

# The Interplay of Workload and Motivation in Predicting Burnout Among Healthcare Workers in Tourism-Based Clinics

Workload and  
Motivation on  
Burnout

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## ABSTRACT

Increasing service demands in tourism-based health facilities heighten the risk of burnout among healthcare workers. This study investigated the effects of workload and work motivation on burnout among healthcare workers in tourism-based clinics in Indonesia, focusing on emotional exhaustion, depersonalization, and personal accomplishment. A cross-sectional analytical design was applied to 124 doctors and nurses within the Klinik OMSA Medic Bali network. Workload was assessed using NASA-TLX, motivation with the Nursalam Motivation Scale, and burnout with the Maslach Burnout Inventory. Data analysis included descriptive statistics, Pearson correlations, multiple linear regression, and mediation testing using Hayes PROCESS Model 4 with 5,000 bootstrap samples. Emotional Exhaustion was the most prevalent burnout dimension. Results showed that workload significantly predicted higher levels of emotional exhaustion and depersonalization. Work motivation was significantly associated with lower emotional exhaustion and depersonalization and higher personal accomplishment, indicating a protective role. However, motivation did not mediate the relationship between workload and any burnout dimension, as indirect effects were not significant. Workload emerged as the main contributor to burnout, while motivation functioned as a supportive but non-mediating factor. Organizational strategies aimed at workload management and motivation enhancement are recommended to reduce burnout and sustain healthcare service quality.

**Keywords:** Burnout, Healthcare Workers, Medical Tourism, Motivation, Workload.

## INTRODUCTION

Burnout is a multidimensional, work-related syndrome characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (Maslach et al., 1997; Edú-Valsania et al., 2022). Recognized in the ICD-11 as a condition arising from poorly managed chronic workplace stress, burnout is particularly prevalent among healthcare professionals, who regularly encounter emotionally intense patient interactions, high cognitive and emotional demands, and complex clinical decision-making (Portoghese et al., 2014; Hillert et al., 2020). Globally, approximately 30% of nurses and up to 67% of physicians experience burnout, while in Indonesia, prevalence estimates range from 33% to 45%, highlighting its serious implications for national healthcare systems (Woo et al., 2020; Lamuri et al., 2023). Burnout has been associated with lower job satisfaction, increased medical errors, compromised patient safety, and higher turnover, positioning it as a major managerial and policy concern (Kim et al., 2017; Wu et al., 2021).

Workload, encompassing mental, physical, and emotional demands, has been consistently identified as a primary determinant of burnout. High workload limits

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recovery time, increases fatigue, and contributes to emotional exhaustion (Asamani et al., 2015; Dall’Ora et al., 2020; Melander, 2021). In healthcare environments influenced by medical tourism, clinicians face additional stressors such as diverse patient expectations and rapid service delivery, which further elevate the risk of burnout (Sandberg, 2017). Empirical evidence confirms that workload strongly predicts emotional exhaustion, while personal and organizational resources can buffer this effect (Werang, 2018; Buruck et al., 2020; Park et al., 2021). Psychological factors such as self-esteem, personal accomplishment, and psychological capital further modulate burnout outcomes, emphasizing the multidimensional nature of occupational stress (Dewi & Riana, 2019; López-Núñez et al., 2020; Winarsih & Fariz, 2025; Yuninda & Nababan, 2025).

Motivation, as a key personal resource, encompasses intrinsic and extrinsic drivers that influence persistence, goal achievement, and professional engagement (Nursalam, 2014). Intrinsic motivation linked to purpose, responsibility, and achievement has been shown to reduce burnout and enhance job satisfaction (Alrawahi et al., 2020). Motivated healthcare workers demonstrate stronger coping strategies, higher engagement, and greater resilience when managing workload and occupational stressors (Mitchell et al., 2024). However, the degree to which motivation mediates the relationship between workload and burnout remains underexplored. While some studies report partial mediation, others suggest that motivation primarily serves an independent protective role (Syabani & Huda, 2019; Kurniawati et al., 2023). Drawing on the Job Demand–Resource (JD-R) model, high job demands are expected to increase burnout, whereas personal resources like motivation mitigate its impact (Ten et al., 2011; Bakker & Demerouti, 2017).

