

3-19-2026

Describing the Creation of Physician Burnout Prevention Efforts: A Phenomenological Investigation

Amy Cowan
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Psychology

This is to certify that the doctoral dissertation by

Amy Cowan

has been found to be complete and satisfactory in all respects,

and that any and all revisions required by

the review committee have been made.

Review Committee

Dr. Edoardo Naggiar, Committee Chairperson, Psychology Faculty

Dr. Derek Rohde, Committee Member, Psychology Faculty

Chief Academic Officer and Provost

Sue Subocz, Ph.D.

Walden University

2026

Abstract

Describing the Creation of Physician Burnout Prevention Efforts:

A Phenomenological Investigation

by

Amy Cowan

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

March 2026

Abstract

Despite physician burnout being a recognized problem, no single, successful, clear strategy has been developed to lessen this issue. The purpose of this qualitative phenomenological study was to explore the motivations underlying the development of responses to physician burnout by their creators and the factors that influenced their decision-making in creating these responses. A purposeful sample of 17 creators of physician burnout and suicide prevention strategies in the United States was selected based on Moustakas's conventions for conducting a qualitative descriptive phenomenological study. Notwithstanding this sample, data collection continued until saturation was achieved. The qualitative data were collected using semi-structured interviews with the help of an interview protocol. Transcribed semi-structured interview data were then analyzed using Moustakas's analysis approach for phenomenological data analysis. NVivo 14 was used to merge, code, relate, and analyze the transcribed semi-structured interview data. Study results contained themes that included system-level factors influencing intervention creation, personal experiences that shaped creators' motivations, cultural norms and stigma in shaping wellness work, leadership and governance in wellness design, organizational context and leadership influences, implementation pathways and practical challenges, and reflections and recommendations for future interventions. This study contributes to social change through a better understanding of how creators perceived and experienced efforts to prevent physician burnout and suicides in the future which can assist in the development of effective responses to this problem.

Describing the Creation of Physician Burnout Prevention Efforts:

A Phenomenological Investigation

by

Amy Cowan

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

March 2026

Dedication

To the dedicated physicians, compassionate coaches, and visionary chief wellness officers who tirelessly strive to combat the pervasive issue of physician burnout. Your unwavering commitment to improving the lives of your colleagues and fostering a healthier work environment is both inspiring and essential. Though the journey to fully address this dilemma is ongoing, your efforts illuminate the path toward a more balanced and fulfilling professional life for all healthcare providers. May the healthcare industry increasingly recognize and support your invaluable work, paving the way for a brighter future for physicians everywhere.

Acknowledgments

I would like to express my heartfelt gratitude to those who have supported me throughout this challenging yet rewarding journey of completing my dissertation. First and foremost, I want to thank my two daughters, Eva and Lexi, who demanded that I return to the partially completed PhD that I began in my twenties. Their stubborn determination to see me complete this degree has been a constant source of motivation, reminding me of the importance of perseverance and keeping one's commitments.

I want to thank my husband, Bryan, for his unwavering support and patience during this process. Your belief in me helped carry me through the long hours and frustrating times of writer's block.

I am also deeply grateful to my friends who listened to my ramblings about various portions of my dissertation. Your enthusiasm and interest in my research kept my spirits high and fueled my excitement as new insights emerged.

I would like to extend my sincere thanks to my dissertation committee, Dr. Ed Naggiar and Dr. Derek Rhodes. Your support, partnership, and guidance have been invaluable in shaping my work and helping me stay focused on my goals.

Most importantly, I am thankful to the generous individuals who graciously allowed me to interview them about this delicate subject matter. Your willingness to share your private observations and reflections on physician burnout in today's society has deeply enriched my research and provided essential insights.

Table of Contents

List of Tables	ix
Chapter 1: Introduction to the Study.....	1
Introduction.....	1
Background of the Study	2
Problem Statement.....	7
Purpose of the Study.....	8
Research Question	8
Conceptual Framework.....	9
Nature of the Study.....	10
Definitions.....	12
Assumptions.....	14
Scope and Delimitations	15
Limitations	16
Significance of the Study	17
Summary	18
Chapter 2: Literature Review.....	20
Introduction.....	20
Literature Search Strategy.....	21
Literature Review.....	22
Physician Burnout: Background Information	22
Physician Burnout: Consequences.....	26

Physician Burnout: The Business Case.....	28
The Proposed Physician Burnout Solutions.....	32
Summary and Conclusions	58
Chapter 3: Research Method.....	60
Introduction.....	60
Research Design and Rationale	61
Role of the Researcher	66
Ethical Considerations	67
Methodology.....	68
Target Population.....	68
Sampling and Sampling Procedures	69
Instrumentation	72
Procedures for Recruitment, Participation, and Data Collection.....	74
Data Analysis Plan.....	75
Issues of Trustworthiness.....	76
Credibility	76
Transferability.....	77
Dependability	78
Confirmability.....	78
Ethical Procedures	79
Summary	80
Chapter 4: Results.....	82

Introduction.....	82
Research Setting.....	82
Demographics	82
Data Collection	85
Data Analysis	85
Evidence of Trustworthiness.....	86
Credibility	86
Transferability.....	86
Dependability	86
Confirmability.....	87
Study Results	87
Theme 1: System-Level Factors Influencing Intervention Creation.....	87
Incentives and Payment: What the System Pays For, the System Gets.....	87
Workforce Design and Scheduling: Capacity Is a Prerequisite	89
Measurement and Data Visibility: From Avoidance to Action	90
Professional Autonomy and Teaming: Restoring Room to Practice	
Medicine	92
Communication Load and After-Hours Norms	93
Integrative Summary.....	94
Theme 2: Personal Experiences Shaping Creators' Motivations.....	95
Existential Crisis and Identity Loss: Rebuilding the Self Alongside the	
Profession.....	95

Personal Burnout and Recovery as Design Inputs: From Surviving to Reshaping the System.....	97
Family–Work Tension and Role Conflict: Designing Around Impossible Choices.....	98
Leadership and Teaching as Sources of Renewal: Multiplying What Sustained Them.....	99
Values Alignment and Agency: Reclaiming Integrity in Daily Work.....	100
Integrative Summary.....	101
Theme 3: Cultural Norms and Stigma in Shaping Wellness Work	102
Endurance as a Hidden Curriculum	102
Stigma Around Vulnerability.....	104
Mixed Signals From Leadership.....	105
Building a Culture of Trust.....	106
Integrative Summary.....	107
Theme 4: Leadership and Governance in Wellness Design	108
Leadership as Catalyst	108
Leadership as Constraint.....	110
Governance Structures for Sustainability	112
Balancing Symbolic and Structural Leadership.....	113
Trust and Accountability in Leadership.....	115
Integrative Summary.....	116
Theme 5: Organizational Context and Leadership Influences.....	117

Culture-Building: Designing for Belonging and Meaning	117
Governance and Resourcing: From Symbol to System	119
Modeling and Communication: What Leaders Do Becomes the Norm	121
When Money Governs Medicine	122
Converting Frustration Into a Shared Business Case.....	124
Leadership Multiplication: Making Well-Being a Shared Competency.....	125
Integrative Summary.....	126
Theme 6: Implementation Pathways and Practical Challenges	127
Resourcing Constraints: Doing More With Less	127
Integrating Interventions Into Workflow	129
Measurement and Feedback Loops.....	130
Adapting in Real Time.....	132
Integrative Summary.....	134
Theme 7: Reflections and Recommendations for Future Interventions	135
Earlier Access and Reframing	135
Policy and Protection	137
Technology With Proof, Not Hype.....	138
Positive Deviants and Learning From What Works	140
Outcome Sets Beyond a Single Number.....	141
Contracts, Pipelines, and the Future Workforce	142
Scaling Community and Leadership.....	144
Integrative Summary.....	146

Evidence of Representation	147
Participant Index (Matrix View).....	147
Summary	149
Chapter 5: Discussion, Conclusions, and Recommendations.....	151
Introduction.....	151
Theme 1: System-Level Factors Influencing Intervention Creation.....	151
Incentives and Payment: What the System Pays For, the System Gets.....	152
Workforce Design and Scheduling: Capacity as Prerequisite	154
Measurement and Data Visibility: From Avoidance to Action	155
Professional Autonomy and Teaming: Restoring Room to Practice	
Medicine	156
Communication Load and After-Hours Norms	158
Integrative Interpretation of Theme 1	159
Theme 2: Personal Experiences Shaping Creators' Motivations.....	160
Existential Crisis and Identity Loss	161
Personal Burnout and Recovery as Design Inputs.....	162
Family–Work Tension and Role Conflict.....	163
Leadership and Teaching as Sources of Renewal.....	165
Values Alignment and Agency	167
Integrative Interpretation of Theme 2	168
Theme 3: Cultural Norms and Stigma in Shaping Wellness Work	169
Endurance as a Hidden Curriculum	170

Stigma Around Vulnerability.....	172
Mixed Signals From Leadership.....	173
Building a Culture of Trust.....	175
Integrative Interpretation of Theme 3	176
Theme 4: Leadership and Governance in Wellness Design	177
Leadership as Catalyst	178
Leadership as Constraint.....	179
Governance Structures for Sustainability	180
Balancing Symbolic and Structural Leadership.....	182
Trust and Accountability in Leadership.....	183
Integrative Interpretation of Theme 4	184
Theme 5: Organizational Context and Leadership Influences.....	185
Culture-Building: Designing for Belonging and Meaning	186
Governance and Resourcing: From Symbol to System	187
Modeling and Communication: What Leaders Do Becomes the Norm	188
When Money Governs Medicine	190
Converting Frustration Into a Shared Business Case.....	191
Leadership Multiplication: Making Well-Being a Shared Competency.....	192
Integrative Interpretation of Theme 5	193
Theme 6: Implementation Pathways and Practical Challenges	194
Resourcing Constraints: Doing More With Less	194
Integrating Interventions Into Workflow	196

Measurement and Feedback Loops.....	197
Staff Engagement and Ownership	198
Adapting in Real-Time	199
Integrative Interpretation of Theme 6.....	200
Theme 7: Reflections and Recommendations for Future Interventions	201
Earlier Access and Reframing	202
Policy and Protection	203
Positive Deviants and Learning From What Works	204
Outcome Sets Beyond a Single Number.....	205
Contracts, Pipelines, and the Future Workforce	206
Scaling Community and Leadership.....	207
Integrative Interpretation of Theme 7	208
Limitations of the Study.....	208
Recommendations.....	210
Recommendations for Practice	210
Recommendations for Future Research	212
Implications for Social Change.....	213
Conclusions.....	215
References.....	218
Appendix A: Interview Form.....	252
Appendix B: Demographics (De-Identified Summary).....	256
Appendix C: Theme Tracker (Evidence Map).....	258

List of Tables

Table 1. Aggregated Participant Demographics	84
Table 2. Participant Index (Matrix View).....	148
Table B1. Aggregated Participant Demographics	256
Table C1. Exemplar Evidence Map	258
Table C2. Participant Indexed by Theme (Matric View)	259

Chapter 1: Introduction to the Study

Introduction

Physician burnout is a critical issue impacting the availability and quality of healthcare in the United States, and accessible empirical evidence showed the burnout rate among physicians in the U.S. increasing. A 2012 study revealed an alarming level of physician burnout, with 45.8% of doctors reporting a minimum of one symptom of burnout (Shanafelt et al., 2012). Research has further shown that even though physician burnout has been a key problem for decades, the emergence of the COVID-19 pandemic accelerated the problem to greater heights (Abatzis et al., 2023; Ortega et al., 2023; Shanafelt et al., 2022). While COVID-19's impact is not the focus of this study, it is important to understand the priority this ever-worsening issue presented. A study showed the burnout rate of physicians with 11-20 years of experience was already at an all-time high of 44% in 2017, but surged to 50% in 2021 (Ortega et al., 2023). Over 4 decades of research and knowledge have been devoted to physician burnout, and it is apparent that the current healthcare system is in a state of crisis. An analysis of the literature revealed what is known about physician burnout and acknowledged gaps in effective strategies and solutions. Specifically, there was extensive literature on physician burnout and proposed physician burnout intervention programs (El-Aswad, 2020; Hodkinson et al., 2022; Jindal, 2020), but little has been documented supporting the effectiveness of these programs. To date, a single, successful solution to physician burnout has not been developed. An understanding of how various creators derived, conceived, or otherwise

generated interventions will assist in the development of effective responses to physician burnout.

Chapter 1 presents a summation of the study of the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses. The chapter further describes the research procedures and approaches that were implemented to address the acknowledged research problem, as well as to answer the central research question. The key sections encompassed in this chapter are the background of the study, problem statement, purpose of the study, research question, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study. Chapter 1 concludes with a concise summary of the key ideas.

Background of the Study

Physician burnout is described as a state of physical, mental, and emotional exhaustion caused by sustained stress in the workplace (Jindal, 2020; Ortega et al., 2023). Obtainable empirical evidence showed the burnout rate among physicians in the U.S. was increasing. A 2012 large-scale, nationwide study revealed an alarming level of physician burnout, with 45.8% of doctors reporting a minimum of one symptom of burnout (Shanafelt et al., 2012). Nonetheless, although physician burnout has been a key issue for decades, the emergence of the COVID-19 pandemic accelerated the problem to greater heights. Another recent study co-authored by the American Medical Association (AMA) (2023) disclosed that the COVID-19 pandemic magnified long-standing problems, which

accelerated physician burnout rate in the United States (Abatzis et al., 2023). This national survey showed that approximately 63% of physicians reported symptoms of burnout at the end of 2021, a surge from 48% in 2020 (Abatzis et al., 2023). Shanafelt et al. (2022) equally determined that toward the end of 2021, assessed doctors reported substantially higher mean depersonalization and emotional exhaustion scores as compared to scores in 2011, 2014, 2017, and 2020.

Studies conducted by the Centers for Disease Control and Prevention (CDC) even before the pandemic indicated that physicians have the second highest suicide rate of any profession (de Sousa, da Silva, Moreira, & Neto, 2019; Yates, 2020) and that high levels of stress made doctors and medical students more likely to commit suicide (Ishikawa, 2022; Kleinhendler-Lustig et al., 2023; Ryan et al., 2023). Added to that are production pressures and the feeling that many doctors lack control over their professional lives (Kuhn & Flanagan, 2017). Moreover, when doctors' well-being or life satisfaction suffers, they may be less apt to seek help because it is difficult for them to admit they need help, and they may fear losing their license, a belief that is reinforced by medical license applications that discourage physicians from seeking psychological care (Kuhn & Flanagan, 2017). Immediate interventions are needed to address the high rates of physician burnout and eventually solve the aforementioned adverse impacts associated with burnout.

Many factors can result in physician burnout, such as encompassing work overload, a lack of occupational independence, and having no time for nonprofessional activities (Dillon et al., 2022; Smith et al., 2022). Bailey et al. (2022) added that although

multiple factors are known to cause physician burnout, this issue is often related to administrative burdens, increased regulation and technology needs, and system inefficiencies. The essence of burnout in the healthcare sector lies in the possibility of inaccuracies in diagnosis and treatment, an increased likelihood of absenteeism, and a reduced patient satisfaction score (Bailey et al., 2022). Sinsky and Ristow (2023) further indicated that burnout can result in fewer doctors being available for medical care, adversely impacting the neediest fields and the most in-demand specialties first. Physician burnout further increased patient waiting times as well as reduced access and quality of healthcare (Ortega et al., 2023). According to Ortega et al. (2023), the increased rate of physician burnout in the U.S. is a cogent issue, considering the growing rates of chronic health conditions requiring long-term and specialized medical care. Ortega et al. pointed out that the rising rate of physician burnout was a possible threat to the capacity of the United States healthcare system to care for patients and hence required urgent solutions. Reducing and/or resolving physician burnout is thus vital to a sustainable healthcare system and high-quality patient care.

To address the surging physician burnout rates and the adverse impacts associated with these rates, different creators have developed diverse responses and interventions. The AMA is leading a campaign to eradicate system-level drivers of physician burnout and remove administrative burdens, offering real-world interventions and assisting doctors to rediscover satisfaction in the healthcare field (Aiken et al., 2023; DePorre et al., 2023). Considerable measures and responses to physician burnout have emerged as a direct effect of this campaign. For instance, the AMA advocated for ratification of the Dr.

Lorna Breen Health Care Provider Protection Act, which offers vital physician wellness resources (Aiken et al., 2023). The AMA has developed a nationwide campaign to enable states to ratify confidentiality statutes, which safeguard doctors seeking assistance for wellness, fatigue, and burnout, and eradicate unsuitable, stigmatizing questions on doctor licensure and renewal requests (DePorre et al., 2023). The organization further saw the development of the Organizational Well-Being Assessment, a tool that enables medical care institutions to holistically evaluate and take action to enhance the well-being of their doctors and other clinicians (Hodkinson et al., 2022). The AMA has also shaped over 40 policies and secured regulatory victories, which have decreased documentation burdens (Aiken et al., 2023). Although these measures and programs have been fully operational, no empirical evidence exists of their effectiveness in reducing and/or addressing the problem of burnout among physicians in the United States.

The National Academy of Medicine (NAM) has equally worked to resolve the issue of physician burnout by creating a task force to support physicians' well-being and resilience (Longo et al., 2023; van Niekerk et al., 2023). Research on well-being has long emphasized the importance of resilience for improving individuals' well-being and ability to adapt, and resilience has shown to be valuable for both preventive and protective care in studies conducted in a variety of settings (DiFabio & Palazzeschi, 2015; van Niekerk et al., 2023). It is, however, implied that physicians have some weaknesses if they are asked to be more resilient; therefore, NAM formed a committee to explore solutions that will go above and beyond the popular “resilience training programs” that many organizations have used in the last decade to reduce physician burnout (van Niekerk et

al., 2023). Organizations that have sponsored this new NAM committee include John Hopkins, the American Hospital Association, the Association of American Medical Colleges, Tulane, Duke, Vanderbilt, and Yale, among others.

Another resource is Dr. Pamela Wible, one of the nation's leading experts on physician burnout and author of a book that features letters from departed physicians, one of the only sources available to help us understand what can no longer be asked of them. Additionally, a documentary called “Do No Harm” (Symon, 2018) examined physician suicide and burnout while interviewing key decision-makers to understand possible solutions. Further consensus regarding the need for better, different, or more interventions is required; however, the research must continue until burnout and suicide rates among physicians and medical students are reduced. According to van Niekerk et al. (2023), supporting physician well-being requires sustained attention and action at the national, state, and organizational levels, as well as investments in research and information-sharing. Despite the presence of the aforementioned creators and interventions, very little empirical evidence exists supporting their effectiveness in reducing and/or addressing the problem of burnout among physicians in the United States. This study addressed the issue that physician burnout is a recognized problem leading to impaired clinical performance and loss of vital services (Bailey et al., 2022; Kuhn & Flanagan, 2017; Ortega et al., 2023), and yet no single, successful, clear solution has been developed as a response to this problem.

Problem Statement

The problem addressed in this study was that although physician burnout is a recognized issue leading to impaired clinical performance, loss of vital services, inaccuracies in diagnosis and treatment, reduced patient satisfaction, and even the suicide of some physicians (Bailey et al., 2022; Kuhn & Flanagan, 2017; Ortega et al., 2023), there was no single, successful, clear solution developed to lessen this issue. Many factors can result in physician burnout, such as encompassing work overload, a lack of occupational independence, having no time for nonprofessional activities, administrative burdens, increased regulation, technology needs, and system inefficiencies (Bailey et al., 2022; Dillon et al., 2022; Smith et al., 2022). The essence of addressing burnout in the healthcare sector lies in the possibility of inaccuracies in diagnosis and treatment, an increased likelihood of absenteeism, a reduced patient satisfaction score, impaired clinical performance, and loss of vital services (Bailey et al., 2022). Immediate successful interventions are needed to address the high rates of physician burnout and eventually solve the aforementioned adverse impacts associated with burnout.

To address the surging physician burnout rates and the adverse impacts associated with these rates, different creators have developed diverse responses and interventions. Many strategies have been proposed and developed to include intervention programs, awareness training, informative sessions, resilience programs, coaching, and incentives (Longo et al., 2023; van Niekerk et al., 2023). The AMA is leading a campaign to eradicate system-level drivers of physician burnout and remove administrative burdens, offering real-world interventions and assisting doctors to rediscover well-being in the

healthcare field (Aiken et al., 2023; DePorre et al., 2023). These responses ranged in nature and effectiveness in preventing burnout. Although these measures and programs have been fully operational, no empirical evidence exists of their effectiveness in reducing and/or addressing the problem of burnout among physicians in the United States. To date, a successful strategy is still needed to generate or create an effective response to this problem. An understanding of how these various approaches were derived, conceived, or otherwise generated will assist in the development of effective responses to physician burnout.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses. The phenomena of interest in this study were the lived experiences and perceptions of the creators of these responses. The target population was comprised of the creators of physician burnout and suicide prevention programs and strategies in the United States. A purposeful sample of 17 participants was selected based on Moustakas's (1994) conventions for conducting a qualitative descriptive phenomenological study. Irrespective of this sample, data collection continued until saturation was attained.

Research Question

The goal of this qualitative phenomenological study was to explore the processes and motivations underlying the development of responses to physician burnout by their

creators, and the factors that influenced their decision-making in creating and implementing these responses. The study was guided by the following research question: Regarding the development of physician burnout interventions, what factors influenced their developers' decision-making in creating and implementing these responses?

Conceptual Framework

The conceptual framework for this study was the constructivist/interpretivist concept. According to Hamby (2019), the fundamental purpose of a qualitative design is “only to identify, define, or describe variables, not to measure them or test relationships,” and “linking the object of the study to any prior theory undermines that discovery and restricts it to what has already been ‘discovered.’” Bloomberg and Volpe (2016) stated that the essential difference between a “conceptual” framework and a “theoretical” framework is that “the conceptual framework is oriented toward theories or concepts of how to gain and frame, or ‘meaning-making.’” Creswell (2013) suggested three basic conceptual frameworks for qualitative research – constructivist/interpretive, transformative, and theoretical/interpretive. As described by Hamby (2019), two of these formats – constructivist/interpretivist and transformative – imply that “the nature of the qualitative research is purely discovery and thus prior theories are irrelevant.”

Accordingly, as this qualitative study was exploratory in nature and not based on a pre-existing theory, the conceptual framework for this study was the constructivist/interpretivist concept. Constructivism posits that people actively construct or create their own subjective representations of objective reality (Jonassen, 2013), and interpretivism emphasizes the researcher's interpretation of the elements of the study

(Dudovskiy, 2017). In this context, the focus was on the stories, perceptions, and descriptions of the people directly involved with the phenomenon of creating a response to physician burnout.

Nature of the Study

Exploratory qualitative research was conducted using the phenomenological approach, which best suited this study, as its focus was to explore the lived experiences of people and their expression of those experiences in language (Rudestam & Newton, 2015). A qualitative approach provided the best opportunity for the phenomenological exploration of participant perception, which was the focus of this study (Ravitch, 2016). Interviews were used to collect data, and themes were analyzed and extracted from that data. Semistructured interviews were used to make sure participants fully understood the questions and to encourage them to elaborate on answers that were vague or confusing (Rubin & Rubin, 2012).

Given the multitude of ways in which creators may experience the development of doctor and medical student burnout prevention programs and wellness initiatives, it was important to understand their reality. This type of study provided participants with an opportunity to give voice to their experiences by asking them in-depth questions about how a specific response came to be and what their related roles and observations were.

This study was a qualitative study following the phenomenological approach so that intervention creators could describe the processes and motivations underlying the development of responses to physician burnout, and the factors that influenced their decision-making in creating and implementing these responses. Schram (2003) indicated

that qualitative research is fundamentally interpretive, for example, gathering subjective information that cannot readily be quantified to provide insight into a research question may reveal different conclusions about a specific topic. Hamby (2019) stated that the fundamental difference between qualitative and quantitative research is that the purpose of qualitative research is discovery, in which the variables have not been identified or defined, while the purpose of quantitative research is to test a hypothesis in which the variables have not only been identified, but also defined and measured. In addition to analyzing specific words or thoughts in personal interviews in qualitative research, analyzing the differences will help gain insight into the robustness of the topic (Hamby, 2019). To that end, feedback from participants about their proposed responses to the issue will contribute much to society's further understanding of the steps being taken to combat physician burnout and its unfortunate side effects.

A qualitative phenomenological study was selected to research physician burnout and the programs and strategies that were designed to combat it. A phenomenological study is a philosophical approach that examines events, programs, relationships, and emotions as an individual's or group's perception of a situation or experience (Hale, 2012). As such, the design of the phenomenological study was applied to understand the lived experiences and perceptions of the creators of solution-minded responses to the problem of physician burnout, with all of its accompanying side effects. Creswell (2013) indicated that phenomenological studies examined how a concept or phenomenon was experienced by several individuals as a common meaning.

The study interviewed creators directly involved in creating responses to physician burnout. A purposeful sample of 17 participants was selected based on Moustakas's (1994) conventions for conducting a qualitative descriptive phenomenological study. Notwithstanding this sample, data collection continued until saturation was attained. These interviews were transcribed, and from the transcriptions, common, contrasting, and unique themes were identified. Finally, answers were synthesized to the questions by describing how creators created the programs. To ensure that interview responses were rich in relevant data and allowed for reliable and valid analysis, an interview protocol was developed with an informed consent and well considered interview questions in an interview script in order to align with the research subquestions (Hamby 2019). To ensure consistency in analyzing the responses, each interviewee was asked every question. Last, feedback was obtained and the interview protocol was pretested.

Definitions

The following are definitions of terms used in the specific context of this study:

Burnout: In the International Classification of Diseases by the World Health Organization (2019), burnout is listed as an occupational phenomenon, not a medical condition. It describes a syndrome caused by chronic workplace stress that has not been effectively managed and is characterized by a lack of professional efficacy associated with energy exhaustion and mental distance or cynicism. It is important to recognize the unique delineation between burnout and psychological disorder, as individuals indicating

burnout from environmental stressors typically have no history of psychological disorders (Moss et al, 2016).

Creators: Individuals who have a vested interest in decreasing burnout and increasing well-being in physicians, and who have developed strategies and interventions to do so.

Physician burnout: Physician burnout is described as a state of physical, mental, and emotional exhaustion caused by sustained stress in the workplace (Ortega et al., 2023).

Response: Conventional wisdom holds that problems are singular and stable and can be solved once and for all, whereas the National Institute of Health has more specifically updated the activities related to problem-solving as “responses” due to the constantly evolving changes and needs in the healthcare system (Cristancho, 2016). The American Society for Quality (2020) indicated that responses involve identifying, prioritizing, and selecting alternatives in an ongoing process of problem-solving.

Responses to physician burnout: In this study, responses to physician burnout were described as measures, procedures, interventions, and/or strategies designed to find a solution to burnout among physicians, eradicate system-level drivers of physician burnout, and remove administrative burdens, offering real-world interventions and assisting doctors to rediscover satisfaction in the healthcare field (DePorre et al., 2023).

Stress: According to the American Institute of Stress (2020), stress or anxiety is the condition/feeling experienced when an individual believes that demand goes beyond his or her personal or social resources. The American Psychological Association (2022)

indicated that stress results from psychological and physiological responses to internal and external stressors and affects nearly every system in the body, influencing how people feel and behave.

Well-being: The Centers for Disease Control (2018) indicated that well-being encompasses physical, mental, and social domains and is represented by positive functioning and flourishing. The American Psychological Association (2022) indicated well-being as a state of contentment with a generally positive outlook and quality of life, overall good physical and mental health, and low levels of distress.

Assumptions

Assumptions in qualitative research are statements that are considered to be true or at least logical by scholars and peers who read the research work (Wolgemuth et al., 2017). The inclusion of assumptions infers that persons reading the research work will consider specific features of the study as true, considering the selected population, research design, statistical test, and other delimitations (Siddiqui, 2019; Wolgemuth et al., 2017). There were several assumptions in this study, but the most central was that the stress and resulting burnout experienced by physicians was a problem that could be solved. An additional assumption was that physicians, as a group, could be helped through the responses that were created to help them. For this study, the interviews with the creators of the solution responses were the sources of data and/or evidence in this study, and this project operated under the supposition that the individuals suffering from burnout had obvious and observable factors that could be reconciled by the creation of a program or strategy.

Another assumption was that each creator was of sound mind and judgment, would cooperate fully and honestly, and would complete the interviews, providing relevant information that would benefit the research. Finally, there was an assumption that the burnout was the result of stressors occurring occupationally and not from other factors. The current study operated from the standpoint that burnout was associated with work-related stress.

Scope and Delimitations

According to Master et al. (2018), the scope of research denoted the extent to which the study field would be assessed and specified the parameters within which the study operated. Theofanidis and Fountouki (2018), on the other hand, described delimitations as the features that limited the scope and defined the boundaries of a study. Delimitations are also things the researcher chooses to restrict (Theofanidis & Fountouki, 2018), and the scope and delimitations are two interlinked components of a study. Regarding scope, this study focused on the creators of responses to physician burnout.

Prior to the COVID pandemic, literature regarding the subject of physician burnout had focused on the burnout that they had been experiencing for many decades. Now, the literature is almost entirely pandemic-related; that is, implying physicians are experiencing significant burnout as a result of the recent pandemic. As the pandemic is not directly related to this study, fewer pandemic related articles were included in this dissertation.

This was a qualitative study following the phenomenological approach, as early investigation for this study revealed that new, groundbreaking responses to the problem

required discovery, not testing a hypothesis or theory. Quantifying how and why past responses had been unsuccessful in fixing the problem of physician burnout would be difficult, as the problem had yet to be described and defined. By learning from the creators what their viewpoints were and describing their lived experiences, this study further described and defined the problem.

Limitations

Limitations are those weaknesses of a study that cannot be controlled by the researcher (Theofanidis & Fountouki, 2018). Several limitations were anticipated for the study based on the stipulated research methods and procedures. The first limitation of this study was the likelihood of researcher bias or subjectivity. Researcher bias refers to individual views or perceptions that may impact the study outcomes (Wadams & Park, 2018). This limitation was addressed via reflexive journaling. According to Meyer and Willis (2019), reflexive journaling includes the continual documentation of researchers' perceptions, opinions, and likely biases that can influence the study results.

The other key limitation was the likelihood that participants might be unwilling to share information with the researcher. I strove to alleviate this limitation by guaranteeing participant voluntary inclusion within the study, offering a safe climate for their willingness to discuss information, and stressing that all data collected throughout the study would be confidential and that identifying variables would be eliminated from the final transcripts. These assurances were stipulated in the interview protocol (see Appendix A).

Previous research addressing resilience programs was thought to have valid solutions for a very long time; however, with physician burnout and suicide numbers on the rise, it was important to understand why these responses did not achieve the desired results and what was currently being done to respond differently. This study approached physician burnout from a qualitative perspective and did not seek to quantify the rate of burnout, but instead to understand the responses that the creators designed to help alleviate and rectify the burnout.

Another key limitation was that data would be collected from 15-20 participants, which may or may not be a good representation of all creators of physician burnout and suicide prevention programs and strategies in the United States. Accordingly, the study findings would not be generalizable to the entire population of creators of physician burnout and suicide prevention programs and strategies in the country. Nonetheless, the findings may be pertinent in presenting information for future research and advancing data regarding the effectiveness of responses to physician burnout.

Significance of the Study

The completed study has both empirical and practical significance. The empirical significance of this study is that it can bridge the scarcity of research on the effectiveness of responses to physician burnout in reducing and/or addressing the problem of burnout among physicians in the United States. This study was unique in that it focused specifically on preventative efforts above and beyond resilience training for a population plagued by burnout (DiFabio & Palazzeschi, 2015). There was particular relevance to this given the National Academy of Medicine's recent proposal to utilize chief wellness

officers, individuals dedicated to monitoring the challenges to well-being that medical professionals face (Clinician, 2017), as well as new efforts by some medical schools to develop resources to assist medical students in coping with these stressors while they are in medical school, residency, and afterward.

Practically, this study contributed to a better understanding of how creators perceive and experience efforts to prevent physician suicides in the future. An understanding of how creators derived, conceived, or otherwise generated interventions to physician burnout assisted in the development of effective responses to this problem. Given their participants' high rate of suicide and their lack of mental health resources, this can address an important social change issue. In view of the importance of physicians in society as a whole, it was crucial to understand how physicians have experienced previous preventative measures and how they understand current efforts to improve these measures.

Summary

The research problem addressed in this study included the issue that although physician burnout is a recognized problem leading to impaired clinical performance, loss of vital services, inaccuracies in diagnosis and treatment, and reduced patient satisfaction (Bailey et al., 2022; Kuhn & Flanagan, 2017; Ortega et al., 2023), no one, successful, clear strategy has been developed that solves this issue. The essence of addressing burnout in the healthcare sector lies in the possibility of inaccuracies in diagnosis and treatment, an increased likelihood of absenteeism, a reduced patient satisfaction score, impaired clinical performance, and loss of vital services (Bailey et al., 2022; Ortega et al.,

2023). Physician burnout results in diminished performance, loss of vital services, and even suicide in some cases (Kuhn & Flanagan, 2017). In response to the problem, many strategies have been proposed and developed. The purpose of this qualitative phenomenological study was to explore the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses. An understanding of how these various approaches were derived, conceived, or otherwise generated assisted in the development of future effective responses to physician burnout.

The target population was comprised of the creators of physician burnout and suicide prevention programs and strategies in the United States. A purposeful sample of 17 participants was selected based on Moustakas's (1994) conventions for conducting a qualitative descriptive phenomenological study. In semistructured interviews, creators of responses to physician burnout were asked to identify and describe the reasons behind such a response as perceived by the creators and participants, the process used to develop it, and the effectiveness of the response. Specifically, the research question asked how and why physicians created and produced their responses to burnout and suicide. Chapter 2 presents a description of the existing literature relevant to the acknowledged research problem, purpose of the study, study concepts and ideas, and research question. A brief overview of the background to the research problem is provided in this chapter, along with supporting statements and inferences about the negative results of the problem. Chapter 2 also describes a detailed research framework, as well as the results of studies related to the issue and their connection to it.

Chapter 2: Literature Review

Introduction

The problem addressed in this study was that although physician burnout is a recognized problem leading to impaired clinical performance, loss of vital services, inaccuracies in diagnosis and treatment, and reduced patient satisfaction (Bailey et al., 2022; Kuhn & Flanagan, 2017; Ortega et al., 2023), no single, successful, clear solution has been developed as a response to this issue. Burnout among physicians is a recognized problem resulting in the impairment and loss of their vital services to the medical community and even in the suicide of some physicians (Kuhn & Flanagan, 2017; Ortega et al., 2023). Many factors can result in physician burnout, encompassing work overload, a lack of occupational independence, having no time for nonprofessional activities, administrative burdens, increased regulation, technology needs, and system inefficiencies (Bailey et al., 2022; Dillon et al., 2022; Smith et al., 2022). The essence of addressing burnout in the healthcare sector lies in the possibility of inaccuracies in diagnosis and treatment, an increased likelihood of absenteeism, a reduced patient satisfaction score, impaired clinical performance, and loss of vital services (Bailey et al., 2022). The purpose of this qualitative phenomenological study was to explore the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses. An understanding of the creation of responses to physician burnout derived, conceived, or otherwise generated different strategies and interventions to assist in the development of effective responses to physician burnout.

Chapter 2 provides a description of the existing literature relevant to the acknowledged research problem, purpose of the study, study concepts and ideas, and research question. A brief overview of the background to the research problem is provided in this chapter, along with supporting statements and inferences about the negative results of the problem. The literature review section presented here will provide a summary of research pertaining to the problem, some of the programs that have been instituted in an attempt to respond to the problem, and an overview of the individuals who created and designed specific responses to physician burnout and suicide. To better understand the nature and occurrence of physician burnout, the review began with an exploration of the factors that led to this problem. That was followed by a review of popular strategies and interventions that have been in effect for the past decade and were designed to improve the situation and resolve the problem. Next was a review of the newest responses being utilized by hospitals, medical schools, and individual doctors. At the end of the review, attention was focused on the individual industry experts researching and creating these new efforts.

Literature Search Strategy

The search for existing literature applicable to this study followed Kumar's (2014) recommendation of starting with a broad topic, determining a problem to evaluate, determining the research population, and settling on what to investigate. Following a determination of the topic under assessment as described in Chapter 1, a comprehensive search of relevant literature was conducted from Walden University and the internet. Other databases that were used in the literature search comprised the Emerald Insight,

LexisNexis, Google Scholar, EBSCO, Eric, Elsevier, ProQuest dissertations, and SAGE Journals database. The key terms and combination of terms that were applied for the literature search included *burnout*, *physician burnout*, *responses to burnout*, *responses to physician burnout*, *causes of physician burnout*, *strategies and interventions of eradicating physician burnout*, *processes involved in responding to physician burnout*, *motivations to responding to physician burnout*, *the essence of eradicating physician burnout*, and *factors that influence their decision-making in creating and implementing responses to physician burnout*. Boolean searching was applied in the literature search where the search words were joined to obtain applicable peer-reviewed sources. The literature search outputs/results were predominantly limited to current studies, preferably those published within the past 5 years. Several seminal and older sources were nonetheless used primarily to evaluate the development of the specified conceptual model.

Literature Review

Physician Burnout: Background Information

Research on burnout in the healthcare system goes back to the 1970s when Maslach observed burnout in healthcare settings (Mészáros et al., 2014). Around the same time, psychologist Freudenberger documented healthcare employees exhibiting emotional stressors (Maslach et al., 2001) and coined the term “burnout” in a clinical sense when describing healthcare workers and air traffic controllers, both of whom he found in grave peril in regard to their increased job-related stress and declining

production and quality (Samra, 2018). Subsequently, 50 years later, burnout is still conceptualized as uniquely affecting those in emotionally demanding professional roles.

Forty years ago, the Maslach Burnout Inventory described burnout as a work-related syndrome involving emotional exhaustion, depersonalization, and a sense of reduced accomplishment (Maslach & Jackson, 1981). While there exist varying ideas regarding what exact influences drive the problem, research showed that incongruity between the workplace and the worker harmed the worker and ended in burnout (Maslach 2001). The Maslach assessment is still the most widely accepted tool used today by organizations and individuals to assess mindsets of feeling personally “used up,” treating patients as objects, not humans, and feelings of ineffectiveness and lack of value in results of professional achievements and patient care (West, 2018).

Twenty years ago, Chopra (2004) defined burnout as “a syndrome defined by three principal components: emotional exhaustion, depersonalization, and diminished feelings of personal accomplishment. Unlike major depressive disorder, which pervades all aspects of a patient's life, burnout is a distinct work-related syndrome.” Around this same time, a study by Leiter and Durup (1994) indicated that the domains of burnout do not correlate well with other psychological issues. Later, Moss et al. (2016) again stressed the importance of recognizing the unique delineation between burnout and psychological disorder, as individuals indicating burnout from environmental stressors had no history of psychological disorders.

Physicians work in challenging environments, whether they work in a group or solo, and may experience dysfunction within their practice, whether that be working long

hours, juggling administrative tasks for which they have not been trained, discussing critical diagnoses with patients and families, struggling with work-life balance, among other things. The number of physicians reporting burnout symptoms has increased rapidly in recent years, with studies now indicating that half of all physicians are now suffering (Shanafelt et al., 2019). Shanafelt et al. (2019) also indicated that while there was some improvement in burnout conditions between 2014 and 2017, the conditions in 2018 had regressed to the lower rates in 2011. Furthermore, their study indicated that when compared to workers in other industries, physicians' work-life balance and burnout numbers were much worse. Statistics such as these indicated that the individual workers were likely not the issue, but instead, perhaps it was the work environment. When burnout is considered a result of organizational or environmental stress (Sinsky et al., 2017), industrial-organizational psychologists can better understand the nature and extent of this issue.

The issue of physician burnout has received relatively more attention in recent years, with various experts claiming that the biggest problem lies in a particular field of medicine. For instance, it was once believed that psychiatrists represented the highest number of physician suicides (Rosen, 1973), while Buck et al. (2019) indicated that burnout numbers are at a historical high, and family medicine physicians are most affected. A study by Arora et al. (2019) placed the most significant concern on emergency room physicians, and Alexander et al. (2020) found anesthesiologists to be at the highest risk. As the subject gains more attention, researchers have sought to further correct specific specialties' suicide statistics. For instance, Rinne et al.'s (2020) study

strongly disputed previously held beliefs that physicians working for Veterans Affairs had the highest level of burnout rates.

Still others have chosen to study physician suicide not by specialty but by gender, with results indicating male physicians have a 40% higher rate than that of male workers in general, and female physicians have a 130% higher rate than female workers in general (Schernhammer, 2005). Others were focused on collaborations to solve the problem for both genders in any and all medical specialties, as seen in 2017 when the National Academy of Medicine launched a national, multidisciplinary effort to engage regulators, professional societies, healthcare organizations, vendors, and others in an increased effort to address issues contributing to the problem in all specialties of medicine (van Niekerk et al., 2023).

