2023

Personal Resilience as an Interventional Strategy to Reduce Physician Burnout

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Walden University
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Abstract

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MBA, Lebanon Valley College, 2014

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

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Abstract

Physician burnout is prevalent in healthcare today. Contributing factors include emotional exhaustion, depersonalization, and a sense of loss of autonomy. Physician burnout negatively affects a physician's ability to provide high quality patient care. Physician burnout indicators include poor behavior, mental decline, depression, narcotics and alcohol abuse, suicidal ideation, and suicide completion. Given the negative impact of physician burnout, it is necessary to understand what can counter this phenomenon. Through lived experiences of physicians who self-identified as burned out, the purpose of this study was to explore personal resilience as an interventional strategy to reduce physician burnout. Personal resilience is adapting well in adverse or traumatic circumstances. Using a conceptual framework, critical social theory and Herzberg's motivation-hygiene theory were used for this qualitative hermeneutic phenomenological study of seven physicians' responses in interviews. Data were coded for similar patterns and themes of burnout and personal resilience strategies. Findings confirmed that physicians employed personal resilience as an interventional strategy to reduce burnout. Some participants stated that inequities in the health system left them with the sense that the organization did not care and made arbitrary decisions without understanding the impact of those decisions. Findings may be used for positive social change by administrators to help physicians provide high quality patient care and favorable patient outcomes, enhanced physician wellness and engagement, and decreased healthcare costs.

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Dedication

This dissertation is dedicated to my dad, William George Rhim, Senior. He served his country during World War II, overcame many obstacles, and loved and cared for his family. He did not complete his formal education; therefore, my dedication honors him and his surname in the realm of academia. This dissertation I also dedicated to my children, Brianah, Tyler, and Serayah (posthumously).

Acknowledgments

The completion of this achievement could not have been possible without the many people who invested their time, effort, and encouragement into me. To the many cheerleaders, study partners, exhorters, academic and professional leaders, prayer warriors, and family and friends who loved me through this journey, thank you. A sincere thank you to my dissertation committee, Dr. Marlon Sukal, Dr. Michelle McCartney, and my URR, Dr. Gallardo. A very special thank you to my children, Brianah, Tyler, and Serayah (posthumously). I love you more than words can ever express; thank you for loving and supporting me. We did it!

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Chapter 1: Introduction to the Study

Introduction

Personal resilience has resurged among researchers, academic healthcare professionals, reputable medical journals, and clinicians alike (Shanafelt et al., 2002). Personal resilience as defined by Card (2018) is the fortitude necessary to appropriately adapt to stressful or traumatic circumstances. Card (2018) ascribed that resilience is a quality that enables a person to thrive during challenging circumstances. Reivich (2012, 2018) further ascribed that the science of wellbeing or positive psychology encompasses the science of resilience and its application in life circumstances.

Physician burnout, more specifically physician wellness, is at the forefront of the Quadruple A in healthcare (Johnson, 2019). The Quadruple Aim is defined as managing healthcare cost, providing high quality care and favorable patient outcomes, improving access to care for patients, and physician wellness (Johnson, 2019). Prior to identifying the four priority focus areas in healthcare, the Triple Aim consisted of managing healthcare cost, providing high quality care and favorable patient outcomes, and improving access to care for patients (Johnson, 2019). The addition of physician wellness in recent years has gained national and global attention in the realm of academia and research for its direct effects on clinicians and patients, among other aspects of the Quadruple Aim (Johnson, 2019; Maslach & Leiter, 2016).

Physician burnout is a phenomenon defined as a syndrome consisting of emotional exhaustion, depersonalization, and a decreased perception of personal accomplishment (Amanullah et al., 2017; Maslach et al., 2005; Maslach & Leiter, 2016;

Olson, 2017). In recent years, a new aspect of research on resilience has identified adult personal resilience as an emerging area of focus, relative to alleviating burnout (Taormina, 2015).

Background of the Study

Maslach and Jackson developed the Maslach Burnout Inventory (MBI) instrument to measure emotional exhaustion, depersonalization, and decreased perception of personal accomplishment (Maslach et al., 2005; Maslach & Leiter, 2016). Reivich presented the premise of positive psychology in the exploration of personal resilience among many of her trainees who are military personnel (Reivich et al., 2011). Reivich (2012, 2018) ascribed that the science of wellbeing or positive psychology encompasses the science of resilience and its application in life circumstances.

Physician burnout is a phenomenon defined as a syndrome consisting of emotional exhaustion, depersonalization, and a decreased perception of personal accomplishment (Amanullah et al., 2017; Maslach & Leiter, 2016; Olson, 2017). Previous research included quantitative studies that used the MBI to measure emotional exhaustion, depersonalization, and perception of personal accomplishment. In recent years, a new aspect of research on resilience identified adult personal resilience as an emerging area of focus, relative to alleviating burnout (Taormina, 2015).

Selected literature relating to physician burnout, the consistent gap in research concerning the exploration of interventional strategies specific to personal resilience, and a consistent limitation of the research including a cross-sectional analysis of the study, reflect similar themes. Acimis et al. (2017) and Ruzycki et al. (2018) presented that

negative behaviors exhibited by physicians are indicators of burnout. Amanullah et al. (2017) concurred with Maslach and Leiter (2016) and Olson, (2017) that physician burnout is a phenomenon defined as a syndrome consisting of emotional exhaustion, depersonalization, and a decreased perception of personal accomplishment. According to Amanullah et al. (2017) and Iorga et al. (2017), higher rates of emotional exhaustion and sleep deprivation were contributors to increased negative behaviors and increased cynicism by physicians. Collier (2017), Diesser et al. (2017), and Fetch et al. (2017) ascribed various stressors such as the clerical burden associated with the electronic health record negatively impact the level of burnout exhibited by physicians. Olson (2017) ascribed that physician burnout is a key indicator of the success or lack thereof of business success. Ruzycki et al. (2018) and Tetzlaff et al. (2018) posited that strategies to decrease burnout, improve wellness, and adjust sleep hours to decrease sleep deprivation are beneficial in the early stages of a physician's training, specifically, in medical school residency; strategies in these areas favorably impacted efforts to reduce burnout.

Problem Statement

There is a gap in research exploring personal resilience as an interventional strategy to reduce physician burnout. Personal resilience as defined by Card (2018) is the fortitude necessary to appropriately adapt to stressful or traumatic circumstances. Physician burnout consists of emotional exhaustion, depersonalization, and a decreased perception of personal accomplishment (Amanullah et al., 2017; Maslach & Leiter, 2016; Olson, 2017). Card (2018) ascribed that resilience is a quality that enables a person to thrive during challenging circumstances. Previous research has shown that burnout may

lead to behavioral outbursts, mental health effects such as depression, misuse of narcotics, and in some instances, suicide (Maslach & Leiter, 2016). Personal resilience, as described by Reivich (2018) during an organizational leadership meeting at Penn Medicine Lancaster General Health, is an interventional strategy at the forefront of physician wellness discussions today. The American Psychological Association (2020) defined resilience as the process of adapting well in adverse or traumatic circumstances. For example, the September 11, 2001 bombing of the World Trade Center invoked a spirit of resilience among Americans (National Center for Biotechnical Information 2006).

Teixeira-Poit et al. (2017) indicated that factors influencing professional life among physicians include job satisfaction. On the contrary, physicians experiencing a lack of job satisfaction may contribute to low enrollment into medical school, early retirement, less than full time equivalent employment, and increased time away from direct patient care. Declining enrollment may hinder patients from receiving timely access to care.

Effectually, when patients do not have timely access to healthcare services, comorbidities may increase, quality of care may be negatively impacted, and quality patient outcomes may suffer, resulting in decreased payer reimbursements and increasing the cost of healthcare. Feteh et al. (2017) further asserted that the psychological state of burnout syndrome is a byproduct of prolonged exposure to stress at work. A lack of teamwork through team-based care, inadequate workflow transitions, minimal focus on

time studies to enhance processes, and time spent using electronic health record technology as implied by DeChant et al. (2019) are key contributors to physician burnout.

Purpose of the Study

The purpose of this study was to explore interventional strategies to reduce physician burnout. It is important to understand burnout and the research regarding potential interventional strategies. To better understand how physicians interpret burnout and interventional strategies, this qualitative study considered lived experiences of physicians who identified as burned out. Personal resilience is important because burnout among physicians may negatively affect the quality-of-care physicians provide to patients (Amanullah et al., 2017). Further research is needed to understand how physicians might apply personal resilience as an interventional strategy to reduce burnout. The goal is to reduce burnout by implementing resilience strategies.

Given the continuous and rapid pace of change, the sicker patients in healthcare, and the global impact of COVID-19, physician burnout is a growing phenomenon and there is growing concern for both the physician and the patient. Personal resilience is necessary to thwart burnout (Citrin & Weiss, 2016). Having determination or willpower to persevere, endurance or fortitude to withstand difficult situations, adaptability, or the ability to adjust to and cope with challenging situations, and recuperability or the ability of reestablishing a sense of normalcy, is essential after experiencing stressful circumstances. Taormina (2015) further defined personal resilience as internal to the individual as compared to resilience which may be internal or external to the individual.

Research Questions

Research Question 1: What is the physician's lived experience of practicing wellness behaviors to reduce burnout as interpreted in an interview?

Research Question 2: What is the physician's lived experience of seeking professional support to reduce burnout as interpreted in an interview?

Conceptual Framework

Based on the research problem, there is a gap regarding personal resilience as an interventional strategy to reduce physician burnout. Using a conceptual framework, critical social theory (CST) and Herzberg's motivation-hygiene theory, sometimes called Herzberg's two factor theory, applied to this study. CST originated out of the Frankfort school in Germany in the 1920s, advanced from a discredited ideology of Marxism, and was later aligned with Max Horkheimer, Theodor Adorno, and Herbert Marcuse in the 1960s and 1970s. CST considers aspects such as power and inequity in a broad sense. Although there are various tenets of CST, Ravitch and Carl (2019) contended that further theoretical specificity is not a necessity, given that all tenets of CST identify issues of power and inequality. CST relates to the exploration of personal resilience as an interventional strategy to reduce physician burnout in that assessing an organization's paradigm and policy of fairness and equality may prove beneficial to alleviating a perception of inequality and unfairness among physicians. Herzberg's motivation-hygiene theory was developed by Frederick Herzberg, a behavioral scientist, in 1959. Sometimes referred to as Herzberg's two factor theory because there are factors that satisfy, known as motivators, and factors that prevent dissatisfaction, known as hygiene

factors. Although somewhat controversial among scholars and researchers, it is valuable when considering the tenets of positive psychology, employee satisfaction, and personal resilience (Sachau, 2007).

Understanding that burnout and resilience are the reality of the physician based on their perception of emotional exhaustion, depersonalization, and decreased perception of personal accomplishment (Amanullah et al., 2017; Maslach & Leiter, 2016; Olson, 2017), an appropriate framework was CST and Herzberg's motivation-hygiene theory. CST and Herzberg's motivation-hygiene theory framework helped me explore interventional strategies to reduce physician burnout, keeping in mind that Maslach and Leiter (2016) defined burnout as emotional exhaustion, depersonalization (sometimes presented as a loss of autonomy or power), and decreased perception of personal accomplishment.

There have been historical debates regarding problems with the conceptual and methodological aspects of the theory (Sachau, 2007). Critics have argued that the theory is biased, and others have argued that there are several definitions of the theory, which makes application of the theory challenging (Sachau, 2007). In recent years, however, with the emergence of positive psychology, Herzberg's motivational theory has been gaining acceptance in the research realm (Sachau, 2007). Positive psychology focuses on wellbeing and human strength as compared to weakness and depression (Sachau, 2007; Reivich, 2018). The premise of Herzberg's motivational theory aligned with this study's exploration of personal resilience as an interventional strategy to reduce physician burnout.

Nature of the Study

The nature of this research was a qualitative hermeneutic phenomenological study. This type of phenomenological research is based on the researcher's exploration of the lived experiences of subjects or participants (Gadamer, 2006; Lewis, 2015; Whame, 2017; Straus, 2020). Hermeneutic philosophy is derived from Hermes, the Olympian god of Greek mythology, in which Hermes was, among several titles, the interpreter of the gods (Gadamer, 2006). Hermeneutics is the interpretation of messages, language, or text (Gadamer, 2006). Given the expanse and ubiquity of language or text, hermeneutics is the discipline of interpreting language, deemed important by humans, based upon historical meaning and interpretation (Gadamer, 2006; Stanford Encyclopedia of Philosophy, 2016).

In researching personal resilience as an interventional strategy to reduce physician burnout as a current gap in the literature, this qualitative hermeneutic phenomenological exploration of physician burnout contributes to the existing body of research. It is essential to understand how physicians define and display burnout. Thus, it was necessary to investigate strategies that physicians perceived would reduce burnout as well as how physicians described or demonstrated personal resilience, what connections or resources were beneficial to reducing burnout, and what support was needed to increase resilience (Matheson et al., 2016; Whame, 2017). These components were beneficial to narrowing the gap in research and literature. Although there are quantitative studies regarding physician burnout, there was opportunity to enhance the volume of qualitative studies on the phenomenon, with a specific focus on personal resilience. A qualitative methodology

using interviews was used for this study. A qualitative approach to personal resilience in a study of physician burnout was essential to understanding the physician's experience of burnout and, ultimately, personal resilience. Quantitative research identifies relationship, focuses on frequency, encompasses control and prediction, and is validated using external instruments for data collection; therefore, I employed a qualitative approach to focus on interpretative experience, investigative discovery, flexible design, and the researcher as the instrument (see Vaitkevičius, 2013).

Phenomenology identifies the essence or intrinsic nature of human experiences (Lewis, 2015; Straus, 2020). Qualitative research is consistent with an exploratory approach using interviews, observations, or focus groups (Lewis, 2015). With a goal of identifying patterns and themes, exploratory qualitative phenomenological research addresses the lived experiences of physicians through observation, interviews, or focus groups (Lewis, 2015; Straus, 2020). The researcher is the instrument, and the responses from the interview or focus group are coded according to themes (Lewis, 2015).

The phenomenon I researched was physician burnout; specifically, I conducted a qualitative study on personal resilience as an interventional strategy to reduce physician burnout. Burnout is consistently defined theoretically in research as a psychological syndrome resulting from extended periods of stress (Maslach & Leiter, 2016). The three recurring components of burnout are emotional exhaustion, which is defined as fatigue and loss of energy; depersonalization, which is described as cynicism and manifests as negative and inappropriate attitudes and behaviors; and a decreased sense of personal

accomplishment, which is described as low morale, coping inabilities, and reduced productivity (Maslach & Leiter, 2016).

Based on my review of the literature, I identified and coded themes of the physician responses to the three defined components of physician burnout, including emotional exhaustion, depersonalization, and decreased perception of personal accomplishment (see Maslach & Leiter, 2016). Using CST and Herzberg's motivation-hygiene theory as a framework, I conducted interviews as a method of inquiry to explore personal resilience as an interventional strategy to reduce physician burnout across various medical specialties. Using a qualitative approach by coding reoccurring themes aligned with the problem and purpose statement of this study.

Definitions

Alexithymia: A psychological component of burnout that refers to people who may disassociate identifying with their emotions and place less emphasis on emotional experience (Iorga et al., 2017).

Coding: A process of identifying themes and categories in qualitative research to determine analysis (Gonzalez, 2016).

Cognitive behavioral theory: First introduced by Beck in the 1960s, CBT focuses on mental aspects such as depression (Beck Institute, 2019). The common theoretical basis of cognitive theory is learning; it posits that human behavior is learned (Adefolalu, 2018).