Despite extensive research on workload and burnout, limited empirical evidence examines the mediating role of motivation, particularly in Indonesian healthcare settings affected by tourism-related pressures. Clinics such as the Klinik OMSA Medic Bali network face unique challenges, including multilingual patient interactions, fluctuating patient volumes, and heightened service expectations (Sandberg, 2017). Understanding how motivation interacts with workload to influence burnout in these environments is crucial for developing targeted interventions and resource allocation strategies.

Therefore, this study aims to investigate the effects of workload and motivation on the three dimensions of burnout: emotional exhaustion, depersonalization, and personal accomplishment, among doctors and nurses across four branches of Klinik OMSA Medic Bali. Additionally, it examines whether motivation mediates the relationship between workload and burnout, addressing critical gaps in the literature and providing evidence to inform policy and management strategies aimed at safeguarding healthcare workers’ well-being and organizational performance.

## **LITERATURE REVIEW & HYPOTHESIS DEVELOPMENT**

### **The Effect of Workload on Burnout**

Burnout is conceptualized as a prolonged response to chronic occupational stress, characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (Maslach & Schaufeli, 2018). Emotional exhaustion is often regarded as the central dimension, reflecting the depletion of psychological resources that may lead to cognitive distancing and reduced professional efficacy (Shirom, 2003; Barelo et al., 2021). Healthcare professionals are particularly vulnerable due to continuous patient interaction, high emotional labor, and decision-making under uncertain conditions (Portoghese et al., 2014). Burnout has been linked to lower job satisfaction, increased medical errors, compromised patient safety, and higher turnover, establishing it as a critical management concern in healthcare organizations (Cotobal Rodeles et al., 2025).

Workload, encompassing mental, physical, and emotional demands inherent in clinical tasks, has been consistently identified as a major contributor to burnout. High workload restricts recovery, elevates fatigue, and increases emotional exhaustion among healthcare workers (Asamani et al., 2015; Dall’Ora et al., 2020; Melander, 2021). In

contexts affected by medical tourism, clinicians encounter additional pressures from diverse patient expectations and accelerated service delivery (Sandberg, 2017). Standardized instruments such as the NASA Task Load Index (NASA-TLX) are widely used to quantify perceived workload across multidimensional task domains (Hart & Staveland, 1988). Empirical studies confirm that workload significantly influences emotional exhaustion, with work-life balance playing a moderating role (Werang, 2018; Buruck et al., 2020).

Beyond workload, psychological and personal resources also shape burnout outcomes. Job demands are positively associated with emotional exhaustion, whereas job resources mitigate both emotional exhaustion and depersonalization (Park et al., 2021). Psychological capital and individual factors, such as self-esteem and personal accomplishment, have been linked to burnout, with personal accomplishment serving more as a personal resource than a burnout dimension (Dewi & Riana, 2019; López-Núñez et al., 2020). These findings underscore the complex interplay between occupational stressors, individual capacities, and burnout, highlighting the need for multidimensional assessment and intervention strategies in healthcare settings.

H1: Workload has a significant effect on emotional exhaustion.

H2: Workload has a significant effect on depersonalization.

H3: Workload has a significant effect on personal accomplishment.

### **The Effect of Motivation on Burnout**

Motivation encompasses internal and external drivers that influence an individual's willingness to work, persist, and achieve goals (Nursalam, 2014). Intrinsic motivation, tied to purpose, achievement, and responsibility, has been consistently associated with lower burnout levels and higher job satisfaction among healthcare professionals (Alrawahi et al., 2020). Motivated healthcare workers demonstrate better coping strategies, stronger engagement, and greater resilience when facing occupational stressors (Mitchell et al., 2024). Empirical evidence also suggests that motivation can directly influence burnout, although the extent to which it mediates the relationship between workload and burnout remains debated. Some studies report partial mediation effects, whereas others identify only independent protective roles of motivation in mitigating burnout symptoms (Syabani & Huda, 2019; Kurniawati et al., 2023).

