians are exposed to high clinical demands, unsafe staffing levels, time pressure, administrative burden, and emotionally complex patient care. Across the included studies, collaborative coping was reflected in structural empowerment, clinician involvement in decision-making, interdisciplinary

teamwork, relational coordination, mutual respect, shared goals, peer support, mentorship, camaraderie, and team spirit during crisis conditions. Structural empowerment and interdisciplinary teamwork were emphasized as organizational mechanisms that supported clinician well-being in hospital practice ([Aiken et al., 2023](#)). Relational coordination, characterized by frequent, timely, accurate, and problem-solving communication, was identified as a key mechanism supporting job satisfaction and intent to stay ([House et al., 2023](#)). A clan-oriented organizational culture was also shown to promote teamwork, mentorship, peer support, and shared responsibility in emergency care ([D'Silva et al., 2024](#)).

Overall, nurse–physician collaboration appeared to transform workload from an isolated individual burden into a shared team responsibility. Effective collaboration helped buffer workload-related strain by strengthening communication, improving role coordination, supporting shared decision-making, and increasing clinicians perceived control within complex hospital environments. Favorable clinician teamwork and adequate nurse staffing were associated with better physician job outcomes, including lower burnout and lower intention to leave ([Aiken et al., 2025](#)). In contrast, when collaboration and administrative support were insufficient, workload-related stressors were more likely to produce maladaptive responses, including emotional exhaustion, moral injury, physical fatigue, job dissatisfaction, and turnover-related outcomes ([Snyder et al., 2025](#)). Thus, nurse–physician collaboration was not merely a background feature of hospital practice, but an adaptive coping mechanism that may help mitigate workload-induced burnout and turnover-related outcomes.

Adaptive Responses Burnout and Turnover Intention

The included studies indicated that adaptive responses were more likely to occur when workload-related stressors were buffered by adequate staffing, supportive clinical environments, and effective nurse–physician collaboration. In

these conditions, collaboration appeared to reduce the progression from workload pressure to emotional exhaustion, job dissatisfaction, and turnover intention. Better work environments and staffing were associated with lower burnout and lower intention to leave among nurses and physicians in European hospital practice ([Aiken et al., 2024](#)). In the US hospital context, physician and nurse well-being were also linked to work environment characteristics, turnover-related outcomes, and patient safety concerns ([Aiken et al., 2023](#)). Aiken et al. further showed that nurse staffing adequacy, clinical care environment, and clinician teamwork were modifiable hospital-level factors associated with more favorable physician outcomes, including lower burnout and lower intention to leave ([Aiken et al., 2025](#)). Relational coordination was positively associated with job satisfaction and intent to stay, while a clan-oriented collaborative culture was linked to lower stress and high job satisfaction in emergency care settings ([D'Silva et al., 2024](#); [House et al., 2023](#)).

In contrast, maladaptive responses emerged when workload stressors were accompanied by weak collaboration, insufficient administrative

support, and limited organizational protection for clinicians. Under these conditions, workload was not absorbed collectively by the team but was experienced as an individual, emotional, and moral burden. This pattern contributed to emotional exhaustion, physical fatigue, moral injury, job dissatisfaction, and turnover-related outcomes. Failures in collaboration and administrative support were reported to contribute to moral injury and physical exhaustion, which led some nurses and physicians to leave direct patient care careers ([Snyder et al., 2025](#)). Similarly, team-based coping helped clinicians navigate the acute phase of crisis, but prolonged exposure to extreme ICU workload contributed to severe mental fatigue, secondary trauma, and uncertainty about future careers in healthcare ([Guessoum et al., 2022](#)). These findings suggest that burnout and turnover intention represent maladaptive outcomes when collaborative coping mechanisms are insufficient, whereas effective nurse–physician collaboration may function as an adaptive pathway that supports clinician retention. The resulting pathway is summarized in [Figure 2](#).

