Cite: Petrashyk, Yurii, & Rudyi, Roman (2026). The role of workplace communication, project and time management in building social capital of early-career healthcare professionals. *Demohrafiia ta sotsialna ekonomika — Demography and Social Economy*, 3 (65), 90—113.

UDC 331.108 + 614.2
JEL Classification: I11, J63, M12, M54

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# THE ROLE OF WORKPLACE COMMUNICATION, PROJECT AND TIME MANAGEMENT IN BUILDING SOCIAL CAPITAL OF EARLY-CAREER HEALTHCARE PROFESSIONALS

*The contemporary global healthcare sector is confronting a critical, systemic challenge regarding the retention of early-career professionals. This specific demographic is highly susceptible to "transition shock" and premature labor attrition, driven by intense clinical demands and complex organizational environments. While baseline compensation and generalized job satisfaction have been exhaustively studied, the structural operational competencies — specifically, workplace communication culture, personal project management, and time management — are increasingly recognized as the foundational elements required to build the social capital necessary to embed and retain clinical staff. This challenge is acutely magnified in conflict zones, such as Ukraine, where systemic fragilities, mass displacement, and wartime infrastructure disruptions exacerbate occupational burnout and force mass labor migration.*

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*This study aims to build a practical framework showing how hospital leadership and operational structures can help build social capital, reduce burnout, and keep early-career healthcare workers from quitting, looking closely at how these strategies apply to the crisis-affected Ukrainian health system. Instead of just looking at higher pay or personal resilience to keep staff, the article combines a few different fields that usually aren't studied together. It considers big-picture workplace social capital and psychological safety with everyday, practical skills borrowed from the corporate world, specifically, personal project management and time management, to create a new way of looking at staff retention in both normal and crisis settings. The study employs a narrative (analytical) literature review rather than a systematic meta-analysis. It critically synthesizes empirical findings, theoretical models, and statistical results reported in international peer-reviewed publications on organizational socialization, psychological safety climates, and clinical operational workflows, integrating them into a comprehensive, multi-level conceptual framework for healthcare workforce retention. The authors substantiate how feeling psychologically safe and having open communication with leaders help new staff feel rooted in their jobs; propose treating daily clinical work like manageable projects and using time-management techniques to lower mental strain; and identify how the lack of clear crisis communication in Ukrainian hospitals might force staff into a "sacrificial" role that speeds up burnout.*

*The findings clearly show that strong workplace social capital and a longer, more supportive onboarding process lead to lower turnover. Giving new staff the tools to manage their time and treat clinical tasks as projects help protect them from emotional exhaustion. For the Ukrainian health system, setting up proper crisis communication and better daily workflows isn't just a management bonus — it is critical to keeping the medical workforce intact. Healthcare institutions must transcend traditional, isolated orientation events and adopt sustained, multi-level retention strategies. Fostering a robust communication culture, instituting operational design that treats clinical workflows as manageable projects, and providing rigorous time-management frameworks are essential prerequisites to cultivating social capital, mitigating burnout, and securing the long-term stability and efficacy of the healthcare workforce.*

***Keywords:*** *labor attrition, social capital, early-career healthcare professionals, organizational socialization, psychological safety, personal project management, time management, workplace communication, transition shock.*

**Description of the research problem.** The contemporary healthcare landscape is currently navigating a profound and accelerating human resources crisis, characterized by escalating rates of occupational burnout, emotional exhaustion, and rapid labor attrition. This crisis disproportionately impacts early-career healthcare professionals, including newly graduated nurses, resident physicians, and junior clinical staff. Upon transitioning from highly structured academic environments to the intensely demanding, chaotic realities of clinical practice, these individuals frequently experience a phenomenon documented in the literature as "transition shock." This psychological and operational disorientation significantly undermines clinical efficacy, compromises patient safety protocols, and often precipitates a premature departure from the employing institution or the medical profession entirely [1]. The fundamental research problem lies in identifying, understanding, and operationalizing the specific organizational and individual-level mechanisms that can successfully anchor these professionals within

their institutions, thereby transforming a highly transient, vulnerable early-career workforce into a stabilized, committed, and highly skilled clinical collective.

At the theoretical core of this challenge is the concept of "social capital" within the workplace environment. In the context of complex healthcare organizations, social capital represents the intricate networks of relationships, shared cultural norms, vertical trust directed toward leadership, horizontal trust among peers, mutual professional recognition, and reciprocity that facilitate collective action and organizational cohesion [2]. Unlike human capital, which resides exclusively within the individual in the form of clinical skills and formal education, social capital is an emergent property generated by the relationships between individuals and their surrounding institutional environment. When social capital is robust, it acts as a powerful psychosocial buffer against the inherent stressors of clinical practice. Conversely, when social capital is impoverished or actively depleted by high turnover, it leads to professional isolation, psychological alienation, and a significantly heightened propensity to leave the organization [3].

While the theoretical importance of social capital is increasingly acknowledged in sociological literature, the precise operational levers required to systematically build, measure, and sustain it remain insufficiently integrated into standard healthcare management paradigms. Specifically, the dynamic interplay between macro-level workplace communication culture and micro level individual operational competencies — such as personal project management and time management — has not been comprehensively synthesized. Healthcare delivery is inherently complex, severely time-pressured, and heavily reliant on flawless interdisciplinary coordination. If an organization lacks a transparent, psychologically safe communication culture, the transmission of essential clinical knowledge and cultural norms is severed, leaving the early-career professional adrift [4]. Furthermore, if these early-career professionals lack the operational skills to manage their cognitive load and coordinate their tasks (conceptualized within this research as applied time and project management), the resulting inefficiency exacerbates baseline stress and erodes the relational trust necessary for social capital to flourish [5]. Without a structured framework to manage workflows, the professional is overwhelmed by the sheer velocity of clinical demands, leading to defensive coping mechanisms that usually culminate in resignation [6].

It is worth clarifying explicitly why this article treats social capital, organizational socialization, psychological safety, personal project management, time management, and crisis communication within a single analytical frame, rather than as separate topics that happen to co-occur in the literature. The rationale is a layered *functional* relationship, not topical similarity: social capital is treated as the macro-level relational resource to be built; communication culture and psychological safety are the meso level organizational conditions through which that resource is transmitted daily; personal project and time management are

the micro level individual competencies that determine whether a professional has the operational capacity to participate in that relational environment rather than being overwhelmed by it; and, in the Ukrainian case, crisis communication functions as a boundary condition that intensifies demands on all three levels simultaneously. This layered logic — rather than a claim that the five fields are conceptually equivalent — is what justifies their joint treatment, and it is formalized as the model in section 6.