The Job Demand–Resource (JD-R) model offers a theoretical framework for understanding these dynamics, positing that job demands such as high workload increase burnout risk, while personal resources like motivation buffer against stress and strain (Bakker & Demerouti, 2017). Baseline burnout may further amplify vulnerability, as elevated job demands coupled with reduced resources, such as social support or informational access, predict increases in future burnout (Ten et al., 2011). Consistent with this model, workload is conceptualized as a direct contributor to burnout dimensions, whereas motivation serves as a personal resource that may reduce emotional exhaustion, depersonalization, and diminished personal accomplishment.

Moreover, burnout has tangible consequences for organizational outcomes, including decreased employee performance and productivity (Wellem, 2023). Syabani and Huda (2019) found a significant effect of motivation on burnout. Understanding the interplay between workload and motivation is therefore critical, highlighting the dual importance of managing occupational demands and fostering intrinsic and extrinsic motivational resources to protect healthcare workers from burnout.

H4: Motivation has a significant effect on emotional exhaustion.

H5: Motivation has a significant effect on depersonalization.

H6: Motivation has a significant effect on personal accomplishment.

### Motivation as Mediating Variable

Motivation, encompassing both intrinsic and extrinsic drivers, plays a critical role in shaping healthcare workers' responses to occupational stress (Tung et al., 2020; Ullah et al., 2025). Intrinsic motivation, linked to purpose, achievement, and responsibility, has been consistently associated with lower burnout levels and higher job satisfaction (Alrawahi et al., 2020; Bakaç et al., 2022). Motivated healthcare professionals demonstrate enhanced coping strategies, stronger engagement, and greater resilience when confronted with high job demands (Mitchell et al., 2024). In the context of the Job Demand–Resource (JD-R) model, motivation functions as a personal resource that can buffer the negative effects of workload on burnout dimensions, including emotional exhaustion, depersonalization, and reduced personal accomplishment (Bakker & Demerouti, 2017). While workload exerts a direct impact on burnout (Asamani et al., 2015; Dall’Ora et al., 2020; Melander, 2021), motivation may mediate this relationship by enhancing individuals' capacity to manage stress, allocate effort efficiently, and maintain professional efficacy (Syabani & Huda, 2019; Kurniawati et al., 2023).

Empirical studies highlight that the presence of strong personal and psychological resources can alter the strength of workload–burnout associations (Ten et al., 2011; Park et al., 2021). Motivation's mediating role is particularly relevant in high-pressure clinical settings, where emotional labor and complex decision-making increase vulnerability to burnout (Portoghese et al., 2014). By mitigating the adverse consequences of workload, motivated healthcare workers may experience lower emotional exhaustion, reduced depersonalization, and sustained personal accomplishment, supporting the theoretical rationale for examining motivation as a mediator (Alrawahi et al., 2020; Wellem, 2023). This framework underpins the proposed hypotheses (H7–H9) that motivation transmits part of the influence of workload on burnout outcomes, emphasizing the importance of fostering both intrinsic and extrinsic motivational resources in healthcare environments.

H7: Motivation mediates the effect of workload on emotional exhaustion.

H8: Motivation mediates the effect of workload on depersonalization.

H9: Motivation mediates the effect of workload on personal accomplishment.