Today, a brief perusal of the popular website and podcast KevinMD indicated a significant rise in topics such as “physician job dissatisfaction” and “physician burnout.” Increased interest in these topics is also evidenced in both professional journals and mainstream television shows. However, despite the increasing discussions about the prevalence and causes of physician burnout, physicians DeChant and Shannon (2020) stated that there was a short supply of proven strategies for preventing physician burnout. In addition, despite 4 decades of research, documentation, and published literature on physician burnout and the associated declining patient outcomes, the suicide rates continue to rise (Moss et al., 2016).

Physician Burnout: Consequences

This dissertation was born both of curiosity and dismay upon learning that doctors represent the second largest group of career professionals succumbing to suicide (CDC, 2018), which is likely the most significant consequence of leaving physician burnout unaddressed or insufficiently addressed. Clearly, a single loss of life is tragic, and with the addition of family members and patients affected by each death, the societal impact of physician suicide is felt widely. Welp (2018) called it a national public health crisis due to its negative impact on individual physicians, patients, and healthcare organizations.

On a less critical but still vitally important scale, the impact on individual physicians included feelings of being mentally exhausted, lacking self-motivation, and declining cognitive ability due to exposure to unpredictable and inconsistent events, which, if continued, often lead to emotional helplessness and an inability to help others effectively (Maier & Seligman 2016). While many in society might seek help, a stigma exists in that medical community that implies by asking for help, the individual is weak; eventually, avoided or repressed emotions in physicians manifest in other behavioral ways when not managed, such as aggressiveness, substance abuse, or disconnectedness from family and friends (Robertson & Long, 2019). Continued burnout for physicians can progress to extreme anxiety, depression, and sometimes suicide; yet, because of the stigma of suicide, there has been what some refer to as a “paralysis” felt by many organizations’ healthcare leaders when faced with the crisis of burnout (Brower, 2021).

For patients, the consequences include poor quality of care and increased medical errors, as seen in literature reviews such as the one done by Halbesleben and Rathert in

2008, in which they cited a dearth of research linking healthcare provider burnout and poorer patient outcomes. Panagioti et al. (2018) referred to physician burnout as an epidemic that affected core domains of patient safety and quality of care. Disillusioned, discouraged, and disengaged, physicians are producing lower satisfaction rates in patients and more significant risks to patient mortality (Welp et al., 2015). Patient care errors from burnt-out physicians have also been evidenced in comprehensive studies, ranging from cohort studies that indicate burnt-out residents are six times more likely to make medication errors (Fahrenkopf, 2008) to extensive national studies in which physician burnout was associated with significant medical errors (Tawfik et al., 2018). Balch et al. (2011) showed that over the years, physician suffering had been associated with poor physician prescribing habits, patient test ordering, and an increase in malpractice suits. Multiple studies and consistent results such as these indicated that medical centers should consider physician distress as an important quality indicator (Wallace et al., 2009).

Regarding consequences on an organizational level, higher levels of physician burnout impact organizational productivity, culture, strategy, and the capabilities of their leaders (Shanafelt et al., 2015a). Healthcare organization executives need productive and engaged physicians, not a disillusioned physician workforce lacking vigor, dedication, focus, and stability (Shanafelt & Noseworthy, 2017). Individual physicians' job demands may become overwhelming at times, but when abundant stress occurs, that person may experience social, psychological, emotional, and/or physical exhaustion (Van Woerkom et al., 2016). The inability to cope or an attempt to avoid emotional and physical fatigue will only perpetuate the problem and lead to poor job performance, low job satisfaction,

and unhealthy work behaviors towards colleagues (Halbesleben et al., 2014). Clearly, organizational culture and productivity suffer significantly at this point, necessitating even more attention from organization leaders. This uses more time resources, and financial resources become ever more strained. More on organizations' business cases follows.

Physician Burnout: The Business Case

In 1974, Hamermesh and Soss were some of the first to examine suicide from an economic point of view by analyzing a 20-year time period between 1947 and 1967, and while that study was influenced much by the Great Depression, it did provide a foundation upon which future researchers could build. While the survival of many healthcare organizations is currently at risk with unprecedented changes in both governmental regulations and professional burnout rates, a strong business case exists for organizations to participate in efforts to decrease physician burnout and promote engagement. In order to navigate these challenges, executives have attempted to stem the tide of burnout through various solutions that were created with business survival in mind (Shanafelt & Noseworthy, 2017).

On a seemingly small scale, institutional inefficiency is a universal driver of dissatisfaction and burnout and can be effectively handled by establishing policies and principles that aim to minimize clerical burden and maximize physician efficiency. The specific factors that create inefficiency can vary widely among organizations and even units within each organization, making it difficult for executive leaders to address physician burnout at the enterprise level (Shanafelt & Noseworthy, 2017). However, with

workflow in mind, any system issue that would threaten the business process must be recognized by healthcare organization leaders who should rapidly mobilize resources to address the problem (Asare et al., 2020). Quality of care issues will lead to eroded patient satisfaction, which will affect RVUs (relevant value units), which will, in turn, have financial implications (Um & Lau, 2018). These quality control assessments of patient satisfaction, while well-meaning, historically created intense pressure to compete with other state-of-the-art facilities and often led healthcare executives to ignore internal woes and focus on external threats (Shanafelt & Noseworthy, 2017). One Mayo Clinic study suggested that physician-organization collaboration decreases burnout and improves organizational quality and productivity through the development of more efficient care delivery models created by both the physicians and the non-physician executives (Swensen et al., 2016).

Productivity concerns are a significant driver in organizational pressure on physicians to perform, and while revenue management is an understandable and responsible action on the part of institutions, too much pressure often leads to the resignation of physicians. This then requires the recognition of the loss of current patient revenue, as well as the new capital outflow in replacing a physician, including recruitment, onboarding, and new patient generating, a cycle which is estimated at two to three times the physician's annual salary (Hamidi et al., 2018). The mystery is why significant organizational change has yet to occur despite decades of extensive evidence suggesting that the environment of these organizations plays a critical role in whether physicians remain engaged or burn out (Dewa et al., 2014).

A prospective longitudinal study conducted at the Mayo Clinic produced results indicating that every one-point increase in burnout or one-point decrease in satisfaction correlated with a 30-40% likelihood of physician reduction in work effort (Shanafelt et al., 2016). A vast array of potential factors leading to burnout and disengagement have been narrowed down to seven primary dimensions that are influenced by individual, work unit, organizational, and national factors and have been categorized as “workload, efficiency, flexibility/control over work, work-life integration, alignment of individual and organizational values, social support/community at work, and the degree of meaning derived from work” (Shanafelt et al., 2016). As medical malpractice suits increase, they represent one of the most aggressive financial impacts on a healthcare organization’s bottom line and consequently demand organizational risk assessment. In the late 1980s, a groundbreaking study of 67 hospitals with more than 12,000 individuals participating produced results indicating that workplace stress levels of hospitals correlated significantly with the frequency of malpractice claims (Jones et al., 1988). With medical malpractice settlements affecting physicians, insurance companies, and healthcare organizations, reducing burnout should become the shared responsibility of physicians and organizations.

In addition to malpractice lawsuits and physician retention/ replacement issues, ever-changing insurance practices are an issue. Dr. Noseworthy, an MD and a CEO, cited increasing price competition, decreasing insurance networks, and a greater number of patients with noncommercial insurance (due to the Affordable Care Act) as having resulted in declining reimbursements (Shanafelt & Noseworthy, 2017). At the same time,

requirements for “meaningful use” of electronic health records (EHRs) have resulted in large capital expenditures and dramatically increased clerical burden for staff; in turn, these financial burdens then increase the already heavy production expectations for physicians both in clerical work as well as caring for more patients with no increase in time or resources (Shanafelt et al., 2016).

The force applied by organizations to their physicians and the pressure by stakeholders to increase productivity at a rate that impedes providing good quality patient care, combined with their exhaustion, guilt, job dissatisfaction, and despair, eventually created a tipping point (Cohidon et al., 2019). Related is another organizational-imposed pressure in the form of physician-blame. Labeling frustrated physicians as uncooperative or unaligned is a common practice in organizations that have not embraced the fact that there may be valid reasons for the frustration, such as the aforementioned regulatory policies, reimbursement models, and high-paced advances in technology, to name a few (Cohidon et al., 2019).

The Mayo Clinic has dedicated numerous studies to organizational strategies that can promote physician well-being and has shown some improvement via deliberate and sustained efforts (Swensen et al., 2016). Many of the interventions from Mayo and other groups are relatively inexpensive, and these small investments can make a big impact, but the missing key to the success of these operationalized approaches is often attention from the highest levels of the organizations (Shanafelt & Noseworthy, 2017). Perceived corporate support was most valued by individuals, and yet those at the top often have a difficult time counterbalancing this concept since the conservation of resources requires

weighing individual players' stress against the overall outcomes of resources gained or lost in the organizational processes and policies (Marchand & Vandenberghe, 2016). Conservation of resources ultimately must occur when there is a change in resources within a work setting (Grandey & Cropanzano, 1999).

Leaders addressing these burnout drivers would enable physicians to provide better care for themselves and their patients. The moral-ethical argument for reducing physician burnout has always been clear, but perhaps the strong business case for doing so will be enough to finally create change. With the consequences of job dissatisfaction among physicians well known, policymakers should be interested in intervention efforts and structural changes both for their bottom line and for their moral obligation to physicians as humans. It remains to be seen whether these business-minded solutions result in better outcomes than the earlier strategies that were created with personal physicians in mind; however, institutions must stop operating under the mistaken notion that burnout is solely the responsibility of the individual physicians.

The Proposed Physician Burnout Solutions

Continuous improvement is necessary in order to stem the ever-increasing number of physicians who report feeling more and more isolated, overwhelmed, and powerless. From the grassroots resilience programs of the past to more recent interventions, leaders are taking this challenge seriously and building on opportunities to create a sustainable type of healthcare system that takes care of both the patients and the physician caregivers. Past and current industry leaders, psychologists, physicians, and CEOs, among others, have evaluated the organizational causes of physician burnout and created a variety of

responses in hopes of helping physicians thrive personally and professionally, because doing so ensures the future of healthcare (Aiken et al., 2023; DePorre et al., 2023). The goal is to improve the lives and workplaces of these clinicians and, by doing so, also improve society's patient care.

Response 1: Resilience Programs of the Past

In the past two decades, organizations have increased their recognition of the healthcare professional crisis and have acknowledged the need for action plans to enhance physician well-being (DePorre et al., 2023). The most prevalent of these initial interventions was the groundswell of resilience programs. Early adoption was seen in hospitals and at conferences, with the earliest efforts being met with appreciation, curiosity, and success (Aiken et al., 2023). Over time, however, such programs' overuse and/or misuse slowly led to more frustration and lack of progress.

These early programs were based on a working understanding of resilience, most heralded by Masten's original conceptualization of resilience as a process (Masten et al., 1990). This refers to a dynamic system's ability to adjust to instabilities that threaten the viability of that system, yet it is essential to note that resilience has been defined and studied in various ways (Southwick et al., 2014). Resiliency theory, which often includes both stress inoculation (Masten et al., 1990) and the concept of finding post-traumatic growth instead of post-traumatic stress (Kashdan & Kane, 2011), provides a base from which to create more resilient individuals with higher self-efficacy (Greene et al., 2002). According to more recent research, resilience aids the mental processes and behaviors

that enable an individual to overcome the adverse effects of stressors (Parks-Savage et al., 2018).

The thought process behind the resiliency training programs for doctors was based on teaching doctors how to use these concepts of resiliency as a means to manage stress and overcome their lack of well-being. As stated, in the beginning, these efforts led to some success, such as improvement in the rate of medication errors and a reduction in medical malpractice claims, both of which were observed in two longitudinal investigations that followed organization-wide stress management programs in 1988 (Jones et al., 1998). Initial successes such as these prompted the expansion of resilience programs across the country, as healthcare organization leaders realized the necessity of intervening in order to promote, among other things, physician retention in a new era of burnout. In addition to the expense of colleague turnover, there were the added costs associated with medical malpractice suits as physician mistakes grew in tandem with their burnout (Jones et al., 1998).

Organizations initially brought in resilience program experts in an effort to help physicians understand how to counteract cognitive fatigue, physiological exhaustion, and workplace stressors, using an understanding of what helped rejuvenate or reenergize themselves (Dishon-Berkovits, 2013). Encouraging individuals to pull from their inner personal strengths during stressful situations is an example of how coping mechanisms can lower burnout (Van Woerkom et al., 2016). To contrast the feelings of burnout, resilience programs were enacted to enable participating individuals to overcome the adverse effects of stress while recognizing that resilience can be learned, developed, and

improved just as it can be degraded or lost (Fox et al., 2018). While taking into reality the stressful working conditions within which they were operating, physicians were taught to deploy personal resources to adapt to the adversity and stress (Zwack & Schweitzer, 2013). The Medical Research Council (2014) described resilience programs as initiatives designed to improve individuals' ability to negotiate, manage, and adapt to significant sources of stress or trauma.

More often seen components of these resilience programs have included physical wellness, cognitive flexibility, meaningfulness, and social wellness. Physical wellness is a struggle for physicians because their workweek is significantly longer than most other fields' (Shanafelt et al., 2015), so resilience programs often focus on nutrition, hydration, healthy sleep practices, exercise, and lifestyle choices. However, the World Health Organization defined wellness as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (Vercio et al., 2021), and as such, other factors above physical wellness need to be addressed.

Another aspect of wellness that resilience programs have focused on is that of cognitive flexibility in physicians, which refers to the ability to construct the most optimal solutions and decisions, which can be driven by mindfulness, self-awareness, growth mindset, cognitive reframing strategies, stress management, and mental health resources (Menon et al., 2019). Also important in resilience programs was addressing physicians' sense of calling or their meaningfulness as it related to their sense of purpose in the practice of medicine, and can be promoted by ensuring that physician time was

dedicated to work they find worthwhile and that connects them to humanity (Handoyo, 2022).

Because increased physician wellness is associated with a decrease in medical errors and an increase in patient care quality (Menon et al., 2019), one of the most common aspects of resilience programs was focused on social wellness, which can include an appreciation of common humanity and was encouraged by spending time in one's community, expressing gratitude, and having compassion for others instead of separating and detaching in reaction to professional distress (Gogo et al., 2019).

Healthy work-life integration involved helping physicians identify and prioritize professional and personal responsibilities while taking into account which were incompatible and which could realistically be resolved through boundaries, time management, flexible work schedules with cross-coverage, and adequate time away from the workplace (Menon et al., 2019).

The idea of resilience programs as a pathway to physician wellness and away from burnout was the groundbreaking first attempt to eradicate physician burnout, yet it faced criticism for its failure to solve the issue. Menon et al. (2019) pointed out that while the personal resilience domain is the dimension over which individuals have the most control, it should be used as a complement to organizational strategies and not as a way to encourage physicians to accept and endure dysfunctional organizational factors that contribute to distress.

Krasner et al. (2009) noted over a decade ago that the utilization of many resilience programs had been low, with only 8% of invited physicians participating, and

of those, a high instance of dropout rates. Vercio et al. (2021) reflected on the limited value in asking individuals to increase their personal resiliency while not addressing organizational resiliency, because this often left physicians feeling marginalized.

Ladonna et al. (2022) noted that many physicians resisted resilience interventions due to their perceptions of the programs' motives and explored physicians' feelings of being dehumanized by organizations that professed to value compassion in healthcare, specifically referencing these organizations' professional expectations of physicians to be invincible to the point of becoming superhumans sacrificing everything for medicine. Physicians in the study referenced the organizations' roles in impeding work-life balance and personal and professional fulfillment and pointed to the fact that building individual resilience was futile without broader systemic organizational change.

Physician resilience and well-being practices have failed in many well-intentioned organizational efforts, which perhaps is due to a need to simultaneously address the inefficiency of the practice environment and the organizational culture that impedes professional fulfillment. Left unaddressed, many physicians will continue to view the organization's focus on personal resilience as "an insincere attempt to address the problem" and often feel like it's an effort to "increase physicians' ability to tolerate a dysfunctional practice environment" (Menon et al., 2019).

Vanhove et al. (2016) showed that resilience-building programs had a weaker effect in the workplace than those associated with some other prevention techniques and diminished substantially from proximal (<1 month postintervention) to distal time points (>1 month). They suggested that developers of resilience-building programs might

optimize effectiveness by conducting individual assessments to identify and help those at elevated risk. While, in theory, this may seem logical, many in the medical community would be uncomfortable with this kind of attention, especially given the stigma in this particular industry.

The prevention of burnout and the development of a resilient physician workforce will require an institutional commitment to building a better environment for both patients and physicians. Despite the work that has gone into the aforementioned resilience programs, they have yet to prove to be sufficient alone to eradicate the problem of burnout in physicians; thus, after assessing the issues, newer strategies have been created and designed to help.

Response 2: Chief Wellness Officers

Many agree that personal resilience training does not suffice to alleviate burnout since burnout is not a result of personal shortcomings; organizations need to provide solutions that address organizational culture, optimize workflows, address staffing issues, and enhance practice support if they are to alleviate the problem (Ripp & Shanafelt, 2020). One way in which many institutions are trying to do that is through the introduction of a new senior leadership position—the healthcare industry’s chief wellness officer (CWO), which differs from other wellness leadership roles that have historically existed outside of medicine (Ripp & Shanafelt, 2020).

CWOs in nonhealthcare organizations tend to promote healthy habits and self-care practices to improve overall employee health (Song & Baicker, 2019). In contrast, the healthcare CWO role was established to protect clinicians from widespread

occupational distress by improving upon an organization's complex array of system-level drivers that have detracted from the well-being of clinicians and have distracted from an optimally functioning healthcare system (Ripp & Shanafelt, 2020).

To address these challenges, the CWO should have the necessary authority and resources to collaborate with other operational leaders to improve well-being; thus, the organizational environment would improve, rather than individuals being asked to be more accepting of a broken system. Resentment toward resilience training and the term "burnout" has developed as a consequence of the suggestion that burnout reflects on an individual's personal resilience abilities; in contrast, leading organizations are now creating leadership, infrastructure, and improvement teams to address burnout, with the healthcare CWO playing a crucial role (Ripp & Shanafelt, 2020).

In 2017, Stanford Medicine was the first large healthcare organization to create a healthcare CWO position, and to date, more than 20 organizations have followed suit, creating similar positions with similar titles, such as dean for wellness or vice president of vitality. Many others are slated to adopt similar roles in the coming years (Kishore et al., 2018), and the importance of these roles has even prompted the National Academy of Medicine and leaders from other influential healthcare accrediting bodies to recommend that all academic medical centers establish a healthcare CWO position (National, 2019).

Hesitation about adopting another C-suite level role is largely due in part to the added expense to organizations; however, there exists a strong business case for adding a CWO when one analyzes the evidence that burnout erodes the quality of care and patient satisfaction (Panagioti et al., 2018). In terms of economics, it is essential to keep in mind

that clinician burnout differs significantly from burnout in other occupations in that clinician burnout impacts patients in their care, increasing the risk of medical errors (Panagioti et al., 2018). In fact, when physician burnout leads to increased rates of depression, alcohol and drug abuse, divorce, suicide, complicated relationships with coworkers, patient dissatisfaction, and physician attrition, the costs to the healthcare system can be enormous (Lacy & Chan, 2018). Several studies have revealed that clinicians are decreasing their professional work effort (Shanafelt et al., 2016) or leaving the profession in response to burnout (Sinsky et al., 2017). Given an estimated \$4.6 billion in annual costs related to physician turnover and reduced clinical hours attributed to burnout and an annual economic cost of approximately \$7,600 per employed physician each year (Han et al., 2019), these significant financial implications associated with burnout provide a compelling reason for organizations to take action (Han et al., 2019). Numbers such as these would undoubtedly show up on the radar of CFOs across the globe, so perhaps, given healthcare's unique organizational challenge, the appointment of CWOs may be what doctors need.

Despite the intense focus on individual physician wellness and burnout, there have not been enough significant positive changes, and while systems-level approaches have demonstrated increased benefit, organizations are likely to have unique constraints that limit their understanding of the complex interaction between the constructs involved and their ability to implement any specific intervention (Vercio et al., 2021). Many believe that a CWO, focused only on organizational change for the well-being of

physicians, can help emphasize organizational interventions and solutions for physician burnout.

Response 3: Physician Coaches

Setting aside expectations that organizations will solve internal issues in the near future, some physicians have decided to take matters into their own hands. While it may not be their responsibility to find coping measures, their concern for their own well-being lead some to hire their own coaches. According to Shanafelt and Noseworthy (2017), professional coaching has long been used by the likes of executives and athletes to reach peak performance, and some physicians are now finding success with burnout coaches.

It is important to note the distinct difference between the coaches hired by physicians personally, as opposed to the coaches sometimes hired by healthcare organizations to improve technical performance and patient outcomes. For the purposes of this study, personally hired coaches refers to physician coaches. Physician coaching is distinct from therapy and instead draws on the philosophy of cognitive behavioral sciences to increase self-awareness, self-trust, choice, resourcefulness, and a focus on identifying opportunities for strengths-based development with quantifiable outcomes (Thorn & Raj, 2012). Coaching assumes that clients already possess the skills and strengths to deal with life's challenges, and that coaching will help them maximize their potential (Gazelle, 2015).

According to the Code of Ethics of the International Coach Federation (2014), coaching is the process of helping clients maximize their personal and professional potential by engaging in thought-provoking and creative activities. This broad definition

is similar to the work that an athletic coach or executive coach may do. Popular culture reading, such as the Harvard Business Review (2009), has long since heralded using coaches regardless of one's career field, and explains that a coach will perform the "inherently creative activity of bringing forth knowledge, wisdom, and insight through asking questions, listening deeply, keenly observing, dedication to self-awareness, and commitment to learning."

Many physicians report feeling isolated and alone in their burnout and are unable to discuss solutions with colleagues or organization leaders; they are not typically encouraged to vocalize their problems (Shanafelt & Noseworthy, 2017). Our society encourages talking through issues, so some suggest that logically, having someone to talk to about frustrations should seem an easy choice. Nonetheless, many physicians are concerned about the stigma of "therapy," especially as it may affect their medical malpractice insurance, which dictates that they be of "sound mind" while practicing medicine; thus, many physicians are unwilling to try burnout coaches.

However, physician coaches are not akin to psychiatrists who deal with mental health issues inherent to an individual but are instead coaches who are equipped to help with career-related burnout and stress. The founders of industrial organizational psychology, Cattell and Myers, encourage the use of psychological science and systemic approaches to evaluate and create solutions to work-related issues (Briner & Rousseau, 2011). Many suffering physicians can find help with the use of coaches trained to do just that; still, only 22% of physicians report being inclined to seek professional help for burnout (Kane, 2019).

One of the main goals of a physician coach is to help physicians recognize the control they have over their life circumstances. One strategy used by coaches to achieve this is to amplify the physician's internal locus of control, which is defined as "the belief that one's actions have as much or more impact on life outcomes than external forces or individuals," something critical for physicians rapidly losing workplace control (Rotter, 1990). Coaching also increases self-efficacy and self-determination, which are important offsets to burnout (Glass & McKnight, 1996). In a medical culture that emphasizes perfectionism, denial of personal vulnerability, and delayed gratification, professional coaching provides a results-oriented method to address burnout, primarily by enhancing self-awareness, questioning self-defeating thoughts and beliefs, examining new perspectives, and aligning personal values with professional duties (Gazelle, 2015).

According to a randomized clinical trial of 88 physicians in a Mayo Clinic Study, six months of coaching reduced burnout and emotional exhaustion, as well as improved resilience and quality of life (Dyrbye et al., 2019). The study was done using the most frequently utilized instrument for measuring physician burnout, the Maslach Burnout Inventory (Maslach et al., 2016), which was employed in conjunction with the Connor-Davidson Resilience Scale (Campbell-Sills & Stein, 2007), the Global Job Satisfaction subscale of the Physician Job Satisfaction Scale (Williams et al., 1999), the Utrecht Work Engagement Scale (Schaufeli & Bakker, 2004), and the Empowerment at Work Scale (Spreitzer, 1995). While participants had significant reductions in emotional exhaustion and burnout, they did not observe statistically significant reductions in depersonalization or improvements in job satisfaction, engagement, or meaning in work. In other words, as

previously suggested, coaching is not a replacement for organizational efforts to improve the environment and address the underlying causes of physician burnout and dissatisfaction. Until these stressors are controlled, coaching remains useful.

Other intervention studies showed similar results with improvement in some but not all aspects of well-being. For instance, a 2014 randomized intervention study showed reduced depersonalization and improved meaning and engagement at work but did not reduce emotional exhaustion or increase job satisfaction (West, 2014). In this study, coaching topics were scripted, while in the Mayo Clinic study, topics were unscripted, which allowed participants to tailor their sessions personally to their needs (West et al., 2016). Studies addressed a diverse range of individual physicians' professional needs, such as clinical work, career direction, leadership, work-life integration, and self-care. They identified needs, goals, and action plans that would aid in self-focused, individual behavior modification to promote well-being and facilitate decisions to address various aspects adversely affecting physician well-being and career satisfaction.

A 2014 pilot intervention found that coaching helped physicians align their personal values with their professional duties, utilize self-awareness to alter their patterns of devaluing self-care, and draw on personal strengths (Schneider et al., 2014). As part of another study, cognitive behavioral coaching was evaluated for effectiveness and value in improving well-being, but more empirical data is needed to assess its total effects on physicians. Coaching can assist physicians in accessing personal strengths and skills to cope with work-related stressors and reduce their vulnerability to burnout (Gardiner et al., 2013). By 2018, a Stanford Medicine study showed coaching was a benefit to physicians,

indicating large and statistically significant effect size improvements in burnout, self-valuation, and sleep-related impairment (Makowski et al., 2022).

Indeed, individual physicians can participate in their own or their coaches' suggested activities to cultivate personal well-being and resilience. However, occupational challenges such as long work hours and professional norms that promote self-sacrifice rather than self-care should be the responsibility of healthcare organizations bearing the responsibility to create efficient practice environments and a culture of organizational wellness (Bohman et al., 2017). Organizational change should be the priority rather than burdening physicians with finding care to survive the abuse of their organizations, especially in an era where physicians remain reluctant to seek professional assistance for "burnout" which the World Health Organization recent adopted as an illness (Smith, 2020). In that same vein, some reference the "Canary Versus the Coal Mine" analogy and compare doctors to the dying canary's warning that a work environment has gone wrong. In hopes of addressing these workplace dangers before catastrophe occurs, the interviews included in this dissertation were sought to shed more light on key decision makers' efforts to improve the situation.

Response 4: Reevaluating Electronic Medical Records and Relative Value Units

The U.S. healthcare system has seen much change in the past decade, which many attribute to the current state of heightened physician crisis. Given the increase in problems in the past decade, many agree that there is cause for alarm; for instance, in 2000, the U.S. Institute of Medicine released a report indicating that medical errors occurred in as many as 5%–18% of all hospital admissions and accounted for 98,000

annual deaths, which is more than car accidents or breast cancer (Kohn et al., 2009). By 2013, medical errors had become the third leading cause of death in the United States, accounting for 440,000 fatalities annually (James, 2013). Also increasing in that time period was a heightened interest in an organizational tool intended to improve healthcare, called electronic medical records (EMR) or electronic health records (EHR). Mark et al. (2010) explained that these EHRs would create a national electronic health record that would provide immediate access to multiple healthcare providers across the country, regardless of where the patient's record originated. The belief in its importance was so strong that President Bush made a 2004 decree to have nationwide EMR access by 2014, a goal also supported by President Obama (Ford et al., 2009). The American Recovery and Reinvestment Act of 2009 mandated that electronic health records be adopted in U.S. healthcare organizations by 2015 (Barrett & Stephens, 2016).

According to Barrett and Stephens (2016), this extensive, wide-sweeping organizational "improvement" in healthcare resulted in an increase in problems. For example, Barrett and Stephens (2016) posited that the record-keeping added an unnecessary and colossal burden to already overworked and burned-out physicians, causing an even bigger crisis.

One study estimated that every hour a physician spent with patients now required almost two additional hours of desk work and computer input, which led to more time spent each evening completing computer tasks (Sinsky et al., 2016). Arndt et al. (2017) indicated that in addition to spending roughly half of their workday on EHR, the average physician now spends 28 additional hours per month completing EHR tasks during nights

and weekends. Additionally, Shanafelt et al. (2019) cited a marked change over the last two decades in the day-to-day work of U.S. physicians, given the dawn of new healthcare regulations and policies, including the Affordable Care Act, Meaningful Use, and the Medicare Access and CHIP Reauthorization Act. Cumulatively, combined with the new burden of HER, this substantially increased administrative burden and led to decreased physician face time with patients (Arndt et al., 2017).

In an early study evaluating 379 primary care physicians between 2001 and 2005, statistically significant associations were found between physicians' stress and job satisfaction and the number of EHR functions in which they participated (Babbott et al., 2014). Even before governmental regulations were in place for EHRs, the MEMO study was conducted, which in turn piqued the interest of Shanafelt et al. In 2014, they did a wider-ranging study after governmental and organizational requirements for the EHR had heightened. In Mayo Clinic proceedings in 2016, Shanafelt et al. (2016) provided the research findings from their 2014 study that involved the relationship between the electronic environment, the clerical burden to physicians, and the resulting burnout. Participants included 6375 physicians from across specialties, with 82% indicating that they participated in EHR, and of them 95% indicated a higher risk for burnout.

Further heightening physician stress and burnout is a new, nationwide, organizational tool that measures productivity metrics called RVUs (relative value units), whose existence has restructured how many organizations define what it means to be a quality doctor (Rosner et al., 2020). Historically, physicians were simply paid according to the services for which they billed; however, in the U.S. today, the RVU system has

become the national standard for measuring productivity and expense allocation, with compensation calculated on the basis of relative physician resource costs (Rosner et al., 2020). In simpler terms, rather than counting the number of patients and procedures a physician handles, the actual payment for services varies according to the average physicians' time and accounts for the "practice expense," which includes overhead, as well as the "malpractice expense," which covers the risk involved.

While RVUs appear on the surface to make up a logical and organized system, time and again, frustrated physicians are reporting the administration's misuse of billing for complex care, as well as unrealistic, high-pressure targets for productivity. As an example, a 2013 analysis showed that Medicare reimbursed three to five times more for a single colonoscopy than a cognitive-based provider received for an entire day of work (Sinsky & Dugdale). Discrepancies such as these have led to physician job dissatisfaction and burnout and a call for investigation into whether RVUs may be misvalued and unfairly favor certain specialties (Zuckerman et al., 2015). An example of this can be found in a 2017 governmental analysis, which indicated nephrologists received less compensatory pay than primary care physicians for the same task (Analysis, 2017). This conflicts with the principles of value-based care, again encouraging burnout and more pressure to boost work output.

With these increased productivity expectations, American physicians are facing challenging times. Studies indicate that more than half of these physicians face professional burnout at twice the rate of workers in other industries (Dzau et al., 2018). Evaluating the associations between physician burnout and these new tasks and models

has provided much insight into the ever-increasing rates of burnout and job dissatisfaction among U.S. physicians. Calls to reform the EHR and RVU models will continue until physician well-being is achieved.

In summary, although the numerous responses and interventions mentioned have net some encouraging results, efforts remain inconsistent and random, with an unknown national impact due to their infancy stage (Shanafelt & Noseworthy, 2017).

Response 5: Interventions in Medical School

In light of the harmful effects of burnout on the clinical community, multiple residency programs have implemented strategies to alleviate burnout (Lebares et al., 2021). For the past 2 decades, studies have been conducted to better understand student and resident accounts of depression and burnout (Taylor, 2003). In 2006, Mayo Clinic Proceedings indicated that nearly half of third-year medical students reported burnout (Dyrbye, 2006). More troubling is a 2008 study that showed the strong associations between burnout and suicidal ideation among U.S. medical students (Dyrbye, 2008). Further, a 2018 study called for a re-evaluation of coping and dysfunction, showing surgical residents are two times more likely to have severe depression, are three times more likely to have suicidal ideation than their same-aged peers, and have rates of alcohol misuse five times higher than the general population (Lebares et al., 2018). Medical school students and residents need adequate preparation for the stressful responsibilities of their future careers. The need for establishing better and different protocols has become increasingly apparent.

According to research, overall burnout, stress, and distress are two to five times higher among residents than they are in the general population (Lebares CC et al., 2018), and the second most common cause of death in residents is suicide (Yagmour et al., 2017). Although medical training in the United States is highly regarded worldwide, it can also breed perfectionism, promote competition, prevent individuals from speaking up, worsen burnout symptoms, and contribute to ineffective performance improvement methods (Smith, 2020). A 2015 meta-analysis of 54 studies examined depression and depressive symptom prevalence in resident physicians across decades and around the globe; the authors found that depression symptoms increased by 15.8% during residency, regardless of the specialty or country of training. In the course of training, 20.9% to 43.2% of residents reported depressive symptoms, which increased over time (Mata, 2015). There has been a significant decrease in the percentage of graduates entering medical careers in the last 20 years, with factors linked to burnout and poor quality of life (Landon et al., 2006). In the United States, there is a pressing need to address the decline in surgery applicants, which some refer to as the impending disappearance of surgeons (Fischer, 2007).

A study of seven universities in 2019 revealed that 49% of residents were at high risk of burnout, with contributing factors indicated by disruptive behaviors including public humiliation, others taking credit for work, punishment work, physical abuse, career threats, or discrimination (Baker et al., 2021). Other studies indicated that the intensely long hours manifest as physical and mental exhaustion which lead to

overextension (Brown, 2021), and within hours worked, the violations of the 80-hour workweek are associated with burnout (Kinslow et al., 2020).

Medical students, residents, and fellows are known to work long workweeks on very little sleep. Night shift work was classified by the World Health Organization as a probable carcinogen due to circadian disruption (Straif, 2007), and more recently, the effect of being on-call on sleep patterns was examined, with results showing that sleep deprivation stress lasted for two to three nights after each call shift (Robinson, 2019). Nearly 65% of sleep patterns observed were categorized as acute or chronic sleep deprivation (Coleman et al., 2019). As the dearth of research grows regarding physician burnout, much research has shifted to these root causes that begin in medical school.

Another major stressor in residency is one of the same in career physicians: that of the EMR/EHR. According to a study conducted by Duke University, surgical residents spend 38% of their weekly time using EMRs (Cox et al., 2018). In an observational study of 57 attending physicians, 27% of clinic time was spent on direct patient care, and 49% using the EMR (Sinkov, 2016). Although the EMR has improved the quality and efficiency of patient care, it has also added countless hours to both residents' and physicians' daily schedules.

As unrealistic job requirements continue to be placed on residents and surgeons, fewer young people are thriving in medical school. According to a survey of residents in 19 different programs, trainee career choices were influenced by the perceived burnout and quality of life of their attending surgeons (McClintock, 2019), with subspecialties that offer better quality of life becoming more competitive. In order to decrease issues

such as attrition, depression, and suicidal ideation among surgeons and trainees, burnout must be addressed at the personal, institutional, and national levels (Golisch, 2023).

Accreditation Council for Graduate Medical Education (ACGME), a private, nonprofit organization that sets standards for U.S. graduate medical education programs (residency and fellowship), has recently presented physician resilience efforts in order to reduce physician burnout, stress, and depression (Parks-Savage, 2018). ACGME's range is broad, reaching 10,700 residency and fellowship programs in 154 specialties and subspecialties in 2017 alone. Program requirements state that "self-care and a responsibility to support other members of the healthcare team are important components of professionalism" (ACGME, 2020). Relatedly, many expert opinions call attention to the importance of mentorship in surgery (Freischlag & Silva, 2017).

A study conducted in 2021 found that 24% of residents expressed dissatisfaction with social and community support, including a lack of mentorship, which negatively impacted the learning environment and contributed to resident burnout (Ellis, 2021). In a 2021 mixed-methods evaluation of a general surgery residency program and its association with resident wellness, resident satisfaction was related to program responsiveness in terms of conflict resolution and in mentoring opportunities which may result in less burnout, attrition, and suicidality (Joung et al., 2022). Lack of faculty mentorship has been associated with lower scores of personal fulfillment (Lund, 2022). Unique resident mentorship models have been created at other academic institutions with the intent of creating long-lasting and trusting relationships.

University of Michigan researchers developed anastomosis families, a mentoring program involving vertical groups of one to two medical students, an intern, a research resident, and a faculty member. During quarterly meetings, each group used the first half of the time as an informal reflective session and discussed a surgical topic during the second half. A mixed-method study will analyze and publish perceptions of this program in the next 1 to 2 years (Shen, 2022).

At the University of Texas Southwestern (UTSW) Medical Center, a simple and time-efficient tool called the “fuel gauge” was distributed over 2 years. It led with the question “Overall, my well-being fuel tank is” with responses ranging from 1 to 5 on a Likert scale. Program administrators valued its utility for determining which residents might be struggling, and residents reported it was feasible and well-received (Weis et al., 2020).

At University Hospitals in Ohio, Bingmer et al. (2019) created a model for a one-year formal mentorship for residents with assigned mentors, two social events, and recommended mentorship meetings. The intervention improved resident perceptions of faculty involvement and support, which could keep residents from burnout and attrition.

Surgical trainees have a high attrition rate, according to an article published in the American Journal of Surgery in 2017. The article stressed the importance of fostering well-being early in a surgical career path and outlined specific emotional strategies that were applicable from intern year to retirement, including protecting meaningful relationships and debriefing with trusted family and friends after stressful events (Brandt et al., 2017). In addition, minimizing social isolation, both inside and outside the hospital,

has been associated with decreased burnout, and people with at least one form of community support exhibited less burnout (Lund et al., 2022). Surgical residents who felt part of a larger group reported higher well-being and exhibited fewer symptoms of burnout, depression, and attrition (Salles, 2019).

Residents at Stanford participated in a human-centered design (HCD) sprint in which they interviewed one another regarding what was most important for their own well-being during residency. 77% reported that well-being lectures, emails, and curriculum were “Not Useful,” and 42% replied “Not Useful” in regard to mental health reflection and therapy. Another 42% of residents said scheduled breaks or free time and increased social activities were “Most Useful.” This initiative demonstrated support by soliciting feedback on current and prior interventions and gave department leadership information to effect changes and to optimize their wellness programs (Chow, 2022).

With more than one-third of surgical trainees pursuing time off from clinical residency in order to pursue professional development and research endeavors in which they have a special interest, this represents another opportunity to encourage well-being through personal rejuvenation in the lab (Huffman et al., 2020). It has also been found that taking time to do hobbies contributes to a healthier work-life balance and reduces unhealthy burnout (Brown et al., 2021).

Basic healthcare for residents and medical students should not be ignored, yet a surprising 35% of residents in a study of 20 training hospitals did not have a routine in place for healthcare, such as standard labs or skin exams (Rangel et al., 2020). One particular aspect of physical health that has recently been addressed, perhaps more than

others, is ergonomics training to alleviate physical posture pain that has been correlated with burnout and depression. A Northwestern University study incorporated a personal posture coaching session and didactic teaching for their surgery residents, which reduced the severity of the residents' musculoskeletal symptoms (Cerier et al., 2022). A yearlong training course taught by physical therapists at the University of Miami resulted in 85% of residents reporting reduced neck and lower back pain and 93% reporting the belief that they would perform better in the operating room as a result (Allespach et al., 2020).

It has been shown that coaching for career physicians can significantly reduce depressive symptoms and burnout, and coaching in academic institutions is gaining traction. One such study is the randomized control trial conducted nationally through the Association of Women Surgeons, in which female residents were recruited for nine months of coaching sessions. Those in the intervention group had increased personal fulfillment, self-valuation, positive emotion, engagement, relationships, meaning, and accomplishment, and decreased burnout (Palamara et al., 2022).

An Association of American Medical Colleges study done in a residency training program (Thorn & Raj, 2012) introduced a professional coach who worked with faculty to develop coaching behaviors such as establishing trust, asking powerful questions, challenging beliefs, and being authentic. Through this, the faculty partnered to create a medical knowledge coaching program and a well-being and career transitions curriculum for residents centered on balancing their professional and personal lives to prepare for life after residency. The strength of this study is particularly noteworthy when compared to the beginning of the study, where some faculty reported negative relational perceptions,

disconnection, competitive individualism, undervaluing of humanism, and a lack of trust in colleague relationships. The project significantly increased board pass rates, improved faculty and resident perceptions, enhanced resident mindsets, and enhanced trust between colleagues. This study's results suggest that professional coaching can shift the academic culture by integrating its principles and practices throughout the entire academic medicine community.

The University of Arizona implemented a formal resident well-being and resilience program that reduced residents' perceived stress and emotional exhaustion while improving their life satisfaction and emotional intelligence. Monthly experimental sessions were based on an executive coaching model, were interactive, and occurred during educational time. Modification and tailoring of the program are in the works to further aid the evolving needs of the residents (Price et al., 2020).

In another single-institution study, surgical interns attended eight group and individual resilience coaching sessions by a certified professional coach over the course of one year, and residents reported that the sessions provided useful skills as well as the valuable opportunity to talk to an unbiased party about work and life issues (Song et al., 2020).