This structural problem is universally prevalent across global health systems but acquires an existential, critical urgency in environments subjected to severe macro-environmental shocks and geopolitical instability. In Ukraine, the ongoing war following the full-scale invasion has inflicted devastating, unprecedented damage on healthcare infrastructure, workforce capacity, and overall system resilience. With thousands of verified military attacks on healthcare facilities, profound demographic displacement, and a rapidly expanding cohort of citizens requiring complex medical, surgical, and psychological trauma care, the Ukrainian healthcare system is operating under sustained, unprecedented duress [7]. In this hyper-stressed environment, labor attrition is not merely a managerial inconvenience or a financial drain; it is a critical, immediate threat to national public health and survival [8]. The historical lack of institutionalized crisis communication forces medical professionals into a "sacrificial position," relying on individual heroism rather than systemic support, which inevitably accelerates emotional burnout and drives significant cross-border labor migration [9]. Consequently, solving the labor attrition problem requires a holistic, exhaustive understanding of how organizational culture, structured communication, and operational management methodologies can collectively generate the social capital necessary to sustain the healthcare workforce through both routine clinical challenges and extreme systemic crises.

**Relevance of the theme**. The relevance of this theme is firmly anchored in the stark demographic and economic realities of modern healthcare systems, where the initial one to three years of a clinician's career represent a period of profound organizational vulnerability. Empirical studies consistently demonstrate that turnover intentions peak dramatically during this early employment phase. For instance, turnover intention among new graduate nurses has been recorded at 23% during the first year of practice, escalating to over 26% from the second year onward [10]. This high rate of early attrition represents a catastrophic loss of institutional investment. The direct financial costs associated with recruiting, hiring, onboarding, and training replacement clinical staff are exorbitant, often equating to multiples of the departing employee's annual salary. Beyond these direct financial losses, high turnover inflicts severe operational damage: it disrupts established team cohesion, severs the continuity of patient care, degrades institutional memory, and significantly elevates the statistical risk of adverse patient events and fatal medical errors.

Table 1 synthesizes national workforce trend data [28], the most recent official PHC personnel report [29], and NSZU's primary-care physician registry [30] to highlight the severe structural imbalances and attrition rates exacerbating the human resources crisis.

The theme gains further academic and practical relevance through the conceptual evolution of how labor retention is measured and managed by human resources departments. Historically, healthcare management relied heavily on simplistic, often uni-dimensional metrics of "job satisfaction." However, contemporary organizational psychology emphasizes "job embeddedness" and "organizational socialization" as far more accurate, multidimensional predictors of actual retention behavior [11]. Job embeddedness encompasses the extent to which an individual is deeply enmeshed within the organizational and social web of the workplace. It is determined by the density of their links to other professionals, the perceived fit between their personal values and the institution's culture, and the perceived psychological and financial sacrifices associated with leaving the community. Organizational socialization represents the ongoing, structured process through which a newcomer acquires the specific knowledge, skills, behaviors, and attitudes required to fully assume an organizational role [12]. Building robust social capital is the fundamental engine driving both embeddedness and socialization; without it, retention strategies fail.

*Table 1.* **Ukraine healthcare workforce demographics & attrition dynamics**

| Metric | Data value |
|---|---|
| Total physicians, trend 2020→2023 | –19.4 thousand (–10.8%) to 160.2 thousand [28] |
| Total junior medical personnel, trend 2020→2023 | –51.2 thousand (–16.6%) to 257.5 thousand [28] |
| Total physicians (excl. dentists), as of 31.12.2025 | 123,024 (62.7% women; excludes occupied territories) [29] |
| Physicians based in rural administrative districts | 44,594 (36.2% of total) [29] |
| Physicians of retirement age | 31,954 (26.0% of total) [29] |
| Total nursing/mid-level personnel, as of 31.12.2025 | 202,633 [29] |
| Nursing personnel of retirement age | 26,412 (13.0% of total) [29] |
| Nurse-to-physician ratio | 1.65 (202,633 / 123,024) [29] |
| PHC physicians contracted under Program of Medical Guarantees | 24,373 physicians at 2,615 provider organizations [30] |
| PHC physician specialty mix | Family medicine 66.2%; pediatrics 18.9%; therapy 14.9% [30] |

*Source:* rows 1—2 compiled by the authors from Volosovets et al. (2025) [28]; rows 3—8 from PHC Form N-17, "Report on Medical Personnel" (2025) [29]; rows 9—10 from the NSZU Program of Medical Guarantees primary-care physician registry [30].

Furthermore, the integration of personal project management and time management into the discourse of healthcare retention represents a highly relevant, novel theoretical advancement. Traditionally, these competencies have been strictly siloed within the domains of corporate business administration, construction, or software engineering. Healthcare education has largely, and understandably, focused on building clinical acumen and diagnostic proficiency, leaving new professionals critically underprepared for the operational and logistical realities of ward management, interdepartmental coordination, and balancing competing clinical priorities. By reconceptualizing patient care episodes, quality improvement initiatives, and complex discharge planning as distinct "projects," healthcare professionals can immediately apply established project management frameworks—such as resource allocation, critical path analysis, risk mitigation, and stakeholder communication—to streamline their daily workflows [6]. Similarly, advanced time management skills — encompassing aggressive prioritization, effective delegation, distraction control, and strategic daily planning — serve to regulate the overwhelming cognitive load that typifies early-career clinical practice [13]. When professionals possess these operational skills, they significantly reduce their personal burnout risk and contribute to a more efficient, collaborative, and socially cohesive team environment, thereby reinforcing the unit's collective social capital.

Finally, the urgency of this theme is dramatically amplified by the global macroeconomic trend of healthcare worker migration, which poses acute, destabilizing challenges for developing nations and those actively navigating military conflict. In Ukraine, the stark disparity in professional compensation — with physician pay lagging sharply behind regional EU comparators even in purchasing-power-parity terms (detailed in section 5) [14] — creates a powerful, undeniable economic pull factor. However, while economic gaps initiate the migration calculus for many professionals, non-financial factors such as workplace safety, professional development opportunities, transparent leadership support, and a pervasive culture of belonging ultimately determine whether a professional chooses to stay in their home country or emigrate. As Ukraine aggressively moves toward European integration, managing workforce mobility without collapsing the domestic healthcare system requires the urgent, deliberate cultivation of highly supportive, communicative, and operationally efficient workplace environments that foster deep job embeddedness [14].