Critical social theory (CST): CST considers aspects such as power and inequity in a broad sense. Although there are various tenets of CST, Ravitch and Carl (2019)

contended that further theoretical specificity is not a necessity, given that all tenets of CST identify issues of power and inequality.

Decreased sense of personal accomplishment: Described as low morale, coping inabilities, and reduced productivity (Maslach & Leiter, 2016).

Depersonalization: Described as cynicism and manifests as negative and inappropriate attitudes and behaviors (Maslach & Leiter, 2016).

Emotional exhaustion: Defined as fatigue and loss of energy (Maslach & Leiter, 2016).

Hermeneutics: The interpretation of messages, language, or text (Gadamer, 2006). Given the expanse and ubiquity of language or text, hermeneutics is the discipline of interpreting language, deemed important by humans, based upon historical meaning and interpretation (Gadamer, 2006; Stanford Encyclopedia of Philosophy, 2016).

Interventional strategy: A plan of action intended to disrupt, intercede, or redirect the original trajectory of a process or phenomenon (Oxford University Press, 2019).

Maslach burnout inventory (MBI): Maslach and Jackson developed the instrument to measure emotional exhaustion, depersonalization, and decreased perception of personal accomplishment (Maslach & Leiter, 2016).

Mindfulness training: Mindfulness-based interventions consist of both mental and physical activities such as meditation and exercise, which promote both mental and physical wellness. Implementing mindfulness-based behaviors is beneficial to people because it conditions people to become more intentional in caring for themselves in order to provide the highest quality of care to patients (Yester, 2019).

Mobbing behaviors: Systematic oppressive behaviors that negatively affect job satisfaction and contribute to low organizational morale. Such bullying behaviors by the organization adversely impact emotional exhaustion and depersonalization and reduce personal accomplishment of employees (Acimis & Tekindal, 2017).

Personal resilience: The fortitude necessary to appropriately adapt to stressful or traumatic circumstances (Card, 2018).

Phenomenological qualitative research: Deals with experiences and meanings, intended to capture how the phenomenon is experienced within the context in which the experience takes place (Straus, 2020). Interpretive phenomenological analysis is an appropriate methodology when researching the perceived experiences of individuals.

Physician burnout: A phenomenon defined as a syndrome consisting of emotional exhaustion, depersonalization, and a decreased perception of personal accomplishment (Amanullah et al., 2017; Maslach & Leiter, 2016; Olson, 2017).

Positive psychology: The study of positive human attributes, including well-being, optimism, forgiveness, self-esteem, fascination/flow, creativity, resilience, savoring, wisdom, and spirituality. The central goal of positive psychology is the study of human strength and well-being rather than human weakness and depression (Sachau, 2007).

Quadruple aim: Consists of managing healthcare cost, providing high quality care and favorable outcomes, improving access to care for patients, and physician wellness. The quadruple aim is a recognition among researchers and healthcare experts that wellness is a critical component of successful organizations (Jacobs et al., 2018).

Saturation: The point when there are no new research themes and the study can be replicated (Fusch & Ness, 2015; Lowe et al., 2018).

The Big Five: Assessment tool that consists of 44 questions that measure personality traits, specifically extraversion, neuroticism, openness, consciousness, and agreeableness (Iorga et al., 2017).

Wellness: A state of being, comprised of physical, mental, and social dimensions, in contrast to solely the absence of illness or disease in health (Bart et al., 2018).

Assumptions

Understanding that assumptions refer to the characteristics of the data, it is important to clearly identify those things that a reader may presume to be expected. These assumptions may in fact differ from the expected. For example, I assumed the physicians provided truthful answers, but because of the sensitivity of personal resilience and burnout, participants may not have been as transparent in their responses. Several assumptions were made regarding the data from physician interviews of their lived experiences. First, I assumed that the clerical burden of the electronic medical record (EMR) contributed to physician burnout across various specialties (see Collier, 2017). Second, although there are various perspectives regarding whether resilience is an individual or organizational responsibility, Taormina (2015) posited that physician burnout is best remedied at the individual level. Resilience is the decidedness of an individual to intentionally proceed despite known or unknown adversity. Third, I assumed that physician wellness is best instituted at the organizational level. Resilience programs, according to Kuhn and Flanagan (2017), need to be supported by

organizational efforts that acknowledge physician wellness as a high priority. Fourth, I assumed that exploring how physicians understand burnout and the benefit of imploring interventional strategies, using a qualitative hermeneutical phenomenological approach, may be advantageous to a practical application of interventional strategies to decrease the phenomenon of physician burnout (see Maslach & Leiter, 2016). Fifth, I assumed that physicians defined wellness similarly across disciplines and burnout similarly across disciplines. Sixth, I assumed that respondents would identify with at least one component of burnout. Lastly, I am a healthcare administrator and interact with physicians in my profession; my assumption, however, was that physician and rater bias were nonissues.

Scope and Delimitations

The specific component of the research problem in this study addressed personal resilience as an interventional strategy to reduce physician burnout. Interviewing physicians to gain insight into their lived experiences using a qualitative hermeneutical phenomenological approach was advantageous to a practical application of interventional strategies to decrease the phenomenon of physician burnout (Maslach & Leiter, 2016).

In this study, I explored personal resilience as an interventional strategy to reduce physician burnout through the lived experiences of physicians in their professional environment. This study did not address external factors such as single or dual income households, single or dual-physician households, single or dual-parenting arrangements, or physician leadership roles and responsibilities. Furthermore, this study did not address nonphysician clinicians and providers. Lastly, this study was nonspecific to age, gender, race, ethnicities, religious affiliation, or clinical disciplines.

Limitations

Limitations to the study included a sample size as it related to generalizability. There is continued discussion among researchers as to a finite process to calculate data saturation in qualitative research. A small sample size may not have adequately represented the perspective of an entire population. Another limitation potentially affecting the study was its explorative nature. Specifically, using self-reported data from interview questions may have yielded decreased transparency, given burnout consists of depression, suicidal ideation, and drug abuse. Belton (2018) and Kuhn and Flanagan (2017) suggested that physicians are healers and not in need of healing. An additional unforeseeable limitation consisted of the COVID-19 pandemic. Ironically, this pandemic may provide substantial future research on resilience, physician burnout, and physician well-being. However, it negatively impacted response rates. An added limitation was the fluidity of perspectives, arguments, and definitions of wellness and resilience among researchers. Further limitations included potential researcher bias, having worked in healthcare for approximately 30 years, with direct interaction with physicians; therefore, it is essential to disclose researcher bias as a potential limitation.

Significance of the Study

Burnout is evident as early as the physician residency programs (Kuhn & Flanagan, 2017; Ruzycki & Lemaire, 2018). Kuhn and Flanagan (2017) further noted that in some cases, physicians become addicted to drugs, or they may commit suicide. According to Dyrbye et al. (2018), burnout occurs in the early stage of a physician's career such as residency, negatively impacting the care of the patient. Shanafelt et al.

(2002) noted the increasing potential for drug abuse by physicians, as well as the increasing vulnerability of physicians to commit suicide.

Significance to Practice

Exploring how physicians interpreted burnout and the benefit of interventional strategies using a qualitative hermeneutical phenomenological approach may be advantageous to the practical application of interventional strategies to decrease the phenomenon of physician burnout (see Maslach & Leiter, 2016).

Significance to Theory

Exploration of an interventional strategy such as personal resilience is important because there is a heightened awareness and concern in the healthcare realm regarding the quality of care being provided to patients; the increasing workload, including the clerical burden resulting from the implementation of the electronic health record, is being placed on physicians (Collier, 2017). Moreover, there is the increased admission by physicians indicating that they have depended on alcohol and drugs as coping mechanisms relative to burnout, and some physicians have considered and attempted suicide in response to burnout (Maslach & Leiter, 2016). Additionally, Penberthy et al. (2018) agreed with Maslach and Leiter (2016) that drug use among physicians is increased because of burnout. West et al. (2016) further asserted that physician suicides are increased because of burnout.

Penberthy et al. (2018) identified physician burnout as a predictor of poor-quality outcomes and increased medical errors. CST considers components such as power and inequity in a broad sense. Herzberg's motivation-hygiene theory has been controversial

among researchers (Sachau, 2007), but a premise of practical motivation approaches is beneficial to engaging employees. There is a gap in qualitative research to explore lived experiences of physicians, specifically exploring personal resilience as an interventional strategy to reduce physician burnout.

Significance to Social Change

Ideal research findings using an exploratory method could show positive social change through reduced physician burnout. Reivich (2018) asserted that the benefits of research and application of strategies may also increase personal resilience. Kuhn and Flanagan (2017) posited that medical student and physician suicide have garnered heightened awareness and continued focus during national medical conferences, in prominent peer-reviewed healthcare journals, and across the global medical community. A cultural imperative of medical training innately develops physicians with a skill and paradigm of excellence, competence, and compassion (Kuhn & Flanagan, 2017). The positive social change implications of this study include physicians providing high quality patient care and favorable patient outcomes, enhanced physician wellness and engagement, and decreased healthcare costs.

Possible Types and Sources of Data

1. The primary sources of my data were the responses and hermeneutical coded themes from the physician interviews. Hermeneutic coded themes focus attention on the authorial intention (Vaitkevičius, 2013). Hermeneutics is the discipline of interpreting language using historical meaning and interpretation (Stanford Encyclopedia of Philosophy, 2016).

2. I collected my data by coding responses from physician interviews of their lived experiences. Using the hermeneutical coding approach in the phenomenon of physician burnout was beneficial to interpreting the language provided in the interviews and coding themes of similar intention (see Vaitkevičius, 2013).

3. To operationalize the data, I identified within the responses, words, or short recurrent phrases throughout the interviews, and again, coded similar themes to accurately reflect the authorial intention (see Vaitkevičius, 2013).

Summary and Transition

This chapter introduced the study of personal resilience as an interventional strategy to reduce physician burnout. The background offered personal resilience as an intervention to emotional exhaustion, depersonalization, and a decreased sense of accomplishment. The problem is burnout may lead to behavioral outbursts and mental health effects, such as depression, misuse of narcotics, and, in some instances, suicide. The purpose of the research study was to explore the lived experiences of physicians who identified as burned out. The significance of physician burnout is that it often begins early in the academic, training, and professional clinical environment. Using a conceptual framework helped me formulate and investigate the research questions. Further research is needed to understand how physicians might apply personal resilience as an interventional strategy to reduce burnout. The goal is to reduce burnout by implementing resilience strategies.

The scope, limitations, delimitations, assumptions, possible types and sources of data, possible analytic strategies were provided in Chapter 1. An overview of the problem

and purpose are further discussed in Chapter 2. The research questions provided a path of exploration into specific strategies to reduce physician burnout. The study was conducted through interviews of physicians through their lived experiences. This provides greater insight into how to further contribute to the research as well as how to narrow the research gap.

Chapter 2 consists of a review of the literature and constructs of physician burnout, including wellness strategies and resilience. The literature review is comprised of the synthesis and analysis of peer-reviewed selections and studies. The various researchers suggested that the literature rendered constancy, as suffering without recoiling. Review of current literature and seminal works reflected that burnout occurs across a variety of disciplines. Personal resilience has been explored and researched in disciplines such as social work, various branches of the military, governmental professions, and healthcare settings, among others. A well-rounded literature review provided similar and opposing perspectives. The resilience continuum detailed how to prepare, process, manage through, and put an action plan in place to cope with stress. Chapter 3 is the research design and rationale. This study is a qualitative phenomenological hermeneutical research design. The study consisted of interviews of the lived experiences of physicians. Chapter 4 includes coding, categorizing, and identifying themes throughout the study, which was essential to analyzing the data. Chapter 5 concludes the study, providing the interpretations, limitations, recommendations, social change implications, and conclusions of the research.

Chapter 2: Literature Review

Introduction

Previous research has shown that burnout may lead to behavioral outbursts, mental health effects such as depression, and misuse of narcotics, and, in some instances, burnout has resulted in suicide (Maslach & Leiter, 2016). However, there is a gap in research exploring personal resilience as an interventional strategy to reduce physician burnout.

Key search terms included *personal resilience, resilience, burnout, physician, clinician, wellness, suicide, healthcare, wellbeing, mental health, depression, emotional exhaustion, depersonalization, decreased perception of personal accomplishment, physician drug abuse, coping, Maslach, positive psychology, burnout syndrome, interventional strategies to reduce physician burnout, poor physician behavior,* and *posttraumatic stress disorder*. Boolean operators are simple connecting words or conjunctions used when searching; "for example," "and," "or," and "not" are connectors. The selected operator provided a level of specificity during the search that helped narrow the search and provide exclusivity. My predominant Boolean Operator was "and."

Databases viewed included Thoreau Multi-Database Search, CINAHL & MEDLINE Combined Search, CINAHL Plus with Full Text, Medline, CMAJ, Directory of Open Access Journals, MEDLINE with Full Text, Psychology Databases Combined Search, PsycTESTS & Health and Psychosocial Instruments Combined Search, Supplemental Index, SAGE Journals, ScienceDirect, SocINDEX with Full Text, and

Taylor and Francis Online. I did not filter my search, I searched databases associated with Industrial and Organizational Psychology.

Conceptual Framework

Based on the research problem, there was a gap regarding personal resilience as an interventional strategy to reduce physician burnout. Using a conceptual framework, CST and Herzberg's motivation-hygiene theory applied to this study. CST originated out of the Frankfort school in Germany in the 1920s, advanced from a discredited ideology of Marxism, and was later aligned with Max Horkheimer, Theodor Adorno, and Herbert Marcuse in the 1960s and 1970s. CST considers aspects such as power and inequity in a broad sense. Although there are various tenets of CST, Ravitch and Carl (2019) contended that further theoretical specificity was not a necessity, given that all tenets of CST identify issues of power and inequality. CST relates to the exploration of personal resilience as an interventional strategy to reduce physician burnout in that assessing an organization's paradigm and policy of fairness and equality may prove beneficial to alleviating a perception of inequality and unfairness among physicians. Herzberg's motivation-hygiene theory was developed by Frederick Herzberg, a behavioral scientist, in 1959. Herzberg's motivation-hygiene theory, although somewhat controversial among scholars and researchers, is valuable when considering the tenets of positive psychology, employee satisfaction, and personal resilience (Sachau, 2007).

There have been historical debates regarding problems with the conceptual and methodological aspects of the theory (Sachau, 2007). Critics have argued that the theory is biased, and others have argued that there are several definitions of the theory, which

have made application of the theory challenging (Sachau, 2007). In recent years, however, with the emergence of positive psychology, Herzberg's motivational theory has been gaining acceptance in the research realm (Sachau, 2007). Positive psychology focuses on wellbeing and human strength as compared to weakness and depression (Sachau, 2007; Reivich, 2018). The premise of Herzberg's motivational theory aligned with this study's exploration of personal resilience as an interventional strategy to reduce physician burnout.

Understanding that burnout and resilience is the reality of the physician based on their perception of emotional exhaustion, depersonalization, and decreased perception of personal accomplishment (Amanullah et al., 2017; Maslach & Leiter, 2016; Olson, 2017), an appropriate framework for this study was CST and Herzberg's motivation-hygiene theory. CST and Herzberg's motivation-hygiene theory framework are intended to explore interventional strategies to reduce physician burnout, keeping in mind that Maslach and Leiter (2016) defined burnout as emotional exhaustion, depersonalization (sometimes presented as a loss of autonomy or power), and decreased perception of personal accomplishment.

There were many aspects considered when exploring personal resilience as an interventional strategy to reduce physician burnout, not only the construct of resilience itself, but the constructs of wellness and burnout, inclusive of emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment. Resilience is an innate attribute of wellbeing, and its intangibility may present challenges when seeking to enhance resilience using interventional strategies (O'Dowd et al., 2018). Resilience

consists of commitment to a process geared toward positive adaptation during challenging situations, stressful circumstances, and adversity (O'Dowd et al., 2018). Given that burnout occurs across a variety of disciplines, personal resilience has been explored and researched in social work, military, and healthcare settings, among others.

