DISSERTATION APPROVED BY

June 7, 2021

Date

Carly Speranza, Ed.D., Chair

Tom Lenz, Pharm.D., Committee Member

Jennifer Moss Breen Kuzelka

Jennifer Moss Breen Kuzelka, Ph.D., Director

Gail M. Jensen, Ph.D., Dean

EXPLORING THE LIVED EXPERIENCES OF HEALTHCARE EXECUTIVES IN THE CONTEXT OF BURNOUT: A PHENOMENOLOGICAL STUDY

By
ANTHONY A. HOUSTON, JR.

A DISSERTATION IN PRACTICE

Submitted to the faculty of the Graduate School of Creighton University in Partial Fulfillment of the Requirements for the degree of Doctor of Education in Interdisciplinary Leadership

---

Omaha, NE
June 19, 2021

Abstract

Executives of healthcare organizations are leading during a burnout epidemic within the industry. Leadership, especially executive leadership, is intrinsically stressful; how healthcare executives experience their own burnout journey informs their leadership in the context of the broader phenomenon of burnout. Leadership is more often measured by the quality of the response than the gravity of the challenge. Without proper understanding of necessary causes of – and coping strategies for – occupational stress and burnout, executive leaders may struggle to muster a quality response for themselves and for their organizations. This qualitative phenomenology study explored the lived experiences of nine healthcare executives in the context of job burnout who, during the study period, lead one or more ministries within CommonSpirit Health. Primary data collection derived from interviews and findings emerged using an inductive thematic coding process supported by member checking. Two key findings emerged. First, the study participants did not describe themselves as experiencing burnout during the study period. Second, although not burned-out, the study participants did share detail on the structural elements of their jobs that create stressors and frustrations. Supporting themes include resilience, self-awareness and the need for a supportive structure, and structural violence. Perhaps the participants were not burned-out because they possess a more positive disposition, are happy, and are resilient given their lived experiences. A practical recommendation based on the study findings is provided along with suggestions for future research.

Keywords: burnout, healthcare, executives, happiness, resilience, self-care, structural violence

Dedication

To Rebecca for your consistent support and love. All along this journey, you have been my rock of support and catalyst for action when the stressors and frustrations moved in. You are my best friend, constant companion, and true love.

To Avery for your inspiration and support as I pursued this dream. Thank you for keeping me grounded and for inspiring me with your strength, happiness, and resiliency.

To Madison for your camaraderie as we journeyed together in pursuit of our dreams of being educators who are grounded in the Jesuit charism of women and men for and with others. Thank you for keeping me focused on the greater good!

To my parents, Joan and Anthony Houston for your unwavering love and support. You have instilled in me the fire to always strive for the *Magis* and to remain grounded while reaching for the stars!

To Christina, my sister who has been my biggest fan from the very beginning. Thank you for your love and for your belief in me.

Although the sound of "Dr. Houston" is nice, my favorite titles are those of husband, dad, son, and brother.

We are…Houston Strong!

Acknowledgements

I extend my most sincere gratitude to my dissertation chairperson, Dr. Carly Speranza. From being a student in your classes to this dissertation journey, you have been a great source of information, insight, and inspiration. Your positive encouragement and honest feedback kept me focused on the goal and proved to be just what I needed to reach my full potential throughout this process. You inspire me to give back as a dissertation chair or committee member in the future.

I am so grateful for Dr. Thomas Lenz who served as a committee member for my dissertation. From the moment we first connected, you have been a consummate supporter of this work and this topic of inquiry. I have learned so much regarding burnout, structural violence, and happiness science because of your insights and support. It has been such a joy to learn and work with you. I look forward to having the opportunity to collaborate with you on this very important topic in the future.

I am grateful for Dr. Candice Bloomquist who is my academic advisor. You set the bar high yet make it all seem achievable through your encouragement and example setting. Your thinking, writing, and living inspire me to keep on learning and growing.