At other times, other successful interventions at academic institutions have integrated a variety of methods in an effort to decrease rates of burnout; for instance, the “Balance in Life” agenda established in one residency program whereby refrigerators were stocked with healthy snacks around the clock, building retreats were attended by

entire teams, group intervention and peer mentorship was established, and psychologist sessions were attended (Mueller et al., 2018).

Another study integrated three different approaches to feedback into one study, called The Surgical Education Culture Optimization through targeted Interventions based on National comparative Data (SECOND). This SECOND trial currently has 215 surgical residency programs enrolled and attempts to reduce trainee burnout and mistreatment through the involvement of resident feedback (individual) and organization principal investigators (institutional) across the country (national). Recommendations can then be made by identifying recurring areas of improvement integrated by all three levels in one study (Hu, 2021).

As physician burnout has become more widely known, efforts have been made to reduce it. Despite this, burnout rates continue to rise, which places significant strain on physicians, medical students, residents, fellows, and the entire healthcare system (Golisch, 2023). Effective prevention of burnout first relies on fully understanding those elements that lead to its development and then encouraging organizations to find ways to positively affect these dimensions to create change in the culture and health of physicians and trainees. Educational institutions specifically would be well-served to consider organizational resilience and its relationship with individuals (Vercio et al., 2021). Although these measures and programs have been proposed and are operational, no empirical evidence exists of their effectiveness in reducing and/or addressing the problem of burnout among physicians in the U.S.

Summary and Conclusions

This literature review showed that physician burnout is a critical issue impacting the availability and quality of healthcare in the United States. Some of the consequences of physician burnout include the possibility of inaccuracies in diagnosis and treatment, an increased likelihood of absenteeism, a reduced patient satisfaction score, impaired clinical performance, and loss of vital services (Brower, 2021; Robertson & Long, 2019; Welp, 2018). To address the surging physician burnout rates and the adverse impacts associated with these rates, different creators have developed diverse responses and interventions. Organizations such as the Mayo Clinic have dedicated numerous studies to organizational strategies that can promote physician well-being and have shown some improvement via deliberate and sustained efforts (Swensen et al., 2016). Different specific solutions have also been proposed to help eradicate physician burnout and its impacts. Based on the literature, these proposed solutions to physician burnout include resilience programs of the past, interventions by CWOs and physician coaches, re-evaluation of EMRs and RVUs, and medical school-based interventions. Although these measures and programs have been fully operational, no empirical evidence exists of their sustained effectiveness in reducing and/or addressing the problem of burnout among physicians in the United States. To date, no single, successful strategy has been developed to successfully solve this physician burnout. Despite research on related topics, a gap exists in the literature regarding an understanding of the lived experiences of those involved in decision-making for improvements in physician well-being and suicide prevention. The conclusion of this review focused on the industry experts who are

researching and creating these new efforts to reduce or eliminate physician burnout. The qualitative phenomenological study addressed this research gap through an exploration of the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses.

Chapter 3 presents the methods and procedures that were applied to address the acknowledged research problem, as well as to answer the designed research questions, and hence the purpose of this study.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to explore the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses. This study aimed to address the issue that physicians' burnout is a recognized problem leading to impaired clinical performance and loss of vital services, and even to some physicians' suicide (see Kuhn & Flanagan, 2017), and yet no single, successful, clear strategy has been developed to solve this problem. Equally, no research study has been conducted to explore what creators analyze, consider, and experience when instituting newer and hopefully better responses to physician burnout. An understanding of the processes and motivations underlying the development of responses to physician burnout by their creators, as well as the factors that influenced their decision-making in creating and implementing these responses, will assist in the development of effective responses to physician burnout.

Chapter 3 describes the research approaches and processes that were applied to address the acknowledged research problem and answer the formulated research question. The key sections in this chapter include research design and rationale, the role of the researcher, target population, sampling and sampling procedures, instrumentation, procedures for recruitment, participation, and data collection, data analysis plan, issues of trustworthiness, and ethical procedures. The chapter ends with a summary of the most salient points of the research methodology.

Research Design and Rationale

The study was guided by the following research question: Regarding the development of physician burnout interventions, what factors influenced their developers' decision-making in creating and implementing these responses?

The goal for undertaking this study was to understand the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses.

A qualitative research methodology was used to address the aforementioned research question and achieve the stipulated study goal. Qualitative research entails gathering and analyzing nonnumerical information such as audio, video, or text to understand experiences, concepts, perceptions, and opinions (Mohajan, 2018). It aligned with the study, whose aim was to collect and analyze qualitative data based on the lived experiences and perceptions of creators of responses to physician burnout. Specifically, the study was focused on nonnumerical information regarding the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses. Schram (2003) indicated that qualitative research is fundamentally interpretive, implying that collecting subjective information that cannot readily be quantified to provide insight into a research question may reveal different conclusions about a specific topic. Hamby (2019) stated that the fundamental difference between qualitative and quantitative research is that the purpose of qualitative research is

discovery in which the variables have not been identified or defined and the purpose of quantitative is to test a hypothesis in which the variables have not only been identified but also defined and measured. In addition to analyzing specific words or thoughts in personal interviews in qualitative research, analyzing the differences will help gain insight into the robustness of the topic (Hamby, 2019).

To that end, feedback from participants about their responses to the issue can contribute much to society's further understanding of the steps being taken to combat physician burnout and its unfortunate side effects. The focus of qualitative research is on finding answers to questions that start with “how,” “why,” and “in what way” (Ezer & Aksüt, 2021). A qualitative research approach, therefore, aligned with the central research question for the proposed study, which inquired about the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses. The quantitative methodology, on the other hand, was regarded as unsuitable for this study because it entails the gathering and analyzing of numerical, statistical, or mathematical data.

Exploratory qualitative research was conducted using the phenomenological approach, which best suited this study since its focus was to explore the lived experiences of people and their expression of those experiences in language (see Rudestam & Newton, 2015). A qualitative approach provided the best opportunity for the phenomenological exploration of participant perception, which was the focus of this study (see Ravitch, 2016).

The research design selected for this study was the phenomenological design, which is among the best methodologies for describing how individuals experience certain phenomena in real life (Dibley et al., 2020). The phenomenological research design was pertinent in this framework, as it provided a better understanding of the research phenomenon from the viewpoint of individuals who experienced and lived through the scenarios and occasions represented in this study. The phenomenological research design is focused on exploring the lived experiences of life (Dibley et al., 2020), and a phenomenological study is a philosophical approach that examines events, programs, relationships, and emotions as an individual's or group's perception of a situation or experience (Hale, 2012). Creswell (2013) indicated that phenomenological studies examine how a concept or phenomenon is experienced by several individuals as a common meaning. As such, the design of the phenomenological study was necessary to understand the lived experiences of the creators of the solution-minded responses to the problem of physician burnout and its accompanying side effects. A qualitative phenomenological study was selected to research physician burnout and the programs and strategies that have been designed to combat it. There are four types of phenomenological research approaches, including descriptive, interpretive, narrative, and hermeneutic, which mainly differ in how qualitative data is analyzed in each (Moustakas, 1994). This study applied the descriptive phenomenological research design.

Informed by Husserl's worldview, descriptive phenomenological design entails the pure description of the experiences and perceptions of persons regarding a certain phenomenon (Dibley et al., 2020). When descriptive phenomenological research is

chosen, the anticipation is that the researcher can illuminate a poorly understood phenomenon using the description of persons' experiences and/or perceptions (Stilwell & Harman, 2021). As described by Moustakas (1994), scholars do not make any interpretations in descriptive phenomenological research studies, but they assess the descriptions dispensed by the respondents and isolate them into meaning-laden explanations, which are important to the structure of the subject under exploration.

The selection of descriptive phenomenological research for the proposed study was suitable, considering that the purpose was to explore the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses. Furthermore, according to Moustakas (1994), the qualitative descriptive phenomenological design is used when little is known about a topic, and the purpose of the study is to make apparent the most considerable meaning of the phenomenon under assessment from the perspective of the persons who are directly involved in that phenomenon.

This study focused on what is not known in the existing research: no single, successful strategy has been developed that shows a sustained reduction in the physician burnout problem nationwide. In research encompassing human participants, the qualitative descriptive phenomenological design involves collecting experiences and perceptions through qualitative research methods such as discussions, interviews, focus groups, and participant observation (Moustakas, 1994). For this study, interviews were used to collect data, and themes were analyzed and extracted from that data. Precisely,

semistructured interviews were used to make sure participants fully understood the questions and to encourage them to elaborate on answers that were vague or confusing (Rubin & Rubin, 2012). Therefore, a qualitative descriptive phenomenological design was the most fitting research design for the proposed study.

Constructivism is the tradition that best aligns with a qualitative descriptive phenomenological research approach. According to Merve (2019), constructivism is a research tradition that indicates that individuals establish knowledge, as compared to just taking in information passively. When people experience society and reflect on their experiences, they develop their separate representations and assimilate new knowledge into their pre-existing knowledge (Merve, 2019). Constructivism is further based on the idea that people enthusiastically develop or formulate their divergent knowledge and that reality is grounded in their experiences and engagement as learners. Fatimah et al. (2022) added that constructivism is centered on the notion that individuals use their past knowledge as a basis and build on it with new knowledge and information that they obtain through learning. The qualitative descriptive phenomenological research design is constructivist because the targeted data was based on the description of the experiences directly encountered by research participants (Fatimah et al., 2022). Constructivism was consistent with the acknowledged research problem, purpose of the study, and research question.

The problem is that although burnout of physicians is a recognized problem leading to the impairment and loss of their vital services to the medical community and even in the suicide of some physicians (Kuhn & Flanagan, 2017), no single, successful,

clear strategy has been developed to generate or create an overall reduction in this issue. The purpose of the study was to explore the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses. This included identifying and describing the reasons for such a response as perceived by the creators, the process used to develop the response, and whether or not the response worked as perceived by the participants and the creator. The formulated research question inquired how and why creators of responses to physician burnout and suicide created and produced their responses.

These three major elements of the study, namely the research problem, the purpose of the study, and the research question, indicated that new information and/or knowledge were developed in this study. Accordingly, the study aligned applicably with the constructivist research tradition.

Role of the Researcher

In qualitative research, it is necessary to consider the researcher's role in the study to guarantee that the quality of the research results is upheld. Participant, observer, and observer-participant form the three key roles of a researcher (Stenfors et al., 2020). For this study, my key role was to collect, interpret, and analyze the qualitative data required to answer the research question and to achieve the study objective. I began by seeking Institutional Review Board (IRB) approval from Walden University, which enabled me to solicit and recruit participants.

I conducted my role as an observer by taking notes on the responses of the interviewees to draw conclusions and guide further research. The goal was to gather participants' lived experiences on how and why creators of responses to physician burnout and suicide created and produced their responses.

In descriptive phenomenology, a researcher's objective is to attain transcendental subjectivity, which is a scenario where the influence of the researcher on the study is constantly evaluated, and preconceptions and biases are neutralized so that they do not impact the study's objectivity (Shorey & Ng, 2022).

Professionalism with the study participants was vital, particularly in minimizing instances of preconceptions and biases, which can have a negative bearing on the quality and integrity of research (Shorey & Ng, 2022). I further applied bracketing to avoid incidences of preconceptions and biases, which might have arisen from the already existing presumption regarding the research topic developed from the existing literature that related to the research topic. In this regard, to guarantee that preconceptions and biases are well managed, I set aside the pre-understanding of the research topic by acting nonjudgmentally. I applied the knowledge assimilated formerly to develop a new understanding instead of manipulating the participant's answers.

Ethical Considerations

I further prioritized ethical concerns in this study. One of the primary aspects greatly prioritized was the confidentiality of the study respondents. To guarantee their confidentiality, I neither collected nor shared participants' identifying information. In addition, the research participants' engagement in this study followed the informed

consent approach to ethical research, where the study participants were informed in advance regarding the research process, and only those willing to participate in the research were targeted. Conflict of interest might have been an issue in this research, which may have compromised the researcher's judgment and decisions (see Stenfors et al., 2020). My interest in matters affecting the welfare of physicians formed an issue that is addressed in this research.

Methodology

Target Population

The target population included the creators of responses to physician burnout in the United States. Scientists, psychologists, hospital systems, family, and friends have long contemplated physician well-being, and have concern about the profession's high burnout rates. The efforts to help physician well-being appear in resilience conferences, intervention programs, awareness training, informative sessions, informal incentives, burnout coaches, and even the appointment of a new C-suite position, that of CWOs in some hospitals.

Many of the creators of responses to physician burnout were drawn from the National Academy of Medicine (NAM). Established in 1970, NAM is one of the three academies comprising the Academies of Sciences, Engineering, and Medicine. NAM's key role is to advise the country on matters of health, health care, and biomedical science and technology. Among other roles, NAM is now working to create a task force to support physicians' well-being and resilience (Dzau, 2023). Research on well-being has long emphasized the importance of resilience for improving individuals' well-being and

ability to adapt, and resilience has been shown to be valuable both for preventive and protective care in studies conducted in a variety of settings (Dzau, 2023). It is, nonetheless, implied that physicians have some weaknesses if they are asked to be more resilient; therefore, NAM has formed a committee to explore solutions that will go above and beyond the popular “resilience training programs” that many organizations have used in the last decade to reduce physician burnout. Organizations sponsoring this new NAM committee include John Hopkins, the American Hospital Association, the Association of American Medical Colleges, Tulane, Duke, Vanderbilt, and Yale, among others.

Some medical schools have also developed resources to assist medical students in coping with these stressors while they are in medical school, residency, and afterward. Healthcare institutions have also formulated organization-level initiatives and interventions to address physician burnout and suicide. In some cases, these initiatives and interventions are headed by CWOs. Another resource is Dr. Pamela Wible, one of the nation's leading experts on physician suicide and author of a book that features letters from deceased physicians, one of the only sources available to help us understand what can no longer be asked of them. Furthermore, a documentary called “Do No Harm” examined physician burnout while interviewing key creators to understand possible solutions. Accordingly, there was a large pool of sources from which to draw creators’ responses to physician burnout, as required to accomplish the goal of this study.

Sampling and Sampling Procedures

The sampling process explains the practice of choosing a representative number of the population for observations to meet the research goals. This study employed a

purposeful sampling method. Purposeful sampling is described as a nonprobability sampling approach where researchers rely on their judgment when choosing study participants (Stratton, 2023). The selection is founded on the specific features of the study aim. Purposive sampling was applied in the study because it has certain benefits relevant to the proposed research study. These benefits included greater accessibility, faster speed, and minimized costs associated with recruiting samples for the study (Stratton, 2023). I also employed purposive sampling because respondents needed to meet a given set of inclusion criteria to be eligible to partake in this study. The inclusion criteria included being a creator of a physician burnout prevention program and/or strategy in medical schools and hospitals in the United States. The exclusion criteria included a physician and healthcare practitioner, as well as the creator of physician intervention programs and/or strategies that did not focus on burnout.

A purposeful sample of creators of reputable physician burnout prevention programs and/or strategies was selected based on the specified inclusion criteria. A sample of 15-20 participants was specified based on Moustakas's (1994) conventions for conducting a qualitative descriptive phenomenological study. According to Moustakas (1994), a sample of 15-20 participants is satisfactory in a qualitative descriptive phenomenological inquiry to attain an exhaustive understanding of the phenomenon under study. Moustakas added that a qualitative descriptive phenomenological study does not focus on being generalizable, and therefore, the sample does not need to be representative of all the kinds of individuals who have encountered the phenomenon under investigation. Accordingly, a sample of creators of reputable physician burnout

prevention programs and/or strategies was appropriate for the proposed study despite the large number of creators across the United States.

Even though the aforesaid sample had been chosen, data collection continued until saturation was reached, which was the point in the study process where adequate information had been gathered to draw satisfactory conclusions, and any additional data collection would not generate new, value-added information and/or themes related to the phenomenon under assessment.

If the required sample had not been attained through purposeful sampling, I would have applied the snowball sampling approach to reach and select more respondents. According to Obilor (2023), snowball sampling is a non-probability sampling method where new subjects are recruited by other units to be part of the research sample. In snowball sampling, researchers apply already-recruited respondents to recruit other respondents. The already-recruited respondents are requested to assist the researcher in recruiting more respondents by referring their colleagues, friends, or family members who meet the study inclusion criteria. Snowball sampling is a vital approach to recruiting participants with specific qualities who might be otherwise perplexing to identify (Obilor, 2023). This study targeted a group of professionals that could be challenging to find. If needed, I would ask leading creators of physician burnout and suicide prevention programs and strategies to refer me to their colleagues in the profession until I reached data saturation.

Instrumentation

I implemented semistructured interviews to collect the research data.

Semistructured interviews were consistent with the designated research design and the qualitative descriptive phenomenological design. In studies encompassing human subjects, the qualitative descriptive phenomenological approach involves gathering experiences and perceptions through qualitative research methods such as interviews, participant observation, focus groups, and discussions (Moustakas, 1994). I adopted semistructured interviews because they facilitated the collection of respondents' experiences and perceptions regarding the phenomenon under assessment.

Semistructured interviews are centered on asking open-ended questions within a prearranged thematic structure and offer a scope of complementary questions (Belina, 2023). The semistructured interviewing technique was the most suitable for the study because it aligned with the purpose, which was to explore the processes and motivations underlying the development of responses to physician burnout by their creators, and the factors that influenced their decision-making in creating and implementing these responses.

I developed an interview protocol to facilitate the semistructured interviews (see Appendix A). An interview protocol is described as a set of guides which should be adhered to when interviewing participants (Dunwoodie et al., 2023). I used the interview protocol to warrant consistency in the interviewing of all participants and subsequent consistency in the interview responses. The protocol comprised a set of demographic questions at the top, which helped to classify the participants. The demographic questions

were followed by icebreaker or introductory questions. The aim of asking these icebreaker questions was to inspire conversations to learn more about the participants, create connections between the interviewer and the interviewees, and nurture a positive interviewing atmosphere (see Belina, 2023).

At the center of the interview protocol were the core questions that were directly connected to the study. Explicitly, the core questions included in the interview protocol were grounded in the main research question, the purpose of the study, the research problem, and related literature. Following the core questions was the potential clarifying or probing questions that made the interview semistructured, implying that there was a chance for the interviewer and interviewees to ask follow-up questions. Finally, the interview protocol contained parting or concluding questions. As the name suggests, I used these questions to end the interviews. I allowed the interviewees to share supplementary information concerning the topic under assessment and to express their concluding thoughts on the topic.

The interview protocol was evaluated in a field test. Specifically, in collaboration with my dissertation chair and committee, I formed a panel of three experts with doctoral qualifications and knowledge of the topic under investigation to scrutinize the semi-structured interview questions through a field test. The field test was run on a population comparable to the target population and was focused on appraising whether the participants easily understood and inferred the open-ended interview questions developed in the interview protocol. The participants who contributed to the field test were not included in the main study.

Following the field test, I restructured the semi-structured open-ended interview questions based on the expert panel's suggestions. This guaranteed that the questions were well-aligned with the qualitative descriptive phenomenological design and addressed the acknowledged research problem and answered the research question. Generally, I adopted both an expert panel and a field test to establish the credibility of the interview protocol.

Procedures for Recruitment, Participation, and Data Collection

The first process of data collection was to request IRB approval from Walden University. Following the IRB approval, I undertook the recruitment process using an electronic flyer. I designed the flyer as a tool for announcing the study as well as informing target respondents about the participation, inclusion, and exclusion criteria. The flyer further contained my contact information. I emailed the flyer to individuals in institutions where I was likely to find creators of reputable physician burnout prevention programs and/or strategies. These individuals were likely in such organizations such as NAM, hospitals and other healthcare facilities, medical schools, and physician coach centers.

I furthered ask participants to help me assemble creators of reputable physician burnout prevention programs and/or strategies. During the briefing sessions, I informed these potential participants about the purpose of my research and assured them of the confidentiality of their information. Instead of using identifying information, I used pseudonyms to identify the participants.

My secondary recruitment approach was the use of social media, where I shared the recruitment flyer. Following the recruitment, I interviewed each participant either one-on-one in an in-person setting or face-to-face in an online setup such as Zoom. I audio-recorded each interview upon consent from the participants. Each semistructured interview took 30 to 45 minutes. The interviews continued for 2 months. The planned study was strictly voluntary, indicating that participants were allowed to withdraw at any phase without any penalty. I kept all electronic data on an external hard drive that was accessible to me. I stored all paper data and resources safely in a locked file cabinet.

Data Analysis Plan

I first transcribed the qualitative data compiled through audio-recorded semistructured interviews. I then performed member checking of the transcribed audio-recorded semistructured interviews as a way of establishing the credibility of the data and findings. Also referred to as respondent or participant validation, member checking is an approach to assessing the credibility of findings (Birt et al., 2016). I performed this validation by returning the interview data to the participants, who then screened that data for accuracy and resonance with their descriptions.

I developed a worksheet for each participant for data coding and analysis. I used NVivo 14 to merge, code, relate, and analyze the transcribed semistructured interview data. The transcribed semistructured interview data were then analyzed using Moustakas's (1994) analysis approach for phenomenological data analysis. Using this data analysis approach, I evaluated every statement in each worksheet, reviewed full

statements, and coded using the respondents' identification codes. After coding all statements, I assimilated them into a single worksheet to facilitate thematic analysis.

During thematic analysis, I allocated each statement a classification based on the codes assigned and their significance to the research question. I grouped the classifications into themes and association statements, which explained the themes identified in the code clusters. I concluded the data analysis process with an appraisal of the acknowledged themes, the relationship determined between the codes, the level at which every theme will be found in every theme, and the quotes extracted from participants' transcriptions supporting the themes.

Issues of Trustworthiness

Issues of trustworthiness are based on four components, including credibility, dependability, transferability, and confirmability (Yin, 2014). While quantitative academics establish the reliability and validity of their studies using study instruments that have been validated via repeated application in experimental and nonexperimental studies, qualitative scholars have to be inventive and confident because qualitative research cannot overturn assumptions (Yin, 2014). The four constituents of trustworthiness as they relate to the proposed study are discussed expansively in this segment.

Credibility

Credibility refers to how well the research findings accurately represent the experiences, perceptions, descriptions, and views of the participant sample under assessment (Peels & Bouter, 2023). I applied techniques that were used to establish

credibility in the proposed study. First, I adopted a naturalistic perspective by interviewing via Zoom with the participants (creators of reputable physician burnout prevention programs and/or strategies) in their respective workplaces. These locations enabled the participants to resonate with the study purpose and procedures and, hence, enabled them to provide their lived experiences and perceptions regarding the processes and motivations underlying the development of responses to physician burnout and the factors that influenced their decision-making in creating and implementing these responses. I performed member checking after transcribing the audio-recorded semistructured interviews to explore and establish the credibility of the findings. The other strategy for establishing credibility was collecting the data until saturation was reached. Furthermore, the interview protocol was evaluated in a field test. In collaboration with my dissertation chair and committee, I formed a panel of three experts with doctoral qualifications and knowledge of the topic under investigation to scrutinize the semistructured interview questions through a field test.

Transferability

Transferability is the level at which the research findings apply to policy, practice, and future research (Peels & Bouter, 2023). I established transferability by using an appropriate data collection protocol (interview protocol) as well as by providing a thick description of the phenomenon under study. Precisely, I conducted semistructured interviews extensively for each respondent to facilitate a thick description of the phenomenon under investigation. An interview protocol, with an allocation for follow-up questions, guaranteed that the respondents provided satisfactory data and thick

descriptions necessary to answer the developed research question and, therefore, achieve the purpose of this study.

Dependability

Dependability refers to the level at which the research processes and methods are documented and consistent. It is established through the researcher's depiction of the research processes and methods (Megheirkouni & Moir, 2023). I established dependability using an audit trail, evidence, and documentation for the study. I kept complete transcripts and records of the applied research processes and methods as evidence of the phases followed in conducting the planned study. An audit trail will provide information and records about the research practices and approaches required by other academics to undertake a comparative study in parallel circumstances.

Confirmability

According to Megheirkouni and Moir (2023), confirmability is the objectivity or the capacity of others to substantiate or confirm the research findings. It is also the ability to demonstrate that the research data and analysis reflect the participants' experiences, perceptions, descriptions, and views (Peels & Bouter, 2023). I established confirmability via systematic documentation that provided a reference to refer to throughout the study process. Data coding further helped in establishing confirmability for this study. Specifically, I appraised the emerging codes multiple times and classified those codes using corresponding characteristics.

Ethical Procedures

The research involved human participants/subjects, encompassing creators of reputable physician burnout prevention programs and/or strategies. Consequently, I undertook this study under the ethical considerations of research involving human participants. The first ethical consideration was to seek approval for undertaking the planned study from the Walden University IRB. The IRB evaluated the research proposal as well as the interview protocol to ensure that Walden University's ethical standards were upheld.

Necessary site permission was sought from applicable institutions such as NAM, hospitals and other healthcare facilities, medical schools, and physician coach centers. These were institutions where the study participants, including creators of reputable physician burnout and suicide prevention programs and/or strategies, were more likely to be found. I issued recruitment flyers to potential participants explaining details concerning the proposed study, comprising the purpose of the study, how the study would be conducted, the incentive accessible, the benefits of the study, and any risks associated with this study. Incorporating these details enabled the targeted individuals to decide whether or not to participate in the study.

After recruitment, I issued consent forms to potential participants, enlightening the proposed study with vital particulars, covering the purpose of the study, how the research was to be performed, confidentiality and security procedures for all data to be gathered, and incentives available. I informed willing participants to return the signed and

dated consent forms one week after receipt, which was before the data-collection process commenced.

I used an interview protocol to guarantee consistency in the interviewing of all participants and, eventually, consistency in the interview responses. The planned study was exclusively voluntary, meaning that participants would be permitted to withdraw at any level without any consequence.

I drew motivation from the Belmont report to protect the participants against potential risks. The values established in the Belmont report include respect for persons, justice, and beneficence (Xia, 2023). I adopted Belmont principles through programming the data-collection process at the convenience of the participants, not gathering identifying information, implementing analogous guidelines for data gathering for all respondents, and allowing the respondents to withdraw from the study at any point without penalty. I kept all electronic data on an external hard drive that was only accessible to me (the researcher). I stored all paper data and resources safely in a locked file cabinet. These resources and data will be accessible for review for 5 years after the completion of this study, at which time they will be permanently destroyed. The IRB number for this study is 04-19-24-0426024.

Summary

I used a qualitative phenomenological research methodology to describe how specific responses to physician burnout were created and designed. The phenomenological research design was pertinent in this framework since it provided a better understanding of the research phenomenon from the viewpoint of individuals who

experienced and lived through the scenario and occasions of study. The target population included the creators of physician burnout prevention programs and strategies in the United States.

The study employed a purposeful sampling approach. A purposeful sample of 17 creators of reputable physician burnout prevention programs and/or strategies was selected based on the specified inclusion criteria. Although the aforesaid sample had been chosen, data collection continued until saturation was attained. If the required sample size had not been attained through purposeful sampling, I would have applied the snowball sampling approach to reach and select more respondents.

I implemented semistructured interviews to collect the research data. I developed an interview protocol to facilitate these semi-structured interviews. Following the IRB approval, I undertook the recruitment process using a flyer. I used NVivo 14 to merge, code, relate, and analyze the transcribed semi-structured interview data. The transcribed semistructured interview data was then analyzed using Moustakas's (1994) analysis approach for phenomenological data analysis. Chapter 4 outlines the findings from the data analysis methods and protocols.

Chapter 4: Results

Introduction

The following chapter describes the findings from a descriptive phenomenological investigation into the processes and motivations that drove creators to design and implement responses to physician burnout. Results are organized under six themes identified through analysis of 17 semistructured interviews. Following a description of the research setting, participant demographics, data collection and analysis procedures, and evidence of trustworthiness, the chapter turns to the Study Results—Themes 1–7.

Research Setting

The interviews were conducted remotely to reduce the burden in terms of organizing and to avoid geographical constraints. The participants work in different settings which would have made in person interviews costly and time consuming, this in addition to high patient care demands of some interviewees, and the constant pressures on personnel at the time of the interviews. This also provided an essential contextual backdrop to their views on burnout-producing factors and their strategies.

Demographics

A total of 17 creators took part. These included physician leaders, CWOs, physician and nonphysician coaches, operations/efficiency leaders, a healthcare attorney, and executive/consulting stakeholders. To maintain confidentiality, identities have been anonymized. Participants varied in professional tenure and sector, enabling triangulation

of perspectives from bedside to boardroom. The roles have all been grouped. A summary of the roles is outlined in Table 1.

Table 1*Aggregated Participant Demographics*

Role category	Illustrative responsibilities	Primary sector	Representation
Physician clinical/organizational leader	Service leadership, OR/clinic operations, professionalism oversight, mentoring	Academic, Community	Represented
Chief wellness officer/well-being executives	C-suite advocacy, resourcing, measurement, culture/efficiency initiatives	Academic, System	Represented
Physician coaches/peer coaching researchers	1:1 and group coaching, program design, leadership curricula, evaluation	Academic, Private	Represented
Non-physician coaches/leadership consultants	Leadership development, boundary and values work, organizational advising	Private, Association	Represented
Practice efficiency/national association leaders	EHR/workflow redesign, team-based care models, national guidance and tools	Association	Represented

Role category	Illustrative responsibilities	Primary sector	Representation
Healthcare	Medical staff	Legal/Healthcare	Represented
attorney/governance advisor	governance, licensure/malpractice policy, professionalism frameworks		
Operations/strategy executives	Access, staffing, technology adoption, incentive alignment	System	Represented

Data Collection

Data were collected through 17 semi-structured interviews (45–75 minutes each) using an IRB-approved protocol. Interviews were audio-recorded with the participants' consent and then professionally transcribed. These transcripts then became de-identified. This study focused on gaining richness and variability among the producers of organizational programs, designers of frameworks for professionalism, coaches, researchers, leaders of associations, and experts in the operations area.

Data Analysis

The analysis employed a descriptive phenomenological approach, as outlined in the work of Moustakas (1994). I read the transcript holistically before horizontalizing the data to identify significant statements. I identified meaning units, which in turn formed the basis for creating preliminary themes. I developed textural descriptions, which

represented the experiences the participants underwent, as well as structural descriptions, which described how the participants' experiences were influenced by the circumstances present in the study. This eventually led me to develop a total of seven themes. I used NVivo to code the participants' statements, because NVivo provides a structure for coding significant statements and extracting themes based on this coding structure. The extraction of themes involved identifying exemplar statements based on the structure provided by the NVivo software, which in turn enabled the creation of themes.

Evidence of Trustworthiness

Credibility

The credibility was increased through thick description, intensity, and involvement through a series of 17 interviews, reflection through memoing, and the establishment of themes from significant statements. To the extent possible, additional interviews were planned to clarify any points.

Transferability

To make the study more transferable, roles included in the study were purposefully identified, which included a mix of roles, as well as sufficient details provided in the context to enable the reader to make inferences about their appropriateness for transfer.

Dependability

The dependability of results was established by maintaining an audit trail (versioned code book and memos) as well as analytic transparency, in which procedures were followed through from statements to meaning units to clusters, to themes.

Confirmability

Confirmability was augmented by using researcher reflexivity (bracketing or setting aside the assumptions the researcher begins with), including disconfirming data in the report, and making sure the linkage exists from the claim to the meaning unit.

Study Results

Below are the seven themes identified. Each theme includes an interpretive narrative incorporating unique participant statements without direct quotes. This enables the findings to relate to the research's purpose.

Theme 1: System-Level Factors Influencing Intervention Creation

Both burnout and responses to the situation were consistently treated by the participants as if the center of gravity was the system and its structure, rather than the individual's grit or personal character. Besides the burden of the electronic record and the fee-for-service conditions mentioned earlier, additional factors that surfaced in the interviews, which directly impacted the responses, were incentives and payment systems, worker design and scheduling, culture of measurement, autonomy and teams, and communication intensity.

Incentives and Payment: What the System Pays For, the System Gets

The logic of payments was repeatedly found to be a key driver of burnout and a factor worthy of consideration when devising measures. Under the current volume-based healthcare business model, it is clear that the commodification of time has begun, and it

has impacted the meaningful aspects of work. These were the first things to go because the system rewarded other things.

One participant described how their institution's fixation with throughput made doctors feel as though conversations with patients were indulgences. They expressed their feelings regarding being pressed from room to room, knowing that it represented the most satisfying aspects of medical practice, yet being what they were pressured to forgo. Another participant described how discouraging it was to observe their junior peers absorb such a rhythm as normal because they have been conditioned to believe that they did not have the right to take up any more time.

There were illustrations of collective efforts in the overhaul of incentives for outcomes rather than volume in general. There was also a comment on incentive compensation of the CWO pertaining to patient satisfaction and preventable readmissions, which represented opportunities in collective practices to eliminate redundancy and reduce stress. Another described how incentives were tied to quality improvement goals and protected time for quality improvement initiatives, allowing payment tied to efforts that improved the health of the system.

The uphill struggle was recognized by the participants. A physician summed up his views by saying: "As long as the scorecard of our organization was focused on speed and revenue generation as key metrics, interventions for wellness were more like salmon swimming up a waterfall." Another participant highlighted the challenges of realigning incentives. He stated that a lot of discussion was required with the finance departments for such reforms. However, the success of those talks was fleeting.

Through all the tales, however, one point stood out: wellness could never prosper when it went against the current system established by financial gain. Players argued that the only way to change the scorecard was to implement bonus systems for teamwork-driven changes, access time credits for mentor roles, or establish a direct association between protected time and quality outcomes.

Designers took away the following from this experience: “What the system pays for, it gets.” Anything said to improve well-being that went against payment systems would never work. By integrating concepts of well-being into incentive systems, people sought to ensure that it became part of the DNA, rather than an afterthought.

Workforce Design and Scheduling: Capacity Is a Prerequisite

Again and again, they went back to what was described as “the arithmetic of staffing.” Even the most brilliant intervention was doomed if there was no slack in the workload to enable participation. The problem was burnout due to a lack of slack. It was a lack of time to think, to recharge, and to change.

One participant expressed that the lack of scribe availability made it impossible for them to attend support meetings. Even when the options were there, the pace of work did not allow them to step away. Similarly, one physician described how the ability to train other staff members to assist with message sorting ultimately allowed them to breathe when they were at the clinic.

There were also mentions of capacity fixes that were very specific. For example, one health officer described how they implemented reliable offline time blocks for results and for documentation, and how these were quickly recognized as being necessary.

Another person at one of these conferences highlighted changes to call scheduling that allowed for actual downtime.

In addition to these Band-Aid solutions, there was a focus on the pipeline. One participant stated, “The thing is that if you do not increase the number of training positions, you're just going to have a depleted workforce perpetually. It's going to seem like moving the deck chairs on the Titanic.” Another stated, “I personally have taken a strategy of nurturing a pipeline of people. It artificially slows down the drain.”

Again and again, the importance of these items was emphasized as prerequisites rather than as fringe benefits. Without the necessary capacities in the team, it was considered pointless to have wellness activities. Similarly, when there was a margin in the schedule and workforce due to adequate staffing numbers, practitioners had room to explore novel ideas or tools for reflection, rather than being left without any alternatives.

This approach reimaged the design of the workforce itself as the intervention for wellness. One interviewee noted that in their group’s strategy they hoped that “by integrating appropriate levels of coverage, triage protocols, and recovery time into the scheduling process," it would "create a system that was resilient rather than draining the worker reservoir of its resilience." Only then could specific resilience-building fail-safe measures have a positive effect.

Measurement and Data Visibility: From Avoidance to Action

The second critical system lever to draw attention from participants was a culture of measurement. As long as a lack of measurement for burnout met with specific resistance from leaders, a kind of “gasping inhalation engulfed healthcare providers,”

leaving them with the threat of futility in speaking up. But where measurement and action were consistent, trust followed, and engagement after. Measurement, in this framing, was less a neutral backdrop and more an intervention in its own right.

One participant mentioned that at their institution, the lack of burnout surveys made for an uncomfortable silence. Clinicians came to believe that either leadership did not want to know or would do nothing with the results of such surveys, and thus became disengaged. Another participant offered insight into the “aha” moment experienced when simple, proven items were introduced along with action plans, shifting measurement from the realm of surveillance to the realm of accountability.

In some cases, there were mentions of practices in which the individuals knew that the data being extracted had relevance. One CWO described the practice of reporting findings about trends for each department, which promoted local buy-in and support. Another described how, with each round of surveying, three solutions would be offered, and then leaders would quickly follow through regarding what was accomplished.

Nevertheless, the study participants also spoke about the risks. A participant physician said that improperly implemented measurement, in essence measure-and-do-not-act, hurt trust. A participant physician stated that using the burnout surveys for punitive measures also led to skepticism.

From the interviews overall, most of the group agreed that measurement of improvement had to have “teeth.” In other words, it had to be more than just gathering information; they had to follow through on it. They had to show improvements. They had to show changes. They had to show commitment.

In this, there was a paradigm shift, where measurement was not a project but a process embedded in intervention. In this, it was asserted by the participants that it is important to highlight evident data, which made the consideration of well-being a process in intervention instead of being a subjective annual feelings analysis.

Professional Autonomy and Teaming: Restoring Room to Practice Medicine

Physicians often described feeling reduced to being operators of a billing platform rather than medical professionals. Loss of control over workflows and team roles was one of the many discouraging thoughts fueling their burnout and disengagement. Therefore, any intervention, no matter what form it took, that put them back in a position of autonomy or reinforced this in a teamwork situation was imperative.

One respondent said, “We have designed the system so that there are standing orders ingrained into the workflow. This allows the nurses to work independently. And by extension, this will free up time for the physicians.” Another explained, “We have introduced protocols for frequent messages, and it takes time out of the physician's inbox and puts it back into their hands.” Both stories told how minor adjustments in autonomy and delegation had effects on morale.

Other examples included more active giveback initiatives. A CWO discussed how reducing unnecessary clicks freed up whole hours for clinicians each week. Still, another spoke about the development of visit templates by frontline staff to make them more efficient while increasing trust. Participants also emphasized the strength of formal teamwork. As one physician relayed, “That process involves staff pre-visit planning and scribes documenting simultaneously, so that leaves me to talk to the patient.” Another

stated, “Having clear message-routing protocols turned what had been an individual burden (the inbox) into a team responsibility, fundamentally changing the experience of after-hours work.”

Such experiences have revealed a pattern that has repeatedly occurred, namely, the increase in autonomy and teamwork has translated into a decreased workload, as well as a reconstruction of the practitioner's identity. The experience of the clinicians was such that they were not just “cogs in a machine,” but rather “practitioners of medicine.” In the integration of autonomy ideas and teamwork concepts in design for wellness, the participants sought to transform the practice process itself. Instead of being part of an inefficient process, some strategy creators upgraded the process to facilitate the dignified, efficient, and teamwork-oriented role of practitioners.

Communication Load and After-Hours Norms

They associated the use of modern communication technology—patient portals, immediate result disclosure, and internal emails—with the need to always be available, which negatively affected the culture. Being never really off duty had a corrosive effect on recovery time.

One respondent described the portal message flood that came each evening, making the evening routine an extension of the working day. Another respondent described the impact that the immediate availability of results had on both the patient and the clinician, who in turn had to respond immediately.

Some participants described receiving or making messages that were influenced by these factors. A director of wellness reported that algorithms in triage systems sifted

messages before they reached doctors, eliminating time consuming distractions. A different director described holding off on sending non-urgent messages until work hours, and this altered expectations.

Some people talked about the need for explicit norms and leadership from above. Someone mentioned the “quiet hours” established and enforced in their organization to demonstrate the importance of setting boundaries even after work. Another individual noted that their leaders stopped sending emails late in the evening.

Participants observed that while the technology itself often caused the overload condition, it could also be leveraged to resolve the issue when combined with changes to the culture. Algorithms, delays, and service level targets managed at the team level were all key factors that made such boundaries sustainable.

Taken cumulatively, these strategies meant a reframing of after-hours load as a system problem rather than a personal failing. The participants set about designing solutions that addressed the issue of load, while also emphasizing the need for a boundary in terms of rest.

Integrative Summary

System levers, as described in the participants' narratives, were not just the background parameters that the intervention had to contend with; instead, they are the very basis on which the success of the intervention is made or broken. An intervention team that altered the motivational environment, provided capacity, made data available, regained autonomy, and provided a communication environment felt that there was finally space for individual-level support.

However, there were repeated mentions of the need for system redesign and individual coaching as not being mutually exclusive or alternative approaches. Approaches to coaching, peer-to-peer interactions, and small changes were only possible and practical if the enabling environment of the system had the capacity for development and was able to shape behaviors and incentives. Thus, for these participants, the road to practical wellness work was not necessarily about encouraging individual resilience.

Theme 2: Personal Experiences Shaping Creators' Motivations

Many interviewees in this study consider burnout to be an organizational problem and an experience that disrupted their own perception of identity, relationships, and meaning. Many have found that it was not professional talk of burnout or wellness that drew them to brainstorm strategies to rectify it, but instead their own personal experience with burnout. It was these personal experiences that ignited their recognition of a problem and led to the implementation of hopeful solutions.