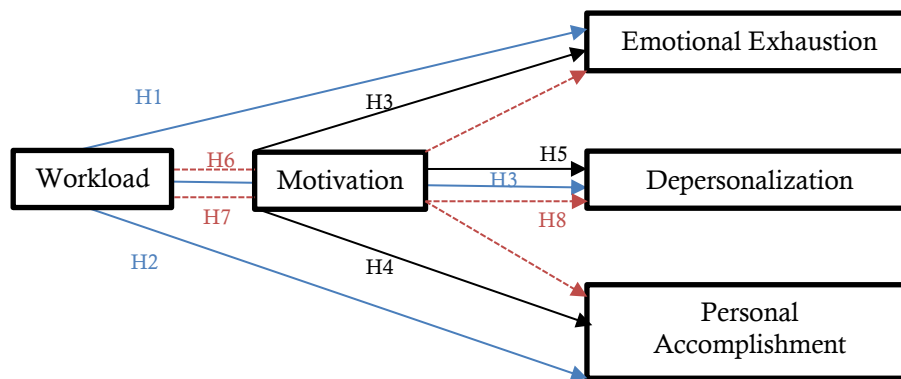


Figure 1. Research Framework

Figure 1 shows the research framework of this study is grounded in the Job Demand–Resource (JD-R) model, conceptualizing workload as a key job demand and motivation as a critical personal resource influencing burnout outcomes among healthcare workers. Within this framework, workload is hypothesized to exert a direct effect on the three core dimensions of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment (H1–H3), reflecting the strain caused by high mental, physical, and emotional demands. Simultaneously, motivation, encompassing both intrinsic and extrinsic drivers, is posited to directly affect these burnout dimensions (H4–H6) by enhancing coping, engagement, and resilience under stressful conditions. Beyond its direct influence, motivation is proposed as a mediating variable that may transmit part of

the impact of workload on burnout outcomes (H7–H9), suggesting that higher levels of motivation could buffer the negative effects of workload and mitigate emotional exhaustion, depersonalization, and diminished personal accomplishment.

## **RESEARCH METHODS**

This study applied a cross-sectional analytical approach to assess the effects of workload and motivation on burnout syndrome among healthcare workers. The research was carried out within the clinical network of Klinik OMSA Medic Bali, a multisite outpatient healthcare provider operating in four areas: Denpasar, Jimbaran, Seminyak, and Ubud. These clinics cater to both local communities and international patients, creating distinctive operational and psychosocial pressures for healthcare staff. The study was implemented in accordance with the ethical standards of the Declaration of Helsinki. Ethical clearance was granted by the Research Ethics Committee of Klinik OMSA Medic Bali (Approval Number 354/VI/2025/PT.OMD).

Data collection was conducted concurrently across all clinic branches from June to August 2025 to obtain a representative overview of workplace conditions and psychological responses during the research period. A cross-sectional design was chosen to assess the main study variables at one specific time point, allowing the identification of associative relationships and predictive trends within the organizational setting. The study population included all doctors and nurses working in the four branches of Klinik OMSA Medic Bali. A total sampling approach was implemented to maximize participant coverage and reduce the risk of selection bias, yielding 124 eligible respondents. Participants were included if they had been actively performing clinical duties for a minimum of six months prior to the study, ensuring sufficient exposure to occupational demands and organizational routines.

Three validated psychometric instruments were used to measure the main study variables. Workload was assessed using the NASA Task Load Index (NASA-TLX), which evaluates perceived workload across six dimensions (mental demand, physical demand, temporal demand, performance, effort, and frustration), with total scores categorized as low (<60), moderate (60–79), or high (≥80). Motivation was measured using the 25-item Nursalam Motivation Scale covering intrinsic factors (e.g., achievement and self-development) and extrinsic factors (e.g., organizational policies and work conditions), rated on a five-point Likert scale and classified into low, moderate, or high levels. Burnout syndrome was evaluated using the Maslach Burnout Inventory (MBI), consisting of 22 items across Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA), rated on a seven-point Likert scale, where higher EE and DP and lower PA indicate greater burnout severity.

Data were gathered directly at the clinic sites through structured, self-administered questionnaires. Descriptive analyses were applied to summarize participant demographics and the distribution of workload, motivation, and burnout scores. The normality of continuous variables was tested using the Shapiro–Wilk method, as the sample size was under 200. Chi-square tests were used to explore categorical relationships between demographic variables and burnout categories. Pearson correlation analysis was conducted to assess the strength and direction of associations among the primary variables. To examine predictive effects, multiple linear regression models were run with each burnout dimension as a separate outcome variable. In addition, mediation analysis was performed to determine whether motivation mediated the relationship between workload and the three burnout dimensions. Data were analyzed using SPSS with Hayes' PROCESS Macro Model 4. This mediation test utilized Hayes' PROCESS Macro Model 4 with 5,000 bootstrap resamples to produce bias-corrected confidence intervals. All statistical tests applied a two-tailed significance threshold of  $p < 0.05$ .