It was Dr. Jennifer Moss Breen Kuzelka who helped me “whiteboard” my dissertation topic early during this journey. Thank you for your facilitation of our dissertation support group. Thanks as well for providing the right dose of realism and optimism to keep me on pace.

To my fellow members of Cohort 41: Dania, Karalee, Kenya, and Nicole. We made a shared commitment to support each other on this journey. To the crew from our dissertation support group: Teresa, Ophelia, Kevin, Dave, Pamela, Cara, Abby, Angela,

Anne, and Alissa. Thank you for all your feedback and encouragement along the way. I cannot wait to start the next chapters with all of my “doctor” friends.

To the faculty and support team of the Creighton Interdisciplinary Leadership program. Thank you for believing in me and for your support in helping me realize this dream. I look forward to staying connected as an alumnus and a forever fan of the Creighton ILD. Go Bluejays!

To Chad Aduddell, Janelle Reilly, and Larry Schumacher – my great bosses who helped me to balance the pursuit of this degree while serving as a senior healthcare leader at CommonSpirit Health. You inspire me to be a transformational leader focused on reveling the healing presence of God in our world.

Finally, I am grateful to the nine senior healthcare leaders who participated in this study. Thank you for your willingness to support this important work by sharing your experiences. Your positivity, optimism, realism, and focus on the greater good is an inspiration to me and I hope to others as we tackle the root causes of burnout in healthcare.

“If you never try then you’ll never know” – Coldplay, *Speed of Sound*

Table of Contents

List of Tables

Page

List of Figures

Page

CHAPTER ONE: INTRODUCTION

Healthcare workers are increasingly suffering from burnout (Wohlever, 2020) as half of physicians (Shanafelt & Noseworthy, 2017) and over a third of hospital nurses (Bodenheimer & Sinsky, 2014) state they are experiencing or have experienced burnout. Additionally, the World Health Organization has declared stress as a 21st century global epidemic (Kermott et al., 2019). The phenomenon of burnout is a relevant concern within the healthcare industry and this study explored how the lived experiences of healthcare executives regarding their personal burnout journey influences their leadership practice in the context of burnout within the healthcare industry.

Chief Executive Officers (CEOs) or Presidents of healthcare organizations are tasked with establishing a clear vision and pathway for success to include: endearing high engagement of employees, physicians, and patient customers; promoting a safe environment; attaining top-performing quality outcomes; and maintaining a strong and growing financial position. Effective healthcare leaders are expected to deliver on these outcomes while exhibiting high levels of integrity, innovation, and optimism (Wicks & Buck, 2013). Additionally, with the pressures of changing regulations, political shifts and swings, reimbursement pressures, the battle for talent, and intense competition (Shanafelt & Noseworthy, 2017) – executive leaders of health organizations are increasingly susceptible to burnout as a result of increased workplace stress (Wicks & Buck, 2013).

Much of the foundational burnout research focused on those who work in human services professions (Maslach & Jackson, 1981). As burnout research has progressed, it has been demonstrated that burnout occurs in many professions to include those not directly involved in providing human services (Demerouti et al., 2001). Additionally, a

heightened focus on burnout in healthcare has emerged (Shanafelt et al., 2012) to include a focus on burnout amongst health care workers closest to the patient such as physicians, nurses, and therapists. Leaders of healthcare organizations are increasingly challenged to do more in terms of helping to mitigate burnout within the caregiver workforce (Shanafelt & Noseworthy, 2017; Wohlever, 2020). Furthermore, executive leaders are being encouraged to practice self-care themselves (Johnson & Humble, 2020) in order to promote burnout awareness and mitigation strategies in their organizations (Reith, 2018).

Demonstrating leadership through action is a critical element of successful leadership (Lee & Cummings, 2008; Lowney, 2003). When a CEO promotes a personal and organizational commitment to self-care, burnout is mitigated (Voci et al., 2016). Exploring how healthcare executives' lived experiences influence their understanding of burnout to include how their personal experiences informed their leadership approach regarding burnout within the healthcare workforce was a key driver of my interest in conducting this study.