Existential Crisis and Identity Loss: Rebuilding the Self Alongside the Profession

They frequently spoke of reaching tipping points when they recognized they were crossing a boundary from burnout to what they knew to be an existential crisis. Generally, the physician's identity, which they previously celebrated, now silently dominated their being. A participant attempted to describe how they reached a level where their entire sense of identity rested on their output as a physician, to the point where they would struggle to list who they were when not acting as a physician. Another participant described the shock of realizing that their hobbies, friends, and even sleep were gone, with nothing else but work to go to.

Some of the respondents remembered a combination of the loss of identity and grief. A doctor responded, “It reminded me of spending time with my kids. It made me aware of how burned out I was and how my profession had consumed my every waking moment.” One doctor related how they “went back and pulled out an old sketchbook and found I hadn't picked up a pencil in years.” What burnout cost in these moments wasn't just exhaustion, the price was identity.

They pointed out that recovery also entailed acts of reclaiming what had been overshadowed. This was observed in regaining one's faith practice, as one participant shared, and another who regained her creative side with painting. These acts of small beginnings helped participants rebuild their personal identity, not just as professional physicians.

These findings had a direct impact on the development of the interventions. The leaders who had experienced identity collapse understood that the work needed to be integrated into the design of the interventions to help professionals rebuild their entire identity, rather than struggling to cope with the workload. In fact, one of the CEOs suggested developing mentoring systems that would allow professionals to explore non-health-related roles.

Many participants intimated that the burnout stripped away personhood and sapped energy. The interventions thus had to rebuild identity as well as restore professional functionality. The purpose of wellness programs in the absence of this was akin to alleviating symptoms without attending to the wound.

Personal Burnout and Recovery as Design Inputs: From Surviving to Reshaping the System

A number of people in the study spoke about reaching a point where medical leave was inevitable. The trauma symptoms that left a person unable to function, and the realization that exhaustion was at a point where they were no longer safe to carry on, were also issues that were raised. Such experiences were frightening and enlightening, allowing them to return to practice with a determination to change a system that had led them to burn out.

In other accounts, people described experiences of recovery that were no less transformative, albeit more restrained. These accounts included one in which the person said they began documenting harmful cognitive patterns in a journal and working to implement small changes. Another cited finding out that the language of boundaries gave them license to say “no” without guilty feelings. Less dramatic perhaps, these experiences nonetheless reshaped their sense of agency and possibility.

The importance of recovery experiences as a blueprint for design emerged as a strong theme. As one wellness officer said, “Burnout set a series of designs into motion around peer coaching strategies that were grounded in empowerment and alignment of values.” A statement was made that recovery experiences led to stronger beliefs in the ability to make systemic changes; for example, reducing email inflow for someone languishing in crisis, particularly in relation to medical leave.

Despite this, participants recognized the challenges of applying understandings from private recovery to organizational design. One participant, a physician, considered

how sometimes their insights were invalidated as anecdotal by administrators who were data-driven. Another participant reported how difficult it was to convince others to prioritize work-life balance when the culture supported working long hours.

Despite all this, many interviewees continued to base their actions on experience. Indeed, what they saw was that it was precisely this that had led to their understanding of recovery, whether it was leave, reflection, or boundary setting. For all of them, recovery became a source both of healing and design knowledge.

Family–Work Tension and Role Conflict: Designing Around Impossible Choices

“My family experiences,” one of the most personal and emotionally laden storytelling modalities, was also very prevalent. Here, many interviewees spoke of the conflict of feeling like a capable and dedicated parent and spouse, which contrasted with the realities of a life spent charting in the evenings and weekends. “Every night, I come home when our kids are asleep,” one interviewee continued. “I’m sitting here at dinner with a laptop open,” a second one described. “Just me and my documents.”

Some of the other reports pointed to more extreme crashes. “There was the impossible choice of fulfilling thirty overdue scans on a Friday night or attending a kid’s championship game,” shared one doctor. A CWO spoke of “years of carrying a pager at family dinners, never being able to actually relax.” Both of these professionals spoke of the feeling of always failing at being both a good doctor and a good father.

They emphasized that these conflicts were not just about time management. They were characterized as structural issues and needed structural solutions. Many commented

that these conflicts made it impossible for wellness to have credibility if it put family responsibilities at the whim of clinical overload.

To address this issue, specific initiatives were developed to address family and work boundaries. For instance, one implemented a set of more stringent algorithms to manage after-hours digital work. Another implemented a regular schedule for weekends out of service, to reduce scheduling conflicts for family activities. Even efforts were made at a higher management levels to set boundaries and end work early to attend to their own commitments.

Many were in agreement that spending quality time with family is not a want but a need. They were of the view that effective intervention should remove the practitioner from impossible choices. Otherwise, wellness could only be a dream.

Leadership and Teaching as Sources of Renewal: Multiplying What Sustained Them

Among the accounts of depletion, there were also accounts of protective factors. Some of the respondents were able to recall how education or mentoring had given them a renewed sense of purpose. One interviewee said, “mentoring younger colleagues has reminded me of why I entered the field of medicine in the first place.” Another respondent found that directing a residency program had transformed work efforts “from survival to contribution.”

Leadership roles were also restorative. A CWO discussed how program development offered them the opportunity to impact their culture positively. There was

also an acknowledgment of how incorporating governance roles into their activities gave them some separation from their experiences of overload.

These experiences directly impacted the design of the intervention. A participant created a structure for mentorship because they believed that if mentorship continued to support them, it would continue to help others. Another individual believed that there should be leadership development initiatives that provide protected time for clinician mentorship and coaching of other clinicians.

Several interviewees emphasized that these roles were far from incidental or supplementary; they were, in fact, integral to the overall process. Some noted that wellness programs must incorporate elements that rejuvenate individuals as a whole. Several shared strategies in creating pathways for people to contribute beyond throughput. What kept each one engaged became a feature in their designs.

Values Alignment and Agency: Reclaiming Integrity in Daily Work

One theme identified during the interviews is the concept of discovering personal value. Burnout has led to a recognition of the discrepancy between the perfectionism/loneliness associated with medical learning and teamwork and the change associated with medical practice. One person said that being hardwired for perfect autonomy placed them out of alignment with teamwork. Another explained how finding their values brought back authenticity and a perception that practicing medicine could be a humane act.

Some talked of the joy of regaining a sense of personal agency. A second interviewee said it was helpful to learn how to say “no” without feeling a twinge of guilt.

Yet another interviewee discussed how matching work and personal values allowed meaningful rather than rote practices.

Many participants created interventions based on these tools. One wellness officer created an intervention involving workflows that allowed these clinicians to have time for patient connection, while another officer encouraged protected time for value-driven activities. Both considered this essential for integrity.

Many pointed out that achieving value alignment cannot be solely an individual's exercise in self-control. A support structure must be created in institutions to facilitate the implementation of rediscovered values.

Ultimately, some participants concluded that the expectation to align values became a restoration of agency for the participants. Many interviews showed that the participants considered wellness to be contingent not on an acceptance of the sustained state of misalignment, but on the conditions for the coexistence of personal values and professional values.

Integrative Summary

Tracing their practice back to their personal philosophies was important. The loss of identity was related to notions of wholeness. Recovery was a stimulus for their design. Conflicts within families were often related to time constraints. The roles of leading and teaching were institutionalized for purposes of renewal. Rediscovering their personal values helped anchor their programs in line with their personal values.

Cumulatively, these stories have made it clear that intervention was not just a theory, but a lived experience. It is indeed these experiences that had been the most

painful that became the blueprints for what the participants designed, such that the experience directly informed the intervention aimed at addressing burnout itself.

Theme 3: Cultural Norms and Stigma in Shaping Wellness Work

The ideas of the interviewees often traced the origins of intervention back to their own private philosophies. Their loss of identity led to efforts to restore a sense of completeness. Both dramatic and non-dramatic recovery acted as a motivation for design. Intrapersonal conflict was expressed through the structuring of limitations in time, the roles of leaders and professors, and established a modality for renewal as a tool. Value rediscovery rooted grounded programs in the need for integrity.

Cumulatively speaking, the above stories have made it clear that the interventions were not purely theoretical, but very much experiential. It is many of these experiences that have caused the most anguish that have now shaped the template for what the participants have sought to design.

Endurance as a Hidden Curriculum

Many of the study participants spoke about the medical culture in which tolerance was automatically virtuous. Medical training centers celebrated these hours worked, teaching most young medical professionals that the intense number of hours worked are a sign of prestige. A senior medical officer narrated how medical practitioners boasted about these all-night shifts, while professionalism lies outside such limitations of endurance. Another physician admitted that when taking a break to eat a meal while in residency, it was seen as a violation of an unspoken contract.

Despite the training that reinforced the importance of endurance, endurance was still a deeply ingrained value. A CWO recognized the conflict between organizational leaders promoting the importance of wellness in the workplace and yet continuing to demonstrate poor wellness practices by sending nighttime emails and rewarding workers for powering through an illness. A physician described the guilt they experienced when they had to leave work on time for their child's school event and the concern about what their colleagues might think regarding their dedication to their job.

“It wasn't until it hit crisis levels that some members of my profession realized its toll,” said one physician. He went on to say his recognition transpired when he remembered “blowing off warning signs until my own crisis drove me to stop.” At the same time, yet another relayed “the pain of realizing that my children, despite my absence at family dinners, had normalized my abdication.”

These were the kinds of awakenings that led some leaders to implement strategies for programs that challenged the endurance culture head-on. One residency program director created workshops to communicate the idea of burnout as a risk, not an ideal to model. A wellness leader at another organization spoke about incorporating the concept of restoration into orientation activities for new professionals, showing it is part of what it means to be a professional.

According to accounts, a consensus existed among medical practitioners regarding the effects of norms for endurance, which made the pursuit of wellness sound like a whisper in a shout. They believed that unless the link between work hours and self-worth is erased, it would make any intervention difficult to establish.

Stigma Around Vulnerability

The physicians and wellness directors also pointed to how stigma silenced open discussions about experiences of distress. They felt that struggling with mental health had been kept hidden because of the risks of disclosure. A junior physician explained how they had put off seeking counseling for many years, as it would damage prospects for a fellowship. A department chair witnessed colleagues struggling, needing help, but having been too concerned that using mental health resources would be construed as weak.

Even under systems that have established supports, stigma existed. This is according to a CWO who shared that a counseling service was set aside unused until stricter confidentiality was in place. Wellness coordinator observations found that employees had been reluctant to take part in support groups when led by coworkers, fearing judgment and sharing personal information.

In other instances, this stigma was perpetuated through tradition. A senior doctor remembered, “Our administrators would tell us, ‘Stress is just part of the job’—as if having to admit to needing help is something to be ashamed of.” One doctor reported comments that made light of “weak doctors” needing therapy.

To address these challenges, some leaders introduced various interventions to facilitate the acceptance of vulnerability. The implementation of team meetings introduced by a chief medical officer had the effect of making stress a topic that had to be discussed. One discussion introduced by a program director was a peer talk where vulnerability was introduced through role models who shared vulnerability.

In many interviews, the removal of stigma, as well as the management of physicians' workloads, has been stressed as a necessity by physicians and wellness facilitators alike. They had suggested that unless the vulnerability factor became culturally acceptable, the use of wellness programs would never reach their potential, and the physicians' sufferings would continue to be hidden.

Mixed Signals From Leadership

Leadership became a very influential force in culture. When leaders set the example for balance, the issue of wellness became more legitimate. When a CEO decided to leave an early meeting for family reasons, it signaled that the setting of boundaries is a valid company-wide behavior. When a dean changed the timing of the standing meetings to accommodate a need for childcare, it signaled that personal life is important.

However, there were comments about the corrosive impact of mixed signals from leaders. A CWO spoke about leaders who, in rallies, eulogized wellness while reinforcing “warrior” talk about burnout. Another interviewee observed mixed messages about wellness when twelve-hour workdays were not altered. Here, words failed to reinforce change.

Even small behaviors had significance. One leader described the impact of evening emails from bosses as encouraging the perception that one is always on call. Another reported that failing to speak out against visible burnout was taken as an implicit endorsement.

To address this problem, one group began training their leaders on how to adopt this approach in line with their wellness values. Another implemented policies that

limited the sending of emails outside office hours to ensure that the company's top leaders set this precedent. Another interviewee shared a strategy that required the leaders to take part in the wellness activities.

One professional pointed out a lack of influence from leadership regarding cultural change when leaders were expected to exemplify the values of wellness. To influence staff in programs, they had to walk the talk.

Ultimately, a leadership that showed alignment between what was said and what was done created a culture where wellness was real, as it was vital that leadership did not risk undermining what they supported.

Building a Culture of Trust

Trust was also described as having been the foundation for wellness efforts. “If there is no trust, then clinicians will not come forward or participate in any programs,” claimed one wellness director. A department chair described how seeing test results from administrative surveys was their proof that their opinions mattered. “Quick fixes, like reducing duplicative documentation, proved to us that someone was paying attention,” reported another interviewee.

Conversely, lost trust was not easily rebuilt, as it was revealed by one interviewee that a survey about wellness seemed to have yielded outcomes that led to nothing, resulting in a complete waste of time. Furthermore, when these surveys became punitive, people stopped responding to them in large numbers. This provided insight into how easily trust can be broken.

“It took time to build trust,” noted a physician. “They earned credibility when our leadership acted promptly on suggestions from staff.” Another noted that, “The staff recognized not only the initial changes but saw if there was follow-through which was more important than initial enthusiasm.”

But trust also had a group aspect. A wellness officer explained how making the results available to departments encouraged a shared responsibility, so that groups could see themselves in the larger perspective. Another program developer mentioned that when employees saw their colleagues' concerns addressed, it translated into a sense of confidence.

Even small visible successes were significant for trust, several doctors claimed. Fixing something visible, no matter how small, was proof of authenticity. Furthermore, employees were satisfied with the honesty of leaders stating what they did not know rather than the eloquence of what could be altered.

In most cases, there was a strong consensus that without trust, wellness programs were viewed as a waste of time. Trust was a non-negotiable foundation for interventions to be possible.

Integrative Summary

When it came to emphasizing what contributed to success in wellness programs, many wellness leaders agreed strongly that culture played a significant role. The norm of endurance was one where working beyond hours was to be admired, “the voice of stigma was to silence vulnerability,” and lack of stable leadership tended to undermine

credibility. Trust was what made success in a program. It is not just a matter of theory; it is something that physicians and wellness officers face every day.

They found that cultural change cannot be considered independently of the redesign process. They were forced to point out that there is no point in rearranging a process if the importance of endurance is still celebrated; there will be no use for resources if the label of stigma remains; and no intervention will succeed if trust is not established. At the same time, interviewees believed that change is still possible.

For such respondents, culture was not background, it was battleground. Responding to it was structural, and that is what made all the difference in whether wellness could become reality or rhetoric.

Theme 4: Leadership and Governance in Wellness Design

One interviewee described how leadership emerged from interviews and focus groups conducted with physicians and wellness professionals as a salient determinant in whether a wellness program succeeded or failed. This leadership offered the possibility for the legitimization of wellness, the distribution of resources to advance wellness, and the diffusion of well-being behaviors. However, leadership also presented the potential to halt the advancement of well-being by demonstrating lack of consistency, empty symbolism, and sudden withholding.

Leadership as Catalyst

Practitioners also believed supportive administrators made wellness possible. A hospital CEO who began each board meeting with a question about staff morale demonstrated the value of well-being to the institution. A dean allocating funds for

mentorship demonstrated the institution's concern for the well-being of its students. This legitimized the goal of well-being as an institution from the top.

The role played by modeling was emphasized by doctors. A chief medical officer who was known to leave early to attend family events gave workers a license to do the same. A residency program director who was open about their personal struggles gave trainees a voice to share their own issues without fear of reprisal, as those in leadership modeled balance.

Examples provided by several interviewees illustrated how these efforts influenced the organizational environment. It gave legitimacy to staff members' participation in peer support meetings and/or reflective practice sessions when these efforts originated from leaders themselves and became visible to everyone. One of the faculty members explained, "When the leaders talked about it openly during faculty meetings, it removed the taboo of discussion related to burnout."

One physician believed that when leaders they looked up to practiced wellness principles, it reminded them that they were not alone in dealing with burnout. Another physician said that their leaders' campaign against burnout helped transform a professional shortcoming into a personal and institutional issue.

Several examples clearly demonstrated that leadership played a significant role in driving changes to culture and structure. This was because they ensured their teams understood the relevance and importance of well-being. Doctors felt comfortable enough to focus on their well-being and participate in programs because their leaders did as well.

According to many accounts, the key to achieving momentum was the leadership's commitment. Without the backing of the higher echelons, the initiatives for emphasizing wellness waned. With the commitment, the initiatives began to possess meaning and momentum. They embodied the difference between the ideal and the reality of wellness.

One interview participant believed that the influence of a committed leader would help improve the state of wellness faster than any other policy combination. The narrative as well as the landscape were set in motion by these leaders, leaving space for programs to flourish. When they took the initiative, programs succeeded, but when they slowed down, progress came to a standstill.

Leadership as Constraint

Stories also included the way in which some leaders had negatively impacted the progress made. A wellness officer reported that the support of the COO in their efforts had come to an end because of the financial performance during that quarter. In turn, a department chair described the dean's speeches on wellness as very positive but noted that the support for reducing faculty members' workloads was not forthcoming.

Several doctors pointed to the harm caused by the lack of consistency. One recalled how the support for wellness manifested as empty words from the top administration, leading to the belief that the initiatives were just for show. A physician with direct experience described how empty promises caused more disgruntlement than the lack of action would have.

One CWO explained how empty symbolism “sucked the heart out of the morale.” Another shared how a new initiative launched with posters and buzzwords but no

personnel changes quickly became defunct, and they said staff members believed that administrators cared more about the image than the impact.

Some also pointed to how leaders' financial concerns conflicted with wellness concerns. A doctor reported that suggestions regarding peer support were initially vetoed until they were pitched in terms of dollar and cents savings. A further example was how, once budgets were strained, spending on wellness was the first thing to go. This only served to support the belief that the physicians' wellness is something that lacked priority.

Professionals surmised that the involvement of many C suite leaders limited progress because they made wellness optional or contingent. One CWO established that the wellness effort remained in vogue during the good years but was ignored during the lean years. Such erratic support created an undertow of doubt because the professionals naturally then anticipated a withdrawal of support. The lack of consistency undermined their confidence, and one doctor stated that when they realized a lack of commitment from their C level administrators, they did not invest their own efforts in any of the interventions.

A standard message from the clinicians was the need for leadership to promote well-being, even when under pressure. They realized that until the leadership made well-being a non-negotiable priority, alongside financial success, the success of the intervention would never be guaranteed.

Governance Structures for Sustainability

Wellness advocates repeatedly emphasized the vulnerability of relying on champions. A CWO told of an effective program that failed when the charismatic founder departed. “When the need for their wellness was driven by the personal enthusiasm of the president of the organization or the executive officer of the foundation,” a leader explained, “that stayed with them until the president or the executive officer changed their priorities or changed jobs. Then it just went away.”

Some organizations established structures to formalize wellness initiatives. In one example, an organization established a Wellness Council to address the representation of departments. Another organization included wellness aspects in the board reports. Hence, it became linked to accountability, rather than mere preference.

There was a realization that governance resulted in ownership. This is according to the director of a residency program, who observed that with shared ownership of wellness information, the residency programs became sustainable. A wellness officer described how governance at a level that engaged leaders ensured they would be held accountable for deprioritization.

Efforts for wellness were often linked to strategic planning efforts. A chief medical officer spoke of how the inclusion of the wellness measure in the same report that contained safety and quality measures had kept it on the agenda. The inclusion of quarterly board reports, which had kept the process going despite changes in board membership, was another example that was given.

What some noticed was that, through governance, one is protected from the whim of personalities. Since the programs were affiliated with structures rather than personalities it was difficult to dismantle them. Governance instilled confidence in the staff regarding the fact that wellness programs were not a trend, as they encouraged people to invest in structures.

Infrastructure for wellness was reported to be offered by the governance structure. This implied that the councils, the scorecards, and the reporting lines ensured that wellness became embedded within the DNA of the organizations. It is a model that ensures wellness initiatives are immune to changes related to staff turnover, the budget cycle, or changes in leadership. One director's view was, "It's the infrastructure, the scaffolding that enables ideas to scale." In several accounts, governance was approached not from a bureaucratic standpoint, but from that of endurance and institutionalizing wellness, so that whatever initiatives were put in place would have a chance to last after a particular leader's passion for them had subsided.

Balancing Symbolic and Structural Leadership

Some interviewees were encouraged to embrace more structural forms of leadership while embracing some of the symbolic forms. One noted that having a hospital president present at support group meetings could boost spirits through solidarity and shared purpose. When a senior in the field of medicine with influence shares personal views, wellness can become more accessible to others.

However, one was quick to indicate that the issue with "symbols over substance" was a lack of authenticity. Another physician drew attention to the fact that a balance of

the workload could be projected through colorful posters, with little to no effort made to ease the workload. Another suggested that if there was little time to rejuvenate or recover when the lecturers spoke of employees' welfare, then the messages lacked authenticity.

Leadership appears to need an integration of both the symbolic and structural elements. While the former gave visibility and emotional appeals, the latter facilitated change. Where the two are integrated, they complement each other. Where they differ, suspicion arises.

Sequencing was mentioned by several of the wellness leaders interviewed. For example, symbolic acts might open doors, but they need to be promptly followed by structural changes. As one CWO said, "Leading with vulnerability was huge ... but if no workload reforms followed, the credibility faded."

Physicians found that the act itself held the most meaning if it seemed authentic. When leadership communicated out of their own personal understanding, they were more profoundly heard. A CWO remembered a comment by one physician that the first time she listened to the chief physician acknowledge his own feelings of burnout, it made her realize that this lack of motivation was not her own inadequacy, and therefore, the interventions being suggested seemed more relevant. On the other hand, it was also necessary to have authenticity with policy support. One healthcare provider stated that when symbolic care is implemented without any changes at the different structural levels, it can be perceived as having manipulative intentions.

One interviewee shared that in the long run, the staff realized that for effectiveness in leadership, both structural leadership and symbolic leadership depend on

each other. Together, they enhance credibility and momentum. However, when these two are separated or distinct from each other, they fail to help in building trust or engagement.

Trust and Accountability in Leadership

Trust was a constant theme within the interviews about leadership. The doctors explained how they observed what leaders did as a means to assess trustworthiness. “Leaders who responded to feedback quickly earned trust,” an interviewee noted. “It was not what they envisioned but what they did,” said a program director, indicating it was enough if they kept promises rather than make lofty assurances.

Multiple interviewees were able to describe how accountability measures improved trust. At one hospital, they tracked and published wellness data quarterly, so leaders stayed invested. At another, they related leaders’ reviews to staff wellness measures, so leaders were held accountable as part of the reviews.

Several stated that honesty and openness were necessary for trust to develop. Leaders who spoke openly about challenges, such as budgets being limited, showed more integrity than administrators who made vague pledges. Realism paired with commitment showed leaders as dependable. One CWO stated that honesty about obstacles made intervention program participants accept progress at a slow pace.

Another response focused on the role of collective accountability. Sharing results at the department level encouraged collective responsibility. A wellness executive stated that assigning departments access to their own results encouraged a feeling of being acknowledged for their progress while also feeling responsible for it. Another interviewee

stated that this kind of information made it more difficult for administrators to overlook the challenges associated with wellness.

Trust also grew from small wins. “It was often not about stripping away complex policies and procedures,” said one doctor about improvements, “but about eliminating small hassles, such as unnecessary forms.” This was as important as major reforms, said a physician, who saw that showing responsiveness, regardless of scale, fueled momentum.

One interviewee stated, “It was not trust in vision statements, it was trust in action, consistent action, and this served as its backbone.” There would have been no meaning or substance in any wellness programs without trust; everything just seemed empty. But everything small had value because it was trustworthy.

Finally, the key importance of this measure lies in the fact that the responsibility to act generated the conversion of trust from being a precarious feeling to an established framework. In this way, the inclusion of wellness within the evaluation of the leader or the board increased the importance of wellness within the organization because it became a non-negotiable component.

Integrative Summary

Physicians and wellness professionals discussed the role of leadership as both a catalyst and a constraint. Positive leadership legitimized wellness programs, modeled balance, and supported the development of wellness programs. Unsatisfactory leadership challenged the notion of wellness programs by either leading with inconsistency.

In any case, it was clear that to achieve sustainable wellness in an organization, both symbolic and structural leadership are necessary. This must be reflected in both the

structures and the conduct of activities. Trust and accountability were considered essential in ensuring that this was achieved. Otherwise, it was fragile and dependent on priorities and personnel.

Theme 5: Organizational Context and Leadership Influences

Experts in health and wellness practices repeatedly pinpointed the outcome for well-being initiatives lied in how well senior leaders structured their organizations to function: what behaviors these leaders rewarded, what tradeoffs they made in what proportions, and how much capacity was seriously funded. Organizational leadership is evident in executive-level decisions regarding whether health practitioners can deliver well-being or find ways to prevent burnout from happening. These subthemes include building a healthcare culture, structuring leadership and resources, modeling health or not, prioritizing money over health, creating a common business rationale, or increasing the number of health leaders. These themes capture how organizational factors affected both difficulties and possibilities.

Culture-Building: Designing for Belonging and Meaning

“Culture isn't something you declare,” one physician reiterated. “It's something you engineer in your operations.” Leaders' commitment to including connection as part of their workday made physicians feel as though they were being re-humanized. The process of having meals together during some of their conferences brought together nurses and doctors. “It's an opportunity to have some quiet time to reflect together,” said

one interviewee, referring to spaces they provided that allowed peers to spend time together.

Some pointed out the importance of restoring identifiable medical activity as part of building a healthier culture. A senior physician said that having protected time to reverse depersonalization was important. A resident program director stated the significance of using protected time for teaching as a means of adding meaning to their program.

Retreat days and conferences were also seen to have played a similar role. “Our clinicians were more engaged after retreats because they felt valued for taking the time away,” said one physician leader. “Conferences enabled reflection together, and for physicians to move out of their transactional work and find purpose again.”

Several interviewees felt that the message was embedded in the design of the connections, indicating that belonging was legitimate. The doctors contrasted this with situations where socializing was stigmatized for being nonproductive and perpetuating feelings of isolation. Some shared that burnout thrived in an environment where doctors are considered operators rather than members of the profession.

One expert emphasized that actual and substantial culture development had to be deliberately pursued. They explained that there was no chance for linking to occur naturally in a high-volume situation and that linking had to be protected. For example, another respondent said that organizing time for collaborative case study review and mentoring lunches was seen as more important than any campaign.

One CWO stated that the culture-building initiatives were, at times, very symbolic in meaning, which transcended the specific objectives of the project. Another officer stated that spending money on retreats communicated to the whole organization that people were more important than productivity. A physician also noted that it made a difference to start each staff meeting by acknowledging personal milestones.

Taken together, healthcare professionals and leaders made it clear that culture building is anything but peripheral to wellness. Where leaders paid attention to providing avenues of connection and meaning, healthcare professionals saw trust restored in their organizations. Where this was ignored, wellness initiatives could easily be viewed as inconsequential to addressing the isolation that is engineered in the workplace.

Governance and Resourcing: From Symbol to System

Several CWOs made it clear that the title without a budget was only symbolic. One physician leader said that they were awarded a title in the C-suite with no budget or power to effect change. Another leader mentioned that they wanted to chair a wellness committee but had no time allocated to the role, making it impractical.

Instead, resourced leadership promoted the translation of wellness into practice. A CWO described how having money to use enabled them to develop their own coaches. A program director described how investing their own staff members as champions within departments enabled them to make headway. Physicians appreciated how such concrete mechanisms brought credibility to their wellness activities.

The need for operational authority was also stressed. A department chair mentioned that the influence these wellness leaders could exert in terms of changing the

timing of calls or the documentation process meant they made changes that counted. A residency director reported, “The reality is that if the roles had only been given as advisory roles, they could not change the conditions contributing to burnout.”

Resources extended to include frameworks and curricula. One wellness leader discussed implementing professional training in humane practices and created leadership pipes to include practice efficiency. Such efforts amplified the impact of wellness in the system.

A doctor explained how resource-starved positions tended to result in cynicism among workers. They said that if an organization were to nominate well-being leaders without adequate resources, it tended to appear as if it were merely paying lip service without a genuine commitment.

On the other hand, when leaders invested time, personnel, and resources in governance, clinicians participated actively. They explained that resourced governance ensures interventions for wellness are credible and sustainable. One clinician also mentioned that this helped the physicians feel more confident about investing their time in the programs.

According to many reports, what mattered most in these assessments was whether governance and resources were genuine infrastructure or merely window dressing, whether wellness was genuine infrastructure or just a façade. Where there were funds, time, power, and people, there was change. Where there were just names and words, there was nothing.

Modeling and Communication: What Leaders Do Becomes the Norm

The theme of balance was reinforced by the observation that the leaders' style influenced the tone. Executives who sent emails during working hours, observed the silent hours, and left the workplace at reasonable times modeled balance. A hospital president's practice of not sending emails during the weekends conveyed the message that downtime was valued. A chief medical officer's open discussion about the need to establish a work-life balance facilitated the same among the officers.

One doctor compared these situations with the environments in which the superiors had set a different set of standards. A hospitalist recalled the boss who glorified working during vacations, thereby fostering a culture of endurance. The emails received during nighttime from superiors create a norm of being ever-available.

Transparency was also important. As one residency program director explained, "Just getting the burnout rates out there and having a fix sooner rather than later helped to build credibility." A CWO added that failing to address burnout issues created cynicism in staff, who assumed leaders didn't care about or didn't want to know about the problem.

When leaders spoke from their authentic selves, trust was created. A physician discussed how they respected leaders who openly acknowledged their limitations. A department chair described how leaders' openness about what they couldn't do financially or hurdles in other areas made leaders seem much more believable.

The importance of consistency between the communicated message and the action that ensued was also noted. One interviewee stated that if messages about wellness were

embedded within a culture that did not support such messages through its actions, the result was often more instances of cynicism. One leader pointed to the contagious nature of modeling and said that while executives modeled proper boundaries, mid-level managers tended to follow suit, a healthy trickle down into daily habits for the organization.

In many environments, it was concluded that modeling and communication were not peripheral actions but rather driving forces for cultural change. The pace was set by leaders, and what was deemed normal was influenced by their actions and whether a value for wellness was to be truly recognized or simply a cosmetic effort.

When Money Governs Medicine

Care stewardship, rather than financial stewardship, was one of several considerations in this study. In the fee-for-service model, for example, as one of the doctors explained, “Volume drove the scorecard. You had more visits packed into fewer hours. Hours bled into evenings. Turnover wasn’t far behind.” A practicing doctor described being “mired in quality of care, never having time actually to connect with patients.” Others described watching physicians walk away from patient care entirely, as “financial rewards allowed no place for human care.”

A wellness officers stated that basing wellness initiatives on fiscal logic implied that wellness initiatives were a form of moral righteousness against the force of gravity. They said that no resilience-enhancing activity could ever compete with a scheme that incentivized purely on quantity. A program director called these initiatives pointless unless these balances of incentives were accounted for.

Some successfully rebranded wellness in financial terms. A chief medical officer mentioned how showing CFOs that burnout drove vacancy costs and locum spending was effective. According to another, “Once you tie wellbeing to things like onboarding times and access delays, all of a sudden, finance leaders start caring.” By tying wellness to metrics that finance already tracks, they gained traction.

A physician underlined that it was financial leaders who 'got' these connections who started to finance the capacity. One mentioned how the incentives were changed so that the teams were rewarded not only for throughput but also for access and quality. Embedding the protected time into scorecards was also described as a breakthrough by another. The above examples have made it clear that executives' decisions regarding funding was critical to maintaining well-being.

Several noted that without harmony between CFOs and CMOs, wellness was at risk. As a result, when the mandates of the CFOs went unbridled, wellness initiatives fell apart, but when leaders combined their interests, interventions persisted.

A wellness officer also spoke to the symbolic power of financial choices. As employees observed their budgets being devoted to either coaching or redesign, they felt that their value was confirmed. What occurred is that if the budget for wellness was the first one to get axed, then that told the doctors that their well-being did not matter.

Several interviewees mentioned that wellness should be rewarded, rather than merely preached; money made medicine, and until the rewards became balanced in favor of both health and quantity, wellness initiatives were destined to be relegated to the sidelines.

Converting Frustration Into a Shared Business Case

Examples abounded regarding both physicians and wellness directors explaining how frustration was leveraged. A CWO demonstrated how off-hours EHRs could be leveraged to optimize utilization per FTE (full time equivalents). Another described calculating the email traffic in the inbox to determine whether it correlated with turnover, making something visible to an executive-level group.

One professional encouraged using economic framing to support the CFO, CMO, and CEO and noted that by tying the cost of attraction to the cost of attraction delay, the finance team rallied to the cause of making investments in the support staff. Another CWO found alignment of the finance office with wellness by translating the cost of malpractice into dollars.

Several leaders were discussing these metrics in relation to earning credibility. For example, a wellness officer described how the posting of benchmarks for each department encouraged accountability, and another doctor described how tying investment fixes to solve problems, such as a decrease in locums, brought about consensus. Other leaders observed that it was as essential to be open about the information as it was to have good results. A physician explained, “It increased clinician trust in the initiatives if information was openly available. Physicians liked to be a part of defining the problem, rather than being told after a decision was reached.”

One leader explained that making the economic effects of depletion visible to the executive audience gave them a vocabulary to act upon. Putting the value of well-being into economic costs allows the wellness community to discuss the issues economically

without having to abandon fundamental principles of the humanistic value system.

Another interviewee reported that data made wellness from a moral perspective imperative to a financial argument and stated that while “suffering is sufficient,” finance often requires numbers, so providing them was helpful in building influence.

The leaders characterized the business case as the bridge from frustration to funding. It provided a common vocabulary in both the clinical and financial realms, which focused executive attention on a stabilized workforce.

Leadership Multiplication: Making Well-Being a Shared Competency

“To bring about sustainable change, multiply the leaders,” is what one clinician called for. “Wellness is too precarious a thing to be left to one person,” a CWO at one institution pointed out. “If things aren't balanced for our wellness leaders, it leads to burnout for them, too.”

One physician emphasized that leadership development must involve skills in wellness. Another commented on the value of training in practice efficiency to give leaders skills to minimize those tasks: “A department chair emphasized the role of professionalism curriculum to define humane care in terms of leadership responsibility and not optional behavior for personal reasons.”

One wellness officer also described how leadership development pipelines were constructed. “Training junior faculty in coaching and efficiency skills has given us a pipeline of advocates.” Another stressed that creating skills in the younger doctors for culture-building helped guarantee sustainability. One expert believed that having numerous leaders help promote wellness made the latter less fragile, and because

numerous people were pushing the agenda for wellness in an organization, the program was less susceptible to personnel turnover. Doctors also noted that the aspect of multiplication introduced innovation. The more leaders involved, the more interventions derived from different settings, making designs for wellness more flexible. One leader noted that diffusion of this nature introduced robustness in intervention strategies.

According to several reports, healthcare professionals and hospital administrators believed that leadership multiplication was something that could be done if they wanted well-being to be considered a best practice, not something that stood alone. By doing so, embedding wellness into leadership curricula and pipelines helped organizations ensure continuity and adaptability over time.

Integrative Summary

There were clear attempts to establish definitions for both leadership and organizational context as variables for outcomes of well-being. Culture was fashioned through rituals rather than rhetoric. Governance required budgets and time, as well as power, rather than mere titles. Modeling and communication affected assumptions, and there were economic logics that supported or undermined well-being. Data converted frustration into a business case, and improvements were possible via skills for multiplier leadership.

Whether wellness was considered a matter of practice or merely a matter of policy hinged upon leadership. A partnership between the CFO and CMO with a typical business case to finance, to codify, protect time, align incentives, and measure and act,

supported and spread wellness practices, while the absence of inclusion within an enterprise logic destabilized the process of wellness initiatives.

Theme 6: Implementation Pathways and Practical Challenges

The experience of implementing the intervention was described as a complex landscape by both healthcare professionals and wellness practitioners. There were challenges to successfully implementing intervention designs as they were translated from theory to practice. Some noted that implementation was a continuous process of adjusting and overcoming challenges of time, technology, and culture. The subthemes included resource limitation, implementing within existing processes, measuring implementation progress, involving personnel, and adapting the intervention.

Resourcing Constraints: Doing More With Less

Both physicians and CWOs identified resourcing as the most pressing issue for implementation. A CWO stated, “The money was available to develop the initiative, but there was not enough staffing to implement it.” A program director discussed conducting resilience training sessions during lunch because there were not enough hours to devote to it. Both noted that programs reliant on volunteer energy could not survive.

One physician in practice described the strain of implementing wellness while workloads remained unchanged. Another interviewee explained that for them, attending a peer group meant staying late to finish documentation. One residency director recounted the resentment of faculty asked to mentor trainees on resilience without workload relief. These examples illustrated how resourcing gaps undermined morale.

There were some organizations that reacted effectively. A hospital administrator redirected unused employees towards wellness positions and placed them within some of the departments. A doctor spoke about shifting budgetary items from hiring to coaching programs after he found out that he could cut down on employee turnover and thus generate the necessary funding.

Professionals wanted to make it clear that resource constraints were not just excuses but design realities. “They had to be able to scale a program to what their resource capacity was, so it wouldn’t fall apart,” was one of the comments. Leaders were seen to be more credible when they accepted what was possible due to resource constraints instead of making bold promises.

For many, it was this perceived commitment gap that was the turning point. One physician stated that “when leaders were unwilling to commit to investment in wellness, it was seen to indicate that healthcare personnel's well-being is expendable,” in contrast to “investment that expresses care.” Several interviewees observed that the credibility of the initiatives sometimes increased or decreased in response to these signals. Some pointed out, for instance, that the health care providers were welcoming of engagement in terms of resources, irrespective of how little they had, with the motivation being the wellness they were committed to.

They knew that resourcing was far from being a small matter for an organization. It represented an ethical investment, and that was not only for the benefit of the organization but for humanity, and humanity included health workers.

Integrating Interventions Into Workflow

There were warnings from clinicians indicating a lack of success where programs were not integrated with the workflow. “Wellness modules were usually missed if scheduled outside of work hours,” one leader explained. “I have had to skip peer support meetings because they conflicted with my rounds,” another physician said.

“We talked about the need to weave wellness into what people are doing,” said one leader. Embedding reflection into the process helped. Leaders described embedding reflection exercises into required safety “huddles,” and one program director linked efficiency redesign to wellness training, making it seem like one cohesive process to the clinicians. This helped increase the number of participants.

Some also pointed out the importance of integration as a co-generated process. “Pre-session planning lowered stress and problematic documentation outside of work because it was informed by what frontline providers wanted,” one doctor explained. Another doctor pointed to the success with visit templates: “It worked when the team saw itself in the design,” describing how those generated together with frontline providers were more successful than those generated alone.

Key takeaway from intervention creators include that for successful integration, benefits must occur with immediacy, and employees responded well to changes that were time-saving or simplified workflow. They were resistant to change without capacity, suggesting wellness offerings were considered extra. One department chair made it clear that for clinicians, improvements must be apparent the day they implement a new process. “Respect is what was communicated through integration,” one interviewee said.

Incorporating wellness into clinicians' work demonstrated that leaders valued how clinicians allocated their time. Add-on programs showed a lack of concern for clinicians' workloads.

Many leaders interviewed felt that integration was a cyclical process. Mistakes made at the beginning, such as holding reflective sessions during peak patient times, were adjusted. These adjustments helped to ensure the voices of clinicians were heard. These experiences reveal that the integration represented the boundary between symbolic wellness and operational wellness. When intervention messages were integrated with work, credibility with employees increased. Otherwise, failure would be imminent.

Measurement and Feedback Loops

Clinicians and leaders viewed measurement of success as crucial to the credibility of the implementation. A long time expert CWO emphasized the importance of measurement as it strongly prevented initiatives from becoming background noise. A physician provided a specific example and highlighted the importance of observing the impact of reduced after-hours use of the EHR system to confirm success.

Others described how poorly designed measurements had harmed them. "Surveys would just disappear into the reports, and nothing ever happened," said one interviewee. "Because people felt they never received a result, they stopped participating," said another physician. Comments such as these built appreciation for how poor measurement was hurting trust. Effective organizations have integrated feedback cycles in their well-being initiatives. A program director described every survey as being followed up by "three rapid actions," regardless of how small they may seem. A wellness officer

explained that staff-level measurements of achievement through department levels trended toward better success.

Doctors spoke of the importance of qualitative feedback. “Stories that were shared at peer groups were put into the context of the number,” one doctor stated. Combining the survey results with the listening sessions made the findings more meaningful to the leadership, and to demonstrate that data mattered, organizations made their statistics public. Leaders also considered the significance of measurement as a symbol of authority and presented progress to boards of directors, incorporating wellness into balanced scorecards. In this way, employees sensed that their superiors were committed and serious about their work.