As I explored the constructs of personal resilience, wellness, emotional exhaustion, depersonalization, and a decreased sense of accomplishment, it is important to note literature contributing to the paradigm of these constructs. In 1685, the essays of Michael Seigneur de Montaigne were early contributions to the study of resilience. One example was an essay titled "Of Constancy," in which the author ascribed that humans are not exempt from life's challenges and obstacles, but during those times, humans are to be constant in their resilience to remain strong. He further articulated, "And the business of constancy is chiefly to suffer without flinching, those inconsistencies against which there is no remedy" (Montaigne, 1685, p. 49). According to Montaigne (1685), Socrates, in Plato, summoned Laches who defined resilience as standing firm when faced with an enemy. De Montaigne (1685) acknowledged, although somewhat unclear, there is an opposing view by Homer indicating that retreat may be as effective as standing firm because in retreating, the cavalry would flee in various directions and thereby become less of an identifiable target.

Mortimer-Granville (1885) provided a personified interpretation of depression and resilience, noting the fluctuation of emotion being misinterpreted as recovering from a state of depression or malady. He posited that an avenue to recovery from depression is a self-contained strength, which is the optimal and sustainable resolution to cure the evil

spirit of malady. Mortimer-Granville (1885) contended that experiencing fleeting moments of happiness is more detrimental than simply remaining in a constant state of depression because when the intermittent happiness flees, the depression returns with a greater energy than before the happiness interjected. He presented the dynamic of emotional highs and emotional lows as unhealthy brain function. Introduction of stimulants to modify or alter the mental state of an individual is less ideal, according to Mortimer-Granville (1885), because response to the stimulant is a misinterpretation of a healthy mind, which may be inaccurate.

Cintrin and Weiss (2016) stated that there are various occurrences within organizations that contribute to overwhelming angst, frustration, and a defeated attitude. The authors posited, however, that resilience is the aptitude to effectually navigate challenging and traumatic experiences in a way that strengthens the individual or advances the organization as a result. Proactively creating a cadence or rhythm of resilience is essential to navigate the challenges resulting from stressful and traumatic experiences. The resilience continuum serves as a framework to address stress and trauma before, during, and after it occurs (Cintrin & Weiss, 2016). Consisting of three elements, the resilience continuum identifies how to prepare for stressful situations, provides processes to navigate through challenges, and provides a plan of action to recover, learn, and grow from these encounters (Cintrin & Weiss, 2016). According to Cintrin and Weiss, providing strong and consistent strategies prior to experiencing challenges, stress, and trauma is essential to developing and implementing an approach and paradigm shift to navigate successfully through these situations.

Resilience

Acimis and Tekindal (2017) conducted a study to assess whether burnout (emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment) and mobbing (systematic process of an organization, to subject an individual(s) to emotionally disturbing behaviors: workplace bullying) affect physician health. The study was conducted through mailing surveys to participants, and burnout was assessed through the MBI questionnaire. Using a Turkish version of the MBI survey with a 5-point Likert Scale, participants were asked to respond using 1--*never*, 2--*rarely*, 3--*sometimes*, 4--*frequently*, and 5--*always*. Research was conducted in May 2013, and of the 158 surveys mailed to possible subjects, 41.1% agreed to participate (Acimis & Tekindal, 2017). Using IBM SPSS 20, the data were analyzed using descriptive statistics and assessed using categorical and continuous variables to mobbing and burnout (Acimis & Tekindal, 2017). Reliability was determined using Cronbach's Alpha (α). The study was conducted using Levene's test to assess the assumption of homogeneity of variance of parametric tests (Acimis & Tekindal, 2017). The comparison of means of two independent groups was assessed using an independent two-sample *t* test. If the assumptions were not met using the *t* test, an alternative test was used: the Mann Whitney-U. One-way ANOVA was used to assess comparison of means for three or more groups (Acimis & Tekindal, 2017). Tukey's honest significant difference test was used for multiple mean comparisons. If the assumptions were not met, Kruskal Walls and Bonferroni-Dunn's were used to assess multiple comparison tests (Acimis & Tekindal, 2017).

An assessment of mobbing behaviors conducted through Leymann's typology behavioral assessment, consisting of 45 behaviors, was categorized into five behavioral areas (Acimis & Tekindal, 2017; Yelogluh & Karahan, 2016). The first category of mobbing behavior is the prevention or restriction of opportunities for self-expression and communication development by superiors. The second category of mobbing behavior is isolation from social interactions. Third, attacks on an individual's reputation, in which the victim is ridiculed, made the subject of unfounded rumors, and is the subject of sexual innuendos. The fourth category includes attacking the victim's quality of life and occupational position; furthermore, meaningless work is assigned to victim. The fifth and final category of mobbing consists of direct attacks on the victim's health by assigning difficult physical tasks and bullying, to include physical abuse and sexual threats.

Findings of Acimis and Tekindal's (2017) study revealed that 58.4% of physicians were men, and 46.2% (30) ranged in age from 23 to 30 years old, 56.9% (37) were married, and 47.7 (31) were fellows. The mean for emotional exhaustion was 26.6 ± 6.88. The mean for personal accomplishment was 24.52 ± 3.61. Using Leymann's typology, the mean for the attacks on reputation category was 21.05 ± 11.59 and for the category of prevention of self-expression and communication was 20.23 ± 10.36. There was a statistically significant difference in the prevention of self-expression and communication category, attacks on reputation category, and attacks on quality of life and occupational position, between age groups (Acimis & Tekindal, 2017).

Burnout and mobbing among physicians can adversely affect physicians and potentially impact the quality of care provided to patients. A strength of the study

conducted by Acimis and Tekindal (2017) compared to other studies was the emphasis on the importance of measuring burnout and mobbing categories among physicians across health facilities in the city. An limitation of this study was the limited number of participants who volunteered; a small sample size may not have accurately reflected the population.

Wallace et al. (2018) explored the concept of family resilience through the lens of health visitors in Wales alongside the purpose of developing a concept map to identify the perception of the health visitors. The ability of a health visitor to assess, analyze, and support positive outcomes is essential to family resilience. Wallace et al. (2018) identified a health visitor in the United Kingdom as synonymous with a community public health nursing service, more specifically, a registered nurse or midwife having additional training in community public health nursing.

Resilience, whether personal, group, team, family, or organizational, is a growing aspect of research across a variety of disciplines, including healthcare and psychology. Tiitinen et al. (2019) conducted a study to explore experiences of first-time fathers, specific to their resilience in the experience. Research was conducted by studying multicultural suburban households in Stockholm, Sweden, with fathers striving for stability in their early stage of being a new father. Children in suburban areas of Stockholm displayed poorer health disparities. To improve health development among children in these areas, a postnatal home visit program was created in 2013-2014 wherein families of children in their first 15 months of life were offered six home visits by a pediatric nurse and a parental advisor from social services. Detailed interviews were

conducted with nine fathers employing the constructivist grounded theory. The program and evaluation participation rate of families was 94%. Participation of fathers in the program was 53% wherein the father was present in two or more home visits. The core research consisted of exploring striving for stability in living conditions; three additional categories of exploration included everyday life conditions, adjustment to fatherhood in Sweden, and channels of support. The research concluded with benefits in resilience and structural level support as a result of the extended postnatal home visits program. Fathers perceived the program strengthened their knowledge of available social services and local resources for their families, as well as enhanced their parental confidence.

O'Dowd et al. (2018) ascribed that research is limited on psychological resilience specific to physicians and understanding how it manifests, and how to improve and sustain psychological resilience requires further study. O'Dowd et al.(2018) and Underdahl et al. (2017) presented research that identified the disruptors of resilience and catalysts for burnout, specifically, physician turnover, inconsistent patient care, financial burden impact to healthcare organizations, declining patient safety, poor quality outcomes, and detrimental impact to institutional profitability. If further research is not conducted, according to O'Dowd et al. (2018) these areas of opportunity may yield an increase in negative consequences to physicians as well as patients.

Underdahl et al. (2017) noted that from 2011 to 2014, physician burnout in the United States increased by 10%, and burnout among physicians providing specialty care ranged from 37% to 61%. The decline of physician engagement, decreasing harmonious collegiality, an unhealthy work environment, substandard quality patient outcomes,

organizational toxicity, job dissatisfaction, emotional exhaustion, and a decreased sense of accomplishment contribute to physician burnout, and they are the antithesis of resilience.

O'Dowd et al. (2018) suggested that positive psychological resilience is sustained optimally when interventional strategies are implemented at the organizational level, more so than the individual level. While Taormina (2016) provided research on personal resilience and O'Dowd et al. (2018) provided research on psychological resilience; the aspects of both studies on resilience have contributed to narrowing the gap in research on a construct that can affect a variety of disciplines. Specific interventional strategies that address staffing, organizational resources, and workload, according to O'Dowd et al. (2018) lend favorably to successful and sustainable psychological resilience among physicians.

Underdahl et al. (2017) offered that turning around the depleted efforts in an organization can have a positive organizational impact in reducing burnout, improving wellness, and enhancing resilience among physicians. For example, efforts to decrease turnover, burnout, and a siloed work environment, may have favorable effects regarding onboarding, recruitment, retention, quality patient outcomes, and revenue growth. Employing a strategy of physician led teams, physician led organizational efforts, and physician led system engagement can be the catalyst to turning a negative organization into a positive organization.

Resilience continues to be a construct researched across multiple disciplines. Taormina (2015) ascribed to a new theory in its early stages of development. Aligned

with positive psychology, Taormina (2015) noted that historically, resilience was studied as a solution to burnout. Currently within the parameters of positive psychology, resilience is optimal when applied strategically and proactively. Purposeful implementation of resilience strategies, not in response to a need, but as a foundational aspect of an organization's culture, is beneficial to organizations, clinicians, and employees.

Personal resilience, as compared to general resilience, consists of four components within its construct: determination, adaptability, endurance, and ability to recover (Taormina, 2015). Taormina (2015) delineated resilience of inanimate objects (such as a deflated ball) which spring back or bounce back from external forces (putting air in the ball), from personal resilience of humans to endure and recover from stressful or traumatic circumstances. Beyond personal resilience, Taormina (2015) argued that adult personal resilience warranted further research, noting the vast amount of research on the resilience of children.

The four dimensions of adult personal resilience, according to Taormina (2015), are internal to humans and not the result of external sources. Determination is the resoluteness of an individual to accomplish a task. Determination is further identified as an internal strength that manifests when individuals need to persevere through difficult circumstances. Determination is the "conscious or cognitive dimension of personal resilience" (Taormina, 2015, p. 36). The decidedness of an individual to intentionally proceed despite known or unknown adversity.

Adaptability as described by Taormina (2015) is the ability to cope with challenging circumstances and environments, and to adjust to such changing dynamics. This adaptation requires a greater shift psychologically rather than physiologically. For example, an organizational paradigm or culture shift such as moving from productivity to physician wellness, may warrant the same shift or transition at the individual level.

Uema et al. (2020) conducted a survey to investigate concepts of understanding performance adjustments among individuals. Understanding that adaptive behaviors develop over time as a result of constrained resources, Uema et al. (2020) presented a questionnaire to 346 critical care physicians to investigate how work is achieved in complex healthcare settings. Resilient health care (RHC) is a theoretical approach for understanding how work is achieved. Work as imagined (WAI) and work as done (WAD) are core concepts for determining work adjustments among individuals (Uema et al., 2020). The specific study focused on KCl (Potassium Chloride) safety, methods, administration, policies, and physician opinions. In 2017, 105 out of 346 (30.3%) physicians agreed to participate in the study. Thirty-five physicians (33.3%) used the standard products in compliance with the safety policy, 69 out of 95 physicians (72.6%) used concentrated KCl solutions in an unsafe manner. Performance adjustments were necessary after assessing the gap between WAI and WAD by the physicians who introduced a new risk of opposing events despite the use of safer products. The study showed that RHC theory is beneficial in producing safer products. Additionally, it is essential for policy makers to understand WAD when applying to complex adaptive systems such as health care (Uema et al., 2020).

Endurance, an additional component of personal resilience, is an intangible trait, intrinsic to individuals which empowers an individual to be aware of challenges and barriers to a goal, but to continue concentrating on reaching a preset goal, accomplishment, or outcome (Taormina, 2015). Endurance can be both cognitive and physical. Cognitive endurance is defined as reasoning, mental intellect, perception, or psychological competence. Physical endurance is defined as overcoming challenges, impairments, or impediments to the physical body. Individuals who recover from traumatic occurrences may experience endurance as a positive outcome of negative situations. For example, mental or physical recovery from addiction, assault, or abuse.

Eyles et al. (2015) conducted a comparative case study concentrated on transforming public health services to better meet the needs of primary care patients and providers. The study, according to Eyles et al. (2015) is intended to understand mechanisms of endurance, resistance, and resilience, through the lens of coping and agency literature theoretical views. The case study examined how patients and providers cope in an overburdened, dysfunctional, hierarchical system with high systemic demands (Eyles, 2015). As part of a larger research project in 2009 and 2010, this study consisted of semi-structured interviews and observations at healthcare facilities in three South African provinces. A specific component of the study explored coping strategies of patients and providers regarding access to health care. Within the study, four cases consisting of two patients and two providers, were identified from an interpretive base, as best informed on endurance, resistance, and resilience. Commentary from other responders was included to provide a more global perspective of coping mechanisms.

Results from the four case studies revealed micro-practices employed by patients as coping mechanisms to be resilient in the pursuit of health care despite the overburdened, under-resourced, and in some instances, poorly managed system. Additionally, the provider respondents noted their coping mechanisms included utilizing peer support and increasing their knowledge of providing good service to patients. Elyse, et al. (2015) concluded although resistance and resilience are limited, respondents show the adaptive power of individuals to endure or persevere through illness, circumstance, or treatment settings. Successful transformation of health care would require a mutually supportive interaction between patients and providers.

Posttraumatic Events and Posttraumatic Stress Disorder

Bonanno et al., (2006) provided studies showing that a majority of adults experience trauma but vary in their degrees of reaction to posttraumatic events (PTEs). A subset of these individuals also experienced posttraumatic stress disorder (PTSD). A vast amount of research exists on child resilience, but limited research exists regarding adult resilience because of PTEs. Researchers who prescribe to the theory of resilience, sometimes question the effect of resilience during episodes of extreme stress or traumatic experiences (Bonanno et al., 2006). Studies of resilience on specific PTEs such as the death of a spouse, which would seem to show obvious high levels of stress, did not actually reflect high stressor responses. In some instances, healthy individuals exhibit low levels of psychiatric symptoms, this was considered when finalizing the resilience cutoff score for the study. For the purpose of the study, the scoring for resilience and trauma were set conservatively in determining symptoms of PTSD. The quantitative study

consisted of a random sample of New York, New Jersey, and Connecticut residents; across multiple languages that were interpreted back to English, six months after the September 11th attacks, and a sample size of 2752 participants. This sample size consisted of participants who were present during the attacks and participants who were in the aftermath of the attacks. The overall results of the study reflected that resilience was widespread among the participants who were present during the attacks as well as those in the aftermath of the attacks. A strength of this study included the findings reflective of widespread resilience. More than half the participants were resilient based on the study. A weakness of this study is that little is known about the adult capacity to maintain healthy, symptom-free functioning, or resilience, following PTEs. Additionally, there is limited research on resilience of adults experiencing posttraumatic events. The PTSD data were collected by phone, and this presented a limitation to assessing the clinical assessment of PTSD. A final study limitation resulting from the use of a large probability sample, is a narrow definition of resilience.