**Analysis of recent studies and publications.** The academic literature surrounding healthcare labor attrition has undergone a significant paradigm shift over the past decade, moving decidedly away from a primary focus on individual psychosocial traits toward a robust, empirical examination of organizational structures, relational dynamics, and unit-level operational design.

The conceptual foundation of this contemporary shift is heavily indebted to the rigorous quantitative study of social capital. Strömgren et al. (2016) provided

a landmark prospective cohort study assessing the vital importance of social capital — defined meticulously through parameters of professional recognition, vertical trust in management, horizontal trust among peers, and ongoing reciprocity — among healthcare professionals [2]. Analyzing data from intensive care, emergency, and surgical units across five Swedish hospitals, the researchers found positive, statistically significant associations between all measured aspects of social capital and active engagement in clinical improvements regarding patient safety. Crucially, their prospective analysis established strict causality: increased social capital confidently predicted subsequent, sustained gains in job satisfaction, work engagement, and clinical-improvement activity, operating independently of baseline variations [2]. Oksanen et al. (2013) strongly reinforced this structural view, utilizing advanced multilevel-multinomial logistic regression models on a massive cohort of 43,167 employees. They demonstrated that organizational metrics, such as unit size and employment patterns, directly and mathematically dictate the formation of individual social capital. They found that a 20% increase in baseline employee turnover was associated with a 24% higher odds of experiencing low social capital, highlighting a dangerous, self-reinforcing vicious cycle where turnover depletes social capital, which in turn drives further turnover among the remaining staff [3].

Cho et al. (2023), Hessler et al. (2025), and Hebles et al. (2022) converge on communication openness and psychological safety as central retention levers, but each targets a different point in the causal chain: Cho et al. show communication openness mediates the psychological-safety-to-outcomes link [4]; Hessler et al. show leadership behavior (structured rounding) causally raises psychological-safety scores over time [5]; and Hebles et al. show psychological safety buffers pandemic-era cognitive stress, with supervisor support as its direct antecedent [15]. Read together, these studies sketch a plausible chain — leadership behavior → psychological safety → communication openness → reduced turnover intention — but no single study tests the full chain at once, and none incorporates the individual-level operational competencies (project/time management, sections 3—4) that determine whether a professional has the capacity to benefit from a safe climate in the first place. Bridging that gap between meso level climate research and micro level competency research is precisely what Proposition P2 in section 6 is designed to do.

The specific vulnerability of early-career professionals has generated a distinct, highly focused subset of literature centering on organizational socialization and onboarding frameworks. Ho et al. (2021) qualitatively explored the "transition shock" routinely experienced by newly qualified nurses, concluding that adequate support resources, team morale, and a supportive environment dictate whether a new nurse achieves vital 'job embeddedness' or succumbs to alienation and leaves the profession entirely [1]. Song et al. (2025), in a robust multicenter cross-sectional study of 415 newly graduated nurses across 12 ter-

tiary hospitals, statistically validated that authentic leadership, feedback-seeking behavior, and the perception of decent labor are significant, independent predictors of job embeddedness [11]. Addressing exactly how to instill this embeddedness early, Varma and Hastings (2023) introduced the highly effective concept of virtual onboarding to preemptively establish cultural norms and positive team-enabling behaviors before the professional even begins their first clinical shift, colorfully describing this cohesive organizational effort as "keeping the frogs in the wheelbarrow" [16]. Nagib et al. (2025) further proved through longitudinal tracking that onboarding experiences peak in efficacy around day 30, but comfort and satisfaction precipitously and predictably decline by day 60 and 90 if systemic support is not actively sustained, proving beyond doubt that one-off orientation programs are fundamentally insufficient for retention [17].

While communication and culture understandably dominate the sociopsychological literature, a parallel, highly pragmatic stream of research has begun defining the explicit operational skills required to survive the modern clinical environment. Chiocchio et al. (2015) provided definitive multi-level efficacy evidence showing that a combined intervention of interprofessional collaboration and formal project management training significantly improved goal clarity, interdepartmental coordination, and project performance among healthcare teams [6]. Govindaras et al. (2023) explored the lack of sustainable management settings in project environments, finding that an effective structural management system is an absolute prerequisite for alleviating job stress, preventing burnout, and negating turnover intentions driven by defensive coping mechanisms [18]. Regarding time management, Pestovska (2024) synthesized the European Union experience for Ukrainian enterprises, treating time management not merely as a personal habit or productivity hack, but as an essential organizational competency involving strategic planning, delegation, and the establishment of a "productivity culture" essential for modern personnel management [13].

Finally, the unique, extreme challenges facing the Ukrainian healthcare system are increasingly documented, highlighting severe systemic fragility that requires immediate intervention. The World Health Organization (WHO) and Physicians for Human Rights have documented over 2,881 to 3,000 verified attacks on healthcare facilities in Ukraine since the full-scale invasion, causing unprecedented infrastructure degradation, mass displacement, and civilian casualties [7, 8]. Amidst this physical destruction, Chaban and Salnikova (2020) highlighted the immense psychological toll, arguing that the Ukrainian medical professional is often forced into a "sacrificial position" due to a reliance on societal myths of heroism rather than systemic institutional support, resulting in severe, unmitigated emotional burnout [9]. Hudoshyna et al. (2025) provided an empirical analysis of crisis communication potential within Ukrainian medical institutions, concluding that the communication function remains alarmingly un-institutionalized, with fragmented implementation of WHO princi-

ples and weak coordination across management levels [19]. Nefodov et al. (2025) and Yavorovsky et al. (2023) both underscore the urgent need for a transformation in public administration and patient safety culture dynamics, respectively, as domestic facilities show declining safety indicators compared to pre-war baselines [20, 21].