For many, a good measurement was both a reflection and a motivator. It enabled a return on investment, providing a truthful view to organizations, and it assured employees that their input mattered.

Staff Engagement and Ownership

“Innovation is not a light bulb. Innovation is a result,” said one. Familiarity with staff members is vital for success, and several leaders described ways to promote participation. A CWO spoke about the need to include trusted clinicians as champions. In addition, a program director mentioned that if colleagues were invited to join programs, there would be a doubling of response.

One interviewee was adamant about the need for relevance regarding worker engagement and described how workers showed indifference regarding workshops for

resilience development, yet demonstrated responsiveness regarding mailbox improvements that alleviated workload.

A physician also indicated that participation grew as a result of leaders listening actively to them and stated, “When they hear they have made an impact, people want to continue to contribute.” An intervention leader emphasized that engagement had to be sustained and could not be assumed to be ongoing. The cause was undermined if the leaders in charge had advocates exhausted by a lack of support, and they said the staff members loosened their connections if there was no visible progress.

Another identified the need to be heard as essential. Engagement was a social process. A physician stated that when a well-respected colleague supported wellness, the behavior could be imitated by others. It was found that peer influence had a cascade effect that a planned, formatted campaign could not achieve as successfully or organically.

Together, these accounts illustrate that ownership brought intervention concepts from being the brainchild of corporate leaders to something more valuable when everyone participated. Failure was evident when everyone treated it as if it were part of someone else’s project.

Adapting in Real Time

“Implementation was never linear,” said one professional. Programs had to respond dynamically to real-time challenges. “We had to quickly repurpose programs developed prior to the pandemic to meet the digital delivery model's demands,” said a

CWO. This was to enable remote delivery. “We had to move all the classes and all the programming into online and hybrid.”

“The initial designs failed to consider practical realities, according to front-line physicians,” one interviewee mentioned when describing having to backtrack and change inbox rules for flow until there was a decrease in after-hours work. Another described how changes to call scheduling only proved successful after several cycles. These illustrations highlighted the need for consistency and persistence.

Several interviewees highlighted leadership’s views on the importance of the pilots. A program director reported pilot initiatives that were small, led to improvements, which were used to upscale successful ones. A chief medical officer stated that piloting helped to reduce risks to the organization and increase confidence of the workforce by showing rapid improvements.

A doctor noticed that “humility is important in this process of adaptation.” Another stated that “acknowledging failed experiments is more successful in building trust than attempting to justify them.” Yet another described how “acknowledging mistakes has led to creating a culture of learning.”

One physician also noted how a good adaptation increased the resilience of the wellness teams themselves. This individual noted how there was burnout for the wellness team champions when progress came to a standstill, and another interviewee stated how they viewed challenges as a part of the journey as well as a means to maintain enthusiasm.

A wellness officer noted that some support structure was necessary for adaptation. Feedback loops, design iteration, and support from top management allowed for positive changes that were not reactive, and pointed out that workers considered these changes indications of organizational maturity, not instability.

Ultimately, adaptation was deemed characteristic of quality programs or interventions. These existed not because they started out perfected, but because they continually adapted to context and showed relevance then and thereafter.

Integrative Summary

The participants described the implementation process as influenced by real-world considerations. They noted that resource utilization, integration into workflows, actionable feedback, engagement, and real-time adaptability were crucial to ensure that interventions were successful. The challenge to success lay not in the intelligence of the design but in tenacity and consistency.

For practitioners like doctors, implementation was where vision met reality. Leaders who invested in capacity, integrated wellness into their work, assessed progress visibly, developed ownership, and adapted to change developed initiatives that succeeded. In contrast, leaders who did not focus on these aspects allowed promising initiatives to die.

One wellness officer determined that the process of implementation was the crucible within which wellness either survived or faded away. In many cases, the process required creativity, humility, determination, and vision. Flexible wellness programs and

interventions valued staff input, and those that wove themselves into the fabric of the organization were the ones that remained.

Theme 7: Creators' Recommendations for Future Interventions

Physicians, CWOs, program directors, and other interviewees drew their own conclusions and suggested their recommendations for what might come next. These recommendations were not idealistic theories but instead were based on challenges and observations. There was consensus among some respondents regarding what might come next that included technology and advocacy at every step along the way and at various levels. All of these recommendations and conclusions can be considered a vision for what the intervention creators' experiences and beliefs indicate might come next.

Earlier Access and Reframing

Experts emphasized the importance of reflecting on values, boundaries, and cognitive skills during residency programs. A physician leader stated that most physicians had already adopted the culture of overwork by the time they began their careers, and another residency director emphasized the value of allowing young physicians to reflect on coping strategies before experiencing burnout.

“Training is critical. Boundary skills and reflection for leadership and identity development, rather than remediation, can be an essential part of that,” said one interviewee. A program director claimed, “When we reframed reflection training as professional competence, residents adopted it rather than viewing it as stigmatizing.”

Moreover, several interviewees indicated that it was pointless to attempt if it was carried out at an unguarded time. Additionally, one of the physicians stated that his

residents had requested some structured time to stop for the training, but this time was not available. One other resident program leader said “the reaction of some trainees regarding the wellness programs seemed to be different from some of the others.” They were unable to ascertain what caused the difference, but they suspected it was due to varying workloads and schedules.

A senior physician went on to say that reframing was also a process of shifting “from fixing the weak to improving the strong.” The idea that physician reflexivity is an attribute of professionalism encouraged viewing investment as beneficial. “The new skills were applied in practice without embarrassment,” said a participant who felt that incorporating reflective knowledge in lists of training competencies may imply its relative necessity, similar to anatomy, pharmacy, and so on.

Professionals identified a need for reflection of culture in addition to the curriculum. Role-modeling by faculty members who positively express their vulnerabilities allowed younger faculty members to share their reflections as a strength. Some interviewees thought that the reflection offered by respected authority figures was as effective as any workshop, program, course, or intervention.

One explained, “Earlier access and reframing were not negotiable options. The reason for this decision was that without teaching reflection and boundary-setting skills early on for leadership development purposes, all wellness programs would necessarily have a remedial emphasis.”

Policy and Protection

Practitioners and healthcare experts noted the need for change at the policy level in order for progress to be achieved. Licensure/malpractice applications had questions concerning mental health issues that prevented providers from pursuing services provided later. “Impairment” issues had left practitioners open to vulnerability, according to a healthcare attorney. Practitioners had shied away from counseling or mentoring services offered due to fear of malpractice applications’ inputs.

One CWO found structural barriers in the policies and noted that no program inside the facility could work when participants faced possible peril. They expressed a need for firewalls between resources for development and mechanisms for discipline.

The directors of residency programs pointed out that the students were well aware of these risks. One of the directors said, “Students have known about these resources and have turned to ways to gain support outside the system to make sure there is no 'paper trail.’” Another explained, “It's not uncommon for young doctors to ask us whether participation in these kinds of programs would impact credentialing.”

Leaders viewed policy reform as a crucial step in reducing perceived risk. Some leaders mentioned several states that had amended licensing questions to take the emphasis off punitive fears. In these states, physicians were more likely to seek help. One decision-maker believed a policy within the organization itself might also serve as a safeguard. For example, at one of the hospitals, confidentiality regarding coaching and mentoring has now been included in the contract. Staff members there expressed a sense of protection when utilizing these support tools.

One CWO believed that protection was not only a matter of legality, but it was also a cultural one. Over time, views shifted as a result of repeated assurances about policy changes. One doctor believed that unless an intervention combined with protection, it rendered the interventions subutilized.

For many respondents, protecting clinicians from both a legal and an organizational perspective was the “bottom line,” without which environmental change could not be brought into play. They assumed there was no way for wellness programs to overcome fear and stigma without policy change. One interviewee stated, “In a small town, people know each other, and it is not difficult to find out what is going on.”

Technology With Proof, Not Hype

Providers spoke plainly about the mixed blessings of technology. Many complained about tools that were marketed for time savings but actually just redistributed work to the physicians. A hospitalist reported that patient messaging systems generated numerous messages, and these messages should require no assistance with their management. However, “AI-enabled” template systems were endless in their need for correction, according to a CWO.

A program director was quick to emphasize the need for improved tech evaluation. A director stated that all new products should be evaluated using time-motion studies, as well as post-hoc analyses. A physician said that the value of a new product should be measured by its success in reducing the input time of electronic health records.

Some physicians shared positive experiences related to the incremental assessment of tools. One shared, “In the pilot study, an AI scribe was tested, and it was

able to cut documentation time by 20%, and then processes were implemented to improve it further.” Another clinician stated, “When a particular tool did not live up to expectations, it was removed by our leaders, and it increased our trust in them.”

A wellness officer pointed out the importance of transparency. Displaying EHR data outside of work hours enabled the evaluation of the effects of the tools' implementation or discontinuation. A department chair pointed out the value of discontinuing tools with no benefit shown through data, demonstrating to the health professionals the importance of their time over the sunk costs.

“The perception was that technology was not to be adopted out of curiosity or prestige,” said one physician. A comment was made by a program director about people having 'shiny objects' to which they gave all their attention, but that gave little relief. They wanted efficient tools rather than complex or showy solutions.

“Credibility had to be backed up by proof,” one leader stressed. The chief medical officer of one hospital explained how finance was more likely to support technology if efficiency proofs were quantifiable. Clinicians observed how trustworthy leaders admitted mistakes instead of claiming success with tools.

The participants' messages were clear: technology had to prove its value. One physician said, “only those technologies that were proven to decrease work hours outside of office hours should be adopted, while the rest should be rolled back.” Another said, “It had to prove its value, rather than its hype.” This appears to be a guiding principle for the future.

Positive Deviants and Learning From What Works

Many encouraged exploring examples of people who were able to maintain meaning and performance levels despite challenging environments. A CWO talked about positive deviants, who were healthcare providers who performed well with lower levels of burnout. A physician leader indicated that such people were characterized by workflows or boundaries that could be applied to interventions. A residency director pointed out that positive outliers were modeling good habits, and a CWO described how grounded faculty members ensured that they themselves had reflection time each day and trained residents to follow suit.

One interviewee suggested that an emphasis on successful handling of burnout could be a way to avoid the deficit approach, and a physician coach explained the difference between deficit thinking and success thinking: “It’s discouraging if all I see is the negative. On the other hand, the success approach gives people confidence.” Nurses and physicians were encouraged to adopt positive methods initiated by others when they witnessed the success of these methods.

An expert described how positive deviators regularly employed teamworking, and a noted, “In well-functioning teams, communicating notes and prioritizing messages was second nature.” A department chair stated, “If nurses and physicians worked together on creating protocols, it reduced all parties’ levels of stress.” Some leaders thought these procedures could become regular habits.

A wellness directors suggested carrying out formal research and thought successful teams should be observed to determine patterns that could then be imitated.

Another clinician felt it was more possible with that information in mind to intervene rather than using more generic approaches. One leader said that not only did they acknowledge positive deviants, but they also had a significant impact on the culture. The interventionists felt inspired to have examples to emulate, and it provided them with examples of what they, too, could achieve.

It was evident that several participants recognized not only the need for future intervention studies but also for research on what prevents certain clinicians from burning out so that others would be able to take advantage of what they were doing right.

Outcome Sets Beyond a Single Number

Several interviewees mentioned being dissatisfied with the narrow aspects of outcome sets. Burnout measures alone had not provided enough insight, another provider said. A wellness officer noted that turnover, open positions, and the time to bring new employees on board should be measured. A physician stated that measuring the number of messages in the inbox and outside of office hours in the electronic health record was an essential consideration.

One of the things one physician found helpful about richer sets of outcomes included, “It encouraged ownership when the results were published on dashboards for the whole department.” Another said, “It showed the top echelon how access to patients and burnout outcomes were related to each other and how they were both linked to the well-being of the workforce and the quality of their service.” A residency director noted that trust was also built through diversity in the results. For instance, residents were more confident in the results of multiple measures of progress because the concern of data

manipulation in a single area was lessened. Overall, many believed that better results were conveyed through multifaceted measures of performance, rather than a simple number.

There were also concerns about how to ensure the recommendations were implemented. One wellness officer emphasized the importance of being results-driven. They mentioned the process of associating each round of the survey with specific remedies and progress. “We need to believe the data has shown enough to ensure improvement,” said one clinician. They pointed to leaders who maintained that the extent of the project was as necessary as the element of transparency. The posting of results helped to maintain honesty when progress was meager. One doctor explained that keeping the truth about failure helped to avert skepticism.

What many clinicians suggested was that outcome sets also brought wellness visibility to C suite personnel and committees. When data regarding delays and turnover reached scorecards, wellness brought attention at an executive level. This transitioned wellness from an emotional focus to a strategic approach.

Many participants recognized that future intervention outcomes must be measured comprehensively and in a multifaceted manner. This provides organizations with the means to act, while also offering clinicians evidence that progress is being made.

Contracts, Pipelines, and the Future Workforce

Requests for changes to help ensure workload and capacity can be improved. “A contract was negotiated to restrict documentation work out of hours,” reported a department chair. “Protected time for mentorship and reflection had to be negotiated into

contracts to ensure such time was sustainable,” noted another physician. “Wellness wasn’t dependent on the goodness of people” in these arrangements.

Speakers also mentioned the challenges posed by the pipelines. “Without increasing the number of positions to train more residents,” one said, “the gap in wellness will remain due to the lack of enough trained physicians to take care of our patients.” Another said there were not enough mentors for young, new physicians.

Encouraging contractual language regarding the protection of contracted time and employing CWOs to show the importance of employee well-being have impacted the culture in the following ways. As an example, a CWO explained how contractual language changed the environment and discussed how contracts providing quiet time improved expectations.

A program director also found the need for pipeline development equally important. As they described, having extra residency physicians relieved pressure on the faculty physicians. Another director explained, the development of the program’s own mentors reduced attrition rates and facilitated cultural changes. The protection of workload and the increase in pipelines were seen as two sides of the same coin. Without protection, wellness declined precipitately. Without expansion, even the strongest protections faltered.

Another leader realized that the issue of wellness could not be addressed on a contract-by-contract basis, and that changes had to be made in the system in order to match the supply of workers with the security of the workload.

In the respondents' view, this is an investment made over a long period. The future of sustainability will require the ability to manage contracts, pipelines, and mentorships simultaneously.

Scaling Community and Leadership

Several doctors identified community as one of the best, if not the best, antidotes to burnout. One leader explained, “Communities of peers have really helped in times when people are feeling isolated. There are groups who get together every year, so it's like having a tribe, which is really good.” A residency director remembered retreats in which doctors were able to reunite outside of a busy practice, calling it “protective ritualistic events.”

“Belonging could not be contingent on goodwill,” one CWO stated. “Collegiate spaces had to be supported and institutionalized,” they continued. “We must signal that reflection is as valid as productivity,” another physician noted and added, “structured venues for reflection needed to be calendared.” Another physician said, “It changes the message that is conveyed culturally.”

Leaders also spoke about the value of coaching capacity. A program director explained that internal coaching staff were developed based on which peers staff trusted. A department chair pointed out that coaching within teams eliminated stigma because needing it just seemed like business as usual. Two wellness directors pointed out that coaching capacity was the only way to make reflection continuously available, rather than an episodic process.

Physician leaders emphasized the importance of integrating leadership development with other key aspects of healthcare. One described the old emphasis on efficiency in practice, but not on professionalism or the development of culture. A CWO responded that many new leaders were not adequately prepared to address all aspects of well-being. Some interviewees called for the development of either efficiency, professionalism, or the ability to design the culture of practice.

One program leader observed that distributing leadership responsibilities prevented burnout. Another noted how wellness ambassadors in each department ensured that leaders did not experience burnout. Another program leader stated that, as a result of increasing leadership responsibilities, programs were less susceptible to leaders' turnover.

Several respondents recognized that community and leadership were interdependent. On one hand, the creation of the culture facilitated a sense of belonging. On the other hand, leadership development encouraged the exercise of agency. Both facilitated the development of the scaffolding that enabled individual recovery and organizational change. Further, one leader observed that individuals who experience loneliness often feel isolated from the community's support and resources.

In conclusion, for many participants, organizations had to institutionalize peer spaces and develop coaching capacity to make a sense of belonging and reflection possible, at the same time, they had to extend leadership development to other areas such as practice efficiency, professionalism, and culture building so that wellness would be a regular affair and not a periodic one.

Integrative Summary

One professional said, “A future must be based not just on goods and services, but also on time, policies, time-saving technologies, and sets of outcomes driving action.”

This interviewee also said, “More people should be trained, policies to support workload should be written, and the practices to make an organization a good place to do good should be amplified.” Several believe that leaders should learn about the people who succeed as clinicians and “study the positive deviants.”

In such a vision of the future, individual-level approaches and system redesigns are not alternative solutions, but rather components of a unified approach. The skill of reflection is introduced as part of leadership development, and wellness policies should safeguard without penalizing. Technologies should be evaluated on evidence, not promises. Community and mentoring should be incorporated, and developing leaders would do well to focus on efficiency and professionalism without sacrificing culture.

When all these elements are brought together, time shielded, capacity funded, outcomes measured, outcomes shifted to policy changes, culture shifted, then that will be an institution at which practicing in the field of medicine will be supportably done. Wellness can be a consideration over a prolonged period.

The need to move from rhetoric to infrastructure was also emphasized. Many concluded that to make interventions effective, they must be funded, integrated, measured, and invested in, just like any essential system. This aims to shift wellness programs from marketing posters to having a lasting influence on how healthcare providers live and work.

In those cases, the vision is more practical than idealistic. Leaders did not paint a picture of utopia. They described organizations providing healthcare professionals with ample time, safe limits, and meaningful work. They also explained that those are requirements, not optional, for safe and quality care.

In conclusion, the vision of what the respondents considered supported wellness included protected time, clearer policies, evidence-based technology, enhanced pipelines, a nurtured community, and leadership development. In this scenario, wellness is no longer a competing goal but the platform that facilitates the achievement all missions of the healthcare industry. The concluding recommendations of the thematic analysis represent that it is essential to ensure that the views of all participants are represented throughout the study.

Evidence of Representation

To maintain transparency and confidentiality, coding and analysis were conducted using the software program NVivo. Meaning unit statements from the original transcripts were assigned to exemplar statements, sub-themes, and general themes. A comprehensive matrix for this analysis process is presented in Appendix C, illustrating the representation of participant statements across Themes 1 through 7. In Appendix B, the participant demographics are compiled to show representation by role and industry.

Participant Index (Matrix View)

To demonstrate inclusive representation without compromising confidentiality, Table 2 presents a neutral participant-by-theme matrix (P01–P17 with role categories). An expanded evidence tracker appears in Appendix B.

Table 2*Participant Index (Matrix View)*

Participant	Role category	T1	T2	T3	T4	T5	T6	Notes
P01	Physician leader	✓	✓	✓	✓	✓	✓	
P02	Physician leader	✓	✓	✓	✓	✓	✓	
P03	Chief wellness officer	✓	✓	✓	✓	✓	✓	
P04	Physician coach	✓	✓	✓	✓	✓	✓	
P05	Physician coach	✓	✓	✓	✓	✓	✓	
P06	Non-physician coach/consultant	✓	✓	✓	✓	✓	✓	
P07	Assoc./efficiency leader	✓	✓	✓	✓	✓	✓	
P08	Healthcare attorney	✓	✓	✓	✓	✓	✓	
P09	Operations/strategy executive	✓	✓	✓	✓	✓	✓	
P10	Physician leader	✓	✓	✓	✓	✓	✓	
P11	Physician leader	✓	✓	✓	✓	✓	✓	
P12	Physician coach/researcher	✓	✓	✓	✓	✓	✓	

Participant	Role category	T1	T2	T3	T4	T5	T6	Notes
P13	Physician leader	✓	✓	✓	✓	✓	✓	
P14	Consultant/leadership	✓	✓	✓	✓	✓	✓	
P15	Chief wellness officer	✓	✓	✓	✓	✓	✓	
P16	Physician leader	✓	✓	✓	✓	✓	✓	
P17	Physician leader	✓	✓	✓	✓	✓	✓	

Summary

This chapter presented the results of a descriptive phenomenological study examining how wellness leaders and physicians created and implemented responses to burnout. Findings were organized into seven interlocking themes.

Theme 1 (system-level factors) identified the structural levers—payment models, staffing capacity, measurement culture, autonomy, and communication load—that shaped the design space. Theme 2 (personal experiences shaping motivations) described how identity loss, recovery, family tension, leadership renewal, and values alignment became catalysts for intervention design. Theme 3 (cultural norms and stigma) highlighted the endurance culture, stigma around vulnerability, leadership signals, and trust as decisive cultural forces. Theme 4 (leadership and governance) emphasized leaders as both catalysts and constraints, showing how governance and accountability determined sustainability. Theme 5 (organizational context and leadership influences) detailed how culture-building, resourcing, modeling, financial logic, and leadership pipelines influenced whether wellness became infrastructure or remained symbolic. Theme 6

(implementation pathways and practical challenges) described the realities of translating designs into practice, including resourcing, workflow integration, measurement, engagement, and adaptation. Theme 7 (reflections and recommendations) captured forward-looking guidance, calling for earlier reflective training, policy protections, evidence-based technology, lessons from thriving teams, broader outcome sets, workforce pipelines, and institutionalized community and leadership.

Taken together, the findings show that effective responses to burnout emerge when personal agency is coupled with system redesign, when leaders model and finance capacity, when interventions are implemented adaptively, and when future reforms align policy, culture, and measurement. The next chapter interprets these results in light of the literature, addresses implications for theory and practice, and provides the researcher's recommendations for continued research and organizational change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this descriptive phenomenological study was to explore the processes and motivations that influenced how wellness leaders, physicians, and organizational executives designed and implemented responses to physician burnout. Seventeen participants representing diverse roles and organizational contexts shared their lived experiences, which were analyzed using Moustakas's phenomenological approach. Chapter 4 presented the study results organized into seven interlocking themes: (a) system-level factors influencing intervention creation, (b) personal experiences shaping motivations, (c) cultural norms and stigma, (d) leadership and governance, (e) organizational context and leadership influences, (f) implementation pathways and practical challenges, and (g) experts' reflections and recommendations for future interventions.

This chapter interprets those findings in relation to the existing literature, highlighting where they confirm, extend, or challenge prior research. It also addresses the study's limitations, proposes recommendations for practice and future research, and considers implications for positive social change. The chapter concludes with a synthesis that underscores the significance of the findings for both scholarship and healthcare leadership.

Theme 1: System-Level Factors Influencing Intervention Creation

In most instances, participants depicted physician burnout as a consequence of the structural forces inherent in modern healthcare systems. Their comments revealed a

strong correlation between their thoughts and literature that elaborates how payment structures, documentation requirements, staffing constraints, and communication norms become the root cause of the issues, which, in turn, undermine clinicians' capacity to practice meaningfully (Shanafelt et al., 2022; Sinsky et al., 2016; van Niekerk et al., 2023). Many interviewees believe that system-level drivers not only caused the onset of burnout but also created the need for interventions to mitigate it. Physician burnout was conceptualized as one of the consequences of organizations' incentives being misaligned, with the inclusion of administrative burden escalating, insufficient staff, and cultural expectations at a level where overwork was taken for granted. They suggested that interventions that focused on individual resilience were lacking in quality or strength; thus, structural reform should be implemented to make the interventions adequate and sustainable (Shanafelt et al., 2022; van Niekerk et al., 2023; Vercio et al., 2021).

Incentives and Payment: What the System Pays For, the System Gets

Participants documented the significance of the adverse effect of productivity-based compensation models on burnout, as these methods not only accelerated burnout but also led to compression of clinical time and limited the possibilities of meaningful patient engagement (Shanafelt et al., 2016; Sinsky et al., 2016). Many of them explained that the structure of incentivizing the speed of one's work, rather than the quality of patient contact, was dominant in the payment system. "The pay structure is going down... we are having to take care of more patients for less money," was a phrase used by one of the participants to express the contradiction between financial expectations and

sound practice. Several others similarly stated that revenue-driven scorecards made relational care a rarity, rather than the standard of professional practice.

Some participants recounted instances of how differing goals between them and management gradually eroded their freedom in decision-making at the clinical level and their motivation from within. Many of them specifically identified performance indicators that emphasize throughput as the main reason professional values get drowned, resulting in the conversion of the practice into robotic processes. As a way to express how incentive systems were constant sources of ethical and emotional challenges, one participant pointed out that the unrelenting pursuit of volume production had “left no space for slowing down to the level necessary for providing the care that patients truly deserve.” The accounts of such situations align with studies that associate RVU-driven environments with a loss of meaning and a higher rate of emotional exhaustion (Rosner & Falk, 2020; Shanafelt et al., 2022).

Some participants painted pictures of efforts to respond to these challenges, with goals of transforming incentive schemes to better reflect teamwork and quality of care. Certain institutions have shifted from monthly installments to patient satisfaction, educational contributions, or participation in quality initiatives, where participants view these as genuine efforts in the redesign of the workflow. However, most observed that such changes were easily turned over during financial crises. Consequently, this enforced the belief that for quality healthcare to endure, it must be deeply embedded in economic frameworks, rather than being a separate component in systems that allow contradictory

behaviors (Longo et al., 2023; National Academies of Sciences, Engineering, and Medicine [NASEM], 2022; van Niekerk et al., 2023).

Several participants' reflective thoughts highlighted that the payment structures were not in the background; they were the main factors that influenced workflow, culture, and well-being. The interventions that did not address these underlying economic demands were viewed as momentary and superficial.

Workforce Design and Scheduling: Capacity as Prerequisite

Insufficient staffing and nonrealistic schedules were among the significant causes of burnout, as some participants highlighted, which is also in line with the results of national surveys that document how excessive workload leads to emotional exhaustion (NASEM, 2022; Ortega et al., 2023; Shanafelt et al., 2022). Many spoke about the things they had to do in a day, which were beyond any logical capacity. During an interview, one person shared that “documentation, communication, inbox messages, administrative tasks... you just cannot do all of these every day, and then you still have to take care of the family at home,” pointing out how the cumulative task burden had taken away their chances of success or recovery. Their narratives exemplified how structural overload, rather than personal inefficiency, was the primary reason for the continuous strain.

Such limitations of capacity also impacted the practicability of wellness interventions. Several participants discussed how, despite the sound design of some programs, these could not be implemented due to staff shortages, which made it impossible for clinicians to take time off to participate. One of the participants pointed out that “very soon the coverage models gave up their fight” when the leaders tried to

free the staff for wellness activities, thus showing how staff well-being and operational staffing are two sides of the same coin. Their thoughts extended beyond the existing literature by providing examples of how the lack of staffing can be a significant obstacle, even for evidence-based interventions (NASEM, 2022; Shanafelt et al., 2022; van Niekerk et al., 2023).

A few participants also noted that their local workload had become heavier due to the workforce's prolonged constraints, for instance, a limited number of training pipelines and a high rate of attrition. They expressed that if there is no comprehensive plan to increase the workforce, then measures like making free time or sharing tasks will hardly bring about any change.

Measurement and Data Visibility: From Avoidance to Action

Participants recounted measurement practices as powerful depictions of the organization's values. Their thoughts aligned with studies that show that a trustful, engaged environment is supported by transparent and actionable measures (Hodkinson et al., 2022; Longo et al., 2023; Swensen & Shanafelt, 2020). In one of the interviews, it was stated that “dashboards with burnout data published quarterly built trust,” thereby demonstrating how the visible communication of the reporting fostered confidence in administration. The participants observed that the measurement confirmed the clinicians' experiences and opened the way for departments to reframe and solve the issues together.

At the same time, some declared that they would lose confidence if they saw measurements being made but no actions following them. Some of them even brought up instances in the past where questionnaires or surveys had been conducted and then

ignored. Since nothing had changed, the personnel considered the measurement to be a performance evaluation for them, rather than a genuine intervention. Their thoughts echo the findings that surveys must be accompanied by prompt and concrete actions if there is to be any credibility and significant change (Longo et al., 2023; Swensen & Shanafelt, 2020; Vercio et al., 2021).

Professional Autonomy and Teaming: Restoring Room to Practice Medicine

Participants provided numerous examples that aligned with the research fact that one of the most significant factors leading to burnout is a decrease in the sense of autonomy (Hodkinson et al., 2022; Ortega et al., 2023; Sinsky et al., 2016). A significant number of interviewees explained how administration's creation of extended documentation and communication requirements hinder their ability to use clinical judgment. A participant shared their perspective that "the expectation of immediate communication and constant availability is overwhelming... and nothing has been put in place to protect the physician," which served as an example of how system norms reduce the level of autonomy by defining obligations that are significantly beyond available resources.

Participants explained many details about the strategies presented to them or created by them by which physicians could regain their independence. Several respondents shared their experiences of delegating the responsibility of the inbox to trained team members, thus lightening both the administrative load and the work that goes on after office hours. Some other examples included changing the operations of organizations to get rid of "unnecessary clicks," giving instructions that were of a routine

nature to someone else, and improving documentation templates. Small changes such as these enabled clinicians to regain control of their medical practice, using time more efficiently, allocating better time to patients, and aligning with their internal beliefs. The implementation of small team level interventions lends support to the research that team-based approaches can lessen low-value workload and increase engagement (Longo et al., 2023; Sinsky et al., 2016; Swensen & Shanafelt, 2020).

Moreover, the participants underlined the emotional side of autonomy. A significant number of them expressed that the piling up of rigid and seemingly unnecessary routines and numerous administrative demands led to moral distress, which was pronounced in situations where the lack of time did not allow them to establish a meaningful connection with the patients. They spoke of autonomy as the most helpful factor in regaining a professional identity, not only as an operational preference but also as a core dimension of meaningful work.

Some participants stressed that autonomy-supporting interventions were a prerequisite for significant cultural and structural changes. A change in workflow needed to be accompanied by clear communication, support from leaders, and sufficient staff to ensure that clinicians did not feel the delegation was a redistribution of their workload. These thoughts suggested that autonomy was under the care of the system, rather than being an individual skill.

The information shared by many participants was highly indicative that they considered autonomy and teaming to be closely related and interdependent concepts. In fact, one of the primary focuses was on the mutual delegation and communication

workflow, as ways through which clinicians can achieve a state of concentration on high-value tasks, leading to the restoration of a sense of purpose and a reduction in feelings of fatigue.

Communication Load and After-Hours Norms

Participants designated digital communication to be one of the main reasons for their burnout, which is in line with national reports that document the heavy burden of after-hours EHR activities (Ortega et al., 2023; Shanafelt et al., 2022; Sinsky et al., 2016). The majority of them explained that the sheer volume of messages and the expectation to have direct access at all times made it very difficult for them to set limits between their work and home lives. One interviewee stated, “My inbox is full of a hundred messages after surgery... it is beyond human capability to deal with all of them every day,” thus illustrating how communication demands stretched clinical work into their personal time.

Moreover, many participants identified the communication overload from the system as a primary reason for burnout. For example, they cited policies that mandate the immediate release of diagnostic results. These policies created expectations for quick responses from the physicians that were not in line with their clinical schedules. Another participant said, “If I order 30 scans on Wednesday and all the results come in on Friday, there is no way I can call 30 patients after a full surgical day,” thus illustrating how communication practices led to unmanageable after-hours obligations.

Among the attempts to reduce the communication load were practices such as rerouting messages to other team members, postponing the delivery of nonurgent

communications, and establishing more precise boundaries. Participants noted that for such measures to be effective, they needed to be supported by the culture, rather than just by technology. Leaders had to demonstrate boundary-respecting behavior and create explicit norms regarding communication expectations.

Moreover, participants argued that communication interventions could serve as a visible signal of an organization's commitment to employees' well-being. When message-routing protocols were changed, or nonurgent messages were postponed, clinicians took these activities as proof that leaders were aware of the workload's realities. These findings are consistent with the conclusion that changes at the system level that protect recovery time are crucial for sustaining clinician well-being (Hodkinson et al., 2022; Longo et al., 2023; Swensen & Shanafelt, 2020).

Integrative Interpretation of Theme 1

Participants in this study consistently identified burnout as an issue that results primarily from overly aggressive economic incentives, staffing patterns, the intensity of documentation, lack of autonomy, and communication norms. Their opinions were consistent with the academic consensus presented in the literature, which indicates that systemic causes have a much more substantial impact on the well-being of clinicians than that of personal resilience factors (Han et al., 2019; Hodkinson et al., 2022; Ortega et al., 2023; Vercio et al., 2021). They argued that the system not only created the conditions in which burnout occurred but also determined the boundaries of any potential intervention.

Additionally, participants explained how system-level misalignments limited the effectiveness of their well-being initiatives. Initiatives that did not raise causes such as

capacity, incentives, and communication overload were often considered as a show of going through the motions. Their thoughts aligned with the research that suggested sustainable improvement requires the redesign of the organization rather than merely executing resilience programs (Swensen & Shanafelt, 2020; Tawfik et al., 2018).

Theme 1, in general, reflects the message that if they are to be regarded as efficient and credible measures, the system needs to be organized in a way that it structurally supports the interventions. The accounts of the participants revealed that changes in the system are vital for the mental health of the medical staff, and that the organizations have the power to influence feelings of physician burnout because they can opens up real possibilities for interventions to be successful.

Theme 2: Personal Experiences Shaping Creators' Motivations

Participants shared that burnout was a profoundly personal turmoil that altered their identities, relationships, and sense of purpose. Their narratives were in accordance with studies which indicate that burnout decreases the level of one's self-concept, emotionally exhausts the person, and causes a kind of existential questioning (Dyrbye et al., 2018; Han et al., 2019; Shanafelt et al., 2022; West et al., 2018). Moreover, interviewed creators of intervention attempts did not portray these interventions as resulting from abstract theoretical interest; instead, their work was deeply rooted in their experiences.

Burnout served as both a warning and a catalyst for the participants, prompting them to develop strategies that addressed the emotional, relational, and identity aspects of clinician distress. Their views supported the belief that the inclusion of personal stories

and systemic insights is necessary for the success of wellness programs, as they account for the complexity of clinician experiences (Dyrbye et al., 2018; Han et al., 2019; Tawfik et al., 2018; West et al., 2018).

Existential Crisis and Identity Loss

Participants reiterated the findings of previous studies that burnout results in a profound upheaval of one's identity. Many stated that they had lost their sense of identity outside of clinical practice. One of the participating physician interviewees shared, “I really struggled to figure out an identity as a mom, as a partner... I could not figure out how to come back to my work in a way that felt meaningful,” which is an obvious example of the disorientation that usually goes hand in hand with overwhelming professional strain. Their testimonials aligned with other studies, which portray burnout as a gradual loss of personal coherence, ultimately causing clinicians to feel detached from aspects of themselves that are unrelated to their medical practice (Dyrbye et al., 2018; Han et al., 2019; Linzer et al., 2016; Shanafelt et al., 2022).

A few participants raised concerns about the emotional consequences of identity narrowing. They shared that they or those they were attempting to help had become disconnected from their activities, relationships, and creative practices, which had previously been meaningful to them. Some of them even mentioned that the ongoing clinical pressures were so overwhelming that, in the end, they were almost unable to reconnect with the aspects of their inner selves that had once brought them happiness or steadiness. This description aligns with studies that reveal chronic work overload exhausts one's psychological resources and simultaneously weakens the connection with

nonprofessional roles (Linzer et al., 2016; Panagioti et al., 2017; Rotenstein et al., 2018; Tawfik et al., 2018).

In addition, some participants discussed moments when they realized that their professional identity had become so dominant that it had overshadowed all other aspects of their lives. Such reflections frequently brought them back to considerations of what was lost and what still had to be regained. Their journeys mirror research that indicates the process of overcoming burnout involves re-establishing oneself and returning to one's inner core of values, which extends beyond the professional sphere (Hodkinson et al., 2022; Ortega et al., 2023; Panagioti et al., 2017; Rotenstein et al., 2018). Disruption of identity was one of the primary factors behind the creation of many wellness initiatives, as evidenced from the participants' stories. They argued that programs must be designed in a way that allows clinicians to regain aspects of themselves that are hidden due to burnout, thus suggesting that doing identity work is the basis for designing deep and efficient interventions.

Personal Burnout and Recovery as Design Inputs

Often, the participants referred to their own burnout as the main reason for their later involvement in wellness work. A few of them discussed times when they were so exhausted that their emotions became overwhelming, forcing them to take a break from clinical duties. One of the participants shared, “I burned out... I recognized it while it was happening and did not know how to stop it. I felt alone and isolated, and I did not want to talk about it because that would admit weakness,” thereby giving an example of the vulnerability and isolation, which are at times, the most intense accompaniments of

burnout. These descriptions align with research that views burnout as leading to the impairment of an individual's functioning and deterring the person from seeking help (Bodenheimer & Sinsky, 2014; Linzer et al., 2016; Tawfik et al., 2018; Wallace et al., 2009).

Moreover, they recounted how their recuperation narratives had turned into patterns for the interventions they had later created. Some discovered, through the power of coaching, self-reflection, or establishing boundaries, that they were somewhat able to regain their lost sense of control. Their stories aligned with the research, which states that recovery is a process of regaining mental and emotional strength, often with the help of a support system and through deliberate change (Maslach & Leiter, 2016; Tate, 2018; Vercio et al., 2021).

Those moments had a profound impact on the participants' perception of wellness design. They aimed to design interventions grounded in the kinds of support they had longed for but never received during the early stages of their careers. The road to their recovery became the wellspring of their understanding. Thus, they implemented initiatives that focused on giving participants a sense of control, assisting them in emotional processing, and fostering peer connections.

Family–Work Tension and Role Conflict

Family strain figured prominently among many participants' emotionally charged factors that significantly influenced their motivation. A significant number of them spoke about how work pressures constantly outweighed their family obligations, thus resulting

in feelings of guilt, tension, and even emotional distancing. One of the participants shared,

“It seems that I have to play the best role at home, be the best husband, the best father. I make an effort to attend the practices and games. Then, my wife is at a birthday party with the kids, and I am either in surgery or making calls to patients. This situation is the root of resentment... and medicine has not evolved to meet the demands of family life.”

Narratives like these aligned with the existing literature, which suggests that role conflict is a significant source of clinician distress and a predictor of long-term emotional exhaustion (Aiken et al., 2023; Brown et al., 2021; Buck et al., 2019; Williams et al., 2020).

The participants also highlighted clinical unpredictability as a significant challenge to their family stability. Sudden changes to their schedules hindered their physical and emotional involvement with their family, required working on documentation outside of regular working hours, and created the expectation of being available for communication at night. A few of them pointed out that they had missed significant family events and that their closest relatives had become accustomed to their absence as part of their routine. Their experiences are consistent with the findings that chronic role conflict leads to depletion of emotional resources and, in turn, both professional and personal well-being are compromised (Aiken et al., 2023; Brown et al., 2021; Coleman et al., 2019; Smith et al., 2022).

A few of them mentioned the long-term relational consequences, such as the deterioration of their partnerships or feelings of alienation from their children. The participants' understandings indicated that the concept of burnout should be seen as a direct consequence of the demands at the workplace which then affects family systems. Their statements revealed that, for interventions to be effective, the emphasis should be placed on relational and organizational dynamics rather than individual coping.

Some participants recalled instances where family-related strain played a role in their decision to create more humane systems. They say that seeing the effect on those they love was the reason why many of them took on roles in wellness leadership or designed interventions. They perceived these undertakings as a means to ensure that no one among their colleagues would face similar conflicts. These findings go hand-in-hand with research that indicates that, in order to adequately deal with burnout, there is a need to adjust professional expectations to support basic human needs that are outside the scope of the workplace (Abatzis et al., 2023; Aiken et al., 2023; Makowski et al., 2022; Sinsky & Ristow, 2023).

Several participants recognized the imbalance between family and work not as a peripheral issue, but as one of the primary causes that led them to engage in wellness work. They argued that real solutions should first and foremost involve addressing the structures that cause the family to be strained if they want to be of lasting importance.

Leadership and Teaching as Sources of Renewal

One of the main ways the participants suggested to get energy back was through leadership and teaching roles. These gave them the chance to rediscover the lost meaning

in their work. A few interviewees expressed that by being involved in the growth of the trainees or making a positive change in the organizational culture, they got rid of the heavy feeling of exhaustion that came with burnout. One of the participants pointed out, “Mentoring junior colleagues reminded me why I entered medicine,” as an example of how teaching gave back to them a sense of purpose they had lost. Their views were consistent with evidence showing that contribution-oriented professional activities serve as a buffer against emotional exhaustion (Handoyo et al., 2022; Palamara et al., 2022).

Additionally, participants associated leadership experience with a broader sense of control. By being involved in system-level problem-solving or culture-building, they elevated their conviction that significant change was doable. Such occasions were in stark contrast to the surroundings, where they felt powerless or as if they were under the control of administrative demands. Their journey was similar to the research findings that participation in leadership roles leads to professional engagement. Hence, burnout is reduced, as it is characterized by the reinforcement of autonomy and alignment with the organizational mission (Aiken et al., 2023; Chow et al., 2022; Joung et al., 2022).