Burnout

Iorga et al. (2017) also conducted research on physician burnout. Burnout as defined by Maslach is emotional exhaustion at work; compared to depression which may not be work related. Additional components of burnout beyond emotional exhaustion include depersonalization or cynicism, and a decreased sense of personal accomplishment. Burnout has affected quality of life for physicians as well as their patients. Burnout also contributes to suicidal ideation and suicide. Environmental and personal factors have predisposition towards burnout. This study is intended to identify

the influence of environmental factors and the Big Five personality factors on burnout. Surveys were offered to 220 obstetric and gynecologic physicians, of which 116 respondents participated in the study. The MBI consists of 22 questions which measure the level of burnout, specifically emotional exhaustion, depersonalization, and a decreased sense of accomplishment; and the Big Five consists of 44 questions which measure personality traits, specifically extraversion, neuroticism, openness, consciousness, and agreeableness. The study also conducted a self-administered assessment which measures alexithymia.

Alexithymia is a psychological component that refers to people who may disassociate identifying with their emotions and place less emphasis on emotional experience. Results of the MBI reflect an average level of burnout, with men having a lower level of burnout than women (emotional exhaustion, 18.73 ± 13.48 versus 24.14 ± 11.71; depersonalization, 5.97 ± 5.45 versus 7.70 ± 5.29). Results for the total alexithymia score (TAS-20) reflect a low level of alexithymia in both male and female participants. TAS-20 used cutoff scoring as follows: ≤51 indicates nonalexithymia; ≥61 indicates alexithymia. Scores of 52 to 60 indicate possible alexithymia.

Emotional Exhaustion

Emotional exhaustion and depersonalization are positively correlated with the personality measure of neuroticism. Depersonalization is negatively correlated with the other four measures of the Big Five assessment. Personal accomplishment positively correlates with four of the five measures of the Big Five; specifically, with the personality factors extraversion, agreeableness, conscientiousness, and openness.

Limitations of the study include a small sample size and therefore could not be generalized. The physicians worked in urban areas and in maternity hospitals in larger cities; the access to care and proximity of facilities could lessen the degree of professional exhaustion. The study is a preliminary study and may not include many of the factors influencing burnout. An additional limitation is the study represents a point in time and may not be indicative of identifying factors as a cause or outcome. A strength of this study shows that although burnout affects emotional exhaustion and depersonalization, it does not negatively impact a sense of personal accomplishment.

Personal Accomplishment

As physicians gain tenure in their profession, have families, and continue professional development; they continue to have a sense of personal accomplishment. A prospective cohort study of 740 interns across 13 U.S. hospitals, conducted by Sen, Kranzler, Krystal, Speller, Chan, Gelernter, and Guille (2010) intended to identify psychological, demographic, and residency program factors associated with depression among interns and medical internships to understand the moderating effects of polymorphism.

Using the 9-item patient health questionnaire (PHQ-9) and the 5-HTTLPR genotype assessment to assess psychological traits of depression as well as potential stressors. Participants were assessed prior to beginning their internship and again in 3-month intervals during their internship. The results of the study showed statistical significance with an increased depression score from 2.4 prior to beginning the internship, to a mean of 6.4 during the internship; with $p <. 001$. Participants who met

criteria for depression increased from 3.9% pre-internship to a mean of 25.7% during; $p < .001$.

Both the PHQ-9 and the 5_HTTLPR assessments revealed an increase in depressive symptoms during internship as compared to pre-internship. In September 2015, researchers Tetzlaff et al. (2018) completed a study to assess the personal and professional aspects of burnout and job satisfaction among physician assistants (PA) in oncology. The five-month study lasted through January 2016 and was measured using the MBI survey to measure the personal and professional aspects of oncological PAs, the organizational structure, the career satisfaction, and the perception of leadership from the collaborating physician (CP). The study showed that while PAs have a high level of job satisfaction, they also have a high risk of burnout associated with the perceived leadership qualities of the CP. Among the 250 PAs surveyed, 34.8% reported professional burnout, 30.4% reported emotional exhaustion, 17.6% reported a high sense of depersonalization and 19.6% reported a sense of decreased personal accomplishment. In this multivariable study, although high levels of career satisfaction were identified; factors affecting burnout were age, time spent on indirect patient care, and relationship with CP. A limitation of the study was the response rate of 29.2% was low and may indicate an increased bias. A strength is, while the response rate was low, it is similar to or larger than other studies assessing burnout among PAs in oncology.

Clinician burnout has reached epidemic proportions as evidenced by historical and recent national research studies. As clinician burnout worsens, the negative effects are reflective of decreased quality of care and safety for the patient as well as clinician,

unprofessional behaviors exhibited by the clinician, and threatened healthcare viability. Continued research is needed regarding prevention and reduction of burnout. The method of research was conducted using a systematic review a meta-analysis study of interventional strategies to prevent and reduce burnout, to include single-arm pre-post comparison studies. The articles, data and measures used in the study were specific to physicians, excluding medical students and nonphysician clinicians. The study assessed a change in overall burnout, an emotional exhaustion score, and a depersonalization score. To calculate pooled mean difference estimates in each outcome, the researchers used random effects models. Among the 2617 articles reviewed, 15 studies were randomized, to include 716 physicians; 37 cohort studies including 2914 physicians, met inclusion criteria. The results reflected a reduction in overall burnout from 54% to 44%, a 95% CI, and statistically significant with $p<0.0001$. Emotional exhaustion decreased from 23.82% to 21.17% with a 95% CI, and statistically significant at $p<0.0001$. Personalization decreased from 38% to 34% and $p=0.04$. The research data are inadequate to support a hypothesis of increased involvement by physicians in the design and implementation of an intervention.

Wellness

According to Jacobs et al. (2018), employee wellness and employee engagement (particularly in healthcare in this case) are connected, and improvement of one or the other would benefit the employees, patients, and the organization. Within current research, there is a movement to transition the focus of healthcare from the triple aim to the quadruple aim (Jacobs et al., 2018). The triple aim consists of the quality, cost, and

patient experience of healthcare. The quadruple aim encompasses these three aspects as well as incorporating wellness as a factor of success. With the recent federal regulatory and reimbursement requirements within healthcare, as well as the pace of change required to remain a sustainable business, employee wellness has become a priority. Jacobs et al. (2018) suggested that wellness lends favorably to improved employee retention, decreased employee turnover, better patient experience, better quality outcomes, and increased employee wellness.

According to Bart et al. (2018), wellness is comprised of physical, mental, and social dimensions, in contrast to solely the absence of illness or disease in health. The researchers contend in order to understand what wellness is, it is important to understand what wellness is not (Bart et al., 2018). The researchers contended that wellness differs from health in that wellness transcends improving health through medicinal treatments, it is the balance of wellbeing against the challenges of wellbeing. Some implied challenges to wellbeing include work demands, resources or lack thereof, and external barriers which can impede progress. Quality of life (QOL) is yet another aspect of the wellness ideology, but it differs in that it is subjective based on the perception of the individual. Essentially, wellness is the evolutionary process towards realizing one's full potential (Bart et al., 2018). A variety of instruments intended to measure wellness, are presented in this study. The lifestyle assessment questionnaire (LAQ), also known as the testwell wellness inventory, was developed by the Wellness Institute in 1983; a 100-item questionnaire used to assess 10 domains of wellness, using a five-point Likert scale (Bart et al. 2018). The instrument assessed the physical components of fitness, nutrition, and

self-care; social, emotional, intellectual, occupational, and spiritual awareness and control; and drugs and driving awareness. The study was conducted with college undergraduates, college freshman, and wellness professionals.

Another instrument used in measuring wellness was the wellness inventory (WI) from the 1980s. Bart et al. (2018) posited the WI consisted of 120 questions across 12 domains: a) Self-responsibility and love, b) breathing, c) sensing, d) eating, f) moving, g) feeling, h) thinking, i) playing and working, j) communicating, k) intimacy l) finding meaning, and m) transcending. The undergraduates were assessed with the wellness inventory.

The life coping inventory (LCI) is an additional instrument used to measure wellness. It assesses coping behaviors using 142 questions across seven distinct behavioral dimensions; a) coping style, b) nutrition, c) physical care, d) cognitive and emotional behaviors, e) low-risk behaviors, f) environmental actions, and g) social behaviors (Bart et al., 2018). The LCI instrument also assessed undergraduate students as participants.

Mindfulness-based interventions as implied by Belton (2018), within the healthcare setting is an essential approach to caring for the caregiver; thus, it is important to carve out definitive time to enhance wellness within organizational structures. It could be argued that mindfulness-based interventions should be as high a priority as direct patient care. Understanding that the quality of care rendered to a patient is reflective of the caregiver's ability to provide such care. These interventions are intended to provide

actionable coping skills, stress reducing practices, and sustainable wellness behaviors that contribute to the wholeness of the care provider.

Shanafelt et al. (2002) posited wellness has been delayed and ignored with stagnant responses from both government and private sectors. A resurgence over the last 20 years, however, has reinvigorated research, discussion, and strategies specific to reducing burnout, as well as improving wellness for optimal work-life balance. Shanafelt et al. (2002) further ascribed that work-life balance, burnout, and wellness became more prominent when households became dual-income households. European countries have laws in place beyond limited maternity and paternity leave, but childcare services in some cases, modified work schedules, extensive bonding time inclusive of paid leave, and accommodations in the workplace to meet the needs of parents. Yester (2019) and Shanafelt et al. (2002) both note that burnout and work-life imbalance contribute to poor patient outcomes, increased physician use of alcohol, drugs, suicidal ideation, and suicide.

Shanafelt et al. (2002) conducted a cross-sectional study, using mailed surveys, to 115 internal medicine residents in Seattle, Washington. The study was conducted to determine the prevalence of burnout in residents and explore its relationship to self-reported patient care practices. Using the MBI to measure burnout, five survey questions were presented to participants. Burnout was defined as scores in the high range for medical professionals on the depersonalization or emotional exhaustion subscales. The study contained five questions using self-reported patient care practices which suggested suboptimal care was provided to patients (Shanafelt et al., 2002). For example, survey

questions included: a) Not fully answering the patient's questions or fully discussing treatment options, b) I made errors that were not due to a lack of knowledge or inexperience. Results of the study reflected, of 115 (76%) participants, 87 (76%) met burnout criteria. When comparing nonburned-out residents to burned-out residents, burned-out residents are significantly more likely to self-report suboptimal care (53% vs 21%; P = 0.0004). In multivariate analyses, burnout was strongly associated with self-reporting of one or more suboptimal patient care practices at least monthly, odds ratio 8.3 [95% CI, 2.6 to 26.5]; gender, depression, or at-risk alcohol use was not strongly associated with suboptimal patient care practices. When separately assessing each aspect of burnout, only a high score for depersonalization was associated with self-reported suboptimal patient care practices. Yester (2019) concluded that burnout was common among residents and burnout was associated with self-reported suboptimal patient care practices (Shanafelt et al., 2002).

Interventional Strategies

Belton (2018) provided several benefits of implementing mindfulness-based interventions within the healthcare setting to combat multiple potential adversities of organizational wellness. Specifically, although not limited to the healthcare industry, the effects of burnout yield a high rate of employee turnover, a higher rate of burnout for the employees who subsequently remain, decreased employee engagement, poor quality outcomes, decreased productivity, increased costs to the organization resulting from employee illness and absenteeism, diminished organizational stability, competitive disadvantage, and substandard patient experience outcomes. Mindfulness-based

interventional strategies are put in place proactively to thwart burnout as opposed to implementing mindfulness practices in response or reaction to an already burned-out organization. Mindfulness strategies implemented to augment stress reduction may reflect activities such as yoga, meditation, coping skills and strategies.

Mindfulness based interventions consist of both mental and physical activities such as meditation and exercise, which promote both mental and physical wellness. Yester (2019) ascribed mindfulness training as the prominent source of strategic implementation in current literature today. According to Belton (2018), implementing mindfulness-based behaviors is beneficial to people because it conditions people to become more intentional in caring for themselves in order to provide the highest quality of care to patients.

Branch et al. (2017) conducted a study over one year, to explore motivators and barriers to physician wellbeing, specifically the humanistic approach to enhance humanistic teaching and role modelling. Sixty-eight physicians participated across eight U.S. medical schools, in this qualitative study. Using the humanistic teaching and evaluation questionnaire (HTEQ), participants met twice monthly for 90 minutes, and the study consisted of experiential learning, critical reflection, and supportive group-process. The 68 participants represented a 74% response rate, and they were asked to complete an open-ended reflections journal describing motivations and barriers to practicing medicine from a humanistic approach. The participants offered the following motivators: a) relating with humanistic values, b) physicians providing care to patients as if they were caring for their family, c) relational connectedness is an important motivator, d) sharing

values through role modelling, and e) being mentally and emotionally present. Barriers identified during the study included: a) time constraints, b) high stress, c) culture, and d) episodic burnout. The study concluded that although there was not complete resolve to barriers, an individual's tenacity to live by a set of values, within a professional identity, was beneficial in lessening barriers. The implications of the study are reinforcement of time-honored values that foster relational and nurturing skills in the development of medical students. Study limitations reflect that the participants may not be representative of nonacademic disciplines. Another limitation is the cross-sectional study did not allow for follow up to expand on the data.

Summary and Conclusions

The literature review provided evidence-based scholarly research, consisting of quantitative and qualitative studies. At the point of saturation, the varying opinions of scholars were clearly identified in the research exploring the phenomenon of physician burnout and personal resilience as a strategy to reduce burnout. Literature supports the conceptual framework using CST and Herzberg's motivation-hygiene theory. CST considers components such as power and inequity. Herzberg's motivation-hygiene theory has been controversial among researchers, but a premise of practical motivation approaches is beneficial to engaging employees. Motivators encourage positive self-directed behaviors such as achievement, recognition, responsibility, and advancement. Hygiene factors align with feelings of job dissatisfaction such as salary, policy, physical working conditions, and management relations.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the lived experiences of physicians who identified as burned out. I explored personal resilience as an interventional strategy to reduce physician burnout. The approach of this qualitative hermeneutical phenomenological study consisted of interviewing physician participants across various disciplines to gain insight into their lived experiences in a healthcare setting. Personal resilience is important because burnout among physicians may negatively affect the quality-of-care physicians provide to patients. Further research is needed to understand how physicians might apply personal resilience as an interventional strategy to reduce burnout. The qualitative research design and rationale was to gain insight through interviews of physicians' lived experiences to reduce burnout by implementing resilience strategies.

Research Design and Rationale

Qualitative phenomenological hermeneutical research design in this study addressed personal resilience as an interventional strategy to reduce physician burnout. Using a conceptual framework in this research study helped me formulate and investigate the qualitative research questions. Lewis (2015) proposed that qualitative research design uses inductive data analysis to understand the meaning of an issue or problem by identifying codes, themes, and categories.

A qualitative approach to this study delved into the phenomenon of physician burnout and personal resilience strategies as interpreted by the lived experiences of

physicians actively practicing medicine in the form of direct patient care. I specifically explored physician burnout through physician interviews, using the lens of the physician's lived experience of employing personal resilience as an intervention to reduce burnout. I interpreted the phenomenon of physician burnout using hermeneutics to identify and code recurrent themes and categories of language within the participant's responses.

This same approach was employed to answer the research questions, specific to practicing wellness behaviors and seeking professional support. Specifically, I aimed to address what was the physician's lived experience of practicing wellness behaviors to reduce burnout as interpreted in an interview, and what was the physician's lived experience of seeking professional support to reduce burnout as interpreted in an interview.