**Research methods.** This study employs a narrative (traditional) literature review methodology, designed to critically synthesize disparate strands of organizational psychology, clinical operations research, and public health systems management into a cohesive conceptual framework. Sources were identified through targeted searches of PubMed/MEDLINE, Scopus, and Google Scholar (2013—2026) using combinations of the keywords "social capital," "psychological safety," "organizational socialization," "job embeddedness," "project management," "time management," and "turnover intention," combined separately with "Ukraine" and "war" for the national-context literature. Of the 76 records initially identified, 30 were retained based on relevance to at least one of the four core constructs and on reporting a quantifiable statistical estimate (e.g., odds ratio, standardized regression coefficient, or explained variance). No formal risk-of-bias assessment, PRISMA-type screening, or statistical pooling of effect sizes was performed; the study is therefore presented as a narrative critical review rather than a systematic meta-analysis, consistent with its aim of theory-building rather than effect-size estimation. The analytical process prioritized studies that generated quantifiable, structural metrics regarding healthcare labor attrition and social capital formation.

Furthermore, the methodology incorporated a strict multi-level perspective, acknowledging that labor attrition is driven simultaneously by macro-environmental factors (e.g., wartime infrastructure destruction, international wage disparities, global pandemics), meso level organizational factors (e.g., unit leadership dynamics, institutional onboarding programs, team communication norms), and micro level individual competencies (e.g., personal project management efficacy, cognitive stress regulation, time management skills). Data pertaining specifically to the Ukrainian healthcare system was triangulated using recent empirical academic analyses, international NGO reports (such as those from the WHO, IOM, and Physicians for Human Rights), and domestic demographic assessments to provide a highly contextualized, accurate examination of crisis-state labor dynamics. By seamlessly synthesizing these quantitative metrics with qualitative insights into transition shock and clinical burnout, this methodology constructs an exhaustive, evidence-based paradigm specifically tailored for redefining early-career healthcare retention.

**The goal and tasks.** The primary goal of this article is to construct a comprehensive, multi-level framework that identifies the structural and operational factors required to cultivate social capital and mitigate labor attrition among early-career healthcare professionals, with a specific focus on the crisis-affected

Ukrainian health system. To achieve this, the research sets several key tasks: first, to synthesize empirical evidence linking organizational socialization and workplace social capital directly to reduced turnover intention; second, to evaluate the mediating role of psychological safety and transparent leadership communication in fostering deep job embeddedness; third, to conceptualize personal project management and time management as critical operational buffers against clinical cognitive load and emotional exhaustion; and finally, to contextualize these interventions within the extreme systemic fragility and wartime infrastructure disruptions currently threatening workforce stability in Ukraine.

**Innovative character.** The novelty of this article lies specifically in the authors' conceptual model, which operationalizes abstract sociological concepts (social capital and psychological safety) through highly practical, micro level corporate tools (project and time management). The authors' unique contribution is applying this corporate-clinical synthesis specifically to extreme wartime duress, moving beyond standard retention models. Furthermore, the research brings a novel perspective to crisis administration by applying this integrated framework to the unprecedented conditions of the Ukrainian healthcare sector. It argues innovatively that institutionalizing crisis communication and rigorous operational work design are not merely administrative enhancements, but existential, system-level prerequisites for overcoming the "sacrificial" burnout of medical staff and preventing mass labor migration during severe geopolitical shocks.

The original contribution of this article is twofold: first, the four-level integrative model presented in section 6, which specifies functional relationships between these constructs (rather than listing them as merely co-relevant) and yields four propositions (P1—P4) not previously articulated together in this form; and second, the application of this model to the empirically under-examined case of the wartime Ukrainian healthcare workforce, grounded in national workforce data (Table 1) rather than international literature alone.

**Results and discussion**

**1. Social capital and organizational socialization as the primary retention anchors.** The empirical evidence synthesized in this review strongly and consistently indicates that individual psychological resilience and competitive financial compensation, while necessary foundational elements, are entirely insufficient to guarantee the long-term retention of early-career healthcare professionals. The primary structural anchor required for sustainable retention is the deliberate cultivation of dense, highly interactive networks of workplace social capital. Social capital within a clinical unit fundamentally transforms a group of disparate, potentially isolated practitioners into a cohesive, mutually supportive organism capable of withstanding immense clinical pressure.

Together, Strömgren et al.'s (2016) prospective findings and Oksanen et al.'s (2013) large-sample modeling (introduced above) converge on a single struc-

tural claim: social capital and unit instability form a mutually reinforcing cycle — social capital predicts subsequent gains in job satisfaction and clinical engagement [2], while instability erodes it, with a 20% rise in turnover corresponding to 24% higher odds of low social capital, and each 30-person-year increase in unit size cutting the odds of high social capital by 6% (OR = 0.94, 95% CI 0.91–0.98) [3]. Neither study, however, addresses the relative weight of this cycle against the meso- and micro level factors examined in sections 2—4 below — does strong project/time-management practice offset weak baseline social capital, or the reverse? This is the open question our model formalizes as Proposition P1 in section 6, rather than a settled finding in the existing literature.

To actively build and preserve this vital capital, institutions must invest heavily and structurally in "organizational socialization," particularly during the highly volatile initial onboarding phase. The socialization process dictates whether a newcomer successfully navigates transition shock to achieve "job embeddedness." Alp and Yanik (2025) demonstrated that comprehensive organizational socialization is positively associated with deep emotional commitment and accelerated career development, and strictly negatively associated with turnover intention among healthcare workers [12]. Tomietto et al. (2014) effectively quantified this exact effect, establishing through regression modeling that robust organizational socialization significantly reduces both turnover intention ($\beta = -0.67$, $p < 0.001$) and clinical therapy error rates ($\beta = -0.24$, $p = 0.003$) within the critical first three years of nursing practice [10].

Table 2 provides a comprehensive summary of the key structural predictors that actively drive job embeddedness and mitigate turnover intention among early-career professionals, drawn directly from recent multivariate analyses.

These empirical findings dictate a radical, necessary restructuring of how early-career professionals are integrated into hospital systems. Varma and Hastings' (2023) concept of "keeping the frogs in the wheelbarrow" through immersive virtual onboarding is highly instructive; it posits that vital cultural transmission and team-enabling behaviors must be firmly seeded *before* the chaotic reality of clinical work begins to overwhelm the newcomer [16]. Furthermore, as Nagib et al. highlight through their chronological analysis, onboarding cannot be treated as a localized, week-long HR event; it must be a meticulously sustained, longitudinal process that actively buffers the professional through the 60- and 90-day marks, periods empirically proven to link to high transition shock and plummeting career satisfaction [17].

**2. The mediating force of workplace communication culture and psychological safety.** If social capital serves as the structural anchor for a clinical unit, communication culture and psychological safety represent the interactive, daily medium through which that capital is expressed and utilized. The academic literature unequivocally positions institutional communication not as a secondary "soft skill," but as a critical, highly measurable operational and retention variable.