## **RESULTS**

A total of 124 healthcare workers participated in the study, comprising 24 doctors (19.4%) and 100 nurses (80.6%) distributed across four branches of Klinik OMSA Medic

Bali. The majority of respondents were female (69.4%) and predominantly within the younger age groups of 25–35 years (68.6%). Most participants were married (71.0%) and had a work tenure of fewer than three years (67.7%), reflecting the relatively recent establishment and workforce expansion of the clinic network. Respondents were evenly distributed across clinic locations, with the largest proportion assigned to Denpasar (32.3%), followed by Jimbaran (24.2%), Seminyak (22.6%), and Ubud (20.9%). The details of the demographic characteristics of the respondents are explained in Table 1.

Table 1. Demographic Characteristics

Variable	Category	Frequency (n)	Percentage (%)
Profession	Doctor	24	19.4
	Nurse	100	80.6
Gender	Female	86	69.4
	Male	38	30.6
Age Group	25–35 years	85	68.6
	Other age groups	39	31.4
Marital Status	Married	88	71.0
	Unmarried	36	29.0
Work Tenure	< 3 years	84	67.7
	≥ 3 years	40	32.3
Clinic Location	Denpasar	40	32.3
	Jimbaran	30	24.2
	Seminyak	28	22.6
	Ubud	26	20.9

In examining levels of perceived workload, motivation, and burnout, descriptive analysis indicated that overall workload experienced by participants was moderate to high, with a mean NASA-TLX score of 70.4 (SD = 10.1). More than half of respondents (54.0%) fell within the moderate workload category, while 31.5% reported a high workload. Motivation scores showed a mean value of 34.9 (SD = 5.7), with most respondents classified as having moderate motivation (62.9%). A notably smaller subset displayed high motivation (21.0%), and 16.1% reported low motivation. Distribution of burnout symptoms, measured through the Maslach Burnout Inventory (MBI), demonstrated substantial emotional strain among participants. Emotional Exhaustion (EE) was the most prominent dimension, with nearly half of the respondents (49.2%) classified in the high EE category. An additional 39.5% experienced moderate EE, leaving only 11.3% in the low-exhaustion category. Depersonalization (DP) was less severe by comparison, with 40.3% of respondents demonstrating moderate levels and 29.0% classified as high. Regarding Personal Accomplishment (PA), most respondents reported moderate (37.9%) to high levels (32.3%), whereas 29.8% fell within the low PA group, which reflects reduced professional efficacy. Mean scores for EE, DP, and PA were 27.5 (SD = 8.3), 10.3 (SD = 5.1), and 34.1 (SD = 6.7), respectively, as shown in Table 2.

Table 2. Descriptive Statistics

Variable	Mean (SD)	Low n (%)	Moderate n (%)	High n (%)
Workload (NASA-TLX)	70.4 (10.1)	18 (14.5)	67 (54.0)	39 (31.5)
Motivation	34.9 (5.7)	20 (16.1)	78 (62.9)	26 (21.0)
Emotional Exhaustion (EE)	27.5 (8.3)	14 (11.3)	49 (39.5)	61 (49.2)
Depersonalization (DP)	10.3 (5.1)	38 (30.7)	50 (40.3)	36 (29.0)
Personal Accomplishment (PA)	34.1 (6.7)	37 (29.8)	47 (37.9)	40 (32.3)

Analysis of demographic predictors revealed that gender was significantly associated with levels of emotional exhaustion ( $\chi^2 = 11.177$ ,  $p = 0.0037$ ), indicating differential vulnerability between male and female workers. Other demographic factors, including marital status, work tenure, job category, and clinic location, did not demonstrate significant associations with burnout levels. Normality testing using the Shapiro–Wilk approach showed that all primary variables were normally distributed except for Depersonalization, which required subsequent non-parametric testing. Mann–Whitney

analysis found no significant difference in DP scores between male and female respondents ( $p = 0.9578$ ), suggesting that gender differences were specific to emotional exhaustion rather than depersonalization.