The rationale for this qualitative phenomenological hermeneutical approach was identifying specifically the lived experiences of physicians in their natural environment of caring for patients and to engage feedback from physicians regarding their perspectives. Additionally, coding, categorizing, and identifying similar themes throughout the respondent feedback were beneficial to narrowing the gap in research, using a qualitative approach.

Role of the Researcher

My role as the researcher was to create an environment of trust for the participants, provide anonymity to enhance genuine participant response, disclose the purpose of the study, and provide detail for how the data would be used and shared. In

this study, my role as researcher included conducting the interviews. Additionally, my role as researcher in this qualitative study encompassed coding themes identified within participant responses. I served as an instrument within the study to ensure ethical standards and minimize the potential for rater influence and bias; this study was conducted using participants through social media outlets such as LinkedIn, Facebook, and Instagram. Participants were external to my sphere of influence, and for any participant who contacted me within my organization, there was no reporting structure conflict of interests.

Methodology

Participant Selection Logic

The population and participant selection in this study consisted of United States Board certified physicians, actively practicing direct patient care, using social media outlets such as LinkedIn, Facebook, and Instagram. Using social media, I ensured participants responded directly to me via a link to my Walden email address. Participants were unable to see one another's input or identity. The sampling strategy for this study was not exclusive to gender, race, tenure, geography, patient comorbidities, or specialty. The criterion for participant selection consisted of using participants on social media outlets such as LinkedIn, Facebook, and Instagram. I posted my study, and individuals contacted me, if interested. I posted my electronic flyer seeking physician participants to social media with an expectation that 20 to 30 respondents would participate. Research has indicated that qualitative data sampling reaches saturation when there are no new themes and the study can be replicated (Fusch & Ness, 2015; Lowe et al., 2018).

Participants were identified as P1, P2, P3, …P30. This study consisted of 13 interview questions specific to exploring the physician's lived experiences of employing personal resilience strategies to reduce burnout and wellness behaviors to reduce physician burnout.

Procedures for Recruitment, Participation, and Data Collection

It is necessary to reach data saturation within a qualitative study. If data saturation is not reached, the content lacks trustworthiness and credibility may be questionable. Saturation is indicative when the data and all the necessary information have been acquired to answer the research question. Thematic saturation is realized when no new themes occur (Lowe et al., 2018). Theoretical saturation transpires when additional research can no longer contribute to further developing qualitative information from the data.

To begin the data collection process, I developed a 13-question instrument to interview study participants (see Appendix). The questions were derived from identifying five to six questions specific to addressing the research questions. The research questions were developed through the lens of conceptual framework and theory. As previously discussed, recall conceptual framework provides explanation for the constructs within the study. Specifically, the constructs of resilience, burnout, posttraumatic events, PTSD, emotional exhaustion, personal accomplishment, interventional strategies, and wellness (Sachau, 2007). CST and Herzberg's motivation-hygiene theory applied to this study. CST considers aspects such as power and inequity in a broad sense. Herzberg's motivation-hygiene theory, although somewhat controversial among scholars and

researchers, is valuable when considering the tenets of positive psychology, employee satisfaction, and personal resilience (Sachau, 2007). The conceptual framework is used to identify what data are relevant to the study, to define data and their application within the study, and to explain findings within a study.

Theory is the system for explaining how the world is the way it is (Patton, 2002). Psychological theory, specifically, explains why people behave the way they do (Patton, 2002). Three threats to validity in qualitative research include respondent bias (Robson, 2002), researcher bias (Patton, 2002; Robson, 2002), and reactivity bias (Robson, 2002). Respondent bias occurs when respondents do not tell the truth for various reasons, such as their perception that full transparency may negatively impact career growth (Robson, 2002). Respondents may feel compelled to give the answers they think the interviewer wants to hear or lacks trust regarding complete anonymity (Robson, 2002). Researcher bias, according to Patton (2002), consists of a researcher potentially having a biased perspective based on previous knowledge or assumptions of the study. This may be a potential limitation in the study. Robson (2002) claimed that reactivity bias is the impact of having a role as interviewer or direct observer in the study. Ensuring credibility and trustworthiness of the research data is essential to minimize bias.

Robson (2002) suggested minimizing the potential influence of these three biases by considering six strategies to increase credibility and trustworthiness that would be beneficial to the study. Prolonged involvement and presence of the researcher may benefit the level of trust between the researcher and participants. This strategy may reduce the level of responder bias and participant reactivity. It is important to note,

however, that there is a risk to increased researcher bias, which may lead to assumptions within the research. Triangulation of data, methodology, or theory are keys to validate research. Peer debriefing consists of input, feedback, and constructive criticism from others help improve researcher objectivity and better identify research limitations. Member-checking is when the researcher seeks clarification from the participants as to their interpretation of the data as compared to the researcher providing interpretation of the data. This equates to a communication between the researcher and participant regarding clarity of a response. The researcher may also opt to send the complete transcript to the participant for feedback to clarify what the interviewee meant.

Another strategy to apply credibility and trustworthiness to qualitative research is for the researcher to conduct a subsequent interview to ensure the researcher is interpreting as the interviewee intended (Robson, 2002). Negative case analysis entails identifying outlier data or data that do not fit into the coding, category, or theme of the research study. In this strategy, the negative case analysis can serve to validate the trustworthiness of the codes, categories, or themes of the research because the outlier does not match the other patterns or trends identified in the study. Negative case analysis not only identifies the difference of the data but also highlights the similarities of the data. Finally, a sixth strategy used to validate the trustworthiness of a qualitative study is conducting an audit trail, meaning keeping record of all activities throughout the study, such as audio recordings, methodological decisions, researcher diary, and coding book. These actions provide transparency and trustworthiness of the findings.

I collected data from various physicians across multiple disciplines through conducting telephone interviews. Prior to beginning the interview, I emailed the informed consent document, which informed the participant that I also intended to audio record the interview. The sample size was seven and the saturation as achieved. I concluded my study and communicated to the participants during the member checking process. I also thanked the participants upon completing the study.

Data Analysis Plan

Data were analyzed manually and using Excel. I used a framework or structured analysis approach to code participant responses. Interpretative phenomenological analysis, a type of qualitative coding, is optimal to deciphering authorial intent (Straus, 2020). This is the participants' conceptual understanding of their lived environment. Participant responses were populated using a framework or structured analysis that provided consistency in coding authorial intent, as well as queried and analyzed data (see Huff et al., 2014). Patton (2002) asserted that the human factor is the greatest strength and weakness in analyzing qualitative research data. Manual and automated participation in analyzing the data may be more beneficial to learnings of the researcher. Dissimilar to quantitative data analysis, the researcher using a qualitative research design is obligated to monitor and report analytical process and procedure. One of the tenets of the Ethical Code of Conduct is to do no harm (APA, 2020).

The research questions and the corresponding interview questions are detailed below.

Research Question 1: What is the physician's lived experience of practicing wellness behaviors to reduce burnout as interpreted in an interview?

1. Give a specific example of a situation that required you to demonstrate personal resilience in your role as a physician.
2. What personal resilience strategy(ies) do you employ to reduce physician burnout?
3. What are major contributors of burnout you experience as a physician?
4. How do you define personal resilience?
5. What wellness behavior(s) do you find most beneficial to you as a physician?
6. What boundaries have you put in place to ensure work-life balance?
7. How has your wellness as a physician, affected your patients?
8. What do you perceive to be the greatest success to creating a sustainable work environment of wellness?

Research Question 2: What is the physician's lived experience of seeking professional support to reduce burnout as interpreted in an interview?

1. What do you perceive to be the greatest success to creating a sustainable work environment of wellness?
2. What professional support have you found valuable to your efforts to reduce burnout?
3. What support measures do you apply for long term sustainability?
4. What measures do you use for emergent coping strategies?

5. How has professional support enhanced your work-life balance?

I conducted manual, thematic coding as well as used Excel to perform the actual coding of the data. For any discrepant cases, it was important to confer with the participant to clarify their intention.

Issues of Trustworthiness

Credibility

Credibility is comparable to internal validity in quantitative research. **Connelly** (2016) asserted that the question to answer regarding credibility is whether the study was conducted using standard approaches for qualitative research. Techniques used to establish credibility included member-checking and reflective journaling.

Transferability

Interviews with self-reporting by physicians indicated the results were accurately reflected. This study included interviews, making the transferability high. It is important to understand; however, that each experience or study may differ physician to physician and researcher to researcher.

Dependability

The strategy used to establish dependability in this study was triangulation. Specifically, the premise of triangulation is having more than a single data collection method or multiple sources of data. In this study, I used triangulation, and, therefore, dependability given the data collection of self-reported physician interviews, researcher reflective journaling, and member checking.

Confirmability

The strategy used to establish confirmability is reflexivity. Having been in healthcare and having worked with many physicians over 30 years, I have observed physicians who displayed behaviors or countenance reflective of burnout. It is appropriate to identify my professional experience as a potential limitation relative to bias. Although confirmability is a component of trustworthiness in qualitative research, it is equally as important to ensure bias is minimized.

Ethical Procedures

Ethical procedures for this study included obtaining informed consent from participants. Informed consent as defined by the American Psychological Association (2020) is how researchers engage human subjects to participate in a study as well as how they describe and define the process and intention of the study. Additionally, it is based on the subjects' understanding of the project's methods and goals and obtaining the subjects' consent to participate in the research.

The informed consent was provided to participants via email, prior to conducting the study. The Walden IRB approval number for this study is 05-10-21-0658767.

The participants documented their consent by responding "I consent" in an email response to me. The American Psychological Association (2020) contains the Code of Ethics, and within the Code of Ethics are legal obligations to which the researcher must adhere. Section 3.10 in the Ethics Code identifies informed consent, ensuring reasonably understandable language, and Section 8.02 provides even greater specificity to research.

The informed consent to conduct a research study provides the participant with the following:

> When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers (APA, 2020).

Summary

Qualitative research, whether stand alone or combined with quantitative research, facilitates the participant's subjective view of a phenomenon. It provided context beyond or in collaboration with, statistical data. In chapter 3, I restated the purpose of the research study as described in chapter 1, to explore personal resilience as an interventional strategy to reduce physician burnout using a qualitative research design. I provided research design and rationale using defined central concepts of the phenomenon, physician burnout. Additionally, I identified the various instruments to be used in this study, specific to the lived experiences of physicians in their natural setting. I

identified the role of the researcher, described the methodology, field study, procedures for recruitment, participation, and data collection.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore personal resilience as an interventional strategy to reduce physician burnout. To better understand how physicians interpret burnout and interventional strategies, in this qualitative study, I considered lived experiences of physicians who identified as burned out. The qualitative research questions included the following: What was the physician's lived experience of practicing wellness behaviors to reduce burnout as interpreted in an interview? What was the physician's lived experience of seeking professional support to reduce burnout as interpreted in an interview?

Chapter 4 includes a description of collecting qualitative data through semi structured interviews with physicians. The interviews consisted of 13-questions to explore the lived experiences of physicians who self-identified as using personal resilience as an interventional strategy to reduce physician burnout. I developed the interview questions using the research questions. Specifically, what is the physician's lived experience of practicing wellness behaviors to reduce burnout as interpreted in an interview and what is the physician's lived experience of seeking professional support to reduce burnout as interpreted in an interview? Chapter 4 additionally includes organization of data through manual thematic coding using Excel. I coded aggregate themes across all participant responses. Lastly, I report my research findings by reviewing the themes across all participant responses for each interview question. For example, Interview Statement/Question 1 was, "Give a specific example of a situation

that required you to demonstrate personal resilience in your role as a physician." Thematic coding reflected that participants identified that their ability to continue providing high quality care for patients during Covid demonstrated personal resilience in their role as a physician. Thematic indicators of resilience across participants and across multiple questions included the ability to bounce back from challenges. For example, during Covid, healthcare workers were one of the first groups to mandate Covid vaccination. The impact of healthcare workers declining to vaccinate imposed critical staffing shortages with a mass exodus of clinical staff. Those remaining workers concentrated their efforts toward personal resilience strategies to ideally set a positive atmosphere for each other and the patients (Peterson et al., 2022). Keeping in mind that physicians operate in the world of science via medicine, several participants noted the pandemic as an exciting time to be a physician, given their passion for medicine, interacting with patients, and the multiple aspects of learning a new virus. Additional indicators of personal resilience included setting and respecting boundaries specifically around work-life balance. Physicians noted the clerical burden of the electronic health record and the need to minimize or eliminate emails and chart review outside of scheduled work hours.

Setting

The study was conducted as an individual interview with each physician participant. I conducted the interviews after physicians completed office hours. The organizational conditions consisted of hybrid conditions due to Covid precautions. Some physicians worked entirely remotely, conducting virtual visits where both patient and

physician were offsite; other physicians worked in the office while patients were virtually located; and still other physicians worked offsite, and patients came into the office. In any scenario, there was a virtual component to the patient visit, and this was the result of modifying normal operations to meet Covid precautions.

Demographics

Participant demographics consisted of United States Board certified physicians, actively practicing direct patient care. The sampling strategy for this study was not exclusive to gender, race, tenure, geography, patient comorbidities, or specialty.

Data Collection

Over the span of 3 months, seven physician participants reached out via LinkedIn. Participants were identified as P1, P2, P3, …P7. This study consisted of 13 interview questions specific to exploring the physician's lived experiences of employing personal resilience strategies to reduce burnout and wellness behaviors to reduce physician burnout.

I collected data from various physicians across multiple disciplines. I collected data through conducting telephone interviews. Prior to beginning the interview, I emailed the informed consent document, which informed the participant that I would audio record the interview. With an unexpectedly small sample size of seven, saturation did not prove to be a challenge. The themes were consistent across participants. I report this in my results. I concluded the study and communicated to the participants during the member checking process. I also thanked the participants upon completing the study. One discrepant occurrence during the informed consent process included one physician

declining to send an email stating, “I consent.” The physician offered his verbal recording to acknowledge his informed consent.

Data Analysis

Data were analyzed manually, using Excel. I used a framework or structured analysis approach to code participant responses. The process I used to move inductively from coding terms or phrases to thematic analysis was to pull each participant response per interview question and identify common themes within the response. For example, for Question 1, I pulled the responses to that question from each of the participants. Participants were asked in separate interviews to give a specific example of a situation that required them to demonstrate personal resilience in their role as a physician. Participant P1 stated, “I can give a recent example because I switched jobs partly because of burnout. I got this magic ticket of a job and then Covid hit, and we’re scared...I prayed to God to please help me help the people.” A common theme included physicians making efforts to care for patients and providing the highest quality of care during the Covid pandemic as well as the subsequent Covid vaccine mandate. The mandate resulted in significant staffing shortages and physicians were functioning in both clinical and clerical realms. Participant P2 reflected,

> Recently I have been trying to take a step back and really think through things, maybe it’s in the best interest of the system for some of these people to leave if they realize they are not going to be happy here. I realized this might be an opportunity to rebuild, a chance to turn a negative into a positive.

Clerical burden and staff shortages were clear examples of categories of increased work and decreased support staff, where physicians self-identified as needing to demonstrate resilience. A common theme among the physician participants of demonstrating resilience included being able to continue providing care to patients, laughter, prayer, peer support, work-life balance, setting boundaries, and spending time with family and friends.

There were also discrepant responses which did not fall to a category or theme. Specifically, participant P3 noted of the pandemic, “It’s an exciting time to be a physician.” While this may have been true for that physician, this was not an identified category or theme across participant responses. Therefore, the response was an anomaly and not included in themed responses.