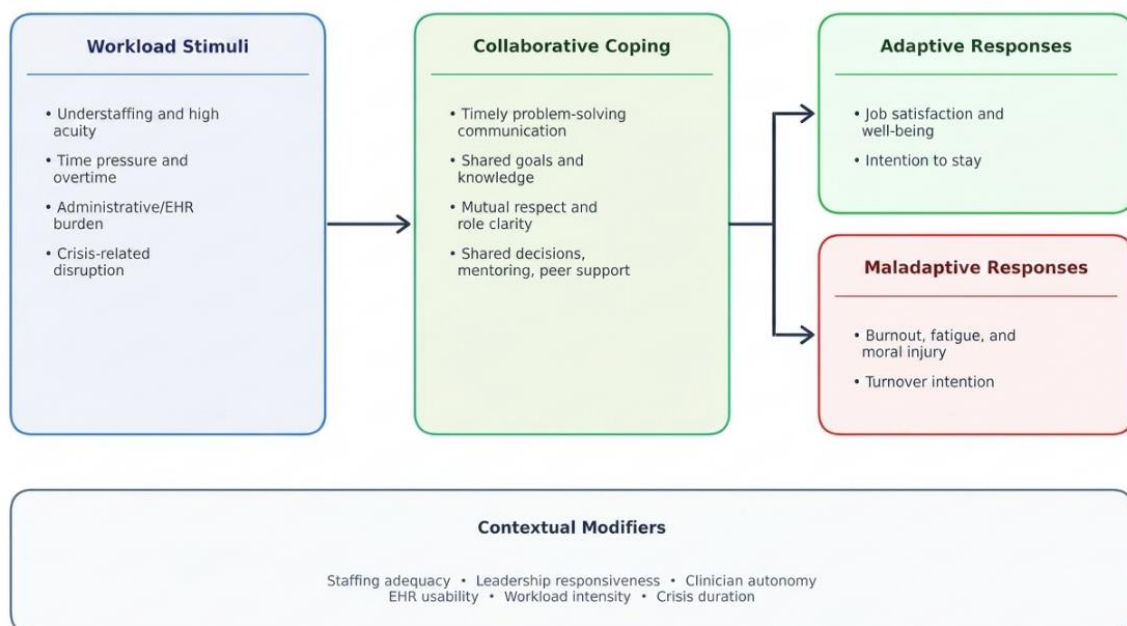


Figure 2. Conceptual Model of Workload Stimuli and Collaborative Coping

Recommended Mitigation Strategies

The included studies identified mitigation strategies that primarily targeted organizational and interprofessional levels rather than individual coping alone. At the organizational level, the main strategies included improving nurse staffing adequacy, reducing unsafe patient-to-staff ratios, decreasing administrative and clinical documentation burden, enhancing electronic health record usability, strengthening leadership responsiveness, and increasing clinicians' control over work schedules and practice environments. Adequate nurse staffing, supportive clinical care environments, and effective interdisciplinary teamwork were associated with more favorable clinician job outcomes, including lower burnout and lower intention to leave ([Aiken et al., 2025](#)). At the interprofessional and team-support levels, the studies highlighted structured nurse–physician communication, teamwork training, shared accountability for patient outcomes, formal mentorship, peer-support systems, clinical briefing and debriefing, professional counselling, and targeted psychotherapeutic support. Relational coordination and team-based support were identified as relevant mechanisms for strengthening job satisfaction, intent to stay, and resilience in high-pressure hospital settings ([House et al., 2023](#)). In crisis or pandemic-related acute care environments, mitigation strategies also included protected rest time, psychotherapeutic support, retention incentives, staff-to-patient ratio standards, and dedicated institutional roles for clinician well-being ([Guessoum et al., 2022](#); [Snyder et al., 2025](#)). Overall, the findings suggest that mitigating workload-induced burnout and turnover-related outcomes requires integrated organizational and interprofessional strategies that combine adequate staffing, responsive leadership, collaborative team structures, manageable documentation systems, and accessible psychological support.