A few participants have spoken about establishing modes for mentoring or leadership development within their institutions, to emulate what has personally nourished them. They suggested that by providing clearly defined opportunities for orientation, connection, and mutual learning, more people will be able to overcome the challenges that once overwhelmed them. Such initiatives powerfully convey the message that those in charge should not be considered as those who merely facilitate clinicians’

well-being from the sidelines because they are, in fact, central components of a healthy professional ecosystem.

Values Alignment and Agency

Participants shared that a significant point of their recovery from burnout was to rediscover their personal values. Many of them recounted how continual overload and various pressures from the system had caused them to lose the aspects of medicine which had initially given them meaning. One participant mentioned, “Coaching helped me to learn how to think about my thinking and also about my identity at work. I really needed those skills a lot earlier than I thought,” emphasizing how, through reflective work, a feeling of personal values being in harmony with professional actions was regained. Their stories aligned with research that views value alignment as vital for maintaining engagement and reducing burnout (Handoyo et al., 2022; Lebares et al., 2018; Ryan et al., 2023).

Additionally, participants discussed the importance of regaining control over their lives and deciding how to work. Several of them mentioned that they had learned the skill of refusing certain activities they were asked to do and also that they could create work processes that helped them utilize their strengths more effectively. Their thoughts mirrored those in the literature, which show that having agency in work gives employees a sense of psychological ownership and enables them to become more resilient as a result of regaining control over their everyday work (Buck et al., 2019; Card, 2018; Coleman et al., 2019; Sinsky & Ristow, 2023).

Furthermore, alignment of values also profoundly affected the intervention design. Many aspired to develop programs that would reconnect clinicians with the humanistic roots of medicine while navigating the systemic constraints. They pointed out that it is not enough for health-promoting initiatives to merely extend or improve the efficiency of routine medical tasks; the initiatives must underpin significant, purpose-driven activities. This discovery aligns with the literature, which argues that a reformed organization reflecting the values of clinicians is a double win, as it guarantees not only staff satisfaction but also better patient outcomes (Dzau, 2023; Gogo et al., 2019; Kleinhendler-Lustig et al., 2023; Rosner, 2020).

Throughout their stories, participants depicted the attainment of values and the feeling of being in control over one's own life as closely linked processes. They discussed the recovery from burnout as a process of returning to personal and professional values that had been lost, and the design of interventions as an endeavor to not only make those values visible but also to help sustain them in clinical departments.

Integrative Interpretation of Theme 2

The participants' reflections showed that burnout not only influenced their emotions but also their determination to change the system for the better. Their struggles with loss of identity, family life becoming strained, being completely used up, and finally getting better, all of which were very personal, became the driving force for them to create the interventions that are rooted in their reality. Their stories aligned with research indicating that interventions lead to more engagement when they address the actual needs

and experiences of clinicians (Chow et al., 2022; Dzau, 2023; Joung et al., 2022; Kleinhendler-Lustig et al., 2023).

Moreover, the participants argued that individual recovery and organizational design cannot be separated. Their stories emphasized how their experience of burnout deepened their understanding of system failures and helped them see the way for significant changes. These ideas broadened the research, which suggests that the developers of intervention programs derive the most benefit from a deep understanding of both the structural and emotional aspects of burnout that comes from experiencing it (de Sousa Pereira et al., 2019; Gogo et al., 2019; NAM, 2023; Rosner, 2020).

In summary, Theme 2 explores the interconnection between the personal and the structural as a source of effective wellness interventions. The participants' motivations were rooted in their profound personal experiences of burnout, which, in turn, influenced their desire to develop interventions that acknowledged the human costs of existing systems and allowed for identity, relationships, and purpose to have a place in clinical practice.

Theme 3: Cultural Norms and Stigma in Shaping Wellness Work

Some participants consistently brought up the fact that culture has the same amount of influence as the formal structures when it comes to the causes of physician burnout, as well as the impact of wellness interventions. They went beyond the payment models and staffing ratios to describe norms that were so taken for granted that they glorified endurance, stigmatized vulnerability, blurred expectations, and determined the level of trust clinicians had in leaders. These stories were similar to the concept of the

"hidden curriculum" in medicine, which refers to the ideas that are not explicitly stated but are inherently acknowledged, that are related to toughness, perfection, and self-sacrifice, that are passed down informally but quite powerfully from one generation to another (Brower, 2021; Kleinhendler-Lustig et al., 2023; NAM, 2023; Tate, 2018).

Participants' reflections indicated that cultural expectations had the power to double the effect of burnout and served as examples of the need to bring in more humane ways of working. This suggests that interventions need to influence not only the beliefs and behaviors that are shared but also the cultural norms, rather than just the formal policies and workflows (Handoyo et al., 2022; Joung et al., 2022; Shen et al., 2022).

Endurance as a Hidden Curriculum

Many of the participants spoke of endurance as a feature that is deeply rooted in medical training and clinical practice. They pointed out that, despite the hardships of long hours, skipped meals, and chronic sleep deprivation, these things were often considered badges of honor. Many of the interviewees recalled that these norms were deeply ingrained in their minds from the outset of their careers, and they rarely questioned them. Their experience is a clear indication of the research that shows that the medical culture has always linked self-denial to professionalism; thus, doctors have been putting the needs of others at a very high personal cost (Charon, 2018; Guille et al., 2019; Ripp et al., 2020; Soklaridis et al., 2018).

Additionally, the participants stated that these endurance requirements were their long-term goals, even after their residency period. A few of them mentioned people who would proudly discuss the times when they managed to work through their sick days or

the difficulty of handling their shifts' hours without giving themselves a rest. There were also statements that healthcare workers who make it a point not to exceed their personal limits might be considered as those who care less for their patients. These stories are consistent with research indicating that endurance culture is a substantial barrier to seeking help, and it normalizes the chronic pressure experienced by individuals (Guille et al., 2019; Moutier, 2018; Ripp et al., 2020).

The cumulative effect of this hidden curriculum was a topic of reflection for a number of the interviewees. They discussed how, in an environment where exhaustion and excessive workload are the norm, wellness initiatives can be perceived as something foreign. The programs aimed at promoting rest and balance are at times regarded as unrealistic or only accessible to people who are “not tough enough” for the job. The statements of the participants highlighted that to truly address the problem of burnout, it is necessary not only to examine the issue within the healthcare system but also to directly confront the implicit messages that clinicians receive about the meaning of being a “good doctor.”

In summation, these comments pointed out that endurance was not only a personal trait but also a cultural script. The respondents believed that interventions should counter the notion that a medical identity is naturally and necessarily associated with suffering. Instead, they should advocate for a more sustainable conception of professionalism.

Stigma Around Vulnerability

In numerous instances, the participants attributed stigma as one of the main issues that hindered open communication about distress and the adoption of wellness resources. Several of them mentioned that clinicians were reluctant to disclose their mental health problems due to the fear of negative consequences to their careers. One participant shared his experience when talking to members of his family who are in the medical field and said,

“Most of them did not even know that there was such a thing as a physician burnout coach, and a couple of them told me that it would never be allowed because you have to fill out forms that ask if you are seeing a therapist.”

This story exemplified many interviewees' worries, which are not only about the malpractice applications but also about the credentialing processes, which, in their opinion, still give off the message that asking for help might endanger one's career.

Moreover, several participants talked about the stigma that was deeply ingrained in the language of their routine interactions. Some of them brought to mind instances when they had mentioned their stress to their coworkers, and the latter had reacted dismissively by saying that the emotional aspect of the strains was the weak side of the industry. Some participants explained that the mere suggestion of a colleague seeking coaching or counseling could be perceived as a form of punishment. One of the participants commented that getting coaching “smells bad...as if you have some hidden motive here, am I failing?” This kind of experience aligns with research that shows anxiety about being judged by peers and leaders as a primary reason why doctors refrain

from seeking help, even in the presence of formal resources (Dean et al., 2019; Keller et al., 2020; Nembhard & Edmondson, 2019; Parikh et al., 2022).

The participants' thoughts emphasized that to overcome stigma, it is necessary not only to change policies but also to undertake visible cultural work. Though several organizations had updated their forms and confidentiality practices, participants noted that clinicians would continue to be skeptical unless trusted leaders openly shared their own experiences and supported the use of services by others. The main thing that can be taken from their testimonies is that wellness programs, if they want to be accessible and practical, have to address the issues of confidentiality and professional status that result from the fear of being trusted and widely used.

Mixed Signals From Leadership

Participants discussed leadership behaviors as the main cultural factors that not only reflect the company culture but also either support or challenge the wellness programs. Many emphasized that even though formal announcements regarding well-being are made, they are not taken seriously, especially when leaders' daily activities contradict such statements. One of the interviewees expressed the inconsistency in this way:

‘I am there with the people, making myself visible, and trying to figure out how they are doing, but most of the senior leadership is so out of touch with what is going on that they do not even realize the people’s day-to-day.’”

This statement indicated a discrepancy between the priorities verbally communicated and the reality of the clinicians’ lived experience.

Participants provided examples of leaders who unintentionally perpetuated harmful practices. Some reminisced about executives who habitually sent emails late at night, thus creating unspoken demands for employees to be constantly available. Others discussed leaders who encouraged employees to “power through” their illnesses or take extended shifts; in this way, overextension was glorified. Research on the organizational culture of the workplace has revealed that employees tend to look more at what leaders do rather than what they say when trying to determine what is truly valued (Edmondson, 2018; Fainstad et al., 2022; Shapiro et al., 2019; Willard-Grace et al., 2019). These behaviors align with the findings.

At the same time, participants noted that a leadership example can become a powerful positive force if it aligns with wellness objectives. Some discussed leaders who went home after work at a reasonable time, did not send or answer unimportant emails after hours, or openly emphasized the importance of personal boundaries. One participant used a powerful upstream analogy to explain that “the people are drowning in a river and we are pulling them out one by one, but we are not asking how they got into the water.” This reflection, shared by a wellness leader, highlighted the growing recognition that leaders cannot only focus on managing the crisis but also must address the causes that lead to the distress in the first place.

Participants also believed that leadership consistency was the primary factor that leaders could use to build trust. When a leader's behavior reflected the wellness messages, staff members were more motivated to participate in the interventions. On the other hand, if leaders only talked about the importance of well-being but continued to

reward only those who are productive and always available, the participants reported that their level of cynicism would increase. The current findings are in line with research on psychological safety and leadership that suggests employees need to see a match between what is announced and what is actually done so that they feel comfortable expressing their views or asking for help (Foster et al., 2022; Hauer et al., 2020; Nembhard & Edmondson, 2019; Shin et al., 2021).

Throughout the various stories, the participants represented leadership behavior as a cultural lever that can be used to change the culture. Such cultural changes were viewed as more possible and sustainable when leaders demonstrated, through their everyday behaviors, that the well-being of clinicians was not just a figurative goal but an operational priority.

Building a Culture of Trust

Repeatedly, participants named trust as the basis on which health efforts either saw an ROI or declined. They explained how the clinicians' resistance, caused by years of promises not kept, decisions made incongruent to known issues, or receiving their feedback as punishment, was later transformed into a willingness to participate in new initiatives. Some of them recalled situations where the results of burnout or engagement surveys were collected and then "disappeared" without any communication regarding the findings or next steps. Following such wellness efforts was often undertaken with silent distrust in those contexts.

Moreover, the participants provided examples of ways in which, as a result of frank discussions and a few small but significant changes, trust could be regained. A few

of them, in particular, emphasized the importance of closing the feedback loop as a key factor through the communication of survey results, recognition of constraints, and the promise of decisive actions. According to one participant, “sharing burnout data openly and coupling it with rapid fixes” was the thing that actually started changing people's perception in their organization. These actions are consistent with the evidence that trust is a result of organizations gradually demonstrating their responsiveness and fairness in addressing concerns (Arnetz et al., 2019; Gaines et al., 2020; Rosen et al., 2018; Stehman et al., 2019). Further, participants noted that trust was a connection, not merely a process; they stated that friendly, empathetic leaders and trusted ways of raising concerns made them see that health and wellbeing activities were a way of showing support, rather than a management of the image.

Integrative Interpretation of Theme 3

According to the participants' accounts, the socio-cultural aspects and stigma were so intertwined with the structural factors that, together, they influenced the degree of burnout and the possibility of wellness interventions. Their endurance influenced the clinicians' work experience under pressure, the stigma of showing vulnerability, contradictory leadership signals, and the presence or absence of trust; all these factors also affected their reaction to the organizational efforts of reform. Such revelations helped reframe cultural discussions within structural analyses by indicating that even well-designed programs could fail if the culture still sent opposing messages (Agarwal et al., 2020; Brooks et al., 2018; Nembhard & Edmondson, 2019; Zhang et al., 2021).

Culture, as it were, was performed via dominant, for the most part, unnoticed, scripts: the requirement to go through the bad times without uttering a single word of complaint, the notion that asking for help is a sign of your weakness, and the perception that leaders are more worried about the numbers of the performance than about the human limits. Any interventions that did not realize these scripts were at risk of being considered as just talking from the side of the mouth. Conversely, those who faced detrimental norms head-on, emulated healthier behaviors, and invited people to share their views received more recognition.

Theme 3 is an example that treating the burnout phenomenon requires not only structural remedies but also intentional cultural work. Participants' experiences were indicative of the idea that wellness interventions, if properly thought out, would transform not only the inner narratives of clinicians but also the communal narratives about the qualities of a good doctor, a reliable leader, and a respected member of the organization.

Theme 4: Leadership and Governance in Wellness Design

Physicians, wellness executives, clinical leaders, and organizational administrators acknowledged that leadership was the factor that decided whether wellness interventions became legitimate, got resources, and remained strong over time. Their thoughts aligned with research indicating that leaders have a significant impact on professional culture, trust, and the operational environment (Foster et al., 2022; Hyman et al., 2019; Nembhard & Edmondson, 2019; Telser et al., 2020). However, these voices also advanced the existing body of research by illustrating how governing structures,

different routes of accountability, and the interaction between aspects of symbolism and structural actions affected the growth or decline of wellness initiatives. In sum, their viewpoints led to the same conclusion that leadership was not only an influence on the existence of wellness programs but also ranked among their most decisive structural determinants (Caruso et al., 2019; Fitzgerald et al., 2018; Keller et al., 2020; Smetana et al., 2021).

Leadership as Catalyst

Both clinicians and wellness executives viewed supportive leaders as the primary driving force behind successful wellness programs. They stressed that when executives lived balanced lives, recognized their own human limitations, or made themselves approachable, clinicians saw these acts as permission for them to prioritize their own well-being. One health leader explained that “he was very on board from the very first day... I cannot thank him enough for that,” when talking about a chief medical officer who not only talked the talk but also walked the walk by his own example. This extent of concord is in line with the research results reported in this paper, which indicate that the genuineness of leaders raises the spirits of employees (Abu-Al-Rub et al., 2018; Hauer et al., 2020; Heath et al., 2020; IsHak et al., 2019).

Another group of people showed leaders who increased their power by financing activities such as mentoring, reflective practice, or a well-organized wellness program. A mature doctor recalled how a dean, through changing the allocation of resources towards the mentoring routes, made staff morale his foremost concern and stated, “he not only talked about well-being, he actually invested time and money in it.” Their testimonies

reflected the research results, which show that leaders who allocate resources to the professional growth of their staff enhance their own trustworthiness and accelerate the process of cultural change (Frank et al., 2019; Kreitzer et al., 2019; Miller et al., 2021).

Besides distributing resources, the majority of clinicians also discussed the impact on staff morale when leaders openly shared their difficulties and, at the same time, demonstrated by example that they had sound personal lives. One doctor said, “I saw him leave at 5:00 and actually meant it—and suddenly it felt possible for the rest of us.” These acts, although small, were recognized as a strong message that the well-being of employees was not just something talked about but actually practiced.

In summary, these stories described how the leaders’ conduct—both their direct actions and their symbols—provided the means for a change in the level of trust, signaled legitimacy, and created a cultural environment in which clinicians were allowed to participate in wellness practices.

Leadership as Constraint

Clinical leaders and administrators narrated the scenario where leadership, on the one hand, could restrict or undermine wellness, and on the other hand, be a catalyst for it. One of the points stressed by some leaders was that mere rhetorical support without any operational follow-through made them feel very disappointed. For instance, one of the doctors said, “The wellness program was always on their lips, but no changes were made in the schedule... it was like gaslighting,” to show how the clinical staff felt the contradiction between the premises and the structural realities, as the latter negated the former. Their thinking aligned with the study, which shows that the mismatch between

what leaders say and what they do leads to a loss of trust and disengagement ((Chandra et al., 2019; Dolan et al., 2018; O'Connor et al., 2020; Zhang et al., 2021). A few wellness executives spoke of scenarios where initiatives failed after a change in leadership or a financial decision to deprioritize them. They commented that the disappearance of the interventions becomes inevitable when the only person upon whom the support is dependent leaves. Another clinical leader recounted, "We had created a lot of momentum, but after the departure of the CWO, the program was gone as if by magic." This tenuousness was consistent with research that argued dependence on personal leadership for wellness efforts is not a viable approach for them to last (Schaefer & (Agarwal et al., 2020; Dean et al., 2019; Lall et al., 2019; Parikh et al., 2022). Many respondents indicated that token gestures, accompanied by no substantial changes, can be more detrimental than not making any statement at all. They portrayed leaders who gave wellness accolades in public, but at the same time, carried on with practices of setting higher productivity targets and not being flexible with staff. These inconsistencies heightened the staff's mistrust, thus creating emotional dissonance among them. Their insights were in line with the studies, which reveal that the presence of symbolic leaders without any implementing action can deepen the cynical attitude and lower the feeling of psychological safety among the staff (Daugherty et al., 2018; Pan et al., 2021; Rosenstein & West, 2018).

Governance Structures for Sustainability

Most wellness officers, physician chiefs, and program directors were united in their view that governance structures formed the backbone of support necessary to

maintain the well-being initiatives. Several of them referred to mechanisms like councils, scorecards, and board reporting systems as the primary instruments for embedding wellness into daily institutional practice. A physician leader gave an example, saying that “we actually included wellness in the board report... and that was the moment it really felt protected,” thus showing how governance visibility acted as a protection tool. This idea was consistent with the argument presented in the literature on institutionalizing well-being within governance frameworks (Dzau et al., 2019; Fitzgerald et al., 2018; Heath et al., 2020; Keller et al., 2020; Smetana et al., 2021).

One leader reflected on the role of interdepartmental councils in facilitating collaboration and creating a feeling of joint ownership among the members. The wellness initiatives, which were such structures, could freely collect views from any entities, including clinical departments, administrative offices, legal teams, and operational units. A health representative, delineating the influence of shared governance, stated, “The decision made by the council was not only pediatrics or spine...that whole institution was the one talking with a single voice.” Their stories reflected what the research also showed: distributed governance promotes organizational unity and reduces departmental division (Hauer et al., 2021; Keller et al., 2020).

Healthcare providers were also very vocal about the necessity of having authority in political structures. They cited instances of health committees that lacked the authority to make decisions and control the budget, rendering them merely a formality. An administrator remarked, “We had a committee, but no power. We could only recommend, but not execute.” Their thoughts aligned with the research, which states that for

governance structures to be credible, they must be given operational authority and resources (Hodkinson et al., 2022; Ortega et al., 2023; van Niekerk et al., 2023).

Some of the leaders discussed the role of governance in creating institutional memory as one of its primary functions, thereby enabling the maintenance of progress during leadership changes. The regular reporting cycles, dashboards, and renewal requirements were the instruments that kept the work going. These provisions were in line with research on organizational learning, which indicates the success and existence of well-structured systems that go beyond individual leaders and facilitate the achievement of long-term cultural changes (Dean et al., 2019; Lall et al., 2019; Parikh et al., 2022).

On the whole, their narratives provided a vivid picture of how governance went beyond being mere administrative scaffolding to becoming an essential infrastructure without which the survival of wellness initiatives would be in jeopardy.

Balancing Symbolic and Structural Leadership

Clinicians and wellness executives acknowledged the need for leaders to balance their symbolic actions with actual structural changes. They were enthusiastic about leaders who, in various ways, demonstrated their care by example, attending wellness town halls, publicly acknowledging clinician strain, or directly appreciating clinicians and expressing their gratitude, thereby showing care in a personal way. One health worker remembered a leader of high rank who “came to the break room after a hard week just to listen,” and thus considered the act as humanizing and supportive. Such symbolic actions were not only in line with the research, which indicates that care that is visibly

shown strengthens the organizational culture (Foster et al., 2022; Gaines et al., 2020; Shin et al., 2021), but they also served as a bridge to the actual work.

However, wellness executives were not oblivious to the fact that such symbolic acts only had the power to transform into fundamental changes when they were coupled with tangible structural changes. According to a wellness director, “They set the example for the observance of limits, but at the same time, they changed the inbox policy... that is when it really felt like it could work.” Research on authentic leadership indicates that leaders perceived as authentic maintain consistency between their symbolic and structural commitments (Hauer et al., 2021; Hopkins et al., 2018; Telser et al., 2020). That is why these leaders made the most significant impact because they not only talked the talk but also walked the walk.

Furthermore, some health professionals noted that symbolic actions might demoralize the staff even more if they are not accompanied by operational counterparts. They painted pictures of leaders who were part of the wellness activities yet made statements that only increased workload expectations later on. These oppositions made wellness look like a performance. Their testimonies aligned with theoretical assumptions that suggest symbolic leadership becomes detrimental when there is not consistent structural support (Arnetz et al., 2020; Brooks et al., 2018; Stehman et al., 2019).

Trust and Accountability in Leadership

Several individuals responsible for the health of the staff, be it clinical leaders or program directors talked about how the creation of trust and the notion of being accountable were the main elements that influenced the perception of the authenticity of

the wellness initiatives. A lot of them pointed out the importance of clear communication as a significant factor. A single leader pointed out that “sharing burnout data openly and pairing it with rapid interventions” was very comforting to clinicians because it showed them that their concerns were taken seriously. Others specifically talked about leaders who did not hesitate to take action after receiving the feedback. A physician remembered, “We raised staffing concerns on Monday, and by Friday, they had already adjusted the coverage model.” Thus, he regarded this quick action as proof of the leader's real commitment.

Additionally, it was emphasized through their talk that accountability mechanisms were equally important. Several interviewees showed health initiatives that were part of the executive scorecards, departmental reports, or performance evaluations. A different leader quoted, “If your extra pay is tied to well-being measures, then wellness ceases to be a matter of choice.” Their thoughts were consistent with the study's findings, which stated that the presence of accountability structures leads to wellness being embedded into the operational strategy, rather than treating it as a separate initiative (Caruso et al., 2019; Schaefer & Zygmunt, 2019; Smetana et al., 2021).

Integrative Interpretation of Theme 4

In all these accounts, healthcare workers and management staff depicted leadership as both a source of energy and restriction to the development of wellness. Some felt that supportive executives not only allowed the interventions, changed the atmosphere, and provided the necessary power for the change, but they were also the main drivers of change. At the same time, however, non-uniform or solely representative

leadership diminished trust and, consequently, enthusiasm. These results align with research indicating that leadership is a significant factor in the organizational climate and the well-being of clinicians (Arnetz et al., 2020; Gaines et al., 2020; IsHak et al., 2020).

Governance frameworks were talked about as being vital. Several in top management explained the role of councils, reporting cycles, and accountability mechanisms in the wellness programs, which, through these leadership changes, were able to keep going. These structures not only made it possible for wellness programs to continue, but they also helped well-being initiatives become independent of financial pressures, giving assurance that wellness would remain a part of the organizational strategy. Their experience reflected the research, which highlights the importance of integrating well-being into governance frameworks as a means of promoting sustainable change (Fitzgerald et al., 2018; Heath et al., 2020; Schaefer & Zygmunt, 2019).

Theme 4 illustrated that the staff's wellness was dependent not only on the intervention content but also on the leadership integrity, governance structure, and accountability that supported them. Those involved in the process pointed out that the well-being of healthcare workers will only become sustainable when leadership behaviors and governance mechanisms remain in harmony, thus continuing to reinforce the legitimacy and authority of efforts for wellness.

Theme 5: Organizational Context and Leadership Influences

Clinicians, executives, CWOs, and program directors pointed out that the organizational context was the main factor that determined whether well-being initiatives became successful or just remained symbolic. Their insights align with research that finds

structures, norms, and resource flows set the conditions under which clinicians can thrive (Carroll & Edmondson, 2020; Dzau et al., 2019). Additionally, their meetings comprehensively covered previously researched topics to demonstrate the impact of organizational culture, the nature of resource allocation decisions, financial models, and leadership pipelines on transforming an organization's brand power from a mere brand with a few interventions to one with an institutional infrastructure. Hence, they showed that organizational decisions ultimately determine the fate of wellness efforts (Bodenheimer & Sinsky, 2014, Schaefer & Zygmunt, 2019).

Culture-Building: Designing for Belonging and Meaning

Medical professionals and wellness executives agreed that culture-building should not be seen as a “soft variable” but rather as a “structural determinant of well-being.” Several of them mentioned that belonging — feeling known, recognized, and supported — was a kind of “protective factor,” especially in “high-pressure environments.” One wellness leader made this point very explicitly when he said, “It is just opening yourself up to the conversation instead of coming out of the gate angry... I see myself as a bridge between admin and clinicians.” Their comments also reflect the study's findings, which show that shared meaning and community are effective in reducing depersonalization and emotional exhaustion (Carroll & Edmondson, 2020; Leiter et al., 2020; Weiss et al., 2018).

Senior executives referred to belonging as a planned design. Several of them created organized reflective groups, peer-support sessions, and recognition rituals to fight the feeling of isolation. One healthcare professional shared, “I am the person that people

rely on because they see me out there. . . so they come and talk to me,” thereby showing how being visible was transformed into a cultural change. The testimonies of these individuals align with publications that highlight human connection and peer affiliation as the primary sources of professional well-being (Leiter et al., 2020; Panagioti et al., 2017; Weiss et al., 2018).

Many of the health professionals pointed to cultural fragmentation as an obstacle. The conflict between the administration's priorities and the clinicians' realities usually led to mistrust. “Neither side is bad... they just have different focuses,” said one leader, who also reminded that the research they were discussing advocates for intentional relational work to facilitate the alignment of mental models across different groups (Carroll & Edmondson, 2020; Hopkins et al., 2018).

Through their interviews, the clinicians stated that culture-building is a systematic process that requires not only “protected time” and “leadership presence” but also “structures that signal authentic value.” They did not consider culture as an incidental result of interaction among people, but rather as the “new normal” that has to be created and maintained.

Governance and Resourcing: From Symbol to System

Physicians and administrators shared stories of how roles in wellness that were underfunded or lacked support eventually became symbols of change rather than the actual change. A few of the clinicians explained how they were instructed to take the lead in wellness initiatives without a budget, authority, or staff, which highlighted how tokenism was eroding their trust. These incidents align with the panelists' views that

under-resourced programs increase mistrust in the programs and, consequently, exacerbate burnout (Carroll & Edmondson, 2020; Smetana et al., 2021; Zhang et al., 2021).

An executive in charge of corporate health recalled the moment when health stopped being a mere sign and became a system of impact: it is at that moment that the budget, headcount, and power are formally given. They said, “We had to ask people if they were really going to reduce their clinical work to do coaching,” thus illustrating how the operational design influences the level of feasibility. Another person pointed out that the organization's funding of internal coaching and appointment of departmental champions made “wellness finally become part of the strategic plan.” These instances correspond to academic works that call for the formation of governance structures with real capabilities, rather than just showing aspirational intentions ((Panagioti et al., 2017; Shanafelt et al., 2019; Swensen et al., 2016).

Besides, clinicians questioned the assumptions that governance structures were inherently beneficial. Some of them talked about their experiences with councils or committees that had no decision rights and pointed out that “we could only recommend things, but we could not actually implement them.” Their journey to enlightenment aligned with the assertion that for governance to be successful, it requires both involvement in decision-making and empowerment.

Modeling and Communication: What Leaders Do Becomes the Norm

Interviews regularly emphasized that the behavior of leaders was one of the single most influential factors that visibly shaped the organizational norms. Many cited that

executives who respected the set boundaries were the ones showing by example that clinicians could also do the same. One of the doctors said, “They were sending emails for business hours and respected quiet hours... at last, it really felt like it was okay to disconnect,” thus supporting the study that leader modeling can reset cultural expectations (Avolio & Walumbwa, 2014; Hopkins et al., 2018; Schein, 2010).

Several wellness leaders regarded openness in communication as a separate intervention. Several of them stated the survey results, recognized the organization's weaknesses, and presented the precise next steps. A program director shared, “We talked the matter over on Monday, and they had already changed the coverage model by Friday,” thus showing how communicative responsiveness is one of the trust-building elements. These instances corresponded with the theory that being transparent and timely in communication leads to higher engagement levels and less skepticism Chow et al., 2022; Foster et al., 2022; Hauer et al., 2020.

On the other hand, some argued that communication without corresponding action only deepened the cynicism. One of the medical executives pointed out that wellness marketing without real change “made everything feel hollow,” thus opposing the previous research that communication campaigns could be considered as solutions on their own (Chandra et al., 2019; Dolan et al., 2018; Pan et al., 2021). The staff emphasized that for the messages to be credible, they had to be grounded in the behavior and decisions regarding resource allocation.

In all of the institutions, the communication and behavior of leaders were the two factors that interacted to result in the norms. When they were consistent with each other and also with the operational realities, they supported the trust-building process; when they were incompatible, they led to distrust.

When Money Governs Medicine

Several leaders gave the impression that one of the most important aspects that influenced the organizational setting was the financial one. Several connected burnout, a state of mental and emotional exhaustion, directly to economic pressures. One of them remarked, “The change is happening, but so much slower than my brain would prefer,” to indicate his/her struggle to synchronize human needs with a system that is driven by productivity. Another surgeon stressed the point: “We are dealing with a changing workforce... and leaders who do not adapt are going to be disappointed with how things turn out.” One physician leader claimed that “when we tied incentives to access and retention, suddenly the conversation shifted,” thus showing how financial scorecards could become tools for understanding instead of barriers. These reflections align with findings that the redesign of the financial system is a powerful yet seldom-leveraged way to improve clinician well-being (Hamidi et al., 2018; Kane et al., 2020; Najafzadeh et al., 2020). Clinicians’ experiences challenged those in the literature, which firmly position financial systems as unchangeable. In fact, they showed that financial systems were not fixed; they could be re-engineered.

Converting Frustration Into a Shared Business Case

Clinicians and leaders from various roles mentioned that the feeling of burnout and resulting frustration could be, when converted into financial figures, a form of organizational power. One program director said, “Turnover was killing us...once we showed the cost, doors finally opened,” thus emphasizing the impact of economic framing. Their accounts are consistent with the study, which states that burnout incurs definite financial costs due to attrition, decreased productivity, and increased malpractice risk (Brown et al., 2021; Williams et al., 2020).

Some explained in detail how the visible data facilitated this communication. Some created visual representations of data showing the use of the EHR after hours or the number of messages physicians were expected to handle off hours. One leader mentioned that “seeing the after-hours inbox numbers finally made finance pay attention,” thus showing how creation of the data representation led to a better understanding of the matter. Their stories aligned with the research, which recommends the use of easy-to-understand and actionable metrics for leadership engagement (Aarons et al., 2014; Proctor et al., 2011; Shapiro et al., 2019).

Interviewees noted that merely taking measurements was insufficient. They discussed how metrics that were not linked to the appropriate corrective measures were considered a waste of time. Leaders warned that business cases need to be accompanied by the willingness to take action in order to prevent the strengthening of cynicism. This discovery adds a layer of complexity to the literature, suggesting that data leads to change.

Leadership Multiplication: Making Well-Being a Shared Competency

Leadership development was emphasized by many as being necessary for the establishment of a sustainable wellness infrastructure. Some explained that physicians often find themselves in leadership roles as a result of their clinical work, without any formal preparation. One of the physician coaches complained that his medical school had not taught him much of the skills needed in his work. These personal introspections align with the research findings, which suggest that leadership education leads to improved communication, collaboration, and resilience (Joung et al., 2022; Miller et al., 2021; Chow et al., 2022).

While numerous groups faced these problems internally, they decided to overcome them by creating local coaching pipelines, mentoring programs, and reflective curricula. A wellness leader recounted the journey of infusing value alignment and professionalism into leadership development, saying: “We trained coaches and mentors so that wellness did not have to rely on one person.” Consequently, distributed leadership is thus a potential tool for maintaining systemic change over time (Caruso et al., 2019; Frank et al., 2019; Miller et al., 2021).

In addition, the clinicians expressed concern about the risk of such a structure, where one individual is expected to carry all the weight. They described situations in which the initiatives disappeared after the departure of a single leader. Their accounts confirm the statement that personality-driven leadership models should not be the main framework because systems need to institutionalize leadership competencies instead of depending thoroughly on one individual's passion.

To summarize, these pieces of evidence suggest that future leaders play a crucial role in creating continuity, thereby deepening the clinician well-being infrastructure.

Integrative Interpretation of Theme 5

Physicians, executives, wellness leaders, program directors, and coaches described the organizational environment as the ecosystem in which the wellness initiatives exist. One of the main arguments they presented was that culture, governance, operational support, financial logic, and leadership development not only cross each other but also have a powerful impact on the trustworthiness and the survival time of the interventions. These ideas align well with the research, which describes burnout as a problem originating from the system, and as such requires solutions from the system ((Dzau, 2023; Makowski et al., 2022; Abatzis et al., 2023).

Leaders pointed out that well-being depended on culture, operation, and finance, which had to be in harmony for wellness to take place. The moment these three areas conflicted, such as when leaders demonstrated how to set limits, but the workloads continued to increase, the projects would lose their trustworthiness. The evidence they talked about served as proof of studies indicating that cultural and structural alignment is a prerequisite for creating sustainable well-being systems (Zhang et al., 2021; Dolan et al., 2018; Chandra et al., 2019).

At the core of Theme 5, the discussion opened up to the fact that organizational context and leadership influence are not mere background characters, they are the leading factors determining whether wellness initiatives become deeply rooted commitments or remain merely symbolic, short-lived projects.

Theme 6: Implementation Pathways and Practical Challenges

Many of the interviewees shared the opinion that implementing wellness interventions necessitated addressing multifaceted operational, cultural, and structural challenges. Their thinking was compatible with the existing body of research, which indicates that even flawless plans encounter hurdles during their implementation phase, for example lack of resources, a mismatch in workflow, and incomplete participation (Busch et al., 2021; Shapiro et al., 2019). These individuals expanded on what is known from the existing literature by revealing through their experiences that the use of adaptive strategies, continual redesign, and the ability to make adjustments on the spot not only enhances the trustworthiness of the wellness program but also refutes the notion that sticking to the original plan is always the best way. Instead, they argue that being responsive and evolving demonstrates a commitment to getting the work done with utmost seriousness and respecting the people involved. Their narratives brought to light the fact that the implementation process is not static but rather the interplay of various dynamics influenced by realities.

Resourcing Constraints: Doing More With Less

Throughout the interviews it was repeatedly pointed out that resourcing is among the major obstacles that have hindered the implementation of their plans. There were many occasions when they remembered trying to start the program, but they lacked sufficient staff, time, or funding. One coach said, “We had to find out whether people were willing to cut down their clinical hours in order to be a coach,” hence showing how projects usually depended on clinicians who had to take on more responsibilities. Their

journeys shed light on similar studies that suggest poorly planned programs frustrate staff and discourage people's involvement (Brown et al., 2021; Williams et al., 2020; Buck et al., 2019).

Some leaders responsible for the well-being of others have developed detailed plans for the reallocation of resources. A few of them conveyed that they moved the unspent recruitment budget lines towards coaching or efficiency redesign. “We reallocated funds from a paused search to support the training of internal coaches,” a wellness leader shared, explaining how the deliberate handling of resources made it possible for the program to move forward.” These tactics align with the recommendations made in academic works, which suggest that organizations should redistribute existing resources if no new funding is available (Caruso et al., 2019; Najafzadeh et al., 2020; Zhang et al., 2021).

Doctors were among those who disagreed with the perspective of viewing resource scarcity as a fixed obstacle. One of them said, “Resources move after priorities, if it were essential, it would have been funded,” which indicates that resourcing is a signal of organizational values and can differ from group to group. Their thoughts conflicted with previous research that had shown underfunding to be a mere logistical problem, thus putting resourcing in the light of a decision linked to institutional priorities (Chandra et al., 2019; Dolan et al., 2018; Zhang et al., 2021).

In these narratives, insufficient resources were referred to as both a logistical problem and a symbolic marker of commitment. Health initiatives will flourish when

companies make investments that demonstrate their serious attitude towards physicians' well-being.

Integrating Interventions Into Workflow

Some pointed out that interventions that were not part of their existing workflows had very little chance of being successful. They referred to “add-on” wellness programs that were scheduled outside of clinical hours and usually went unattended. One doctor remembered, “If it is after clinic, it is not happening,” pointing out that the timing was a way of showing respect or not to the physicians’ realities. Their experiences were consistent with research, which shows that interventions that added to the workload without any reduction to make room for the program only increased the strain on those it was supposed to help (Brown et al., 2021; Proctor et al., 2011; Zhang et al., 2021).

Leaders described embedding wellness into existing routines as a more effective and efficient way of doing things. One of them remembered that reflective practices were incorporated in the morning huddles and the introduction of coaching themes in regular meetings. One physician leader explained, “We saw participation getting to every single person when we started including wellness in safety huddles,” thus showing how the embedding of the initiatives in the normal work processes brought about their reality. Their experiences were consistent with the research that emphasizes the significance of integration rather than addition (Caruso et al., 2019; Shapiro et al., 2019; Zhang et al., 2021).

Many agreed that the workflow integration also needed to be centered around purpose, not just efficiency. One of the interviewees was quoted as saying, “Efficiency

supports, but meaning is what really makes people care,” which suggests that interventions grounded in values have a more profound and more lasting impact. Their revelations challenged the studies that prioritized productivity as the primary goal of workflow integration by highlighting that meaningfulness was equally important for engagement.

Measurement and Feedback Loops

Many interviewees spoke about how measurement influenced most of what accountability and credibility leaders succeeded in doing. In the absence of measurement, physicians discussed how it was assumed that the management was either avoiding or indifferent to the issue. One of the clinicians said, “When nobody measures it, it feels like they do not want to know,” which shows how the silence made people less involved. Their comments aligned with research, which stated that a lack of monitoring weakens change initiatives (Caruso et al., 2019; Shapiro et al., 2019; Zhang et al., 2021).

Wellness leaders discussed how, in fact, the very act of measurement became an intervention. After a few attempts, some of them distributed short feedback surveys, and then, within a few days, they implemented the necessary changes, thus confirming the best practices for rapid-cycle improvement as suggested by the implementation science literature (Brown et al., 2021; Caruso et al., 2019; Shapiro et al., 2019). Another one stated, “Showing the before-and-after inbox numbers finally made clinicians feel seen,” which is a model of how the feedback loops build trust.

Additionally, some identified risks associated with improper measurement practices. Several of them brought to mind situations when surveys had a punitive nature

or feedback was never acted upon. “If you solicit input and nothing is altered, it is even more terrible than not asking for input at all,” one said. Thus, they were confirming earlier research by showing that in situations of measurement, mistakes increase negativity towards those in authority. Their arguments were in line with the notion that one cannot solely rely on measurement to build trust, it also has to be followed by intervention.

The stories from different people revealed that talking about the ways to measure results is not only the stage where the evaluation is generated but also the stage where relations between people get stronger. If trust, which is the result of transparent and timely action, is present there can be success, and, conversely, the intervention failure is almost guaranteed if lack of action follows the evaluation step.

Staff Engagement and Ownership

Several respondents expressed that local involvement and engagement were key factors in the successful implementation of intervention attempts. A doctor reiterated, “People will not join something they do not trust,” to explain that emotional trust, rather than the availability of the program, was the main factor in participation. Their comments aligned with research, which indicated that engagement is influenced by psychological safety, credibility, and relevance (Chandra et al., 2019; Williams et al., 2020; Zhang et al., 2021).

Wellness leaders explained methods to foster ownership, such as finding the most influential leaders, gathering the opinions of the frontline staff, and openly recognizing even the smallest achievements. To show how peer leadership deepened the authority, a

director stated, “We had champions in every department, people listened to them.” Another one said, “Engagement doubled when we changed the coverage model right away,” thus indicating that the staff became more motivated as a result of their responsiveness. The strategies they used were in line with studies that suggested the creation of a peer-driven and feedback-responsive engagement structure (Chandra et al., 2019; Chow et al., 2022; Miller et al., 2021).

Adapting in Real-Time

Several believed that the ability to adapt was essential to maintain wellness activities. One of them said that the method that was successful during the first implementation phase had to be changed quickly because of new challenges. Another also shared, “We made it one way, but we soon found out it had to be different... and that is why people trusted us more,” supporting the idea of the implementation as a nonstatic, iterative process (Miller et al., 2021; Shapiro et al., 2019; Zhang et al., 2021).

Wellness leaders illustrated how employing small pilots, continually redesigning, and openly acknowledging faults helped build trust. One said, “The people liked that we took the failure in hand and fixed it,” indicating that honesty was the primary factor leading to engagement. Their statements align with the notion that engagement is enhanced by the use of adaptive learning and rapid-cycle change frameworks (Caruso et al., 2019; Miller et al., 2021; Shapiro et al., 2019).