For Question 2, the physicians were asked what personal resilience strategies they employed to reduce physician burnout. Codes included prayer, exercise, sleep, eating healthy, setting boundaries, breathing, practicing mindfulness, and church and faith. Participant P4 recalled, “Exercise, walking, cocktails, and family time were my go-to strategies.” I categorized these responses as healthy habits, work-life balance, and faith. The theme for employed strategies to reduce physician burnout is wellness behaviors. Discrepant responses to Question 2 consisted of a physician thinking through issues, recentering, and changing their daily routine by seeing patients with different diagnoses, for example caring for patients with addictions or transgender patients. Given the small sample size of participants, it is important to identify the anomalies as they may be prominent themes in future research with a greater sample size.

For Question 3, the physicians responded to what they self-identified as major contributors of burnout they experience as a physician. The EMR, work demands, poor communication, staffing shortages, system and insurance constraints, lack of vaccinated patients, and clerical burden proved to be consistent codes contributing to burnout. Participant P6 noted a contributor to burnout:

> I don't think anyone fails to mention the electronic medical record problems. A lot of people would say the electronic medical record, but I would be more apt to say it was the mis-implementation of the electronic medical record by corporate entities and administrators. I was hoisted on people without adequate introduction, training or forethought and it ended up being a good idea implemented with malicious intent.

Categories included EMR, bureaucracy, and staffing. Discrepant responses included a physician self-identifying as feeling unappreciated by the organization, IT interruptions, and staff not working at the highest level of license. Participant P6 further identified a contributor to burnout: "I would say one of them is accusation. That is always very difficult to deal with and there is always invariably plenty of it." These codes may resurface in future studies and are therefore worth mentioning here.

For Question 4, the physicians were asked how they defined personal resilience. Participant P4 reflected,

> Being able to do your job well and still have compassion for that patient and concern for your co-workers, all while making that patient better. I think

> resilience is being able to do that and continue to be there for your family, your friends, and still enjoy life.

Participant responses included being able to get up every day and care for patients, even when it is hard; being able to push through tough times; getting through a problem and being as good or better than when the burden began; having the adaptability to change, maintain sanity, perspective, and level-headedness during chaotic circumstances; waking up and wanting to go to work; doing an excellent job regardless of circumstance; maintaining a patient-centric focus with multiple distractions; and getting proper rest, eating, and exercise. Question 4 did not present identifiable discrepant data in the participant responses.

Question 5 of the participant interviews involved identifying what wellness behaviors the physicians found most beneficial. Participant P4 identified,

> Doing things outside of the office because I am not all physician, I sing, I bike, I have a child so I spend time with her, I read nonmedical books, all of that helps me refuel the other batteries, so when it's time to work, I can just focus on that.

Consistent codes and themes revealed physicians find healthy eating, exercise, sleep, setting clear boundaries for work-life balance, and support from family and friends to be wellness behaviors they find most beneficial. Participants also noted hobbies such as reading nonwork-related books or materials, bike riding, and maintaining good spiritual and physical health, as wellness behaviors. Discrepant data for Question 5 was shared by participant P7: "Drinking coffee, being less reactive, and sitting on things for 24 hours to think things through."

In Question 6, the participants were asked what boundaries they put in place to ensure work-life balance. A consistent theme throughout many of the responses across multiple interview questions included a priority to set boundaries. Participant P3 commented, “The EMR has made things a bit easier as far as data retrieval and coordinating care with other physicians.” Discrepant data reflected ensuring responsibilities were covered by other providers as important.

Interview Question 7 asked the participants how their wellness as a physician has affected their patients. Physicians presented the theme that their patients could assess their authenticity and mood. An additional theme of Question 7 was that physicians stated their patients would call them out if they perceived the physician was not being authentic. Participant P4 stated, “I have a really awesome patient panel and they know when I’m stressed. They ask when I am going on vacation, and I tell them I just got back!” Discrepant data reflected that patients want to feel they are in competent hands and having wellness enables physicians to be more fluid, flexible, tolerant, and resilient when serving many masters.

Question 8 consisted of physicians identifying what they perceived to be the greatest success to creating a sustainable work environment of wellness. Participant P2 identified, “Teamwork is a consistent theme of a sustainable work environment of wellness.” A secondary theme of setting boundaries was noted in previous responses. Staffing, manpower, working at the highest level of licensure, and staff development were also mentioned. These aspects were discrepant and presented as barriers to wellness more than successes to creating a sustainable work environment of wellness.

Question 9 posed the opposite of Question 8. The participants were asked what they perceived to be the greatest opportunity(ies) to creating a sustainable work environment of wellness. Participant P5 stated, “I think improving staff will help improve critical thinking and reduce low value communication and all those other nuisances of the day that lead to burnout.” Physicians identified short staffing and a lack of standard work with the use of the electronic health record, a lack of support staff, and compensation based on productivity instead of allowing for ample physician-patient time. Two discrepancies included bringing Catholic mass back to hospitals and incorporating structure embracing uniqueness and individual gifts of people.

For Question 10, the participants were asked what professional support they found valuable to their efforts to reduce burnout. Professional coaching, therapy, and external professional societies and relationships were identified by two of the seven participants. Participant P1 shared, “The three doctor colleagues I work with help with burnout. It’s phenomenal if you can have relationships with people. It’s relational.” Physicians identified colleague interaction, support from family and friends, colleague gatherings and social outings, and staffing and building relationships. This aligns with prior themes of wellness. Discrepant data, although noted in prior themes as well, seemed less specific to this question as the responses were not related to professional support.

For Question 11, participants identified what support measures they apply for long term sustainability. Physicians noted self-care, mindfulness activities, gardening, singing, connecting with colleagues, staying connected to family and friends, eating, sleeping, and exercising as priority support measures for long term sustainability.

Physicians commented that mental health improves as these items improve and having a realistic sense of responsibility by understanding that the work will get done even if someone else does it. One participant noted that physicians tend to have an over inflated sense of responsibility and sometimes find it challenging to release the reigns for others to offer help in balancing workloads. Participants identified continuous themes of setting boundaries for work-life balance and not bringing work home as support measures they applied for long term sustainability. Discrepant data showed that reading self-help books and not taking things personally was helpful as a support measure the physician applied for long term sustainability.

Interview Question 12 consisted of participants identifying what measures they employed for emergent coping strategies. Participants offered prayer as one emergent coping strategy. Others asserted that connecting with colleagues, family, friends, therapists, and system leaders or administrators were sources they sought for emergent coping strategies. Discrepant data reflected thinking before acting, assessing if the situation was patient related, having wine, walking the dog, or watching a tearful movie were considerations as well.

The final interview question, Question 13, consisted of participant responses for how professional support has enhanced their work-life balance. Participants ascribed that hearing how their colleagues handle work-life balance helps them create action plans for themselves. Coaching and peer-sharing was a common theme as well as implementing wellness strategies. There were no discrepant data identified in the participant responses for this question.

Evidence of Trustworthiness

Credibility

Credibility is comparable to internal validity in quantitative research. Connelly (2016) offers the question to answer regarding credibility is whether the study was conducted using standard approaches for qualitative research. Techniques used to establish credibility will include member-checking and reflective journaling. Having served as the researcher as well as the instrument in this study, it was important to ensure member checking to reduce researcher bias and increase credibility to the research. Specifically, during the interview I would ask the physician participant the initial question and verify that I understood their response by repeating their response and using intonation for clarity if needed. In other questions, I would write a note and read my note back to the participant to be certain I was conveying what they intended to communicate. I found immediate member checking to be ideal as it occurred in real time, the content was fresh in the mind of the participant and myself as the researcher, and this eliminated the potential delays associated with corresponding for feedback after the interview. In addition to member checking, I used reflective journaling to support research credibility. For example, several physicians noted themes of burnout tied to the EMR because of the additional clerical burden it puts on the physician. Covid 19 is another common theme contributing to physician burnout. Wellness strategies seem consistent across participants: proper eating, sleeping, and exercise. Work-life balance, staff shortages, and greater system demands were notable recurring statements I journaled. Transferability

Interviews with self-reporting physician participants indicated the results were accurately reflected. Although each participant experience could have differed as previously stated, I discovered participant responses reflected similar themes of burnout and similar responses regarding wellness activities to foster resilience. Specifically, getting proper rest, eating a healthy diet, exercising, spending time with family and friends, and setting boundaries were consistent themes throughout the data relative to resilient strategies. Regarding contributors to burnout, the EMR and staffing shortages were consistently identified in participant responses. While this study is specific to lived experiences of physicians, actively practicing direct patient care, the phenomenon of burnout, wellness, and resilience are highly transferable across other disciplines external to healthcare.

Dependability

The strategy used to establish dependability in this study was triangulation. Specifically, the premise of triangulation is having more than a single data collection method or multiple sources of data. This study demonstrated triangulation, and therefore, dependability given the data collection of self-reported physician interviews, researcher reflective journaling, and member checking.

Confirmability

The strategy used to establish confirmability, is reflexivity. Having been in healthcare and worked with many physicians over 30 years, I have observed physicians who displayed behaviors or countenance reflective of burnout. It is appropriate to identify my professional experience as a potential limitation relative to bias. Although

confirmability is a component of trustworthiness in qualitative research, it is equally as important to ensure bias is minimized. I found member checking to be beneficial in minimizing bias. Seeking clarity from the physician participants via member checking provided opportunity for the physicians to give any additional content or context to their response.

Results

In this study exploring personal resilience as an interventional strategy to reduce physician burnout, through lived experiences of physicians, actively practicing direct patient care at the time the interviews were conducted, reflect physicians do use personal resilience as an interventional strategy to reduce burnout. In response to research question one, "What is the physician's lived experience of practicing wellness behaviors to reduce burnout as interpreted in an interview?", participants responded they employed personal resilience strategies such as setting boundaries for work-life balance; they maintained healthy eating, sleeping, and exercise habits; they connected with family and friends; faith, and prayer, and they engaged in hobbies such as gardening, playing instruments, and vacationing.

Research Question 2 was as follows: What is the physician's lived experience of seeking professional support to reduce burnout as interpreted in an interview? Participants noted they sought professional support through therapy, their faith and prayer, self-talk, and talking with colleagues. One common theme among physician participants for accelerated burnout was the electronic health record and its associated shift of clerical burden from the support staff to physician. The impact resulting from the

electronic health record and the shifted clerical burden to physicians was increased documentation needing to be completed by the physician. This in turn resulted in physicians extending their workday or working remotely outside of normal operating hours to complete patient medical record documentation. Physicians additionally noted that the demand of caring for patients through the Covid 19 pandemic, as well as the subsequent vaccine mandate for healthcare workers, resulted in a mass exodus of clinical support and was an added burden to burnout for which they needed to employ resilience strategies.

There were also discrepant responses which did not fall into a category or theme. Specifically, a participant noted that the pandemic was an exciting time to be a physician. While this may have been true for that physician, this was not an identified category or theme across participant responses. Therefore, the response was an anomaly and not included in themed responses. Additional discrepant responses consisted of a physician thinking through issues, recentering, and changing their daily routine by seeing patients with different diagnoses. For example, caring for patients with addictions or transgender patients was a way for a physician to break up the monotony of their day and see patients outside of their usual scope. Given the small sample size of participants, it is important to identify the anomalies as they may be prominent themes in future research with a greater sample size. Discrepant responses included a physician self-identifying as feeling unappreciated by the organization, IT interruptions, and staff not working at the highest level of license. These codes may resurface in future studies and are therefore, worth mentioning here. Discrepant data included a physician response of drinking coffee, being

less reactive, and sitting on things for 24 hours to think things through. Discrepant data reflected ensuring responsibilities were covered by other providers as important. Discrepant data reflected patients want to feel they are in competent hands and having wellness enables physicians to be more fluid, flexible, tolerant, and resilient when serving many masters. Staffing, manpower, working at the highest level of licensure, and staff development were also mentioned. These aspects were discrepant and presented as barriers to wellness more than successes to creating a sustainable work environment of wellness. Further discrepancies included bringing Catholic mass back to hospitals, and corporate structure embracing uniqueness and individual gifts of people. Discrepant data showed that reading self-help books and not taking things personally was helpful as a support measure they applied for long term sustainability. Discrepant data reflected thinking before acting, assessing if the situation was patient related, having wine, walking the dog, or watching a tearful movie were considerations as well. Discrepant data reflected thinking before acting, assessing if the situation was patient related, having wine, walking the dog, or watching a tearful movie were considerations as well.

Burnout contributors included the following:

- EMR clerical burden,
- Covid-19 staffing shorting,
- organizational disconnect,
- productivity-based compensation,
- insurance payers,
- difficult patients, and

- not feeling heard, valued, or appreciated.

Resilience strategies included the following:

- prayer, faith, and meditation;
- spending time with family, friends, colleagues socially, and pets;
- proper rest, diet, and exercise;
- nonwork-related activities; and
- therapy.

Summary

This study reflected physicians do use personal resilience as an interventional strategy to reduce burnout. Participants employ healthy habits and lifestyle, rely on their faith, stay connected with family and friends, and enjoy hobbies and recreation outside of work. Participants noted they sought professional support, relied on their faith, and remained connected to colleagues. Chapter 5 concludes the study, providing a concise reiteration of the purpose and nature of the study, a summary of key findings, interpretation of the findings, study limitations, recommendations, implications for positive social change, and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore interventional strategies to reduce physician burnout. To better understand how physicians interpreted burnout and interventional strategies, this qualitative study considered lived experiences of physicians who identified as burned out. The nature of this research was a qualitative hermeneutic phenomenological study. This phenomenological research was based on the exploration of lived experiences of physicians who actively practiced direct patient care.

Interpretation of the Findings

Interpretation of the findings confirmed that physicians employ personal resilience as an interventional strategy to reduce burnout. Some participants stated that inequities in the health system left them with the sense that the organization did not care and made arbitrary decisions without understanding the impact of those decisions. Herzberg's motivation-hygiene theory has been controversial among researchers, but a premise of practical motivation approaches is beneficial to engaging employees. Sachau (2007) asserted that Herzberg's theory is valuable when considering the tenets of positive psychology, employee satisfaction, and personal resilience.

Participant P6 presented hygiene factors such as the mis-implementation and mismanagement of EMR by the administrators. He identified contributors of burnout as accusation, malicious intent, organizational stifling of individuality, and the opposition of corporate culture today to recognize the gifts and uniqueness of people.

CST considers aspects such as power and inequity in a broad sense. Participants noted the inequity of not having boundaries for patients, but strict boundaries for physicians was challenging. Specific confirmation in peer-reviewed literature revealed that physicians self-identified as burned out, exhibiting emotional exhaustion, depersonalization, and a sense of loss of autonomy. The peer-reviewed literature provided evidence-based scholarly research using both quantitative and qualitative studies. Ruzycki & Lemaire (2018) and Tetzlaff et al. (2018) implied that strategies to decrease burnout and improve wellness include adequate sleep. The literature aligned with the current study finding of personal resilience as an interventional strategy to reduce burnout to include healthy sleep habits. The American Psychological Association (2020) defined resilience as the process of adapting well in adverse or traumatic circumstances. The current study revealed that physicians displayed personal resilience by relying on their faith, family, friends, and colleagues during the height of Covid-19, as well as other stressful situations.

The literature, according to Card (2018), has identified resilience as a quality that helps individuals in challenging situations to remain healthy. The findings revealed that several participants relied on colleagues, family, friends, and professional support systems, such as therapy, as resilience strategies to remain healthy. Proper eating and sleeping habits were recurring themes throughout participant responses as well. As pointed out by Reivich (2012, 2018), the science of wellbeing or positive psychology encompasses the science of resilience and its application in life circumstances. Recall positive psychology is the study of positive human attributes, including well-being,

optimism, forgiveness, self-esteem, fascination/flow, creativity, resilience, savoring, wisdom, and spirituality. The central goal of positive psychology is the study of human strengths and well-being rather than human weakness and depression (Sachau, 2007). Physicians in this study provided examples of demonstrating positive psychology throughout their interviews. Participant P5 specifically identified that he had to muster moral courage to tell a patient he was being rude and disruptive. He noted how he needed to remain respectful to the patient and empathetic of his illness and frustration of being in the hospital. He also acknowledged that his faith helped him demonstrate personal resilience in that circumstance.