**Table 3.** Correlation Test

Variable	Workload	Motivation	EE	DP
Motivation	-0.28			
Emotional Exhaustion (EE)	0.49	-0.36		
Depersonalization (DP)	0.32	-0.21	0.55	
Personal Accomplishment (PA)	-0.19	0.44	-0.41	-0.29

Based on Table 3, correlation analysis identified meaningful relationships among the key variables. Workload exhibited a moderate positive correlation with emotional exhaustion and a weaker positive correlation with depersonalization, indicating that higher workload was associated with greater burnout symptoms. Negative correlation was found between workload and personal accomplishment. Conversely, motivation correlated negatively with emotional exhaustion and depersonalization and positively with personal accomplishment, suggesting its potential protective role.

**Table 4.** Regression Result

Predictor	Dependent Variable	$\beta$ (Standardized)	p-value	Model R <sup>2</sup>
Workload	Emotional Exhaustion (EE)	0.41	< 0.001	0.236
	Depersonalization (DP)	0.30	0.004	0.181
	Personal Accomplishment (PA)	-0.07	0.052	0.264
Motivation	Emotional Exhaustion (EE)	-0.29	0.001	0.236
	Depersonalization (DP)	-0.20	0.037	0.181
	Personal Accomplishment (PA)	0.43	< 0.001	0.264

Regression analyses further clarified these relationships. Workload significantly predicted higher emotional exhaustion ( $\beta = 0.41$ ,  $p < 0.001$ ) and higher depersonalization ( $\beta = 0.30$ ,  $p = 0.004$ ). Motivation significantly predicted lower emotional exhaustion ( $\beta = -0.29$ ,  $p = 0.001$ ) and lower Depersonalization ( $\beta = -0.20$ ,  $p = 0.037$ ). For personal accomplishment, only motivation demonstrated a significant positive effect ( $\beta = 0.43$ ,  $p < 0.001$ ), whereas workload had no statistically significant impact ( $\beta = -0.07$ ,  $p = 0.052$ ). The models explained 23.6% of the variance in EE, 18.1% in DP, and 26.4% in PA.

**Table 5.** Mediation Effect

Path Indirect Effect	$\beta$ (Standardized)	p-value / 95% CI
Workload → Motivation → EE	0.03	95% CI [-0.01, 0.08]
Workload → Motivation → DP	0.02	95% CI [-0.01, 0.07]
Workload → Motivation → PA	-0.05	95% CI [-0.13, 0.02]

According to Table 5, mediation analysis using Hayes PROCESS Model 4 demonstrated that motivation did not mediate the relationship between workload and any of the three burnout dimensions. Although motivation independently reduced emotional exhaustion and depersonalization and increased personal accomplishment, the indirect effects were statistically insignificant, with 95% confidence intervals crossing zero across all models. Thus, the influence of workload on burnout appears to operate primarily through direct pathways rather than through changes in motivation.

## DISCUSSION

The study highlights a substantial burden of burnout, particularly in the dimension of emotional exhaustion, which affected nearly half of the respondents. This pattern mirrors global evidence showing that emotional exhaustion is the most sensitive and common manifestation of burnout among healthcare professionals, often emerging as an early sign of chronic occupational stress (Maslach et al., 1997; Shirom, 2003). High prevalence observed in this study is consistent with previous research demonstrating burnout rates

between 30% and 67% among doctors and nurses internationally, and aligns with Indonesian studies reporting burnout among 33–45% of health workers (Woo et al., 2020; Lamuri et al., 2023). Workload emerged as the strongest predictor of burnout across several dimensions. Higher workload was significantly associated with increased emotional exhaustion and depersonalization, reinforcing theoretical propositions of the Job Demand–Resource (JD-R) model, which posits that excessive job demands deplete workers' psychological and physical resources (Bakker & Demerouti, 2017). Similar findings have been reported in other healthcare settings, where time pressure, emotional labour, and cognitive load have contributed directly to burnout (Portoghese et al., 2014; Dall'Ora et al., 2020).