Three recent large-sample studies converge on the same conclusion through different methods, which strengthens confidence in the finding while also exposing its main limitation. Schaechter et al. (2024), Young et al. (2024), and Qeadan et al. (2025) each identify leadership communication — rather than compensation or scheduling flexibility — as the strongest predictor of retention-related outcomes, with Qeadan et al.'s wellness index explaining 53% of departmental turnover variance ($R^2 = 0.53$) [22—24]. None of the three, however, tests whether communication quality is itself an expression of antecedent unit-level social capital or an independent causal lever — a distinction that matters for intervention design and that our model (section 6, P1) treats as an open, testable question rather than an assumption.

The defining, indispensable characteristic of an effective communication culture is the active presence of "psychological safety." Psychological safety is the foundational, shared belief that a professional can speak up, report medical errors, seek critical feedback, and express clinical concerns without any fear of

*Table 2.* **Structural predictors of job embeddedness and turnover intention in early-career healthcare professionals**

| Predictive Construct | Primary Mechanism of Action | Statistical Impact / Outcome Measure | Source Evidence |
|---|---|---|---|
| Organizational socialization | Facilitates rapid cultural assimilation, normative transmission, and deep emotional commitment | $\beta = -0.67$ reduction in turnover intention; $\beta = -0.24$ reduction in therapy errors | Tomietto et al. (2014) [10] |
| Authentic leadership and decent labor | Provides psychological safety, transparent clinical feedback, and highly equitable resource allocation | Significant, independent predictors of high job embeddedness scores across multiple centers | Song et al. (2025) [11] |
| Baseline social capital | Generates vertical/horizontal trust and enforces reciprocity among multi-disciplinary clinical teams | Directly and causally predicts prospective longitudinal gains in job satisfaction and engagement | Strömgren et al. (2016) [2] |
| Wellness and engagement index | Measures holistic institutional support, leadership visibility, and communication efficacy | Explains a highly significant 53% of the total variation in departmental turnover ($R^2 = 0.53$) | Qeadan et al. (2025) [22] |
| Sustained onboarding (day 30—90+) | Actively mitigates "transition shock" by extending structured support far beyond initial orientation | Successfully prevents the precipitous drop in satisfaction traditionally observed at days 60 and 90 | Nagib et al. (2025) [17] |

*Source:* substantiated, identified, formulated, and systematized by the authors based on Tomietto et al. (2014) [10], Song et al. (2025) [11], Strömgren et al. (2016) [2], Qeadan et al. (2025) [22], and Nagib et al. (2025) [17].

institutional retaliation, humiliation, or interpersonal penalty. Cho et al. (2023) established that communication openness acts as the essential statistical mediator between psychological safety and positive nurse outcomes. When early-career nurses feel psychologically safe, their willingness to engage in open communication drastically increases, which directly leads to higher job satisfaction, heavily suppressed turnover intentions, and vastly improved patient safety reporting metrics [4].

This psychological safety mechanism becomes exponentially more important during periods of high environmental stress or crisis. Hebles et al. (2022) studied healthcare teams during the severe, unprecedented disruptions of the *Covid*-19 pandemic, finding that psychological safety actually buffers and prevents the harmful effects of cognitive stress on turnover intentions. Interestingly, their structural models noted that supervisor support does not directly reduce turnover; rather, supervisor support directly and exclusively builds psychological safety, which in turn acts as the protective, stress-absorbing shield against cognitive overload and attrition [15]. Consequently, healthcare institutions must actively, formally train clinical leaders to cultivate this precise climate. Hessler et al. (2025) proved longitudinally that specific interventions — such as explicitly teaching leaders psychological safety tenets and instituting structured, highly visible nurse leader rounding — result in statistically significant increases in the individual psychological safety climate scores of clinical staff over time [5]. Zaheer et al. (2019) echo this imperative, explicitly recommending that healthcare organizations prioritize the relational competencies of frontline supervisors during hiring and provide explicit training in conflict management to strengthen mindful organizing and completely blunt the negative effect of weak teamwork on turnover intentions [25].

This summary Table 3 categorizes the micro and meso level interventions discussed in the literature review, making it easy for policymakers and hospital administrators to map specific operational solutions to retention outcomes.

**3. Personal project management as a critical operational buffer.** While communication culture provides the necessary psychosocial support and relational trust, early-career professionals also require rigid, highly structured operational frameworks to successfully navigate the intense logistical complexity of modern healthcare delivery. This analysis introduces "personal project management" as a highly effective, analytically sound, yet historically underutilized intervention for frontline clinical staff.

Healthcare delivery is rarely conceptualized by practitioners in terms of traditional project management; however, clinical work consists almost entirely of bounded, resource-constrained, multi-stakeholder processes aimed at achieving specific deliverables within a tight timeframe — the exact, textbook definition of a project. Whether a professional is executing a complex patient discharge plan, leading a unit-level quality-improvement initiative, or coordinating a highly in-

terdisciplinary surgical intervention, treating these workflows as formal, manageable projects allows clinicians to apply structured methodologies to otherwise chaotic environments. Chiocchio et al. (2015) provided definitive multi level efficacy evidence regarding the success of this approach. By deploying a combined, intensive training program in interprofessional collaboration and formal project management to actual healthcare project teams, they measured highly significant improvements in individual self-efficacy, collective goal clarity, team coordination speed, and overall project performance metrics [6].

When early-career professionals are explicitly equipped with project management skills — such as critical path analysis, stakeholder mapping, resource leveling, and risk mitigation — they are actively empowered to take executive control of their clinical environment rather than acting as passive, overwhelmed recipients of institutional chaos. Govindaras et al. (2023) highlighted the severe dangers of operating without these frameworks. In project environments lacking sustainable, structured management support, professionals suffer from chronic operational friction, leading directly to job stress, rapid emotional exhaustion, and the activation of defensive psychological coping mechanisms — primarily, the intention to turn over and leave the industry entirely [18]. Furthermore, structural project management strictly enforces operational transpa-