Mindfulness-based interventions consist of both mental and physical activities such as meditation and exercise, which promote both mental and physical wellness. The findings showed that participants employed meditation and prayer strategies to demonstrate personal resilience. Yester (2019) ascribed that implementing mindfulness-based behaviors is beneficial to people because it conditions people to become more intentional in caring for themselves in order to provide the highest quality of care to patients. A theme in the study findings showed that physician who employed mindfulness techniques as personal resilience strategies were more likely to reduce burnout.

Using a conceptual framework in this research study helped devise and explore the qualitative research questions. Lewis (2015) proposed that qualitative research design uses inductive data analysis to understand the meaning of an issue or problem by identifying codes, themes, and categories. Exploring the lived experiences of physicians relative to burnout, by conducting interviews, was an exciting and interesting component

of the study. I had the opportunity to see physicians as human. Physicians are often perceived as elevated, intellectual scientists, having all the answers. Too often, there are missed opportunities to see them as humans, with feelings, angst, and challenges. There was a relational component when interviewing the participants that provided a perspective as a scholar practitioner of empathy for physicians in their life's work. Literature supports the conceptual framework using CST and Herzberg's motivation-hygiene theory. CST considers components such as power and inequity. Participant P1 identified her fear when providing direct care to patients presenting in the urgent care with Covid-19 symptoms. She prayed that she could help the people, and she feared that she might take the virus home and infect her family. She felt powerless at times to give the best care as Covid-19 was still new and the science of the diseases was occurring simultaneously as care was needed for patients. Participant P5 shared how physicians can have an overinflated sense of responsibility, perceiving that if the physician is not present, the goal cannot be achieved when caring for the patient. He implied the vulnerability of physicians during that time and the feeling of powerlessness relative to the disease. Some participants stated that inequities in the health system left them with the sense that the organization did not care and made arbitrary decisions without understanding the impact of those decisions. Herzberg's motivation-hygiene theory has been controversial among researchers, but a premise of practical motivation approaches is beneficial to engaging employees. Sachau (2007) asserted that Herzberg's theory is valuable when considering the tenets of positive psychology, employee satisfaction, and personal resilience.

While motivators encourage positive self-directed behaviors such as achievement, recognition, responsibility, and advancement, hygiene factors align with feelings of job dissatisfaction such as salary, policy, physical working conditions, and management relations. Teixeira-Poit et al. (2017) specified that factors influencing professional life among physicians include job satisfaction. On the contrary, physicians experiencing a lack of job satisfaction may contribute to low enrollment into medical school, early retirement, less than full time equivalent employment, and increased time away from direct patient care. Participant P6 presented hygiene factors such as, "The mis-implementation and mismanagement of EMR by the administrators." He identified contributors of burnout as, "Accusation, malicious intent, organizational stifling of individuality, and the opposition of corporate culture today to recognize the gifts and uniqueness of people." Participants identified organizational opportunities to improve hygiene factors in creating a sustainable work environment of wellness. Participants stated not having to work for productivity metrics but permitting physicians as much time as was needed to care for the patient, as hygiene factors affecting their burnout. CST considers aspects such as power and inequity in a broad sense. Participants noted the inequity of not having boundaries for patients, but strict boundaries for physicians was challenging. Specifically, productivity, quality, and technology boundaries were applicable to CST.

Limitations of the Study

While the study did reach saturation, there were limitations to trustworthiness that arose from conducting the study, specifically from a small sample size. A small sample

size limits how generalizable the study can be because it may be less representative of an entire population. Another limitation was that physician participants provided self-reported data from interview questions. This may have resulted in less transparency as one physician participant noted that physicians have inflated egos. An additional study limitation was the physician's availability and willingness to participate in a study during the height of the COVID-19 pandemic. I intended to interview 20 to 30 participants, but the response time extended for several months and, ultimately, I reached saturation at seven participants and proceeded to finalize the study.

Recommendations

Recommendations for Further Research

According to Maslach and Leiter (2016), previous research showed that burnout may lead to behavioral outbursts, mental health effects such as depression, misuse of narcotics, and, in some instances, suicide. A recommendation for further research includes investigating the various types of behavioral outbursts, mental health impacts, medication dependency or abuse, and exploration of physicians who have considered or attempted suicide because of burnout.

Positive psychology focuses on wellbeing and human strength as compared to weakness and depression (Sachau, 2007; Reivich, 2018). A recommendation for further research is to investigate how employing positive psychology strategies impact Herzberg's motivation-hygiene theory. Further research of investigating personal resilience as an interventional strategy to reduce burnout in nonphysician healthcare providers as well as nonclinical workers may provide more in-depth insight and outcomes

specific to the healthcare industry. A study including direct observation might be ideal to gather a broader perspective of lived experiences. Although member-checking ensures trustworthiness, which is important to minimize bias, an additional recommendation for research might include having a researcher who is not actively working in the healthcare industry.

Recommendations for further research include an increased sample size to benefit the study being generalizable. A final recommendation for further research is to explore personal resilience as an interventional strategy to reduce physician burnout for physicians providing direct care to Covid-19 inpatients at end of life.

Recommendation for Practice

A recommendation for practice from P5 was to ask the patient for their perspective. Interviewing patients relative to their perception of personal resilience of physicians would have an added a layer of explorative research. The sample size, availability, and transparency of self-reported data may reflect different responses. Additional recommendations for practice include exploring alternative compensation models not associated with productivity. Further recommendations for practice include staffing support staff based on volume of work versus provider full time equivalent.

Additional recommendations for practice include expanding research to explore personal resilience and burnout among non clinicians in healthcare. For example, nurses, technicians, administrators, front line staff such as registrars, patient care assistants, medical assistants, and phlebotomists. Given burnout is not discriminatory, research in

these non clinician roles, may in fact provide greater insight to burnout across the complete healthcare industry.

Beyond healthcare, personal resilience and burnout are factors affecting various industries. As a leader, I am privileged to mentor and coach other potential leaders on the value, benefit, challenges, and requirements of successful leadership. For greater than 32 years, I have been honored to develop others in their pursuit. What I have come to better understand as a result of my research, is the importance of exploring personal resilience strategies to reduce burnout among leaders, non leaders, healthcare workers, and many other professions. As a result of my research, I have a greater respect for the need to incorporate, early in the mentoring, hiring, and onboarding processes, how essential it is to explore and build personal resilience strategies to reduce burnout.

Implications

Implications for social change at the individual and organizational levels include providing resources to create a decreased stressful work environment. For example, several participants identified prayer, faith, and meditation as strategies they employ to reduce burnout and promote wellness. At the societal level, physicians who feel supported by their organization provide optimal patient care, with favorable quality outcomes. When providers have an outlet to alleviate stress, they engage their patients in a more positive posture, and patients respond more compliantly. A social change commitment could consist of offering physicians a space for worship within their work setting. This would not only provide a place of sanctuary for physicians, but it would also build trust in the relationship between the physician and the organization. Physicians may

not perceive a sense of depersonalization or loss of autonomy if they have an opportunity to rejuvenate themselves through meditation or prayer. The addition of physician wellness in recent years, as noted by Johnson (2019) and Maslach and Leiter (2016), has gained national and global attention in the realm of academia and research for its direct effect on clinicians and patients, among other aspects of the Quadruple Aim.

Further implications for social change might include organizational policies related to work-life balance and having limited or no access to EMR after normal hours of operation. In conjunction, there would need to be standard processes for enhanced efficiencies within the EMR so physicians could complete documentation within their scheduled work hours. Two examples of standard efficiency processes might include a 1:1 ratio of clinical scribe to physician. In this way, the clinical scribe could accurately transcribe as the physician is providing direct care to the patient. The clinical scribe would serve low-level clinical functions as well as the current clerical burden described by physician participants in the study. This would permit physicians to care for patients and finish their workload during normal hours of operation.

Throughout the study, physicians also identified staff shortages as a challenge. Implications for social change might include assessing staffing models based on work volumes. This aligns with the previous social implication to incorporate 1:1 staffing models of team-based care, essentially providing wellness to physicians, and yielding better quality patient outcomes as a result of decreased burnout from the EMR.

Implications for social change specific to physician perceptions of organizational and administrative missed opportunities such as implementing organizational policy

might include putting strategies in place to create a culture of psychological safety where physicians can provide feedback, have their feedback acknowledged as valuable, and receive clear communication regarding whether changes were able to be implemented based on physician input.

Another implication of social change might include offering onsite therapy, animal therapy, walking trails, and the ability for physicians to step away for a few moments to visit an onsite garden or arboretum. Time designated in the physician's schedule to seek services throughout a day would be needed. These implications are aligned with physicians who employ personal resilience strategies to reduce physician burnout, as identified in this study.

An unintended implication for social change includes having conducted this research during the Covid-19 pandemic may have highlighted personal resilience strategies that may not have otherwise been identified or utilized. Specific personal resilience strategies employed to reduce burnout may be helpful as a component of their medical training, as a component to onboarding into an organization, as a component of physician recruitment, and peer mentoring. While many implications of this study originate at the individual and organizational level, the social implications could be beneficial to communities and scalable beyond the healthcare industry.

Reflexivity

As a researcher and instrument in this study, it is essential to discuss the importance of reflexivity. Components of reflexivity consists of personal, interpersonal, methodological, and contextual reflexivity (Olmos-Vega et al., 2022). Reflexivity defined

in qualitative research is intended to identify, acknowledge, and neutralize the subjectivity of the researcher. Given my personal experience working as a current and legacy healthcare administrator for many years and performing an administrative role in direct association with physicians and nonphysician providers, it is necessary to reflect on prior experiences and motivating factors that influenced my pursuit of a qualitative approach to exploring lived experiences of physicians identifying as burned out.

Personal reflexivity, according to Mann et al. (2009), can reformulate a researcher's paradigm and serve as a catalyst for change. Personal reflexivity answers the question, "How are my unique perspectives influencing the research?" My experience as a healthcare administrator has consistently been through the lens of wanting to understand the humanness of physicians. Physicians are regarded in a variety of paradigms depending on the observer. Physicians are sometimes viewed as servants, as scientists, as heroes, as caregivers, and as life savers. Others might identify physicians as pompous, egotistical, and elitist. I have for many years been perplexed as to why I have only heard physicians identify themselves as human beings, identifying themselves as having a calling to care for others. I intentionally focused my research on a qualitative approach because I wanted to hear directly from the physicians regarding their lived experiences of interventional strategies they employed to reduce burnout. Burnout has become a buzzword, but I was compelled to understand what it looked like through the lens of the impacted physician, and I wanted to understand how the healer employed strategies to alleviate or minimize burnout, as one participant noted, "God, help me to help the people." This resonated with me because the passion of the physician remained

true and was manifested even more so during a healthcare crisis. I sensed the fear of the helper, perceiving they may not be able to help. I saw the humanness of the healer, not from an ego-driven perspective, but from a genuineness of compassion and care for others. What is hard to convey on paper is the sense of urgency in the physician's voice, the need to help as many as possible, as quickly as possible.

Interpersonal reflexivity, according to Olmos-Vega et al. (2022) refers to relational influence among the researchers. I was the sole researcher in this study, and, as a result, interpersonal reflexivity did not apply. Olmos-Vega et al. (2022) further ascribed to value subjectivity, and reflexivity is dependent upon the paradigm of the researchers. The various perspectives on the interconnectedness among each of the aspects of reflexivity is what brings research into being and yields strategies for disseminating communication.

Methodological reflexivity answers the following question: How were methodological decisions made and what were the implications? Understanding that burnout and resilience are the reality of the physician based on his or her perception of emotional exhaustion, depersonalization, and decreased perception of personal accomplishment (Amanullah et al., 2017; Maslach & Leiter, 2016; Olson, 2017), an appropriate framework is CST and Herzberg's motivation-hygiene theory. CST and Herzberg's motivation-hygiene theory framework are intended to explore interventional strategies to reduce physician burnout, keeping in mind that Maslach and Leiter (2016) define burnout as emotional exhaustion, depersonalization (sometimes presented as a loss of autonomy or power), and decreased perception of personal accomplishment. These

theories informed the conceptual framework of this study and recurrent themes of burnout contributors and resilience strategies were presented by the participants. Specific burnout contributors included the electronic medical record, the Covid-19 pandemic, staff shortages, and the vaccine mandate associated with the pandemic. Consistent themes of resilience strategies included nonwork-related activities such as proper rest, diet and exercise, time with family and friends, therapy and professional support, and hobbies.

Contextual reflexivity, according to Olmos-Vega et al. (2022), answers the question, "How does context influence the research, researcher, and participants?" The context of physician burnout has been a topic of research for many years, but there are points in history where contextual shifts were evident. Recall when Health Maintenance Organizations (HMOs) were introduced into healthcare payor reimbursements, when the Affordable Care Act (ACA) became integral to the healthcare industry, and most recently, today's ongoing impact of the electronic health record (EHR) and Covid-19. In some cases, physicians have experienced all these changes and simply state, "healthcare is not what it used to be." The current pace of change in healthcare, whether regulatory or scientific, seems to occur at a greater frequency than legacy changes. Over time, these changes take a toll on not only patients and administrators, but as evidenced through research, there is a burden to our physicians. Immediate and long-term implications reveal physicians assessing whether it is time to retire, patients deciding whether or not to seek care, and administrators assessing what strategies need to be put in place now to ensure a sustainable system of care where physicians can resume their passion of caring for the people.

Conclusion

Physician burnout continues to be a national epidemic effecting physicians, healthcare organizations, and patients. Physician burnout factors include emotional exhaustion, depersonalization, and a sense of loss of autonomy. Physician burnout indicators include poor behavior, mental decline, depression, narcotics and alcohol abuse, suicidal ideation, and death by suicide. Physician participants interviewed in this study provided responses reflecting burnout as well as identified personal resilience strategies they employed as interventions to reduce burnout. Physicians self-identified as burned out as a result of the clerical burden of the EMR, organizational miscommunication, staff shortages, compensation, challenges of work-life balance, and the Covid-19 pandemic.

Physician participants identified strategies to not only reduce burnout, but to employ wellness. According to Carrau and Janis (2021), burnout occurs at the individual and organizational levels. Both are critical to the success of reducing burnout and employing wellness. There must be a moral and ethical priority to focus on physician burnout because of the consequences within healthcare.

Over many years of exploration and investigation to gain insight on physician burnout, personal resilience, quality outcomes, and optimal patient care, it is exciting to contribute to research to narrow the gap relative to the quadruple aim and continuing to place high emphasis on the well-being of the physician. Collier (2017), Diesser et al. (2017), and Fetch et al. (2017) ascribed various stressors such as the clerical burden associated with the electronic health record, negatively impact the level of burnout exhibited by physicians. Prior to Covid-19, physicians were considered healthcare heroes

and continue to be held in the highest regard even more so since the height of Covid-19. There is the presumption that the physician is correct in their medical assessment on all things healthcare and patient related, and they are not impacted by life's stressors. On the contrary, physicians are, in fact, subject to the same life stressors, flaws, and vulnerabilities as nonphysicians. They are experts in their field and skilled in the science of medicine, they are not; however, exempt from life's challenges and insurmountable stress when caring for the life of another. It is imperative that we continue to diligently explore the area of physician burnout, physician wellness, and personal resilience. The greater the research in this regard, the greater potential to narrow the gap in research. If healthcare is to be a sustainable profession and provision of services to patients; it is vital to employ ongoing research to ensure care is being provided to the caregiver.