Statement of the Problem

Healthcare executives are being called to lead an effective response to address the epidemic of burnout within the healthcare industry (Shanafelt & Noseworthy, 2017; Walsh et al., 2019; West et al., 2016; Wohlever, 2020). Well chronicled within the human sciences literature, burnout is defined as a psychological response to chronic work stress and consists of emotional exhaustion (exhaustion), feelings of cynicism or detachment from one's job (depersonalization), and reduced perceptions of personal accomplishment (inefficacy) (Maslach & Jackson, 1981; Maslach & Leiter, 2017). Burnout in healthcare is reaching epidemic levels (Kermott et al., 2019; Shanafelt & Noseworthy, 2017; West et

al., 2016) and research has shown increased patient mortality in organizations that have higher rates of caregiver burnout (Welp et al., 2015). Although much of the research regarding burnout in the healthcare industry is rightly focused on caregivers, via this study, I proposed that room exists to illuminate how healthcare executives themselves experience burnout as they are ever more susceptible to burnout given the pressures of leading healthcare organizations (Wicks & Buck, 2013).

When a CEO experiences burnout, the firm's performance is negatively impacted (Siren et al., 2018). Unmitigated, burnout can lead to decreased personal engagement (Schaufeli & Bakker, 2004) resulting in poor job performance for the individual and for their organization (Siren et al., 2018). Therefore, gaining a better understanding of how healthcare executives experience burnout should prove beneficial for the study subjects and for stakeholders of their institutions.

Purpose of the Study

I believe space exists to add to the knowledge on burnout relative to executive healthcare leaders. Specifically, this study focused on exploring how the personal lived experiences of healthcare executives informs their leadership thinking and approach. Therefore, the purpose of this phenomenological study was to explore the lived experiences of healthcare executives in the context of job burnout. The study participants were drawn from those who hold the title of CEO and/or President at one of the hospitals or multispecialty physician clinics within CommonSpirit Health.

Research Question

Leadership can be inherently stressful (Benson, 1974) and placing emphasis on first caring for self seems straightforward and logical. However, a paradox might emerge

when a leader is expected (either self-imposed or from others) to be selfless and servant-like – leading to the question of which to put first, self or others? Successfully addressing this potential paradox might necessitate a mindful and/or spiritual focus (Boyatzis et al., 2002; McKee et al., 2006). Exploring how healthcare leaders experience burnout and how their journey informs their leadership practice was the main driver and impetus for this study. The following research question guided this qualitative study:

Research question: How do senior executives of healthcare organizations experience and respond to burnout?

Aim of the Study

The aim of this study was to provide evidence-based leadership best practices in the context of job burnout oriented towards leaders of healthcare organizations. The study ideally spurs further exploration and research regarding how healthcare executives personally deal with burnout and how that influences their leadership on the topic. Furthermore, this study aimed to reveal insights for leaders beyond CommonSpirit Health who are dealing with burnout personally or who are leading their organization's response to burnout amongst their workforces.

Definition of Relevant Terms

Rooted within the purpose, problem, and aim statements as well in the research question are terms and concepts that are relevant to the operational focus of my research. Some terms might have varying formal or colloquial meanings. Thus, this section will detail the following contextual definitions relevant to this particular study:

Burnout: Seminal research on burnout was conducted by Christina Maslach nearly forty years ago with a well-established definition. Burnout is a multidimensional,

prolonged psychological syndrome arising from a response to chronic pressure and interpersonal job stressors (Demerouti et al., 2001; Maslach et al., 2001; Maslach & Leiter, 2017). Within this study, burnout will be defined as:

> A psychological syndrome that involves a prolonged response to chronic interpersonal stressors on the job. The three key dimensions of this response are overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment [or inefficacy] (Maslach & Leiter, 2017, p. 160)