*Table 3.* **Summary of structural retention interventions and operational efficacy**

| Intervention Type | Operational Focus | Key Efficacy Findings |
|---|---|---|
| Virtual and sustained onboarding | Pre-emptive culture transmission ("keeping frogs in the wheelbarrow") | Prevents the precipitous decline in satisfaction observed at days 60/90 without sustained support [16; 17] |
| Project management training | Interprofessional collaboration, role clarity, workflow management | Significantly improves team coordination, project performance, and delivery speed [6] |
| Leadership rounding | Building psychological safety and vertical trust | Directly increases individual psychological safety climate scores among clinical nurses [5] |
| Institutionalized crisis communication | Standardizing emergency workflows and information flow | Diagnosed as largely absent in Ukrainian healthcare [19], with its institutionalization advocated — but not yet empirically tested — as a prerequisite for reducing reliance on the "sacrificial position" [21] |
| Time management protocols | Distraction control, delegation, and cognitive load regulation | Fosters a productivity culture essential for optimizing limited human resources [13] |

*Source:* substantiated, identified, formulated, and systematized by the authors based on Varma & Hastings (2023) [16], Nagib et al. (2025) [17], Chiocchio et al. (2015) [6], Hessler et al. (2025) [5], Hudoshyna et al. (2025) [19], Nefodov et al. (2025) [21], Pestovska (2024) [13].

rency. As clinical throughput is governed by constant, unrelenting time pressures, the absence of written plans and systematic communication creates fatal bottlenecks. Instituting daily patient-care huddles — a core agile project management technique adopted from the technology sector — has been shown to drastically improve unit communication, facilitate much earlier discharge planning, and significantly increase patient throughput without penalizing operational cost or patient satisfaction.

**4. Time management and the regulation of cognitive load.** Intimately linked to the application of personal project management is the individual competency of time management. In the context of early-career healthcare retention, time management must be fundamentally redefined. It is not merely a corporate tool for extracting ultimate efficiency; it is a vital, non-negotiable clinical survival mechanism that actively regulates cognitive load and preserves the psychological bandwidth of the practitioner.

Clinical work is heavily characterized by high-velocity, high-stakes diagnostic decision-making subject to constant, highly unpredictable interruptions. Without rigorous, practiced time management, the cognitive load rapidly exceeds the early-career practitioner's processing capacity, leading directly to the emotional exhaustion that predicates professional burnout. Pestovska (2024) rigorously examined the implementation of time management within personnel management, drawing on established European Union experiences to model targeted improvements for Ukrainian enterprises [13]. Time management in this advanced context encompasses aggressive task prioritization, structured daily planning, highly effective interdisciplinary delegation, strict deadline adherence, and uncompromising distraction control, all culminating in a pervasive, institutional "productivity culture" [13].

When early-career clinicians are explicitly and formally trained in these cognitive load regulation techniques, they consistently report higher levels of self-efficacy, reduced anxiety, and much deeper job embeddedness. Time management provides the necessary operational scaffolding that allows a positive communication culture to actually function under extreme clinical pressure. Even the most psychologically safe, highly communicative team will fragment and fail if its individual members are chronically overwhelmed by poorly prioritized, unmanaged tasks. By mastering time management, early-career professionals successfully reclaim autonomy over their clinical day, minimizing the chaotic, unpredictable variables that contribute directly to transition shock and subsequent labor attrition.

**5. System-Level fragility and crisis resilience: the extreme case of Ukraine.** The theoretical constructs of social capital, psychological safety, and operational management detailed above are currently being stress-tested to their absolute breaking points within the Ukrainian healthcare system. The full-scale military invasion of Ukraine has induced a public health and human resources

crisis of historic, unprecedented proportions. According to data compiled by the World Health Organization and Physicians for Human Rights, there have been between 2,881 and over 3,000 verified military attacks on healthcare facilities, ambulances, and medical personnel during the first 1,534 days of the war, resulting in mass casualties, the wholesale destruction of regional infrastructure, and the severe, ongoing disruption of essential medical service delivery [7, 8]. Over 10 million Ukrainians have been internally or externally displaced, and approximately 30,000 medical professionals have joined the Armed Forces of Ukraine, while thousands of others have become internally displaced or emigrated, severely compromising basic healthcare access for roughly 30% of the entire population. Domestic administrative data corroborate this picture in more granular terms: between 2020 and 2023, the total number of physicians in Ukraine (including private and departmental facilities) fell by 19.4 thousand (–10.8%) to 160.2 thousand, while junior medical personnel fell by 51.2 thousand (–16.6%) to 257.5 thousand; physician availability per 10,000 population declined from 24.2 to 23.4, and junior-specialist availability from 66.04 to 55.9 — with the Kherson, Luhansk, Zaporizhzhia, Donetsk, Odesa, and Kharkiv oblasts recording the sharpest losses [28].

As of 31 December 2025, Ukraine's public health system employed 123,024 physicians and 202,633 nursing/mid-level personnel — a nurse-to-physician ratio of 1.65 — of whom 26.0% and 13.0%, respectively, were of statutory retirement age, and 36.2% of physicians were based in rural administrative districts [29]. Within this workforce, 24,373 physicians were individually contracted as primary-care providers across 2,615 organizations under the Program of Medical Guarantees [30], two-thirds of them (66.2%) practicing family medicine.

In this environment of existential, daily threat, labor attrition is driven by factors far exceeding routine professional transition shock. Chaban and Salnikova (2020) highlight a profound, highly damaging psychological mechanism operating within the Ukrainian medical workforce: the "sacrificial position" [9]. Due to historical systemic deficits and the overwhelming, immediate pressure of wartime triage, Ukrainian doctors are often expected — and expect themselves — to operate as entirely self-sacrificing entities, relying on personal resilience and societal myths of heroism rather than structured institutional support. While this sacrificial ethos has miraculously sustained the system through catastrophic shocks, it statistically guarantees severe, long-term emotional burnout and eventual systemic collapse.

Hudoshyna et al. (2025) and Yavorovsky et al. (2023) converge on the same institutional diagnosis from two angles: Hudoshyna et al.'s qualitative analysis finds Ukrainian healthcare's crisis-communication function "not sufficiently institutionalized," with fragmented WHO-principle implementation and weak cross-level coordination [19], while Yavorovsky et al.'s comparative analysis documents measurable pre-war-to-wartime declines in patient-safety-culture in-

dicators [20]. Neither study quantifies how much of this decline is attributable to the communication deficit itself as opposed to the sheer scale of physical destruction and staff loss documented earlier in this section — a distinction that matters, since it determines whether institutionalizing crisis communication can meaningfully offset attrition even absent a resolution of the war. This is the mechanism formalized as the boundary condition (Proposition P3) in section 6.