References

Acimis, N. M., & Tekindal, M. A. (2017). Burnout and mobbing among physicians in a city center. *International Journal of Caring Sciences*, *10*(2), 871-888.

Adefolalu, A. (2018). Cognitive-behavioural theories and adherence: Application and relevance in antiretroviral therapy. *Southern African Journal of HIV Medicine*, *19*(1), 7 pages. https://doi.org/10.4102/sajhivmed.v19i1.762

Amanullah, S., McNally, K., Zelin, J., Cole, J., & Cernovsky, Z. (2017). Are burnout prevention programs for hospital physicians needed? *Asian Journal of Psychiatry*, *26*, 66-69. https://doi.org/10.1016/j.ajp.2017.01.009

American Psychological Association. (2020). *Publication manual of the American Psychological Association* (7th ed.). U.S. Department of Health and Human Services.

Bart, R., Ishak, W. W., Ganjian, S., Jaffer, K. Y., Abdelmesseh, M., Hanna, S., Gohar, Y., Azar, G., Vanle, B., Dang, J., & Danovitch, I. (2018). The assessment and measurement of wellness in the clinical medical setting: A systematic review. *Innovations in Clinical Neuroscience*, *15*(9-10), 14–23.

Belton, S. (2018). Caring for the caregivers: Making the case for mindfulness-based wellness programming to support nurses and prevent staff turnover. *Nursing Economics*, *36*(4), 191–194.

Branch, W. T., Weil, A. B., Gilligan, M. C., Litzelman, D. K., Hafler, J. P., Plews-Ogan, M., Rider, E. A., Osterberg, L. G., Dunne, D., Derse, A. R., Pittman, J. R., & Frankel, R. M. (2017, December). How physicians draw satisfaction and

overcome barriers in their practices: “It sustains me.” *Patient Education and Counseling*, 100(12), 2320–2330. https://doi.org/10.1016/j.pec.2017.06.004

Bonanno, G. A., Galea, S., Bucciarelli, A., & Vlahov, D. (2006, March). Psychological resilience after disaster. *Psychological Science*, *17*(3), 181–186. https://doi.org/10.1111/j.1467-9280.2006.01682.x

Card, A. J. (2018, May). Physician burnout: Resilience training is only part of the solution. *The Annals of Family Medicine*, *16*(3), 267–270. https://doi.org/10.1370/afm.2223

Carrau, D., & Janis, J. E. (2021). Physician burnout: Solutions for individuals and organizations. *Plastic and Reconstructive Surgery. Global Open*, *9*(2), e3418. https://doi.org/10.1097/GOX.0000000000003418

Citrin, R. S., & Weiss, P. A. A. (2016, April 15). The resilience advantage: Stop managing stress and find your resilience (First). *Business Expert Press*.

Collier, R. (2017, November 12). Electronic health records contributing to physician burnout. *Canadian Medical Association Journal*, *189*(45), E1405–E1406. https://doi.org/10.1503/cmaj.109-5522

de Montaigne, M. S. (1685). Of constancy (P. Coste, Ed.). In M. S. de Montaigne & P. Coste (Ed.) & C. Cotton (Trans.), *The essays of Michael Seigneur de Montaigne, in 3 Vols* (pp. 49–52). J Pote, E Ballard, C Bathurst, T Davies, T Payne, J F and C Rivington, S Crowder T Longman. https://doi.org/10.1037/11798-012

DeChant, P. F., Acs, A., Rhee, K. B., Boulanger, T. S., Snowdon, J. L., Tutty, M. A., Sinsky, C. A., & Thomas Craig, K. J. (2019, December). Effect of organization-

directed workplace interventions on physician burnout: A systematic review. *Mayo Clinic Proceedings: Innovations, Quality &Amp; Outcomes, 3*(4), 384–408. https://doi.org/10.1016/j.mayocpiqo.2019.07.006

Dyrbye, L. N., Burke, S. E., Hardeman, R. R., Herrin, J., Wittlin, N. M., Yeazel, M., Dovidio, J. F., Cunningham, B., White, R. O., Phelan, S. M., Satele, D. V., Shanafelt, T. D., & van Ryn, M. (2018, September 18). Association of clinical specialty with symptoms of burnout and career choice regret among US resident physicians. *JAMA, 320*(11), 1114-1130. https://doi.org/10.1001/jama.2018.12615

Eyles, J., Harris, B., Fried, J., Govender, V., & Munyewende, P. (2015, June). Endurance, resistance and resilience in the South African health care system: Case studies to demonstrate mechanisms of coping within a constrained system. *BMC Health Services Research, 15*(432). https://doi.org/10.1186/s12913-015-1112-9

Feteh, V. F., Njim, T., Nji, M. A. M., Ayeah, C. M., Sama, C. B., & Tianyi, F. L. (2017, October 25). Prevalence and determinants of burnout syndrome among physicians in Cameroon: A research proposal. *BMC Research Notes, 10*(508). https://doi.org/10.1186/s13104-017-2833-0

Fusch, P., & Ness, L. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2015.2281

Gadamer, H. G. (2006, January). Classical and philosophical hermeneutics. *Theory, Culture & Society, 23*(1), 29–56. https://doi.org/10.1177/0263276406063228

Gonzalez, M. M. (2016). The coding manual for qualitative research: A review. *The Qualitative Report, 21*(8), 1546-1548. https://doi.org/10.46743/2160-

3715/2016.2561

Stanford Encyclopedia of Philosophy (Winter 2016 Edition). (2016, June 22). https://plato.stanford.edu/archives/win2016/entries/hermeneutics/

Home of cognitive behavior therapy (2019). https://beckinstitute.org/about-beck/team/our-history/history-of-cognitive-therapy

Huff, J. L., Smith, J. A., Jesiek, B. K., Zoltowski, C. B., Graziano, W. G., & Oakes, W. C. (2014, October). From methods to methodology: Reflection on keeping the philosophical commitments of interpretative phenomenological analysis. 2014 *IEEE Frontiers in Education Conference (FIE) Proceedings*. https://doi.org/10.1109/fie.2014.7044253

Iorga, M., Socolov, V., Muraru, D., Dirtu, C., Soponaru, C., Ilea, C., & Socolov, D. G. (2017). Factors influencing burnout syndrome in obstetrics and gynecology physicians. *BioMed Research International*, *2017*, 1–10. https://doi.org/10.1155/2017/9318534

Jacobs, B., McGovern, J., Heinmiller, J., & Drenkard, K. (2018, July). Engaging employees in well-being. *Nursing Administration Quarterly*, *42*(3), 231–245. https://doi.org/10.1097/naq.0000000000000303

Johnson, P. B. (2019, June). Caring for the caregiver: Achieving the quadruple aim through a peer support program. *Nurse Leader*, *17*(3), 189–192. https://doi.org/10.1016/j.mnl.2019.03.009

Kuhn, C. M., & Flanagan, E. M. (2016, December 1). Self-care as a professional imperative: Physician burnout, depression, and suicide. *Canadian Journal of*

Anesthesia/Journal Canadien D'anesthésie, 64(2), 158–168. https://doi.org/10.1007/s12630-016-0781-0

Lewis, S. (2015, April 2). Qualitative inquiry and research design: Choosing among five approaches. *Health Promotion Practice, 16*(4), 473–475. https://doi.org/10.1177/1524839915580941

Lowe, A., Norris, A. C., Farris, A. J., & Babbage, D. R. (2018, January 22). Quantifying thematic saturation in qualitative data analysis. *Field Methods, 30*(3), 191–207. https://doi.org/10.1177/1525822x17749386

Mann, K., Gordon, J., & Macleod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Advances in health sciences education : Theory and Practice, 14*(4), 595–621. https://doi.org/10.1007/s10459-007-9090-2

Maslach, C., Jackson, S. E., Leiter, M. P., Toppinen-Tanner, S., Ojajarvi, A., Vaananen, A., Kalimo, R., & Jappinen, P. (2005). Maslach Burnout Inventory--General Survey. [English Version]. *Behavioral Medicine, 31*, 18–27.

Maslach, C., & Leiter, M. P. (2016, June). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry, 15*(2), 103–111. https://doi.org/10.1002/wps.20311

Matheson, C., Robertson, H. D., Elliott, A. M., Iversen, L., & Murchie, P. (2016, May 9). Resilience of primary healthcare professionals working in challenging environments: A focus group study. *British Journal of General Practice, 66*(648), e507–e515. https://doi.org/10.3399/bjgp16x685285

Mortimer-Granville, J. (1885). *Low spirits. In common mind-troubles.* (p. 57–65). W. H. Allen & Co. https://doi:10.1037/14287-006

O'Dowd, E., O'Connor, P., Lydon, S., Mongan, O., Connolly, F., Diskin, C., McLoughlin, A., Rabbitt, L., McVicker, L., Reid-McDermott, B., & Byrne, D. (2018, September 21). Stress, coping, and psychological resilience among physicians. *BMC Health Services Research, 18*(730). https://doi.org/10.1186/s12913-018-3541-8

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2022). A practical guide to reflexivity in qualitative research: Amee guide no. 149. *Medical Teacher*, 1–11. https://doi.org/10.1080/0142159x.2022.2057287

Olson, K. D. (2017, November). Physician burnout—A leading indicator of health system performance? *Mayo Clinic Proceedings*, *92*(11), 1608–1611. https://doi.org/10.1016/j.mayocp.2017.09.008

Patton, M. Q. (2002, September). Two decades of developments in qualitative inquiry. *Qualitative Social Work, 1*(3), 261–283. https://doi.org/10.1177/1473325002001003636

Penberthy, J. K., Chhabra, D., Ducar, D. M., Avitabile, N., Lynch, M., Khanna, S., Xu, Y., Ait-Daoud, N., & Schorling, J. (2018, December). Impact of coping and communication skills program on physician burnout, quality of life, and emotional flooding. *Safety and Health at Work, 9*(4), 381–387. https://doi.org/10.1016/j.shaw.2018.02.005

Peterson, C. J., Lee, B., & Nugent, K. (2022, June). COVID-19 Vaccination hesitancy

among healthcare workers-A review. *Vaccines*, *10*(6), 948. https://doi.org/10.3390/vaccines10060948

Ravitch, S. M., & Carl, N. M. (2019, December 20). *Qualitative Research: Bridging the Conceptual, Theoretical, and Methodological* (2nd ed.). SAGE Publications, Inc.

Reivich, K. J., (2012, Jul 25). *On positive education and wellbeing.* University of Pennsylvania. https://www.youtube.com/watch?v=wdV1OKkisoI

Reivich, K. J., (2018). Experience Leader Conference. Retrieved from https://www.lancastergeneralhealth.org/health-care-professionals/for-physicians/progress-notes/2018/july/jan-bergen-how-i-reduce-stress

Reivich, K. J., Seligman, M. E. P., & McBride, S. (2011). Master resilience training in the U.S. Army. *American Psychologist*, *66*(1), 25–34. https://doi.org/10.1037/a0021897

Robson, C. (2002, March 20). *Real world research: A resource for social scientists and practitioner-researchers* (2nd ed.). Wiley-Blackwell.

Ruzycki, S. M., & Lemaire, J. B. (2018, January 14). Physician burnout. *Canadian Medical Association Journal*, *190*(2), E53–E53. https://doi.org/10.1503/cmaj.170827

Sachau, D. A. (2007, December). Resurrecting the motivation-hygiene theory: Herzberg and the positive psychology movement. *Human Resource Development Review*, *6*(4), 377–393. https://doi.org/10.1177/1534484307307546

Shanafelt, T. D., Bradley, K. A., Wipf, J. E., & Back, A. L. (2002). Burnout and self-reported patient care in an internal medicine residency program. *Annals of*

internal medicine, 136(5), 358–367. https://doi.org/10.7326/0003-4819-136-5-200203050-00008

Straus, E.-G. S. (2020). ERWIN STRAUS Il sospiro. Introduzione a una teoria dell'espressione Introduzione di SALVATORE GIAMMUSSO L'emozione dà a intendere. Intorno a Il sospiro di Erwin Straus. S&F_scienzaefilosofia.It, 23, 188–251.

Taormina, R. J. (2015, April 30). Adult personal resilience: A new theory, new measure, and practical implications. *Psychological Thought, 8*(1), 35–46. https://doi.org/10.5964/psyct.v8i1.126

Tetzlaff, E. D., Hylton, H. M., DeMora, L., Ruth, K., & Yu-Ning, W. (2018, January). National study of burnout and career satisfaction among physician assistants in oncology: Implications for team-based care. *Journal of Oncology Practice, 14*(1), e11-e22. https://doi.org/10.1200/JOP.2017.025544

Teixeira-Poit, S. M., Halpern, M. T., Kane, H. L., Keating, M., & Olmsted, M. (2017, June 19). Factors influencing professional life satisfaction among neurologists. *BMC Health Services Research, 17*(409), 1–9. https://doi.org/10.186/12913-017-2343-8

Tiitinen Mekhail, K., Lindberg, L., Burström, B., & Marttila, A. (2019, January). Strengthening resilience through an extended postnatal home visiting program in a multicultural suburb in Sweden: Fathers striving for stability. *BioMed Central Public Health, 19*(1), 102. https://doi.org/10.1186/s12889-019-6440-y

Uema, A., Kitamura, H., & Nakajima, K. (2020, January). Adaptive behavior of

clinicians in response to an over-constrained patient safety policy on the administration of concentrated potassium chloride solutions. *Safety Science, 121,* 529–541. https:// doi.org/10.1016/j.ssci.2019.09.023

Underdahl, L., Jones-Meineke, T., & Duthely, L. M. (2017, October 24). Reframing physician engagement: An analysis of physician resilience, grit, and retention. *International Journal of Healthcare Management, 11*(3), 243–250. https://doi.org/10.1080/20479700.2017.1389478

Wallace, C., Dale, F., Jones, G., O'Kane, J., Thomas, M., Wilson, L., & Pontin, D. (2018, July 25). Developing the health visitor concept of family resilience in Wales using Group Concept Mapping. *Rural and Remote Health, 18*(4), 1-13. https://doi.org/10.22605/rrh4604

West, C. P., Dyrbye, L. N., Erwin, P. J., & Shanafelt, T. D. (2016, September 28). Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *The Lancet, 388*(10057), 2272–2281. https://doi.org/10.1016/s0140-6736(16)31279-x

Whame, Simon. (2017). 'A process you may be entering' - Decision-making and burnout in mental healthcare: An existentially informed hermeneutic phenomenological analysis. *Existential Analysis, 28*(1), 135–150.

Yelogluh, H. O. & Karahan, G. (2016, November). The effects of mobbing problem on the academicians and their social lives: The issue of contract. *Journal of Defense Sciences / Savunma Bilmleri Dergisi, 15*(2), 47–71, 25 pages.

Yester, M. (2019, July 9). Work-life balance, burnout, and physician wellness. *The*

Health Care Manager, *38*(3), 239–246.

https://doi/10.1097/hcm.0000000000000277.

Appendix: Interview Questions

1. Give a specific example of a situation that required you to demonstrate personal resilience in your role as a physician.

2. What personal resilience strategy(ies) do you employ to reduce physician burnout?

3. What are major contributors of burnout you experience as a physician?

4. How do you define personal resilience?

5. What wellness behavior(s) do you find most beneficial to you as a physician?

6. What boundaries have you put in place to ensure work-life balance?

7. How has your wellness as a physician, affected your patients?

8. What do you perceive to be the greatest success to creating a sustainable work environment of wellness?

9. What do you perceive to be the greatest opportunity(ies) to creating a sustainable work environment of wellness?

10. What professional support have you found valuable to your efforts to reduce burnout?

11. What support measures do you apply for long term sustainability?

12. What measures do you employ for emergent coping strategies?

13. How has professional support enhanced your work-life balance.