CommonSpirit Health: Formed in 2019 as a result of the merger between Catholic Health Initiatives and Dignity Health, CommonSpirit Health (CommonSpirit) is a $30 billion healthcare delivery company with locations in 21 states. CommonSpirit is a Catholic healthcare ministry focused on serving the common good through building healthier communities, advocating for those who are poor and vulnerable, and innovating how and where healing can happen (CommonSpirit Health, n.d.). CommonSpirit consists of hospitals, surgery centers, imaging centers, medical clinics, home health agencies, long-term care communities, and other health related charities. All of the participants served as CEOs and/or Presidents leading CommonSpirit Health ministries during the study period.

COVID-19 Pandemic: The onset of the novel coronavirus (COVID-19) pandemic in late 2019 in Asia spread across the world in 2020 and influenced all aspects of life. Healthcare organizations had to dramatically modify their operations. Caregivers were on the frontlines of the pandemic as were healthcare executives in leading their organizations and communities in responding to the pandemic (Owens, 2020).

Exhaustion: Often the first sign of burnout, emotional exhaustion is the most cited symptom when people describe themselves as suffering from burnout and is the most widely studied burnout component (Maslach & Leiter, 2017; Maslach et al., 2001). For the purposes of this study, I will focus on the word *exhaustion* alone, as it encompasses both physical and emotional dimensions in response to job stress. In summary, exhaustion is the feeling of being completely depleted and unable to muster the necessary energy to be productive (Maslach & Leiter, 2017).

Leadership: Within this study, I use the framework for leadership as a relationship more than a focus on any one individual (Popper, 2004) to include three elements: the leader, the follower and the context of their relationship (Kellerman, 2016). Leaders and followers freely engage in a relationship based on trust (Burns, 1978) with the intention of realizing the full potential of the other for the pursuit of the common good (Bass, 1990; Lowney, 2003). Context includes those historical, cultural, institutional, and psychological issues that both leader and followers find themselves situated (Popper, 2011).

Moral Injury: Borrowing from the study of warriors, this is a betrayal of what's right by someone who holds legitimate authority (a leader) causing the follower to suffer a deterioration of their character, their hopes and ambitions, and their ideals (Shay, 2014). In healthcare, this occurs when caregivers are unable to fully utilize their knowledge and skills to affect healing in large part because the healthcare system limits this ability more than any individual leader (Talbot & Dean, 2018).

Self-awareness: According to Duval and Wicklund (1973), self-awareness is the reflexive awareness of one's own consciousness. Moreover, self-awareness is one's

conscious understanding of self-existence on an organismic level as a unique object in the world compared to some standard of correctness (Silvia & Duval, 2001). Evolving thinking regarding self-awareness posits that the standard of correctness is malleable and subject to change (Silvia & Duval, 2001).

Self-care: Variable definitions of self-care occur within the literature. Activities focused on an individual's health and well-being in the context of job stress (Bressi & Vaden, 2017) is the foundational definition used in this study. Especially, those activities or programs focused on physical, psychological (mental), emotional, and spiritual well-being (Saakvitne et al., 1996).

Self-reflection: Within this study, self-reflection includes those practices that lead to greater self-awareness, consciousness, and personal growth. These might manifest in the form of meditation or mindfulness practices, spiritual practices, journaling, professional counseling/coaching, etc.

Senior executive healthcare leader: I use the term senior executive healthcare leader synonymously to describe those who hold the position of Chief Executive Officer (CEO) and/or President within CommonSpirit Health and more generally those similarly positioned within the healthcare industry. The participants might be leading a hospital or physician groups (more often titled President) or a market that has multiple hospitals and physician groups (more often titled CEO).

Structural Violence: A two part concept: *structural* elements are those social constructs such as economic, political, legal, or religious frameworks that are embedded in society and in the workplace; *violence* stems from the impairment of a basic human need or causes an injury of some sort (Farmer et al., 2006; Galtung, 1969). Structural

arrangements that put people in harm's way or blunt them from reaching their full potential (Farmer et al., 2006).