Furthermore, as Ukraine aggressively pursues European integration, the healthcare system faces an acute, rapidly accelerating economic and migratory threat. The Ukrainian physician density generally aligns with EU averages, but nurse density is drastically lower, resulting in a highly fragile nurse-to-physician ratio of 1.1, compared to the robust EU average of 2.3 [14]. Economic disparities are glaringly stark; in 2025, the annual average physician salary in Ukraine was approximately $26,700 (PPP), whereas physicians in Bulgaria earned roughly $55,000 and in Poland around $90,000 [14]. EU accession will inevitably facilitate easier labor mobility, threatening a mass, devastating exodus of the surviving, highly traumatized workforce.

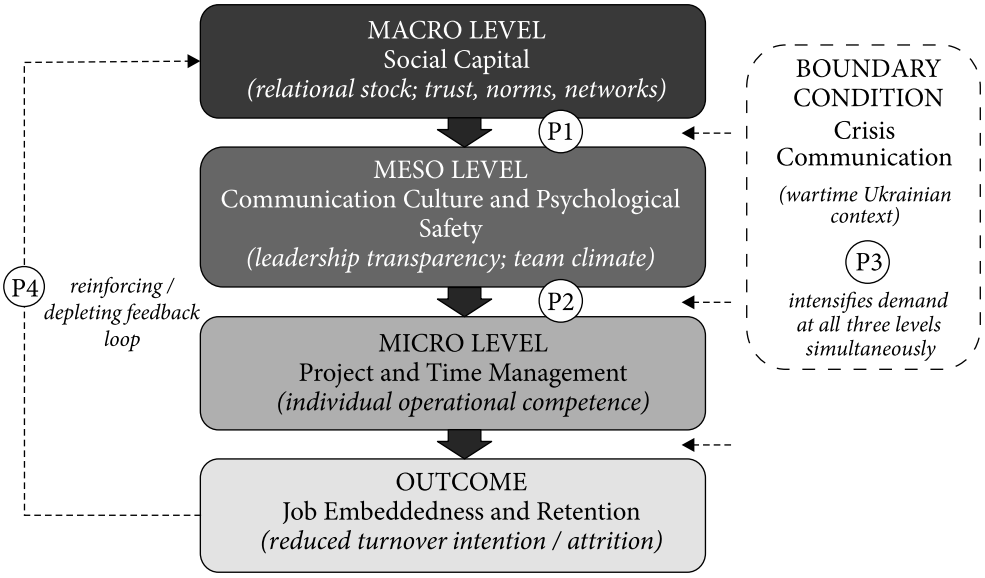
**6. An integrative conceptual model of social capital formation (authors' synthesis).** The evidence reviewed in sections 1—5 is drawn from independent research traditions that rarely cite one another. Building on it, we propose a four-level model that is the original contribution of this study, distinct from any single source cited above.

The model treats social capital as a macro-level relational stock that is generated or depleted by two intermediate mechanisms operating at different levels. At the meso level, workplace communication culture and psychological safety determine whether relational trust and cultural knowledge are actually transmitted between clinicians and leadership on a daily basis. At the micro level, an individual's personal project-management and time-management competence determines whether that person has the operational capacity to participate in — rather than be overwhelmed by — the relational environment created at the meso level. Wartime crisis communication (section 5) is treated not as a fourth, parallel domain but as a boundary condition that intensifies demand on all three levels simultaneously (see Fig. 1).

From this structure we derive four propositions not previously articulated in this combined form in the literature reviewed:

**P1.** The positive effect of communication culture and psychological safety on retention (section 2) is partly mediated by unit-level social capital rather than acting as an independent parallel predictor.

**P2.** Individual project- and time-management competence (sections 3—4) moderates the strength of the relationship between psychological safety and burnout: professionals with low operational competence will show weaker protective effects from a psychologically safe climate than those with high compe-




P1 — effect of communication / psychological safety on retention is partly mediated by unit-level social capital
P2 — individual project / time-management competence moderates the protective effect of psychological safety on burnout
P3 — absent crisis communication multiplies (rather than merely adds to) burnout risk across all three levels
P4 — combined meso + micro interventions strengthen the reinforcing loop more than either alone

***Fig. 1.*** Integrative conceptual model of social capital formation in early-career healthcare worker retention
*Source: developed by the authors.*

tence, because unmanaged workload erodes the capacity to benefit from a supportive climate.

**P3.** In the Ukrainian wartime context, the absence of institutionalized crisis communication (section 5) does not merely add stress additively but multiplies the burnout risk associated with weak meso- and micro level buffers, because crisis conditions remove the slack that normally absorbs individual-level operational failures.

**P4.** Interventions that combine meso level communication training with micro level project / time-management training will outperform either intervention alone — a testable claim not directly assessed in any single study reviewed above, since existing studies (e.g., [6], [18], [5]) each test only one layer in isolation.

Fig. 1 summarizes this four-level model and its associated propositions.

To definitively prevent this attrition, the Ukrainian healthcare system must urgently implement the systemic retention anchors discussed above. As strongly

advocated by Nefodov et al. (2025), a rapid, comprehensive transformation of public administration in the health sector is required, prioritizing ethical and communication dimensions, and rapid digitalization to ensure highly transparent decision-making [21]. Relying on the sacrificial resilience of early-career professionals is an exhausted, highly dangerous strategy. Ukraine must immediately institutionalize crisis communication, implement robust, psychologically safe onboarding for internally displaced or newly graduated staff, and deploy formal project and time management training to maximize the efficiency of its heavily constrained human resources.

**Conclusions.** The successful retention of early-career healthcare professionals is a highly complex, multidimensional challenge that cannot be resolved through simplistic financial incentives, generalized wellness seminars, or brief orientation events. This narrative review demonstrates unequivocally that labor attrition is fundamentally a symptom of deep structural organizational deficits — specifically, the failure of the institution to generate and sustain workplace social capital. Early-career professionals, who are highly vulnerable to the psychological and operational impacts of transition shock, require a meticulously engineered organizational environment to achieve the job embeddedness necessary for long-term retention.

First and foremost, healthcare institutions must actively institutionalize robust communication cultures predicated heavily on psychological safety. The empirical evidence is undeniable: when clinical leadership actively fosters an environment where open communication is normalized and protected, it directly mediates cognitive stress, significantly mitigates emotional burnout, and mathematically suppresses turnover intention. Techniques such as virtual onboarding and longitudinal organizational socialization must rapidly replace brief, isolated orientation events, ensuring that vital cultural norms and team-enabling behaviors are firmly rooted long before clinical pressures mount.