DISCUSSION

This review suggests three mechanisms through which nurse–physician collaboration may interrupt the progression from workload to adverse

workforce outcomes. First, timely and problem-solving communication integrates distributed clinical information and reduces uncertainty, duplication, and preventable coordination work. Second, shared goals, role clarity, and joint decision-making distribute responsibility and increase perceived control. Third, mutual respect, mentorship, and peer support provide relational resources for managing emotional and moral demands. These mechanisms are consistent with the association of relational coordination with job satisfaction and intent to stay ([House et al., 2023](#)) and with international evidence that teamwork and nurse–physician collaboration influence turnover intention through job satisfaction, burnout, and organizational commitment ([Al Sabei et al., 2022](#); [Yilmaz et al., 2023](#)).

The findings also show why collaboration may be effective in some settings but insufficient in others. Benefits were most evident when teamwork was embedded in adequate staffing, structural empowerment, responsive leadership, and supportive organizational cultures ([Aiken et al., 2025](#); [Aiken et al., 2024](#); [D'Silva et al., 2024](#)). In contrast, prolonged crisis exposure, unsafe ratios, mandatory overtime, and weak administrative support exceeded the buffering capacity of team solidarity ([Guessoum et al., 2022](#); [Snyder et al., 2025](#)). D'Silva et al. (2024), for example, reported high job satisfaction within a collaborative culture while emotional exhaustion remained common. This inconsistency indicates that collaboration modifies rather than eliminates workload risk and should not be used to compensate for structural understaffing or dysfunctional work systems. Organization-directed interventions and institutional well-being programs similarly emphasize staffing, leadership, workflow, and system redesign rather than resilience training alone ([Boskma et al., 2025](#); [Longo et al., 2023](#)).

The synthesis is broadly consistent with international studies outside the final sample. Mixed-method evidence from Ethiopian hospitals identified leadership, communication, and organizational support as determinants of nurse–physician collaboration ([Degu et al., 2023](#)), while an

interprofessional shadowing program improved understanding of nursing roles among medical residents ([Low et al., 2021](#)). Global reviews also identify staffing and work schedules as major contributors to nurse burnout and turnover ([Bae, 2024](#); [Getie et al., 2025](#)). Nevertheless, the included evidence was concentrated in high-income Western hospital systems, with only one study from India; transferability to low- and middle-income settings therefore remains uncertain.

Only seven studies met all eligibility criteria because the review required the simultaneous presence of hospital workload, both professional groups or an integrated interprofessional team, a collaboration mechanism, and a burnout- or turnover-related outcome. The full-text exclusions illustrate this narrow intersection: 25 studies were monodisciplinary and 37 did not examine collaborative adaptation. The small and heterogeneous evidence base means the findings are suggestive rather than causal. Most studies were cross-sectional, two were qualitative, measures varied, and several reflected COVID-19 conditions. Future longitudinal and intervention studies should test whether collaboration mediates or moderates workload effects and whether staffing, leadership, unit type, and crisis intensity alter those effects.

Implications for Hospital Management and Multidisciplinary Practice

The findings have important implications for hospital management and multidisciplinary practice. Strategies to reduce burnout and turnover intention should move beyond individual-level resilience programs and address modifiable organizational conditions that shape workload and clinician adaptation. These conditions include nurse staffing adequacy, unsafe patient-to-staff ratios, workload redistribution, electronic health record usability, documentation burden, leadership responsiveness, and clinicians' control over work schedules and practice environments. Adequate nurse staffing, supportive clinical care environments, and effective clinician teamwork were associated with more favorable physician job outcomes, including lower burnout, lower job

dissatisfaction, and greater intention to remain with employers ([Aiken et al., 2025](#)). Therefore, hospital-level workforce strategies should prioritize both structural workload reduction and improvement of the clinical work environment, particularly through organization-directed interventions that address staffing, workload, leadership, and system-level conditions ([Boskma et al., 2025](#)).