Methodology

Utilizing a phenomenological inductive approach provided an opportunity to elucidate rich personal stories of the individuals studied. This qualitative framework supported my desire to explore and describe themes based on the lived experiences of healthcare executives in the context of job burnout. Information contained within the raw interview transcripts were reviewed and iteratively coded; an approach that revealed a rich and deep understanding of the essence of the phenomenon (Creswell & Creswell, 2018; Creswell & Poth, 2018).

Employing a non-probability purposive sampling technique, I used my own sound judgement (Black, 2010) to arrive at a relevant sample size of nine participants, which is sufficient for a phenomenological study (Creswell & Creswell, 2018). The study participants were selected from the total population of more than 100 CEOs and/or Presidents serving in CommonSpirit Health. Tenure in the role (at least five years) was a qualifying characteristic to ensure there was sufficient experiential breadth from which the respondents might recall their lived experiences. Additionally, I focused on ensuring women were represented within the study sample. No members of an ethnic minority were included in this study.

Limitations, Delimitations, and Personal Biases

Limitations are derived principally by the methodology and are often beyond the control of the researcher (Roberts & Hyatt, 2019). Delimitations clarify the boundaries of the study and what is and is not included (Roberts & Hyatt, 2019). As I am a healthcare

executive who has experience with this phenomenon, I focused particular attention to my own personal biases throughout this study to ensure I properly bracketed such experiences so not to bias the study.

Limitations

There were limitations within this study that may impact the ability to generalize any of the findings (Roberts & Hyatt, 2019). The first limitation was the purposeful sampling strategy that focused on persons holding the title of CEO or President for a market, hospital, or a medical group within a singular organization – CommonSpirit Health. Within this group, I included women and men. Additionally, the data were self-reported reflections based on interview prompts, with no guarantee the respondents were truthful or completely disclosed their experiences. An additional limitation was the timing of the study (February-March 2021). Certain unique factors might have been present during this time that may have influenced the responses. Finally, I only conducted one interview with each participant in order to understand their experiences prior to and/or during the study period. I did not conduct subsequent interviews in an effort to explore longitudinal changes within this study group. Perhaps that might be something to explore in a future study. Combined, these limitations led to novel findings bound by this purposefully sampled population during a specific time period making it less likely these findings can be broadly generalized.

Delimitations

The scope of the study was delimited by the participants, the study site, and the phenomenon of focus. At the time of this study, the healthcare executives held the most senior or second most senior position within their organizations. As such, their responses

were likely not reflective of all healthcare leaders. Additionally, all participants worked for the same, Catholic health system and therefore these findings were not representative of all executives working in Catholic healthcare or secular healthcare for that matter. An additional delimitation stems from my focus on studying the lived experiences of healthcare CEOs within the context of job burnout. Participants were included within the study sample regardless of whether they were experiencing burnout during the study period or if they had ever experienced burnout.

Personal Biases

Similar to the study participants, during the study period, I served as a President of three CommonSpirit Health hospitals. As such, I shared similar job stressors that influenced my own standing and journey on the job burnout spectrum. Moreover, I had my own personal self-care practices in the context of job stress and burnout – that may or may not be similar to those of the study participants. In order to mitigate these issues, I bracketed my experiences (Creswell & Poth, 2018) and remained reflexive and self-aware of my biases by journaling my thoughts and reactions throughout each stage of the study process (Creswell & Creswell, 2018). Collectively, these steps intended to provide appropriate mitigation of researcher bias.

Reflections of the Scholar-Practitioner

Leaders have the power to improve the lives of followers (Johnson, 2018). Effective leaders are not required to be completely like every individual as long as they promote a common, shared identity (Haslam et al., 2011). Healthcare executives may face and deal with burnout in different ways than those on the front lines. Leaders are most effective when contemplating how their own personal experience converges with

that of those closest to the work (Olson & Simerson, 2015). Thus, exploring how healthcare executives take measure of their personal journey in the context of job burnout provided useful insights and best practice suggestions regarding effective leadership practices in relation to the epidemic of burnout in healthcare.