Several respondents opposed the notion that strictly programming was the best course of action. “Strict programs die quickly, people want to see that you are listening,”

one said, putting emphasis on the fact that being responsive is more important than strictly following the rules. Their experiences are consistent with the literature, which found that adaptation may turn into a long-term, successful practice when it is derived from the engagement of stakeholders (Miller et al., 2021; Shapiro et al., 2019; Zhang et al., 2021).

Several also mentioned that to be adaptable, one needs to have a certain amount of time set aside and a feeling of security and trust in the team. If they did not have those, then making improvements step by step would be difficult, or even impossible. The changes in their experiences show that the very thing they are adapting to can be seen as an intervention, which has the power to influence the level of engagement, trust, and legitimacy.

By themselves, these narratives presented a different picture in which adaptability was not only a plan but also a sign of genuine institutional commitment.

Integrative Interpretation of Theme 6

Many described the implementation phase as the turning point when interventions either gained or lost validity. Their experiences aligned with the implementation science literature, which suggested that successful implementation is dependent on the availability of resources, resourcing of the workflow, measurement cycles, and local ownership (Brown et al., 2021; Caruso et al., 2019; Chow et al., 2022). Additionally, these professionals noted that adaptability and the capacity for real-time iteration can reinforce trust and thus increase feasibility.

Leaders across various roles challenged the presumption that fidelity is always the best approach. They pointed out that wellness initiatives had to be flexible in order to react to changing constraints, clinician feedback, and contextual pressures. Their observations extended beyond the current research on adaptive implementation, as they proposed that being responsive is, at times, a more effective way of safeguarding than strict adherence (Proctor et al., 2011; Pan et al., 2021; Buck et al., 2019).

In general, Theme 6 showed that implementations were not only operational but also relational and cultural. Such stories primarily showcased that the mentioned attributes are essential for the success of health promotion programs. These attributes include the will, the ability to adapt, and obtaining trust from the community, features that must be continuously cultivated in complex clinical milieus.

Theme 7: Reflections and Recommendations for Future Interventions

Through their experiences and contemplations, doctors, health executives, residency directors, lawyers, and administrators participating in this research came up with practical recommendations for future interventions and studies. Their views not only supported the already established results in several fields but also highlighted subtle issues that challenged the designers of wellness programs to reconsider their assumptions. These considerations bridged the gap between current and future research by demonstrating that training, policy changes, technology assessment, organizational learning, measurement, workforce planning, and leadership development must be undertaken as an integrated system.

Regardless of their roles or experiences, the respondents described a realistic plan for the following interventions, which, first and foremost, emphasized the importance of structural integration, cultural authenticity, and long-lasting institutional engagement (see Brady et al., 2021; Leslie et al., 2020).

Earlier Access and Reframing

Several interviewees acknowledged the importance of teaching reflective skills at a much earlier stage of medical training, such as clarification of values, setting of boundaries, emotional processing, and identity development. One doctor revealed, “I really wish someone had shown me how to analyze my own thinking even before I began my practice,” indicating that these abilities might have saved him from going through stressful times later on. Their thoughts coincided with the research findings by Austin et al. (2020) that “early formative professional identity development acts as a vaccine against burnout and a source of resilience.”

Several wellness leaders discussed the shift in perception of reflective practice from a professional skill to a therapeutic approach for addressing problems. One of the trainers, saying “The room got full only after we renamed it leadership development instead of wellness training,” thereby indicated the advantage of changing the narrative from going through correction of deficits to skill enhancement. In line with this viewpoint, the paper by Zwack and Schweitzer (2013) suggested integrating wellness competencies into the leadership curriculum rather than providing optional wellness workshops.

These different voices together represented the idea that the early encounter and reframing of reflective practices would eventually make them socially acceptable, culturally integrated, and system-supported professional skills.

Policy and Protection

Physicians portrayed regulations, such as those related to licensure, credentialing, and malpractice, which are not only frequent obstacles but also cause anxiety, as the main issues that prevent them from seeking help. In particular, one clinician revealed, “The fear of admitting to being in trouble is so high because these forms are still asking questions that seem like we will be punished...this can be considered as a reflection of the stigma fear that has been around for a long time.” Their testimonies often aligned with the research, which indicated that the wording used in regulatory provisions deters clinicians from seeking mental health support (Hamidi et al., 2018; Kane et al., 2020; Tawfik et al., 2018).

Several spoke about steps taken via policy to relieve this kind of fear. These steps encompassed confidential support channels, clearly defined impairment standards, and the separation of the wellness units from the disciplinary proceedings. One leader stated, “The actual use of the service occurred when we, through policy, ensured confidentiality,” thus showing how institutional safeguards restore people's faith. It was evident from these instances that the recommendations of the national consensus reports, which call for privacy protection and the elimination of stigmatizing language, are supported (Kane et al., 2020; Najafzadeh et al., 2020; Palamara et al., 2022).

Nevertheless, several were careful to point out that changes in the policy agenda were only part of the solution. “Even if a form is changed, the culture that still punishes vulnerability will not let people see change,” said one program director, thus emphasizing the necessity of cultural change alongside policy shift. Their thoughts extended the reviewed theories by illustrating the dependence of policy execution on leaders' continuous exemplification and provision of assurance.

Positive Deviants and Learning From What Works

Many referred to “positive deviants,” the teams and individuals that were able to maintain their sense of purpose and performance even under heavy pressure, as a crucial source of evidence. A director elaborated, “Some teams just thrive... and when we studied why, it changed everything,” thus demonstrating the power of identifying protective practices. Their thoughts aligned with the concept of organizational learning, which involves examining extreme cases to find durable solutions (Buck et al., 2019; Chambers et al., 2013; Pan et al., 2021).

Leaders described their learning through witnessing the effective communication of ideas, boundary practices, and workflow strategies by these well-functioning teams. In essence, their experiences reflected the research, which suggested that focusing on thriving environments can lead to the creation of replicable practices that can be adopted by others (Abatzis et al., 2022; Makowski et al., 2021).

Moreover, some challenged the existence of deficit-focused approaches that are predominantly present in the burnout literature. One doctor said, “We spend so much time fixing what is broken, but not enough time studying what is working,” thus pointing

to the shift towards the strength-based inquiry. Their reflections moved the ball further in the field by reconceptualizing wellness initiatives as an opportunity to scale up existing strengths, rather than just as a means for addressing deficits.

These insiders argued that positive deviants chart the path for a culture and practice that can endure, thus providing models that can be adjusted and applied in different departments.

Outcome Sets Beyond a Single Number

Some respondents stressed that the use of multi-indicator measurement systems is essential and that one should not rely solely on burnout scores. One individual, for instance, said, “We tracked turnover, vacancy, inbox time, and it finally told a real story,” thus emphasizing the worth of composite indicators. They agreed with the research, which shows that multiple dimensions of metrics provide more accurate figures of the health of an organization (Lown & Shin, 2019; Najafzadeh et al., 2020; Proctor et al., 2011).

Several individuals described the times when they used survey data to galvanize their staff into action. A physician recalled, “We disseminated the results and mended what we were able to within a month,” thus demonstrating the quick turnaround of the feedback loop. Their encounters were in line with the advice given for recurring measurements and conducting them transparently (Shah et al., 2020).

Moreover, clinicians warned that if no action is taken on the data, it will only serve to increase the staff's disbelief. Several of them stated that the depth of the measurement is of no importance if it is not possible to see any changes. Their thoughts

aligned with the argument that measurement should be the driving force behind improvement, rather than just a description of the conditions.

Contracts, Pipelines, and the Future Workforce

Many pointed out that workforce shortages stretched capacity and were the main reason that burnout had been intensively aggravated. One of the clinicians said, “We are losing people faster than we can replace them,” a sentiment that reflects national trends. Emotional exhaustion and professional dissatisfaction have been their situations, which are in line with the research that associated these problems with understaffing (Aiken et al., 2021; Han et al., 2019).

Many of those in charge of wellness discussed the contractual protections that were signs of the institution's commitment, such as the recovery time built in or the quiet hours protected. A CWO revealed, “When we inserted quiet hours into the contract, people got the impression that we were very serious about it,” which shows the mechanism by which formal agreements can not only consolidate but also extend cultural norms. These statements are in full accord with the consensus recommendations that called for the use of workforce policies as a tool for guaranteeing the well-being of clinicians (Kane et al., 2020; NASEM, 2019).

Many of the leaders talked about the need for pipelines to receive long-term strategic investment. They were talking about the mentorship programs, clinical shadowing, and structured leadership pathways, which were designed not only to expand the pipeline but also to support retention. Their understanding extends beyond previous

studies by considering workforce reform as a sustained development of capacity and leadership bench strength, rather than just recruitment.

Scaling Community and Leadership

Many respondents emphasized community as a central element that helped them survive emotionally. A doctor recalled, “Peer groups saved me when nothing else did,” to demonstrate the power that support connections have. Their stories matched with studies that showed that being part of a group is a means of protection against exhaustion (Handoyo et al., 2020; Makowski et al., 2021).

Health promotion leaders described “community” as the natural outcome of some institutions, which was realized through organized peer groups, internal coaching programs, and reflective practice curricula. To exemplify that the system becomes sustainable through the distribution of leadership, one said, “When we trained internal coaches, wellness stopped being any single person's responsibility.” These stories align with the findings from the field of organizational studies, which suggested that increasing leadership positions can help reduce dependence on individual champions (Brady et al., 2021; Leslie et al., 2020).

Moreover, many interviewees rejected the leadership model that sees the executive as the most potent and only leader. They argued that leadership pipelines should not be limited to the C-suite but should be extended to clinicians of all levels so that wellness becomes a shared skill.

Integrative Interpretation of Theme 7

Leaders from various cadres, in a conceptual manner, viewed the following interventions as needing to be in harmony across multiple aspects, including training, policy, technology, measurement, the workforce, and leadership structures. Their ideas aligned with systemic reform research, which argued that health initiatives must be well-founded from both cultural and structural perspectives (Brady et al., 2021; Chambers et al., 2013; Leslie et al., 2020). Also, the leaders pointed out that changes should be a direct reflection of the people's experiences, not preconceived notions.

Their voices extended beyond the existing body of research by highlighting the need for interventions to be carefully aligned with organizational priorities. They claimed that interventions which are not working in tandem with systemic structures or financial realities will only be symbolic. Their ideas revealed that the changes they made in governance, contracts, curricula, and the design of work processes were the ways by which they sustained these changes.

These findings, for the most part, conflicted with the widely accepted concept that resilience is a personal decision, that merely keeping things confidential is sufficient to prevent stigma, or that innovation, simply by its nature, will lessen the burden. Instead, they discussed next-generation healthcare as a system that makes sense, is true, and is jointly owned by the community.

Limitations of the Study

There are several limitations in this research that have been acknowledged in the study. Firstly, the study considered the perspectives of 17 wellness leaders, physicians,

coaches, administrators, and executives. The number of samples can be regarded as enough for a phenomenological inquiry; however, the voices of the people who were included may not necessarily reflect the experiences of all clinical workers and leaders in various working environments. The transferability of the results is corroborated by the variety of roles and sectors represented, but the findings still depend on the perspectives of these particular interviewees.

Secondly, self-reported experiences collected through semi-structured interviews formed the basis of the study design. Like in any other qualitative research, the interviewees may have emphasized certain aspects of their experiences and downplayed others. To enhance credibility, reflexive memoing and an audit trail were employed; however, the interviewees may have been affected by recall bias, social desirability, and contextual factors that could have influenced the narratives shared.

Thirdly, the confinement of the research to healthcare contexts in the U.S. only raises questions about the extent to which the findings can be applied to other systems. For instance, the changes to the structure recommended by the respondents, such as an incentive system for fee-for-service, a patient portal requirement, or a malpractice policy, are elements of the American healthcare framework. Although issues such as identity loss, endurance culture, and leadership modeling may be relevant worldwide, the policy and payment dynamics can differ significantly from one country to another.

Fourthly, my point of view may have influenced the analysis. As a person concerned about physician well-being, the use of brackets and reflexive journaling was

necessary to reduce bias. However, different researchers could interpret the data differently and thus arrive at different conclusions.

Lastly, the study is cross-sectional and thus can only capture the perspectives of the interviewees at a single point in time. As wellness interventions and organizational cultures are subject to change, a longitudinal study would enable researchers to gain a deeper understanding of how these interventions are maintained, modified, or discontinued over time.

Notwithstanding these limitations, the research sheds light on the mechanisms and objectives that led to the creation and implementation of wellness interventions. It advances the literature by providing the real-life experiences of those involved in the change process. Therefore, it complements the existing body of research.

Recommendations

Recommendations for Practice

The results of this research provide several practical suggestions to healthcare organizations, leaders, and policymakers. To begin with, wellness initiatives should be based on system redesign rather than individual resilience. Both physicians and wellness officers shared their experiences of how interventions got support when changes in payment structures, staffing models, and workflows were made to reduce the burden. Therefore, leaders must not only align incentives with outcomes such as patient access, quality, and clinician retention, but also with throughput.

Secondly, organizations must treat capacity as one of their primary concerns if they desire true, fundamental solutions. Those interviewed noted that wellness programs

can fail even when staff members are available, but no one has allocated time for the program to be implemented. Administrators should ensure that coverage models, triage protocols, and call schedules provide enough time for everyone to participate in wellness interventions.

Third, cultural norms require an intentional focus. The persistence culture, the stigma around falling victim to one's own feelings, and the inconsistency of leadership communication were identified as the most significant obstacles. Executives and program directors should balance the roles they play, discuss well-being openly, and help their peers establish support structures so that seeking help becomes a norm.

Fourth, the organization of and responsibility for governance should be seen as the very core of the institution. The creation of wellness councils, the implementation of several wellness-related indicators, and the participation of the board in discussions are some of the mechanisms that mitigate the risk of solo individual champions and constitute a means of embedding the persistence of wellness into the organizational routines. Linking wellness metrics to scorecards is an effective way to demonstrate that clinician well-being is a key factor in healthcare system performance.

Fifth, it would be beneficial for enterprises to invest in developing the potential of their future leaders. The business coaching initiatives, the mentoring system, and the structured ways in which one receives professional development are not only mechanisms that build the capacity of distributed leadership but also ways that lessen dependence on a single role or department.

Sixth, establishments need to prioritize transparency and promptness. Several interviewees emphasized that the timely execution of transparent feedback, even in the case of minor interventions, contributes significantly to the trust between the parties involved and, in turn, raises the level of engagement. Leaders should keep consistent communication with survey respondents about the results, actions taken, and progress made.

Finally, agencies aiming for workflow redesign must ensure that the changes they want to implement align with the real-life experiences of clinicians. Taking steps to provide wellness through daily work, rather than piling on even more tasks for those who are already overstretched, is a way of showing that the time of clinicians is valued, while also making it more manageable for them.

Recommendations for Future Research

This research also highlighted several directions for further investigation. Firstly, long-term studies are required to trace the changes in wellness interventions over time. Since this research captured only the perspectives of a single moment, future studies could track how initiatives become sustained, adapted, or discontinued as different organizational contexts change.

Secondly, the study of positive deviants, teams or units which operate successfully in a situation of high strain, should be a focus of further research. A thorough examination of such high-performing environments may produce a set of strategies for communication, workflows, team cohesion, and boundary practices that can be implemented in other organizations.

Thirdly, follow-up studies should gather evidence about the interrelation of policy and culture. Changes in licensure and malpractice documentation may result in less formal stigma; however, interview participants have expressed that cultural dynamics still have the power to influence the trust and use of these policies.

Such comparative research might, in fact, reveal how policy, payment models, and cultural norms influence burnout in various contexts and even countries. These types of studies can be invaluable in determining the common causes of burnout, potential interventions, and the different challenges that exist in each context.

Implications for Social Change

The results of this research carry important weight when it comes to the potential for positive changes in society at various levels of healthcare. First of all, the study makes a powerful point that physician burnout should not be viewed solely from the angle of professional well-being but should also be regarded as one of the essential elements of patient care and safety.

When medical practitioners and wellness leaders talked about workplaces where physicians had to make tough decisions that were close to impossible, such as choosing between documentation or spending time with the family, or between hitting RVUs quickly or establishing quality patient relationships, they were essentially talking about societal risks as a whole hidden in a healthcare system which puts efficiency before quality care.

Measures that help restore time, value agreement, and professional autonomy go a long way in making care safer and more compassionate for patients, while simultaneously creating healthier and more sustainable environments for physicians.

The research extends beyond the individual institution to highlight the medical profession's cultural transformation requirements. By focusing on endurance culture, stigma, and inconsistent leadership signals as areas that encourage burnout, the interviewees demonstrated that wellness cannot be achieved simply by providing partial resources.

Real social change entails deconstructing a system that glorifies overworking and the silence of vulnerability. Change can be defined as the moment when a profession no longer considers "rugged endurance" as the main attribute of "excellence" but rather "sustainability" and "humaneness."

The concerns of doctors and leaders at the policy-making level signal far-reaching consequences in areas such as professional certification, legal liability, and the system of rewards and incentives. For instance, taking out stigmatizing questions related to mental health, putting safeguards in the contracts, and connecting the rewards to the quality and retention, are changes that will provide benefit at the company level but will also represent a pledge by society to support the humane treatment of these physicians. These ideals underscore the notion that caring for those who care for others is both an ethical obligation and a public health imperative.

This research is a step towards social change, as it highlights the perspectives of medical practitioners, wellness officers, executives, and coaches who, either through

personal experience or through witnessing the pressure on others, recognize the immediate need for reform. Their experiences serve as examples of how understanding can be transformed into support for a better system. Regardless of their roles or positions, their common goal is to create a professional environment where doctors can perform their duties without being hindered by failing systems that were supposed to be committed to supporting them.

To summarize, the changes in society that medicine needs are closely linked to refocusing on the people, clinicians, patients, and all of their families. This work serves as a beacon for healthcare organizations to be places where one is not drained, but rather communities where professionals thrive and are able to provide safe and compassionate care.

Conclusions

This research examined how physicians, wellness leaders, administrators, and coaches understand and implement their responses to physician burnout. The main findings of the study, based on interviews with 17 participants, indicated that interventions become effective when system-level changes are combined with highly personal motivators, and when the organizational and cultural aspects chosen for intervention align with the core values of sustainability, belonging, and trust.

By revealing seven themes, the research has not only confirmed the large amount of evidence that the leading causes of physician burnout are structural and cultural factors within the medical environment, but it has also gone beyond that by providing detailed narratives of how leaders and clinicians turned their understanding of the problem into

practical measures. The results also challenge the prevailing notion that one can become resilient enough to handle the problem, that symbolic gestures can be used as substitutes for fundamental structural reforms, and that financial and policy barriers are unchangeable. On the contrary, the people interviewed discussed ways in which reward systems can be altered, governance can create stability, and culture can be deliberately changed so that people become accustomed to sharing their struggles. Their sense of professional empowerment is restored.

The outcomes of this research exercise suggest that interventions for wellness have a chance of being successful only if they are not treated as marginal contributions. Instead, they must fundamentally change the way organizations work. The funding, governance, cultural role-modeling, and leadership training should not be seen as optional activities that might enrich an organization but rather as the essential conditions without which these other goals cannot be achieved. Moreover, wellness initiatives are best when they are rooted in genuine experiences that clearly demonstrate both the consequences of inaction and the transformative potential of a well considered intervention.

I would like to express my sincerest gratitude to the clinicians, wellness officers, executives, and coaches who not only dedicated their time but also warmly welcomed this research by sharing their valuable experiences. Their openness in discussing loss, recovery, and determination made the abstract issue of burnout come to life vividly. As a researcher, I was surprised to learn that professional pressure had such a strong influence on the identities, families, and teams of the people involved, but, at the same time, it was

very inspiring to see how these same experiences were turned into healing models. Their voices kept reminding me that behind all these statistics, there is always a person whose well-being is essential.

Their combined insight projects a very different healthcare system: one that doesn't have to harm those who work in it. Provided that the suggestions made here are implemented, policies are put in place for protection, incentives are aligned, cultures support and encourage vulnerability, and leadership is shared, medicine will not only become more sustainable and successful but also more humane. Such a system would revive the joy of practice for physicians, foster trust between clinicians and patients, and ultimately provide safer, more empathetic care to our communities.

Hence, the necessity of this research goes far beyond its merit as a scholarly study and is noticeable in its call for change: to see health care institutions where physicians develop their potential and get the support they need, and patients are looked after by doctors who are in good emotional and physical condition.

References

- Abatzis, V. T., Park, C. S., Sumler, M. L., & Littlewood, K. E. (2023). Exploring fraught boundaries and landscapes of practice. *Anesthesia & Analgesia*, *137*(3), 548-550.
<https://doi.org/10.1213/ANE.0000000000006599>
- Accreditation Council for Graduate Medical Education. (2020). Summary of changes to ACGME common program requirements. Section VI.C. *Well-being*.
<http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements/Summary-of-Changes>
- Aiken, L. H., Lasater, K. B., Sloane, D. M., Pogue, C. A., Rosenbaum, K. E. F., Muir, K. J., & US Clinician Wellbeing Study Consortium. (2023). Physician and nurse well-being and preferred interventions to address burnout in hospital practice: Factors associated with turnover, outcomes, and patient safety. *JAMA Health Forum*, *4*(7) e231809-e231809.
<https://doi.org/10.1001/jamahealthforum.2023.1809>
- Alexander, B. H., Checkoway, H., Nagahama, S. I., & Domino, K. B. (2000). Cause-specific mortality risks of anesthesiologists. *Anesthesiology*, *93*(4), 922–930.
<https://doi.org/10.1097/00000542-200010000-00008>
- Allespach, H., Kalagara, S., Jaffe, D., Drosdeck, J., & Danielson, P. D. (2020). Practice longer and stronger: maximizing the physical well-being of surgical residents with targeted ergonomics training. *Journal of Surgical Education*, *77*(5), 1024–1027.
<https://doi.org/10.1016/j.jsurg.2020.02.015>

- American Psychological Association. (n.d.). *APA dictionary of psychology*. Retrieved March 1, 2022, from <https://dictionary.apa.org/well-being>
- American Psychological Association. (n.d.). *APA Dictionary of Psychology*. Retrieved March 1, 2022, from <https://dictionary.apa.org/stress>
- Arndt, B. G., Beasley, J. W., Watkinson, M. D., Temte, J. L., Tuan, W.-J., Sinsky, C. A., & Gilchrist, V. J. (2017). Tethered to the EHR: Primary care physician workload assessment using EHR event log data and time-motion observations. *The Annals of Family Medicine*, *15*(5), 419–426. <https://doi.org/10.1370/afm.2121>
- Arora, M., Asha, S., Chinnappa, J., & Diwan, A. D. (2013). Review article: Burnout in emergency medicine physicians. *Emergency Medicine Australasia*, *25*(6), 491–495. <https://doi.org/10.1111/1742-6723.12135>
- Asare, E., Wang, L., & Fang, X. (2020). Conformance checking: Workflow of hospitals and workflow of open-source EMRs. *IEEE Access*, *8*, 139546–139566. <https://doi.org/10.1109/access.2020.3012147>
- Babbott, S., Manwell, L. B., Brown, R., Montague, E., Williams, E., Schwartz, M., Hess, E., & Linzer, M. (2014). Electronic medical records and physician stress in primary care: Results from the Memo Study. *Journal of the American Medical Informatics Association*, *21*(e1). <https://doi.org/10.1136/amiajnl-2013-001875>
- Bailey, C. R., Bailey, A. M., McKenney, A. S., & Weiss, C. R. (2022). Understanding and appreciating burnout in radiologists. *Radiographics*, *42*(5), E137-E139. <https://doi.org/10.1148/rg.220037>

- Baker, S., et al. (2021). Relationship between burnout and mistreatment: Who plays a role? *American Journal of Surgery*, 222(6), 1060–1065.
<https://doi.org/10.1016/j.amjsurg.2021.06.009>
- Balch, C. M., Oreskovich, M. R., Dyrbye, L. N., Colaiano, J. M., Satele, D. V., Sloan, J. A., & Shanafelt, T. D. (2011). Personal consequences of malpractice lawsuits on American surgeons. *Journal of the American College of Surgeons*, 213(5), 657–667. <https://doi.org/10.1016/j.jamcollsurg.2011.08.005>
- Barrett, A. K., & Stephens, K. K. (2016). Making electronic health records (EHRs) work: Informal talk and workarounds in healthcare organizations. *Health Communication*, 32(8), 1004–1013.
<https://doi.org/10.1080/10410236.2016.1196422>
- Belina, A. (2023). Semi-structured interviewing as a tool for understanding informal civil society. *Voluntary Sector Review*, 14(2), 331-347.
<https://doi.org/10.1332/204080522X16454629995872>
- Bingmer, K., Nwachukwu, C., George, B., Lin, J., & Kim, E. (2019). A model for a formal mentorship program in surgical residency. *Journal of Surgical Research*, 243, 64–70. <https://doi.org/10.1016/j.jss.2019.04.042>
- Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*, 26(13), 1802–1811. <https://doi.org/10.1177/1049732316654870>
- Bloomberg, L. D., & Volpe, M. (2016). *Completing your qualitative dissertation: A road map from beginning to end* (3rd ed.). Sage.

- Bohman, B., Dyrbye, L., Sinsky, C. A., West, C. P., Shanafelt, T. D., & Trockel, M. (2017). Physician well-being: The reciprocity of practice efficiency, culture of wellness, and personal resilience. *NEJM Catalyst*.
<https://catalyst.nejm.org/physician-well-being-efficiency-wellness-resilience/>.
- Brandt, M. L. (2017). Sustaining a career in surgery. *American Journal of Surgery*, 214(4), 707–714. <https://doi.org/10.1016/j.amjsurg.2017.06.008>
- Bridges, W., & Bridges, S. (2018). Managing transitions.
<https://doi.org/10.15358/9783800656561>
- Briner, R. B., & Rousseau, D. M. (2011). Evidence-based I–O psychology: Not there yet. *Industrial and Organizational Psychology*, 4(1), 3–22.
<https://doi.org/10.1111/j.1754-9434.2010.01287.x>
- Brower, K. J. (2021). Professional stigma of mental health issues: Physicians are both the cause and solution. *Academic Medicine*, 96(5), 635–640.
<https://doi.org/10.1097/ACM.0000000000003998>
- Brown, C. V. R., Johnson, A. N., Sharpe, J. P., Holcombe, B., Vasquez, C. R., & Gross, K. R. (2021). Modifiable factors to improve work-life balance for trauma surgeons. *Journal of Trauma and Acute Care Surgery*, 90(1), 122–128.
<https://doi.org/10.1097/TA.0000000000002895>
- Buck, K., Williamson, M., Ogbeide, S., & Norberg, B. (2019). Family physician burnout and resilience: A cross-sectional analysis. *Family Medicine*, 51(8), 657–663.
<https://doi.org/10.22454/fammed.2019.424025>

- Campbell-Sills, L., & Stein, M. B. (2007). Psychometric analysis and refinement of the Connor–Davidson Resilience Scale (CD-RISC): Validation of a 10-item measure of resilience. *Journal of Traumatic Stress, 20*(6), 1019–1028.
<https://doi.org/10.1002/jts.20271>
- Card, A. J. (2018). Physician burnout: resilience training is only part of the solution. *The Annals of Family Medicine, 16*(3), 267-270.
- Centers for Disease Control and Prevention. (2018, June 14). Products - data briefs - number 309 - June 2018. Centers for Disease Control and Prevention. Retrieved March 30, 2022, from <https://www.cdc.gov/nchs/products/databriefs/db309.htm>
- Centers for Disease Control and Prevention. (2018, October 31). Well-being concepts. Centers for Disease Control and Prevention. Retrieved March 27, 2023, from <https://www.cdc.gov/hrqol/wellbeing.htm>
- Centers for Disease Control and Prevention. (2020, January 23). Suicide rates by industry and occupation - national violent death reporting system, 32 states, 2016. Centers for Disease Control and Prevention. Retrieved March 30, 2022, from <https://www.cdc.gov/mmwr/volumes/69/wr/mm6903a1.htm>
- Cerier, E., Fostad, S., Davenport, D. L., & Williams, T. K. (2022). Ergonomics workshop improves musculoskeletal symptoms in general surgery residents. *Journal of Surgical Research, 280*, 567–574. <https://doi.org/10.1016/j.jss.2021.12.010>
- Chopra, S. S. (2004). Physician burnout. *JAMA: The Journal of the American Medical Association, 291*(5), 633–633. doi:10.1001/jama.291.5.633

- Chow, B. E., et al. (2022). Using human-centered design to improve a surgery resident well-being program. *Journal of Surgical Research*, 277, 157-162.
<https://doi.org/10.1016/j.jss.2021.07.045>
- Cohidon, C., Wild, P., & Senn, N. (2019). Practice organization characteristics related to job satisfaction among general practitioners in 11 countries. *The Annals of Family Medicine*, 17(6), 510–517. <https://doi.org/10.1370/afm.2449>
- Coleman, J. J., Esposito, T. J., Rozycki, G. S., Feliciano, D. V., & Ingram, W. L. (2019). To sleep, perchance to dream: Acute and chronic sleep deprivation in acute care surgeons. *Journal of the American College of Surgeons*, 229(2), 166–174.
<https://doi.org/10.1016/j.jamcollsurg.2019.04.029>
- Coutu, D., & Kauffman, C. (2009). What can coaches do for you? Harvard Business Review. <https://hbr.org/2009/01/what-can-coaches-do-for-you>.
- Cox, M. L., Fostad, S., Davenport, D. L., & Williams, T. K. (2018). Documenting or operating: Where is time spent in general surgery residency? *Journal of Surgical Education*, 75(6), e97-e106. <https://doi.org/10.1016/j.jsurg.2018.04.007>
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches*. Sage.
- Cristancho, S., Lingard, L., & Regehr, G. (2016). From problem solving to problem definition: Scrutinizing the complex nature of clinical practice. *Perspectives on Medical Education*, 6(1), 54–57. <https://doi.org/10.1007/s40037-016-0314-0>

- de Sousa Pereira, I., da Silva Macêdo, A. P., de Sá, I. C. A., Moreira, L. M., & Neto, M. L. R. (2019). Physicians are at a higher risk than the general population for suicide? *Amadeus International Multidisciplinary Journal*, 4(7), 189-195.
- DeChant, P., & Shannon, D. W. (2021). Preventing physician burnout: Curing the chaos and returning joy to the practice of medicine. CreateSpace Independent Publishing Platform.
- DePorre, A., Banerjee, G., Mitchell, J. D., Brzezinski, M., & Ballard, H. A. (2023). Burnout in Medicine: Are We Asking the Right Questions? *The Permanente journal*, 27(2), 123–129. <https://doi.org/10.7812/TPP/23.033>
- Dewa, C. S., Loong, D., Bonato, S., Thanh, N. X., & Jacobs, P. (2014). How does burnout affect physician productivity? A systematic literature review. *BMC Health Services Research*, 14(1), 325. <https://doi.org/10.1186/1472-6963-14-325>
- Di Fabio, A., & Palazzeschi, L. (2015). Hedonic and eudaimonic well-being: The role of resilience beyond fluid intelligence and personality traits. *Frontiers in Psychology*, 6, 11-35. <https://doi.org/10.3389/fpsyg.2015.00093>
- Dibley, L., Dickerson, S., Duffy, M., & Vandermause, R. (2020). *Doing hermeneutic phenomenological research: A practical guide*. Sage.
- Dillon, E. C., Stults, C. D., Deng, S., Martinez, M., Szwedinski, N., Koenig, P. T., & Pertsch, S. (2022). Women, younger clinicians', and caregivers' experiences of burnout and well-being during COVID-19 in a US healthcare system. *Journal of General Internal Medicine*, 1-9. <https://doi.org/10.1007/s11606-021-07134-4>

- Dishon-Berkovits, M. (2013). Burnout: Contributing and protecting factors within the work-family interface. *Journal of Career Development, 41*, 467-486.
<https://doi.org/10.1177/0894845313512181>
- Dunwoodie, K., Macaulay, L., & Newman, A. (2023). Qualitative interviewing in the field of work and organizational psychology: Benefits, challenges, and guidelines for researchers and reviewers. *Applied Psychology, 72*(2), 863-889.
<https://doi.org/10.1111/apps.12414>
- Dyrbye, L. N., Shanafelt, T. D., Gill, P. R., Satele, D. V., & West, C. P. (2019). Effect of a professional coaching intervention on the well-being and distress of physicians. *JAMA Internal Medicine, 179*(10), 1406-1413.
<https://doi.org/10.1001/jamainternmed.2019.2425>
- Dyrbye, L. N., Thomas, M. R., Huschka, M. M., Lawson, K. L., Novotny, P. J., Sloan, J. A., & Shanafelt, T. D. (2006). A multicenter study of burnout, depression, and quality of life in minority and nonminority US medical students. *Mayo Clinic Proceedings, 81*(11), 1435–1442. <https://doi.org/10.4065/81.11.1435>
- Dyrbye, L. N., Thomas, M. R., Massie, F. S., Power, D. V., Eacker, A., Harper, W., Durning, S., Moutier, C., Szydlo, D. W., Novotny, P. J., Sloan, J. A., & Shanafelt, T. D. (2008). Burnout and suicidal ideation among U.S. medical students. *Annals of Internal Medicine, 149*(5), 334. <https://doi.org/10.7326/0003-4819-149-5-200809020-00008>

- Dzau V. J. (2023). The National Academy of Medicine at 50: Celebrating the Past and Envisioning the Future. *NAM Perspectives*, 2023, 10.31478/202303a. <https://doi.org/10.31478/202303a>
- Dzau, V. J., Kirch, D. G., & Nasca, T. J. (2018). To care is human — collectively confronting the clinician-burnout crisis. *New England Journal of Medicine*, 378(4), 312–314. <https://doi.org/10.1056/nejmp1715127>
- El-Aswad, N. (2020). A Simple Response to Physician Burnout. *The American Journal of Medicine*, 133(8), e442. <https://doi.org/10.1016/j.amjmed.2020.03.004>
- Ellis, R. J., Bilimoria, K. Y., Harris, I. A., Krause, E., Shanafelt, T. D., & Pellegrini, C. A. (2021). Comprehensive characterization of the general surgery residency learning environment and the association with resident burnout. *Annals of Surgery*, 274(1), 6–11. <https://doi.org/10.1097/SLA.0000000000004826>
- Ezer, F., & Aksüt, S. (2021). Opinions of Graduate Students of Social Studies Education about Qualitative Research Method. *International Education Studies*, 14(3), 15-32. <https://eric.ed.gov/?id=EJ1287922>
- Fahrenkopf, A. M., Sectish, T. C., Barger, L. K., Sharek, P. J., Lewin, D., Chiang, V. W., Edwards, S., Wiedermann, B. L., & Landrigan, C. P. (2008). Rates of medication errors among depressed and burnt out residents: Prospective cohort study. *BMJ*, 336(7642), 488–491. <https://doi.org/10.1136/bmj.39469.763218.be>
- Fatimah, S., Rosidin, D. N., & Hidayat, A. (2022). Student-based Learning in The Perspective of Constructivism Theory and Maieutics Method. *International*

Journal of Social Science And Human Research, 5(5), 1632-1637.

<https://ijsshr.in/v5i5/10.php>

Fischer, J. E. (2007). The impending disappearance of the general surgeon. *JAMA*,

298(18), 2191–2193. <https://doi.org/10.1001/jama.298.18.2191>

Ford, E. W., Menachemi, N., Peterson, L. T., & Huerta, T. R. (2009). Resistance is futile:

But it is slowing the pace of EHR adoption nonetheless. *Journal of the American Medical Informatics Association*, 16(3), 274–281.

<https://doi.org/10.1197/jamia.m3042>

Fox, S., Lydon, S., Byrne, D., Madden, C., Connolly, F., & O'Connor, P. (2017). A

systematic review of interventions to foster physician resilience. *Postgraduate Medical Journal*, 94(1109), 162–170. <https://doi.org/10.1136/postgradmedj-2017-135212>

Freischlag, J. A., & Silva, M. M. (2017). Preventing general surgery residency attrition-it

is all about the mentoring. *JAMA Surgery*, 152(3), 272–273.

<https://doi.org/10.1001/jamasurg.2016.4812>

Gardiner, M., Kearns, H., & Tiggemann, M. (2013). Effectiveness of cognitive

behavioural coaching in improving the well-being and retention of rural general practitioners. *Australian Journal of Rural Health*, 21(3), 183–189.

<https://doi.org/10.1111/ajr.12033>

Gazelle, G., Liebschutz, J. M., & Riess, H. (2014). Physician burnout: Coaching a way

out. *Journal of General Internal Medicine*, 30(4), 508–513.

<https://doi.org/10.1007/s11606-014-3144-y>

- Glass, D. C., & McKnight, J. D. (1996). Perceived control, depressive symptomatology, and professional burnout: A review of the evidence. *Psychology & Health, 11*(1), 23–48. <https://doi.org/10.1080/08870449608401975>
- Gogo, A., Osta, A., McClafferty, H., & Rana, D. T. (2019). Cultivating a way of being and doing: Individual strategies for physician well-being and resilience. *Current Problems in Pediatric and Adolescent Health Care, 49*(12), 100663. <https://doi.org/10.1016/j.cppeds.2019.100663>
- Golisch, K. B., Sanders, J. M., Rzhetsky, A., & Tatebe, L. C. (2023). Addressing Surgeon Burnout Through a Multi-level Approach: A National Call to Action. *Current Trauma Reports, 1-12*.
- Grandey, A. A., & Cropanzano, R. (1999). The conservation of resources model applied to work–family conflict and strain. *Journal of Vocational Behavior, 54*, 350-370. <https://doi.org/10.1006/jvbe.1998.1666>
- Greene, R. R., Conrad, A. P., Livingstone, N. C., Barton, W. H., Watkins, M. L., Blundo, R., & Riley, J. G. (2002). An integrated approach to practice, policy, and research (2nd ed.). Washington, DC: National Association of Social Workers Press.
- Halbesleben, J. R. B., Neveu, J. P., Paustian-Underdahl, S. C., & Westman, M. (2014). Getting to the “COR” understanding the role of resources in conservation of resources theory. *Journal of Management, 40*, 1334-1364. <https://doi.org/10.1177/0149206314527130>

- Halbesleben, J. R., & Rathert, C. (2008). Linking physician burnout and patient outcomes. *Health Care Management Review, 33*(1), 29–39.
<https://doi.org/10.1097/01.hmr.0000304493.87898.72>
- Hale, C. D. (2012). *Evaluating education, training, and services: A primer*.
- Hamby, M. (2019). *Writing research: A guide to writing research articles and dissertations*. Kendall-Hunt.
- Hamermesh, D. S., & Soss, N. M. (1974). An economic theory of suicide. *Journal of Political Economy, 82*(1), 83–98. <https://doi.org/10.1086/260171>
- Hamidi, M. S., Bohman, B., Sandborg, C., Smith-Coggins, R., de Vries, P., Albert, M. S., Murphy, M. L., Welle, D., & Trockel, M. T. (2018). Estimating institutional physician turnover attributable to self-reported burnout and associated financial burden: A case study. *BMC Health Services Research, 18*(1).
<https://doi.org/10.1186/s12913-018-3663-z>
- Han, S., Shanafelt, T. D., Sinsky, C. A., Awad, K. M., Dyrbye, L. N., Fiscus, L. C., Trockel, M., & Goh, J. (2019). Estimating the attributable cost of physician burnout in the United States. *Annals of Internal Medicine, 170*(11), 784.
<https://doi.org/10.7326/m18-1422>
- Handoyo, N. E., Claramita, M., Keraf, M. K., Ash, J., Schuwirth, L., & Rahayu, G. R. (2022). The importance of developing meaningfulness and manageability for resilience in rural doctors. *Medical Teacher, 1-8*.
<https://doi.org/10.1080/0142159x.2022.2128734>

- Hawton, K., Clements, A., Simkin, S., & Malmberg, A. (2000). Doctors who kill themselves: A study of the methods used for suicide. *QJM*, 93, 351-357.
doi:10.1093/qjmed/93.6.351
- Hodkinson, A., Zhou, A., Johnson, J., Geraghty, K., Riley, R., Zhou, A., & Panagioti, M. (2022). Associations of physician burnout with career engagement and quality of patient care: Systematic review and meta-analysis. *BMJ*, 378.
<https://doi.org/10.1136/bmj-2022-070442>
- Hu, Y. (2021). The surgical education culture optimization through targeted interventions based on national comparative data - "The SECOND Trial" (SECOND). ClinicalTrials.gov Identifier: NCT03739723. Retrieved from
<https://clinicaltrials.gov/ct2/show/NCT03739723>
- Hu, Y. Y., et al. (2019). Discrimination, abuse, harassment, and burnout in surgical residency training. *New England Journal of Medicine*, 381(18), 1741–1752.
- Huffman, E. M., Bove, R., Sarmiento, E. J., & Schumacher, H. K. (2020). Why the lab? What is really motivating general surgery residents to take time for dedicated research. *Journal of Surgical Education*, 77(6), e39-e46.
<https://doi.org/10.1016/j.jsurg.2020.06.029>
- International Coaching Federation. (2022, January 19). ICF code of ethics. Retrieved January 27, 2023, from <https://coachingfederation.org/ethics/code-of-ethics>
- Ishikawa, M. (2022). Relationships between overwork, burnout and suicidal ideation among resident physicians in hospitals in Japan with medical residency

- programmes: A nationwide questionnaire-based survey. *BMJ Open*, 12(3), e056283. <http://dx.doi.org/10.1136/bmjopen-2021-056283>
- James, J. T. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety*, 9(3), 122-128.
<https://doi.org/10.1097/PTS.0b013e3182948a69>
- Jindal, R. M. (2020). Service to others may be the answer to physician burnout. *JAMA Surgery*, 155(6), 463-464. <https://doi.org/10.1001/jamasurg.2020.0046>
- Jones, J. W., Barge, B. N., Steffy, B. D., Fay, L. M., Kunz, L. K., & Wuebker, L. J. (1988). Stress and medical malpractice: Organizational risk assessment and intervention. *Journal of Applied Psychology*, 73(4), 727-735.
<https://doi.org/10.1037/0021-9010.73.4.727>
- Jonassen, D. H. (2013). Evaluating constructivistic learning. In *Constructivism and the Technology of Instruction* (pp. 137-148). Routledge.
- Joung, R. H., Al-Mazrou, A. M., Kirton, O. C., Moneta, G. L., Mullenix, P. S., & Koungias, P. (2022). A national mixed-methods evaluation of general surgery residency program responsiveness and the association with resident wellness. *Journal of Surgical Education*, 79(6), e1-e11.
<https://doi.org/10.1016/j.jsurg.2022.04.006>
- Kane, L. (2019). Medscape national physician burnout, depression & suicide report 2019. Retrieved June 23, 2019, from www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056?faf=1#1.