At the multidisciplinary practice level, the findings suggest the need to strengthen nurse–physician collaboration through structured communication, shared clinical briefings, interdisciplinary debriefing, relational coordination training, shared governance, formal mentorship, peer-support systems, and team-based accountability for patient outcomes ([Degu et al., 2023](#); [Low et al., 2021](#)). Interprofessional teamwork was linked to nurses' intent to leave through the mediating roles of job satisfaction and burnout ([S. D. Al Sabei et al., 2022](#)). Nurse–physician collaboration was also shown to mediate the relationship between organizational commitment and turnover intention ([Yilmaz et al., 2023b](#)). These findings suggest that staffing adequacy, supportive leadership, manageable documentation systems, and interprofessional collaboration should be integrated as mutually reinforcing strategies for workforce retention, supported by institutional well-being assessment and leadership-level commitment ([Longo et al., 2023](#)). Thus, mitigation strategies should reduce the source of workload while strengthening the capacity of nurses and physicians to cope through coordinated, respectful, and team-based clinical practice.

Evidence Gaps

This review identified several evidence gaps. Most included studies used cross-sectional designs, limiting causal interpretation of the relationship between workload, nurse–physician collaboration, burnout, and turnover intention. Although collaboration appeared to function as a protective or adaptive pathway, few studies explicitly tested nurse–physician collaboration as a mediator or moderator in the pathway from workload to burnout and turnover intention. Evidence is also still limited

from low- and middle-income countries, non-Western hospital systems, and specific high-acuity units such as ICUs, emergency departments, operating rooms, and medical-surgical wards.

Strengths and Limitations

This scoping review has several strengths. It focused specifically on nurse–physician collaboration rather than examining burnout or turnover intention within a single professional group. It also applied the PCC framework and used the Roy Adaptation Model to interpret workload, collaboration, burnout, and turnover intention within a coherent adaptive pathway. In addition, the review included both quantitative and qualitative studies, allowing the synthesis to capture measurable job outcomes as well as lived experiences of workload, moral injury, team support, and career withdrawal.

However, this review also has limitations. The number of included studies was relatively small, and the heterogeneity of study designs, instruments, clinical settings, and outcome measures limited direct comparison across studies. The exclusion of non-English literature and grey literature may also have restricted the breadth of evidence. Finally, as a scoping review, this study aimed to map the available evidence rather than evaluate intervention effectiveness or establish causal relationships. Overall, workload-induced burnout and turnover intention among nurses and physicians should be understood as products of interrelated clinical, organizational, and interprofessional conditions. Nurse–physician collaboration appears to be a central adaptive mechanism, but it must be supported by adequate staffing, responsive leadership, manageable documentation systems, and sustained organizational commitment to clinician well-being.

CONCLUSION

The available evidence indicates that nurse–physician collaboration may reduce workload-related burnout and turnover intention by improving coordination, shared control, and relational support. Its protective value is contingent on adequate

staffing, responsive leadership, manageable documentation systems, and supportive work environments; collaboration alone cannot offset persistent structural overload. Because only seven heterogeneous studies were eligible, these conclusions should be interpreted as a mapped pathway requiring longitudinal and intervention testing.

SUGGESTION

Hospital managers should pair safe staffing and workflow redesign with structured interprofessional communication, shared governance, mentorship, and peer support. Future studies should test mediation and moderation models across diverse countries and high-acuity units using longitudinal, mixed-methods, and intervention designs.

ACKNOWLEDGEMENT

The authors thank Padjadjaran University, Bandung, West Java, Indonesia, for facilitating access to databases used in this review.

FUNDING

This study received no external funding; all research and publication costs were covered by the authors.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest related to this study.

AUTHOR CONTRIBUTIONS

MHT, ASM, and HRA contributed to conceptualization, design, data collection, analysis, and interpretation. MAA, WS, and SS critically revised the manuscript for important intellectual content. RA and VCN conducted the final review and approved the submitted version.

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