Second, the formal integration of personal project management and time management into clinical training and daily ward operations is an absolute operational imperative. Healthcare workflows are intensely complex, highly variable projects operating under severe, unforgiving time constraints. By explicitly equipping early-career professionals with structural project management frameworks and cognitive load regulation techniques (advanced time management), institutions empower clinicians to exert executive control over chaotic environments, thereby drastically reducing the operational friction and stress that drives professionals out of the industry.

Finally, in extreme macro-crisis environments such as the wartime Ukrainian healthcare system, these systemic, evidence-based interventions are an immediate, existential necessity. Relying continuously on the sacrificial heroism of medical staff is a critically flawed, unsustainable strategy that accelerates profound emotional burnout and sets the stage for massive labor migration upon EU

integration. To survive the dual, compounding threats of wartime infrastructure destruction and intense economic pull factors, health systems must rapidly institutionalize crisis communication, transform public administration to ensure transparent support, and deliberately architect clinical environments that actively build, rather than deplete, the social capital of their indispensable workforce. The rigorous implementation of these cohesive, system-level strategies represents the only definitive mechanism to secure the stability, efficiency, and longevity of the next generation of healthcare professionals.

Future studies addressing the retention of early-career healthcare professionals should prioritize the development of comprehensive models that integrate macro level social capital with micro level operational competencies, as the current literature remains largely fragmented across adjacent domains. Because the existing evidence base for early-career interventions — such as structured onboarding and mentorship — is relatively small and predominantly North American, there is a critical need to explore cross-cultural applications and validate these findings in diverse geopolitical and crisis environments. Additionally, future research must undertake direct, empirical tests of specific time management and personal project management interventions within active clinical teams to explicitly quantify their impact on cognitive load regulation and burnout mitigation. Finally, scholars are encouraged to further investigate the mechanisms of moral and authentic leadership in fostering psychological safety, using these insights as a foundational departure point for more robust theories of workforce stability and organizational performance.

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Стаття надійшла до редакції журналу 14.06.2026
Стаття прийнята до друку після рецензування: 10.08.2026
Дата публікації: 00.00.2026

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## РОЛЬ КОМУНІКАЦІЇ НА РОБОЧОМУ МІСЦІ, УПРАВЛІННЯ ПРОЄКТАМИ І ТАЙМ-МЕНЕДЖМЕНТУ У ФОРМУВАННІ СОЦІАЛЬНОГО КАПІТАЛУ МОЛОДИХ МЕДИЧНИХ ПРАЦІВНИКІВ

Сучасна глобальна система охорони здоров'я стикається з критичною системною проблемою, пов'язаною з втратою молодих фахівців. Ця демографічна група є вкрай вразливою до «транзитного шоку» та передчасного відтоку кадрів, що зумовлено високими клінічними вимогами та складними організаційними умовами. Хоча базові рівні оплати праці та загальна задоволеність роботою вичерпно досліджені, структурні операційні компетенції, зокрема культура комунікації на робочому місці, менеджмент особистих проєктів та тайм-менеджмент дедалі частіше визначаються як базові елементи, необхідні для формування соціального капіталу, потрібного для інтеграції та утримання клінічного персоналу. Ця проблема загострюється у зонах конфлікту (як нині Україна), де системна нестабільність, масове переміщення населення та порушення інфраструктури в умовах війни посилюють професійне вигорання та змушують до масової трудової міграції.

Дослідження має на меті розробити практичну модель, що продемонструє, як керівництво лікарень та їх організаційні структури можуть сприяти формуванню соціального капіталу, зменшенню вигорання та запобіганню звільненню медичних працівників на початку кар'єри, уважно аналізуючи, як ці стратегії застосовуються до української системи охорони здоров'я, що перебуває в кризовому стані. У статті використано комплексний підхід до вирішення проблеми втрати молодих кадрів, де поєднано кілька напрямів, які зазвичай не враховуються у дослідженнях. На відміну від наявних розробок, автори пропонують розглядати не лише підвищення зарплати або особисту стійкість як засоби утримання персоналу. До уваги варто брати загальну кар-

тину соціального капіталу на робочому місці та психологічної безпеки у поєднанні з повсякденними практичними навичками, запозиченими з корпоративного середовища (управління особистими проєктами і тайм-менеджмент) для формування нового підходу до збереження персоналу як у звичайних умовах, так і в умовах кризи.

Дослідження ґрунтується на наративному (аналітичному) огляді літератури. Воно критично узагальнює емпіричні дані й результати досліджень, отримані з опитувань, поздовжніх досліджень і статистичних моделей, опублікованих у міжнародних рецензованих журналах, інтегруючи їх у комплексну, багаторівневу концептуальну модель збереження персоналу. Автори доводять, що відчуття психологічної безпеки та відкрите спілкування з керівництвом допомагають новим співробітникам почуватися впевнено на робочому місці; пропонують підхід до щоденної клінічної практики як до управління проєктами і використання методів тайм-менеджменту для зниження психічного навантаження; а також указують на те, як відсутність чіткої кризової комунікації в українських лікарнях може зводити співробітників до ролі «жертв», що прискорює вигорання. Отримані результати свідчать, що стійкий соціальний капітал на робочому місці та триваліший, сприятливіший процес адаптації нових співробітників призводять до зниження плинності кадрів. Надання новим співробітникам інструментів тайм-менеджменту і підхід до клінічних завдань як до проєктів допомагає захистити їх від емоційного виснаження. Для української системи охорони здоров'я налагодження належної кризової комунікації та вдосконалення щоденних робочих процесів — це не просто управлінський бонус, а критично важливий чинник збереження медичного персоналу. Медичні заклади мають відійти від традиційних, ізольованих орієнтаційних заходів та впровадити стійкі, багаторівневі стратегії утримання персоналу. Створення стійкої комунікаційної культури, запровадження оперативного дизайну зі сприйняттям клінічних робочих процесів як керованих проєктів та створення надійних систем тайм-менеджменту є необхідними передумовами для формування соціального капіталу, зменшення вигорання та забезпечення довгострокової стабільності й ефективності медичного персоналу.

***Ключові слова:*** плинність кадрів, соціальний капітал, молоді медичні працівники, організаційна соціалізація, психологічна безпека, управління особистими проєктами, тайм-менеджмент, комунікація на робочому місці, транзитний шок.