Moderate-to-high workload levels reported in this study, particularly within a clinic network serving domestic and international patients, likely reflect operational complexities characteristic of medical tourism environments, including rapid patient turnover, cultural differences, and heightened service expectations (Sandberg, 2017). Such conditions may elevate cognitive and emotional demands beyond those found in conventional outpatient practice. Interestingly, workload did not significantly reduce personal accomplishment, suggesting that professional efficacy may be relatively well preserved despite high operational demands. This may be explained by a relatively young age profile and shorter tenure of the workforce, characteristics often associated with enthusiasm, adaptive capacity, and opportunities for growth (Luthans et al., 2020). Moreover, diverse clinical tasks inherent in tourism-based practice may enhance perceptions of competence even when emotional resources are strained.

Motivation demonstrated a clear protective effect against burnout. Higher motivation was associated with reduced emotional exhaustion and depersonalization and increased personal accomplishment. These findings align with Self-Determination Theory, which asserts that intrinsic motivation enhances psychological resilience, engagement, and professional commitment (Deci & Ryan, 2000). Other studies similarly report that motivated healthcare workers experience lower emotional fatigue and stronger professional functioning (Mitchell et al., 2024; Swakowska et al., 2025). Strong influence of motivation on personal accomplishment in this study supports prior evidence that motivation enhances professional identity and job satisfaction (Alrawahi et al., 2020).

Despite its protective role, motivation did not mediate the relationship between workload and burnout. This suggests that while motivation contributes independently to well-being, it does not buffer the direct impact of excessive demands. Such patterns have been observed elsewhere, where high workload exerts an overwhelming effect that cannot be fully counteracted by personal resources when job demands exceed critical thresholds (Kurniawati et al., 2023). Consequently, interventions that focus solely on enhancing motivation are unlikely to be sufficient unless paired with organizational strategies targeting workload. However, the lack of significant associations with other demographic variables suggests that burnout in this context is shaped more by job-related conditions than by personal characteristics, a pattern widely noted in burnout research (Chirico et al., 2021).

The findings of this study provide important implications for administrators and healthcare managers. Strong influence of workload on burnout highlights the need for organizational strategies that prioritize workforce capacity, staffing adequacy, and workload distribution (Pastores et al., 2019; Kusuma et al., 2024). Managers should consider implementing scheduling systems that reduce excessive shift demands, incorporate micro-breaks, and optimize workflow efficiencies to minimize cognitive and emotional overload. The protective role of motivation suggests that leadership practices such as recognition programs, professional development opportunities, supportive supervision, and clearer communication can enhance employee resilience and satisfaction. By addressing both structural and psychological factors, clinic leaders can create healthier work environments, reduce burnout, and ensure consistent quality of care across branches, particularly in high-demand medical tourism settings.

## CONCLUSION

Burnout remains a critical occupational issue among doctors and nurses in the Klinik OMSA Medic Bali network, with emotional exhaustion identified as the most pronounced dimension. The study confirmed workload as the strongest predictor of burnout, exerting significant direct effects on both emotional exhaustion and depersonalization. These findings underscore the centrality of job demands in driving psychological strain within high-pressure clinical environments, particularly those shaped by medical tourism. Motivation emerged as a valuable psychological resource, independently associated with reduced emotional fatigue and depersonalization and enhanced personal accomplishment. However, motivation did not mediate the relationship between workload and burnout dimensions, indicating that while it supports resilience and professional engagement, it cannot fully counteract the adverse effects of excessive job demands. This emphasizes the necessity of organizational and structural interventions to manage workload, rather than relying solely on individual-level motivational strategies.

The results highlight the importance of comprehensive organizational policies aimed at optimizing staffing, streamlining workflows, and fostering supportive supervision to mitigate burnout. Enhancing motivation through recognition, career development, and positive work culture may further bolster resilience and sustain professional efficacy. Proactively addressing burnout is essential to safeguard healthcare providers' well-being and maintain the quality and continuity of patient care in this growing clinical network. Future research should employ longitudinal and mixed-method designs to better understand causal relationships and examine contextual factors affecting burnout in tourism-based healthcare settings. Limitations of this study include its cross-sectional design, which precludes causal inference, and reliance on self-reported measures, which may introduce response bias. Despite these constraints, the findings provide actionable insights for developing targeted preventive strategies tailored to the unique operational demands of Indonesian outpatient and medical tourism-oriented healthcare services.

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