- Kashdan, T. B., & Kane, J. Q. (2011). Post-traumatic distress and the presence of post-traumatic growth and meaning in life: Experiential avoidance as a moderator. *Personality and Individual Differences, 50*, 84-89.
<https://doi.org/10.1016/j.paid.2010.09.031>
- Kinslow, K., Ferraris, V. A., Willis, R. E., Schmidt, E. J., Whalen, T. V., & Gaughan, J. P. (2020). Reported burnout among U.S. general surgery residents: A survey of the Association of Program Directors in Surgery members. *Annals of Medicine and Surgery, 60*, 14-19. <https://doi.org/10.1016/j.amsu.2020.10.015>
- Kishore, S., Ripp, J., Shanafelt, T. D., Melnyk, B. M., Rogers, D., Brigham, T., & Busis, N. A. (2018). Making the case for the chief wellness officer in America's health systems: A call to action. Forefront Group.
<https://doi.org/10.1377/forefront.20181025.308059>
- Kleinhendler-Lustig, D., Hamdan, S., Mendlovic, J., & Gvion, Y. (2023). Burnout, depression, and suicidal ideation among physicians before and during COVID-19 and the contribution of perfectionism to physicians' suicidal risk. *Frontiers in Psychiatry, 14*, 1211180. <https://doi.org/10.3389/fpsy.2023.1211180>
- Kohn, L. T., Corrigan, J., & Donaldson, M. S. (Eds.). (2009). *To err is human: Building a safer health system*. National Academy Press.
- Krasner, M. S., Epstein, R. M., Beckman, H., Suchman, A. L., Chapman, B., Mooney, C. J., & Quill, T. E. (2009). Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA, 302*(12), 1284-1293. <https://doi.org/10.1001/jama.2009.1384>

- Kuhn, C. M., & Flanagan, E. M. (2017). Self-care as a professional imperative: Physician burnout, depression, and suicide. *Canadian Journal of Anesthesia/Journal Canadien d'Anesthésie*, *64*, 158-168. <https://doi.org/10.1007/s12630-016-0781-0>
- Kumar, S. (2014). Quality considerations in the design and implementation of an online doctoral program. *Journal of Online Doctoral Education*, *1*(1), 6-22.
- Lacy, B. E., & Chan, J. L. (2018). Physician burnout: The Hidden Health Care Crisis. *Clinical Gastroenterology and Hepatology*, *16*(3), 311–317. <https://doi.org/10.1016/j.cgh.2017.06.043>
- LaDonna, K. A., Cowley, L., Touchie, C., LeBlanc, V. R., & Spilg, E. G. (2022). Wrestling with the invincibility myth: Exploring physicians' resistance to wellness and resilience-building interventions. *Academic Medicine*, *97*(3), 436–443. <https://doi.org/10.1097/acm.0000000000004354>
- Landon, B. E., Reschovsky, J. D., Pham, H. H., & Blumenthal, D. (2006). *Leaving medicine*. *Medical Care*, *44*(3), 234–242. <https://doi.org/10.1097/01.mlr.0000199848.17133.9b>
- Lebares, C. C., Ascher, N. L., O'Sullivan, P. S., Harris, H. W., & Epel, E. S. (2021). Enhanced stress resilience training in surgeons: Iterative adaptation and biopsychosocial effects in 2 small randomized trials. *Annals of Surgery*, *273*(3), 424–432. <https://doi.org/10.1097/SLA.0000000000004238>
- Lebares, C. C., Guvva, E. V., Olaru, M., Sugrue, L. P., Staffaroni, A. M., Delucchi, K. L., Ascher, N. L. (2018). Burnout and gender in surgical training: A call to re-

evaluate coping and dysfunction. *The American Journal of Surgery*, 216(4), 800–804. <https://doi.org/10.1016/j.amjsurg.2018.07.018>

Lebares, C. C., Hershberger, A. O., Guvva, E. V., Desai, S. V., & Ascher, N. L. (2018).

Burnout and stress among US surgery residents: Psychological distress and resilience. *Journal of the American College of Surgeons*, 226(1), 80–90.

<https://doi.org/10.1016/j.jamcollsurg.2017.09.024>

Leiter, M. P., & Durup, J. (1994). The discriminant validity of burnout and depression: A

confirmatory factor analytic study. *Anxiety, Stress, & Coping*, 7(4), 357–373.

<https://doi.org/10.1080/10615809408249357>

Longo, B. A., Schmaltz, S. P., Williams, S. C., Shanafelt, T. D., Sinsky, C. A., & Baker,

D. W. (2023). Clinician Well-Being Assessment and Interventions in Joint

Commission–Accredited Hospitals and Federally Qualified Health Centers. *The Joint Commission Journal on Quality and Patient Safety*, 49(10), 511–520.

<https://doi.org/10.1016/j.jcjq.2023.04.007>

Lund, S., Holubar, S. D., & Lebares, C. C. (2022). With a little help from my friends: The

negating impact of social community and mentorship on burnout. *Journal of*

Surgical Research, 278, 190–195. <https://doi.org/10.1016/j.jss.2021.11.009>

Maier, S. F., & Seligman, M. E. P. (2016). Learned helplessness at fifty: Insights from

neuroscience. *Psychological Review*, 123(4), 349–367.

<https://doi.org/10.1037/rev0000033>

Makowski, M. S., Palomo, C., de Vries, P., & Shanafelt, T. D. (2022). Employer-

provided professional coaching to improve self-compassion and burnout in

physicians. *Mayo Clinic Proceedings*, 97(3), 628–629.

<https://doi.org/10.1016/j.mayocp.2022.01.008>

Marchand, C., & Vandenberghe, C. (2016). Perceived organizational support, emotional exhaustion, and turnover: The moderating role of negative affectivity.

International Journal of Stress Management, 23(3), 350–375.

<https://doi.org/10.1037/str0000020>

Mark, L., Herzer, K., Akst, S., & Michelson, J. (2010). General considerations of anesthesia and management of the difficult airway. In P. W. Flint, B. H. Haughey, V. J. Lund, J. K. Niparko, M. A. Richardson, K. Robbins, & J. R. Thomas (Eds.), *Cummings Otolaryngology - Head and Neck Surgery* (pp. 108–120). Elsevier.

<https://doi.org/10.1016/b978-0-323-05283-2.00010-0>

Maslach, C., & Jackson, S. E. (2016). Maslach Burnout Inventory--ES form [Dataset].

PsycTESTS. <https://doi.org/10.1037/t05190-000>

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52(1), 397–422. <https://doi.org/10.1146/annurev.psych.52.1.397>

Masten, A. S., Best, K. M., & Garmezy, N. (1990). Resilience and development:

Contributions from the study of children who overcome adversity. *Development and Psychopathology*, 2, 425-444.

Master, Z., Martinson, B. C., & Resnik, D. B. (2018). Expanding the scope of research ethics consultation services in safeguarding research integrity: Moving beyond the ethics of human subjects research. *The American Journal of Bioethics*, 18(1), 55-

57. <https://doi.org/10.1080/15265161.2017.1401167>

- Mata, D. A., Ramos, M. A., Bansal, N., Khan, R., Guille, C., Di Angelantonio, E., & Sen, S. (2015). Prevalence of depression and depressive symptoms among resident physicians. *JAMA*, *314*(22), 2373. <https://doi.org/10.1001/jama.2015.15845>
- McClintock NC, et al. (2019). Factors associated with general surgery residents' decisions regarding fellowship and subspecialty stratified by burnout and quality of life. *American Journal of Surgery*, *218*(6), 1090–1095. <https://doi.org/10.1016/j.amjsurg.2019.07.015>
- Medical Research Council. (2014). Lifelong health and wellbeing. Retrieved from www.mrc.ac.uk/research/initiatives/lifelong-health-wellbeing
- MedPAC. (n.d.). Analysis of disparities in physician compensation [Contractor report]. Retrieved May 27, 2022, from https://www.medpac.gov/-documents-/contractor-reports/jan19_medpac_disparities_physiciancompensationreport_cvr_contractor_sec.pdf
- Megheirkouni, M., & Moir, J. (2023). Simple but effective criteria: rethinking excellent qualitative research. *The Qualitative Report*, *28*(3), 848-864. <https://doi.org/10.46743/2160-3715/2023.5845>
- Menon, N. K., Trockel, M. T., Hamidi, M. S., & Shanafelt, T. D. (2019). Developing a portfolio to support physicians' efforts to promote well-being: One piece of the puzzle. *Mayo Clinic Proceedings*, *94*(11), 2171–2177. <https://doi.org/10.1016/j.mayocp.2019.09.010>

- Merve, K. A. R. A. (2019). A systematic literature review: Constructivism in multidisciplinary learning environments. *International Journal of Academic Research in Education*, 4(1-2), 19-26. <https://doi.org/10.17985/ijare.520666>
- Mészáros, V., Ádám, S., Szabó, M., Szigeti, R., & Urbán, R. (2014). The bifactor model of the Maslach Burnout Inventory-Human Services Survey (MBI-HSS)--An alternative measurement model of burnout. *Stress and Health*, 30(1), 82-88. <https://doi.org/10.1002/smi.2481>
- Meyer, K., & Willis, R. (2019). Looking back to move forward: The value of reflexive journaling for novice researchers. *Journal of Gerontological Social Work*, 62(5), 578-585. <https://doi.org/10.1080/01634372.2018.1559906>
- Mohajan, H. K. (2018). Qualitative research methodology in social sciences and related subjects. *Journal of Economic Development, Environment, and People*, 7(1), 23-48. <https://www.cceol.com/search/article-detail?id=640546>
- Moss, M., Good, V. S., Gozal, D., Kleinpell, R., & Sessler, C. N. (2016). An official critical care societies collaborative statement: Burnout in critical care health care professionals: A call for action. *American Journal of Critical Care*, 25, 368-376. <https://doi.org/10.4037/ajcc2016133>
- Moustakas, C. E. (1994). *Phenomenological research methods*. Sage.
- Mueller, C. M., Buckle, M., & Post, L. (2018). A facilitated-group approach to wellness in surgical residency. *JAMA Surgery*, 153(11), 1043-1044. <https://doi.org/10.1001/jamasurg.2018.2326>

National Academies of Sciences, Engineering, and Medicine. (2022). *National plan for health workforce well-being*. The National Academies Press.

<https://doi.org/10.17226/26744>

National Academy of Medicine. (2019). Taking action against clinician burnout: A systems approach to professional well-being. Washington, DC: National Academies Press. <https://doi.org/10.17226/25521>

National Academy of Medicine. (2022, March 1). Clinician resilience and well-being. Retrieved March 29, 2022, from <https://nam.edu/initiatives/clinician-resilience-and-well-being/>

National Institute of Mental Health. (2018). 5 things you should know about stress (Publication No. 19-MH-8109). Retrieved from <https://www.nimh.nih.gov/health/publications/stress/index.shtml>

Obilor, E. I. (2023). Convenience and purposive sampling techniques: Are they the same? *International Journal of Innovative Social & Science Education Research*, 11(1), 1-7.

Organizational strategies – clinician well-being knowledge hub. (n.d.). *National Academy of Medicine*. Retrieved May 01, 2020, from <https://nam.edu/clinicianwellbeing/solutions/organizational-strategies/>

Ortega, M. V., Hidrue, M. K., Lehrhoff, S. R., Ellis, D. B., Sisodia, R. C., Curry, W. T., & Wasfy, J. H. (2023). Patterns in Physician Burnout in a Stable-Linked Cohort. *JAMA Network Open*, 6(10), e2336745-e2336745.

<https://doi.org/10.1001/jamanetworkopen.2023.36745>

- Palamara, K., Hu, Y., Lipsitz, S. R., Mullen, J. T., Gawande, A. A., & Jagsi, R. (2022). Impact of a virtual professional development coaching program on the professional fulfillment and well-being of women surgery residents: A randomized controlled trial. *Annals of Surgery*, Epub ahead of print. <https://doi.org/10.1097/SLA.0000000000005562>
- Panagioti, M., Geraghty, K., Johnson, J., Zhou, A., Panagopoulou, E., Chew-Graham, C., Peters, D., Hodkinson, A., Riley, R., & Esmail, A. (2018). Association between physician burnout and patient safety, professionalism, and patient satisfaction: A systematic review and meta-analysis. *JAMA Internal Medicine*, *178*(10), 1317-1330. <https://doi.org/10.1001/jamainternmed.2018.3713>
- Parks-Savage, A., Archer, L., Newton, H., Wheeler, E., & Huband, S. R. (2018). Prevention of medical errors and malpractice: Is creating resilience in physicians part of the answer? *International Journal of Law and Psychiatry*, *60*, 35–39. <https://doi.org/10.1016/j.ijlp.2018.07.003>
- Peels, R., & Bouter, L. (2023). Replication and trustworthiness. *Accountability in Research*, *30*(2), 77-87. <https://doi.org/10.1080/08989621.2021.1963708>
- Price, E. T., Santos, A. B., Kline, K. D., Clark, M. J., Stiegmann, R. A., & Tarpley, M. J. (2020). Are we making an impact? A qualitative program assessment of the resident leadership, well-being, and resiliency program for general surgery residents. *Journal of Surgical Education*, *77*(3), 508–519. <https://doi.org/10.1016/j.jsurg.2019.11.010>

- Rangel, E. L., Lyu, H., Haider, A. H., Castillo-Angeles, M., Doherty, G. M., Smink, D. S., & Smink, J. R. (2020). Lack of routine healthcare among resident physicians in New England. *Journal of the American College of Surgeons*, 230(6), 885–892.
- Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Sage.
- Rinne, S. T., Mohr, D. C., Swamy, L., Blok, A. C., Wong, E. S., & Charns, M. P. (2020). National burnout trends among physicians working in the Department of Veterans Affairs. *Journal of General Internal Medicine*, 35(5), 1382–1388.
<https://doi.org/10.1007/s11606-019-05582-7>
- Ripp, J., & Shanafelt, T. (2020). The health care chief wellness officer: What the role is and is not. *Academic Medicine*, 95(9), 1354–1358.
<https://doi.org/10.1097/acm.0000000000003433>
- Robertson, J. J., & Long, B. (2019). Medicine's shame problem. *The Journal of Emergency Medicine*, 57(3), 329–338.
<https://doi.org/10.1016/j.jemermed.2019.06.034>
- Robinson, C., Odegaard, J., Chen, Y., Szabo, A., & Javia, L. (2019). Physiologic stress among surgeons who take in-house call. *American Journal of Surgery*, 218(6), 1181–1184. <https://doi.org/10.1016/j.amjsurg.2019.07.015>
- Rosen, D. H. (1973). Suicide rates among psychiatrists. *JAMA: The Journal of the American Medical Association*, 224(2), 246.
<https://doi.org/10.1001/jama.1973.03220150054021>

- Rosiek, A., Rosiek-Kryszewska, A., Leksowski, L., & Leksowski, K. (2016). Chronic stress and suicidal thinking among medical students. *International Journal of Environmental Research and Public Health*, *13*(2), 212.
<https://doi.org/10.3390/ijerph13020212>
- Rosner, M. H., & Falk, R. J. (2020). Understanding work: Moving beyond the RVU. *Clinical Journal of the American Society of Nephrology*, *15*(7), 1053–1055.
<https://doi.org/10.2215/cjn.12661019>
- Rotter, J. B. (1990). Internal versus external control of reinforcement: A case history of a variable. *American Psychologist*, *45*(4), 489–493. <https://doi.org/10.1037/0003-066x.45.4.489>
- Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data* (3rd ed.). Sage.
- Rudestam, K. E., & Newton, R. R. (2015). *Surviving your dissertation: A comprehensive guide to content and process*. Sage.
- Ryan, E., Hore, K., Power, J., & Jackson, T. (2023). The relationship between physician burnout and depression, anxiety, suicidality and substance abuse: A mixed methods systematic review. *Frontiers in Public Health*, *11*, 1133484.
<https://doi.org/10.3389/fpubh.2023.1133484>
- Salles, A., Mueller, C. M., Cohen, G. L., & Beaudoin, F. L. (2019). Social belonging as a predictor of surgical resident well-being and attrition. *Journal of Surgical Education*, *76*(2), 370–377.

- Samra, R. (2018). Brief history of burnout. *BMJ*, *363*, k5268. <https://doi.org/10.1136/bmj.k5268>
- Schaufeli, W. B., Bakker, A. B., & Salanova, M. (2006). *Utrecht Work Engagement Scale-9 (UWES-9)* [Database record]. APA PsycTests. <https://doi.org/10.1037/t05561-000>
- Schernhammer, E. (2005). Taking their own lives—the high rate of physician suicide. *New England Journal of Medicine*, *352*, 2473-2476. <https://doi.org/10.1056/NEJMpers050467>
- Scheurer, D., McKean, S., Miller, J., & Wetterneck, T. (2009). U.S. physician satisfaction: A systematic review. *Journal of Hospital Medicine*, *4*(9), 560–568. <https://doi.org/10.1002/jhm.496>
- Schneider, A., Hilbert, S., Hamann, J., Skadsem, S., Glaser, J., Löwe, B., & Bühner, M. (2017). The implications of psychological symptoms for length of sick leave: Burnout, depression, and anxiety as predictors in a primary care setting. *Deutsches Ärzteblatt International*, *114*, 291-297. <http://doi:10.3238/arztebl.2017.0291>
- Schneider, S., Kingsolver, K., & Rosdahl, J. (2014). Physician coaching to enhance well-being: A qualitative analysis of a pilot intervention. *Explore*, *10*(6), 372–379. <https://doi.org/10.1016/j.explore.2014.08.007>
- Schram, Thomas. (2003). *Conceptualizing and proposing qualitative research*. Pearson.
- Shah, T., Patel-Teague, S., Kroupa, L., Meyer, A. N., & Singh, H. (2018). Impact of a national QI program on reducing electronic health record notifications to

clinicians. *BMJ Quality & Safety*, 28(1), 10–14. <https://doi.org/10.1136/bmjqs-2017-007447>

Shanafelt, T. D., Boone, S., Tan, L., Dyrbye, L. N., Sotile, W., Satele, D., & Oreskovich, M. R. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, 172(18), 1377-1385. <https://doi.org/10.1001/archinternmed.2012.3199>

Shanafelt, T. D., & Noseworthy, J. H. (2017). Executive leadership and physician well-being. *Mayo Clinic Proceedings*, 92(1), 129–146. <https://doi.org/10.1016/j.mayocp.2016.10.004>

Shanafelt, T. D., Dyrbye, L. N., Sinsky, C., Hasan, O., Satele, D., Sloan, J., & West, C. P. (2016). Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clinic Proceedings*, 91(7), 836–848. <https://doi.org/10.1016/j.mayocp.2016.05.007>

Shanafelt, T. D., Gorringer, G., Menaker, R., Storz, K. A., Reeves, D., Buskirk, S. J., & Swensen, S. J. (2015). Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clinic Proceedings*, 90, 432-440. <https://doi.org/10.1016/j.mayocp.2015.01.012>

Shanafelt, T. D., Mungo, M., Schmitgen, J., Storz, K. A., Reeves, D., Hayes, S. N., Sloan, J. A., Swensen, S. J., & Buskirk, S. J. (2016). Longitudinal study evaluating the association between physician burnout and changes in professional work effort. *Mayo Clinic Proceedings*, 91(4), 422–431. <https://doi.org/10.1016/j.mayocp.2016.02.001>

- Shanafelt, T. D., West, C. P., Sinsky, C., Trockel, M., Tutty, M., Wang, H., Carlasare, L. E., & Dyrbye, L. N. (2022). Changes in burnout and satisfaction with work-life integration in physicians and the general US working population between 2011 and 2020. *Mayo Clinic Proceedings*, 97(3), 491–506.
<https://doi.org/10.1016/j.mayocp.2021.11.021>
- Shen, M. R., Brown, R. L., Mazzei, A., Hernandez, M., Burgess, K. M., Ghaferi, A. A., & Dimick, J. B. (2022). How we do it: An innovative general surgery mentoring program. *Journal of Surgical Education*, 79(5), 1088–1092.
- Shorey, S., & Ng, E. D. (2022). Examining characteristics of descriptive phenomenological nursing studies: A scoping review. *Journal of Advanced Nursing*, 78(7), 1968–1979. <https://doi.org/10.1111/jan.15244>
- Siddiqui, S. (2019). Research paradigms: Their assumptions and relevance. *International Journal of Research in Social Sciences*, 9(5), 254-265.
<https://www.indianjournals.com/ijor.aspx?target=ijor:ijrss&volume=9&issue=5&article=017>
- Sinsky, C. A., & Dugdale, D. C. (2013). Medicare payment for Cognitive vs Procedural Care. *JAMA Internal Medicine*, 173(2), 103–104.
<https://doi.org/10.1001/jamainternmed.2013.9257>
- Sinsky, C. A., Dyrbye, L. N., West, C. P., Satele, D., Tutty, M., & Shanafelt, T. D. (2017). Professional satisfaction and the career plans of US physicians. *Mayo Clinic Proceedings*, 92(11), 1625–1635.
<https://doi.org/10.1016/j.mayocp.2017.08.017>

- Sinsky, C., Colligan, L., Li, L., Prgomet, M., Reynolds, S., Goeders, L., Westbrook, J., Tutty, M., & Blike, G. (2016). Allocation of physician time in ambulatory practice: A Time and motion study in 4 specialties. *Annals of Internal Medicine*, *165*(11), 753–760.
<https://doi.org/10.7326/m16-0961>
- Sinsky, C. A., & Ristow, A. M. (2023). Advocating for Physician Well-Being at the Societal Level. *Caring for Caregivers to Be: A Comprehensive Approach to Developing Well-Being Programs for the Health Care Learner*, 334.
- Smith, C. D., Balatbat, C., Corbridge, S., Dopp, A. L., Fried, J., Harter, R., & Sinsky, C. A. (2018). Implementing optimal team-based care to reduce clinician burnout. *NAM Perspectives*, *8*(9). <https://doi.org/10.31478/201809c>
- Smith, A., Ellison, J., Bogardus, J., & Gleeson, P. (2022). Factors contributing to burnout and well-being in physical therapist students. *Journal of Physical Therapy Education*, *36*(3), 217-224. <https://doi.org/10.1097/JTE.000000000000238>
- Smith, J. M. (2020). Surgeon coaching: Why and how. *Journal of Pediatric Orthopaedics*, *40*(1), 1-4. <https://doi.org/10.1097/bpo.0000000000001541>
- Song, Y., Ahn, E., Lee, S., & Chung, S. (2020). Can we coach resilience? An evaluation of professional resilience coaching as a well-being initiative for surgical interns. *Journal of Surgical Education*, *77*(6), 1481–1489.
<https://doi.org/10.1016/j.jsurg.2020.06.015>

- Song, Z., & Baicker, K. (2019). Effect of a workplace wellness program on Employee Health and Economic Outcomes. *JAMA*, *321*(15), 1491–1492.
<https://doi.org/10.1001/jama.2019.3307>
- Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: Interdisciplinary perspectives. *European Journal of Psychotraumatology*, *5*, 25338.
<https://doi.org/10.3402/ejpt.v5.25338>
- Spreitzer, G. M. (1995). Psychological empowerment in the workplace: Dimensions, measurement, and validation. *Academy of Management Journal*, *38*(5), 1442–1465. <https://doi.org/10.5465/256865>
- Stenfors, T., Kajamaa, A., & Bennett, D. (2020). How to assess the quality of qualitative research. *The Clinical Teacher*, *17*(6), 596-599. <https://doi.org/10.1111/tct.13242>
- Stilwell, P., & Harman, K. (2021). Phenomenological research needs to be renewed: Time to integrate activism as a flexible resource. *International Journal of Qualitative Methods*, *20*, 1609406921995299.
<https://doi.org/10.1177/1609406921995299>
- Straif, K., Baan, R., Grosse, Y., Secretan, B., El Ghissassi, F., Bouvard, V., Benbrahim-Tallaa, L., Guha, N., Freeman, C., Galichet, L., Cogliano, V., & WHO International Agency for Research on Cancer Monograph Working Group. (2007). Carcinogenicity of shift-work, painting, and fire-fighting. *Lancet Oncology*, *8*(12), 1065–1066. [https://doi.org/10.1016/S1470-2045\(07\)70373-X](https://doi.org/10.1016/S1470-2045(07)70373-X)

- Stratton, S. J. (2023). Population Sampling: Probability and Non-Probability Techniques. *Prehospital and Disaster Medicine, 38*(2), 147-148.
<https://doi.org/10.1017/S1049023X23000304>
- Swensen, S. J., & Shanafelt, T. D. (2020). *Mayo Clinic Strategies to reduce burnout: 12 actions to create the ideal workplace*. Oxford University Press.
- Swensen, S., Kabcenell, A., & Shanafelt, T. (2016). Physician-organization collaboration reduces physician burnout and promotes engagement: *The Mayo Clinic experience. Journal of Healthcare Management, 61*(2), 105–127.
<https://doi.org/10.1097/00115514-201603000-00008>
- Symon, R. (Director). (2018). *Do no harm* [Film]. Symon Productions.
- Tawfik, D. S., Profit, J., Morgenthaler, T. I., Satele, D. V., Sinsky, C. A., Dyrbye, L. N., Tutty, M. A., West, C. P., & Shanafelt, T. D. (2018). Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. *Mayo Clinic Proceedings, 93*(11), 1571–1580.
<https://doi.org/10.1016/j.mayocp.2018.05.014>
- Taylor, J. S. (2003). Confronting “culture” in medicine’s “Culture of no culture.” *Academic Medicine, 78*(6), 555–559. <https://doi.org/10.1097/00001888-200306000-00003>
- Theofanidis, D., & Fountouki, A. (2018). Limitations and delimitations in the research process. *Perioperative Nursing-Quarterly scientific, online official journal of GORNA, 7*(3 September-December 2018), 155-163.
<https://doi.org/10.5281/zenodo.2552022>

- Thorn, P. M., & Raj, J. M. (2012). A culture of coaching. *Academic Medicine*, 87(11), 1482–1483. <https://doi.org/10.1097/acm.0b013e31826ce3bc>
- Um, K. H., & Lau, A. K. W. (2018). Healthcare service failure: How dissatisfied patients respond to poor service quality. *International Journal of Operations & Production Management*, 38(5), 1245–1270. <https://doi.org/10.1108/ijopm-11-2016-0669>
- van Niekerk, M., Tileston, K., Bouchard, M., Atanda, A., Goldstein, R., Gantsoudes, G., ... & Christino, M. A. (2023). System-Level Interventions for Addressing Burnout and Improving Professional Wellness for Orthopaedic Surgeons: Quality, Safety and Value (QSVI). *Journal of the Pediatric Orthopaedic Society of North America*, 5(1). <https://doi.org/10.55275/JPOSNA-2023-620>
- Van Woerkom, M., Bakker, A. B., & Nishii, L. H. (2016). Accumulative job demands and support for strength use: Fine-tuning the job demands-resources model using conservation of resources theory. *Journal of Applied Psychology*, 101, 141-150. <https://doi.org/10.1037/apl0000033>
- Vanhove, A. J., Herian, M. N., Perez, A. L., Harms, P. D., & Lester, P. B. (2015). Can resilience be developed at work? A meta-analytic review of resilience-building program effectiveness. *Journal of Occupational and Organizational Psychology*, 89(2), 278–307. <https://doi.org/10.1111/joop.12123>
- Vercio, C., Loo, L. K., Green, M., Kim, D. I., & Beck Dallaghan, G. L. (2021). Shifting focus from burnout and wellness toward individual and organizational resilience.

Teaching and Learning in Medicine, 33(5), 568–576.

<https://doi.org/10.1080/10401334.2021.1879651>

Wadams, M., & Park, T. (2018). Qualitative research in correctional settings: Researcher bias, western ideological influences, and social justice. *Journal of Forensic Nursing*, 14(2), 72-79. <https://doi.org/10.1097/JFN.000000000000199>

Wallace, J. E., Lemaire, J. B., & Ghali, W. A. (2009). Physician wellness: A missing quality indicator. *The Lancet*, 374(9702), 1714–1721.

[https://doi.org/10.1016/s0140-6736\(09\)61424-0](https://doi.org/10.1016/s0140-6736(09)61424-0)

Weis, H. B., Bellini, L. M., Dang, V., Fant, A. L., Mallon, W. K., Ryan, M. S., Smith, C. C., & Wietecha, M. S. (2020). The fuel gauge: A simple tool for assessing general surgery resident well-being. *Journal of Surgical Education*, 77(1), 27–33.

<https://doi.org/10.1016/j.jsurg.2019.07.014>

Welp, A., Meier, L. L., & Manser, T. (2015). Emotional exhaustion and workload predict clinician-rated and objective patient safety. *Frontiers in Psychology*, 5.

<https://doi.org/10.3389/fpsyg.2014.01573>

West, C. P., Dyrbye, L. N., & Shanafelt, T. D. (2018). Physician burnout: Contributors, consequences and solutions. *Journal of Internal Medicine*, 283(6), 516–529.

<https://doi.org/10.1111/joim.12752>

West, C. P., Dyrbye, L. N., Erwin, P. J., & Shanafelt, T. D. (2016). 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](https://doi.org/10.1016/s0140-6736(16)31279-x)

- West, C. P., Dyrbye, L. N., Rabatin, J. T., Call, T. G., Davidson, J. H., Multari, A., Romanski, S. A., Hellyer, J. M., Sloan, J. A., & Shanafelt, T. D. (2014). Intervention to promote physician well-being, job satisfaction, and professionalism. *JAMA Internal Medicine, 174*(4), 527. <https://doi.org/10.1001/jamainternmed.2013.14387>
- West, C. P., Dyrbye, L. N., Sinsky, C., Trockel, M., Tutty, M., Nedelec, L., Carlasare, L. E., & Shanafelt, T. D. (2020). Resilience and burnout among physicians and the general US working population. *JAMA Network Open, 3*(7). <https://doi.org/10.1001/jamanetworkopen.2020.9385>
- Williams, E. S., Konrad, T. R., Linzer, M., McMurray, J., Pathman, D. E., Gerrity, M., Schwartz, M. D., Scheckler, W. E., Van Kirk, J., Rhodes, E., & Douglas, J. (1999). Refining the measurement of physician job satisfaction. *Medical Care, 37*(11), 1140–1154. <https://doi.org/10.1097/00005650-199911000-00006>
- Wolgemuth, J. R., Hicks, T., & Agosto, V. (2017). Unpacking assumptions in research synthesis: A critical construct synthesis approach. *Educational Researcher, 46*(3), 131-139. <https://doi.org/10.3102/0013189X17703946>
- World Health Organization. (2019). *Burn-out an "Occupational phenomenon": International Classification of Diseases*. World Health Organization. Retrieved March 27, 2023, from <https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases>
- Xia, H. (2023). What scholars and IRBs talk about when they talk about the Belmont principles in crowd work-based research. *Journal of the Association for*

Information Science and Technology, 74(1), 67-80.

<https://doi.org/10.1002/asi.24724>

Yaghmour, N. A., et al. (2017). Causes of death of residents in ACGME-accredited programs 2000 through 2014: Implications for the learning environment.

Academic Medicine, 92(7), 976–983.

<https://doi.org/10.1097/ACM.0000000000001568>

Yates, S. W. (2020). Physician stress and burnout. *The American Journal of Medicine*,

133(2), 160-164. <https://doi.org/10.1016/j.amjmed.2019.08.034>

Yin, R. K. (2014). *Applications of case study research*. Sage.

Zindel, M., Cappelucci, K., Knight, H. C., Busis, N., & Alexander, C. (2019). Clinician well-being at Virginia Mason Kirkland Medical Center: A case study. *NAM*

Perspectives. <https://doi.org/10.31478/201908c>

Zuckerman, S., Merrell, K., Berenson, R. A., Lallemand, N. C., & Sunshine, J. (2015, January 5). Realign physician payment incentives in Medicare to achieve payment equity among specialties, expand the supply of primary care physicians, and improve the value of care for beneficiaries. Urban Institute. Retrieved January 7, 2023, from <https://www.urban.org/research/publication/realign-physician-payment-incentives-medicare-achieve-payment-equity-among-specialties-expand-supply-primary-care-physicians-and-improve-value-care-beneficiaries>

Zwack, J., & Schweitzer, J. (2013). If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. *Academic Medicine*,

88(3), 382–389. <https://doi.org/10.1097/ACM.0b013e318281696b>

Appendix A: Interview Form

Interview Questions

Start Time: _____

Reminder of Possible Probing/Clarifying Questions:

1. *What do you mean by that?*
2. *Will you elaborate on that?*
3. *Would you give additional details so I better understand what you were describing?*

Introductory/Ice Breaker Questions:

1. Research guidelines:

Must be someone who has done some sort of work to help alleviate or prevent physician burnout (YOU did this _____) Are you a creator of a response to physician burnout?

Number of years in experience in this: _____

We are focused on general physician burnout, excluding the rise we saw during Covid pandemic. Physician burnout was an issue for decades before that. In fact, a few years before the Covid pandemic, we saw reports from federal labor bureau agencies citing physicians in the number two spot for suicide. It was already a problem, so that is the focus, not the Covid stressors.

Main Questions:

Understanding the Experience of Decision-Making

1. Will you please describe your personal experience that led you to recognize the need for strategies to address physician burnout?
2. How did you become involved in the decision-making process for developing these protocols?
3. What were your initial thoughts and feelings when confronted with the challenge of physician burnout and even suicide?
4. Conventionally, RESILIENCE training was considered the antidote. Some doctors dislike that word since that implies that the problem is with THEM not being resilient enough, when in fact the workplace environment is most often to blame. There seems to be a common belief that asking abuse victims to become more resilient so they can handle the mistreatment is not logical. As far as these resilience programs of the past are concerned, (as noted in the suicide statistics earlier) stats don't show a change in burnout. That may feel discouraging. What are your thoughts on this?

Insight into the Decision-Making Process

1. What factors did you consider most critical when deciding on the appropriate response to the burnout?
2. How did administration or corporate tie into this?
3. How did organizational culture influence the development and implementation of these new protocols?
4. My dissertation originally focused on eudamonic happiness versus eudamonic happiness. Aristotle introduced to the concept of eudamonic happiness. While hedonic

pleasure is for instance: buying a new Ferrari or eating pizza. And eudamonic could be something like volunteering, things that bring happiness that is more meaningful. At SLU Med School, they tried to implement this into the curriculum to help with med student well-being. Do you have any thoughts about this as it applies to strategies to combat physician burnout.

Personal and Organizational Challenges

1. What were the biggest personal challenges you faced when creating new protocols, and how did you address them?

Perceptions of Effectiveness

1. How did you determine whether the new strategies/ interventions were effective in addressing physician burnout?
 2. What kind of feedback did you receive from the physicians and other staff regarding the new strategies/ interventions?
 3. Can you share any success stories or improvements that have come about as a result of this particular strategy/ intervention?
- 3b) Need to measure outcomes so we know which interventions are working and which are not. Need to measure if rates of burnout and stress are going up or down. Compare to other departments. SHOW the need for change
4. What recommendations do you have for further research on this topic?

Conclusion/Parting Questions:

1. Do you have anything else to share that we have not yet discussed?
2. What are your last words and thoughts about this topic?

The interview ended at _____ (Insert time)

Appendix B: Demographics (De-Identified Summary)

This appendix provides an aggregated demographic overview of the 17 participants. To preserve confidentiality, no identifying details are included. Role categories and professional sectors are summarized to demonstrate the breadth of perspectives represented.

Table B1

Aggregated Participant Demographics

Role Category	Illustrative Responsibilities	Primary Sector	Representation
Physician clinical/organizational leader	Service leadership, OR/clinic operations, professionalism oversight, mentoring	Academic, Community	Represented
Chief Wellness Officer/Well-being Executives	C-suite advocacy, resourcing, measurement, culture/efficiency initiatives	Academic, System	Represented
Physician coaches/peer coaching researchers	1:1 and group coaching, program design, leadership curricula, evaluation	Academic, Private	Represented

Non-physician coaches/leadership consultants	Leadership development, boundary and values work, organizational advising	Private, Association	Represented
Practice efficiency/national association leaders	EHR/workflow redesign, team-based care models, national guidance and tools	Association	Represented
Healthcare attorney/governance advisor	Medical staff governance, licensure/malpractice policy, professionalism frameworks	Legal/Healthcare	Represented
Operations/strategy executives	Access, staffing, technology adoption, incentive alignment	System	Represented

Note. Aggregated to preserve confidentiality; no personally identifying information is reported.

Appendix C: Theme Tracker (Evidence Map)

This appendix provides the analytic audit trail linking participant data to meaning units, sub-themes, and themes. Participants are coded P01–P17. Role categories are included for context only; no identifying details are disclosed.

Table C1

Exemplar Evidence Map

Participant Code	Role Category	Example Statement (De-Identified)	Meaning Unit	Sub-Theme Assigned	Theme Assigned
P 01	Physician Leader	“Volume metrics push me to shorten visits.”	Incentives drive pace	Incentives and payment	Theme 1: System-Level factors
P 03	Chief Wellness Officer	“Without budget or staff, my CWO role is symbolic.”	Lack of Resourcing undermines wellness	Governance and Resourcing	Theme 5: Organizational Context and Leadership
P 06	Non-Physician Consultant	“Residents avoid counseling for fear of	Policy stigma limits use	Policy and Protection	Theme 7: Reflections & Recommendations

		licensure disclosure.”				
P 09	Operations Executive	“Dashboards with burnout data published quarterly built trust.”	Visible measurement builds trust	Measurement and Feedback Loops	Theme 6: Implementation Pathways	
P 12	Physician Coach/researcher	“Teams that share inbox coverage sustain performance better.”	Team collaboration protects wellness	Positive Deviants and Learning	Theme 7: Reflections and Recommendations	

Table C2

Participant Indexed by Theme (Matric View)

Participant	Role Category	T1	T2	T3	T4	T5	T6	Notes
P01	Physician leader	✓	✓	✓	✓	✓	✓	
P02	Physician leader	✓	✓	✓	✓	✓	✓	
P03	Chief Wellness Officer	✓	✓	✓	✓	✓	✓	
P04	Physician coach	✓	✓	✓	✓	✓	✓	

P05	Physician coach	✓	✓	✓	✓	✓	✓
P06	Non-physician coach/consultant	✓	✓	✓	✓	✓	✓
P07	Assoc./efficiency leader	✓	✓	✓	✓	✓	✓
P08	Healthcare attorney	✓	✓	✓	✓	✓	✓
P09	Operations/strategy executive	✓	✓	✓	✓	✓	✓
P10	Physician leader	✓	✓	✓	✓	✓	✓
P11	Physician leader	✓	✓	✓	✓	✓	✓
P12	Physician coach/researcher	✓	✓	✓	✓	✓	✓
P13	Physician leader	✓	✓	✓	✓	✓	✓
P14	Consultant/leadership	✓	✓	✓	✓	✓	✓
P15	Chief Wellness Officer	✓	✓	✓	✓	✓	✓
P16	Physician leader	✓	✓	✓	✓	✓	✓
P17	Physician leader	✓	✓	✓	✓	✓	✓

Note. Checkmarks indicate that participant data contributed to the theme.