I identify with many of the leadership attributes of St. Ignatius of Loyola, the founder of the Society of Jesus (the Jesuits); specifically the notion of being a contemplative in action (O'Malley, 1993). St. Ignatius did not want his company cloistered in monasteries; he encouraged them to be active in the world in order to fully embrace the wonders of God's presence and activity in all things (Burke & Burke-Sullivan, 2009; Manney, 2017; Martin, 2010). Moreover, St. Ignatius led with love and focused on building nurturing relationships (Popper, 2004) that evolve the latent potential for leaders and followers (Lowney, 2003). Lowney (2003) suggests that elemental to the Ignatian way of leading with love, which ultimately emerges as heroic leadership is to make the mission or the core "why" of one's work personal; to create a culture that is loving and supportive; and to provide everyone a chance to make a meaningful contribution to the work at hand.

Contemplative leadership begins with a focus on promoting the common good and is grounded in relational practices that emphasizes caring for and promoting the well-being of others (Grandy & Silwa, 2017). Caring for others starts by caring for oneself as Ignatius promoted self-care amongst his followers and emphasized the need for proper nourishment, rest, recreation, relaxation, and the practice of self-reflection (Ganns, 1991; Geger, 2014). Given the current context of a burnout epidemic in healthcare, leaders will do well to practice elements of contemplative leadership focused on the well-being of self

and others. As a healthcare executive leader myself, I learned from the experiences of these study participants in the context of burnout and how the journey informed and influenced their leadership regarding burnout.

Mitigating burnout has amplifying effects beyond the individual to include their family and their organizations (Zhao et al., 2014). Even if healthcare leaders experience burnout differently than clinical healthcare workers, committing to a plan of action is a critical element of successful leadership (Lee & Cummings, 2008). That said, leaders who demonstrate a committed way of living are more effective than when merely taking action (Haslam et al., 2011; Lowney, 2003). Additionally, effective leaders become in-group prototypes and champions (Haslam et al., 2011). This study included discovery of the experiences of healthcare executives and how they promoted a personal commitment to self-care, which has been shown to mitigate burnout (Voci et al., 2016).

As the burnout epidemic intensifies within the healthcare industry (Kermott et al., 2019; Shanafelt & Noseworthy, 2017; West et al., 2016), health executives are advised to take up the mantle and lead the charge to increase awareness and drive solutions for change (Shanafelt & Noseworthy, 2017). Healthcare executives would do well to follow suit and likewise make well-being in the context of burnout a top priority for their organizations and themselves.

Demonstrating leadership more through actions than words is a noted leadership best practice (Lowney, 2003) and should be a hallmark for successfully leading in the context of healthcare job burnout. Thus, this study aimed to explore how the study group of healthcare executives faced the challenge of leading in the context of burnout.

Insomuch in their acting as a leader as in their own way of living and responding to how burnout informed their personal leadership journey.

As much of the extant healthcare burnout literature focuses on frontline healthcare workers, this study adds to the knowledge by focusing on the study participants' experiences with burnout and how they have personally responded and how each has informed their leadership practice. In describing the rich essence of the experiences of the study group, the emergent study themes may resonate with other healthcare executives and their stakeholders. Additionally, these study findings and the examples shared by these executives might provide helpful examples for others experiencing burnout or leading an organizational response to burnout.

Although this study focused on the lived experiences of healthcare executives, factors exist beyond the individual that impact burnout. Successfully addressing the burnout epidemic requires healthcare executives to acknowledge and assess the underlying causal factors of burnout (Shanafelt & Noseworthy, 2017). Additionally, being self-aware of one's own journey and having the commitment to address the endemic issues should prove attractive and inspiring to others (Olson & Simerson, 2015; Shanafelt & Noseworthy, 2017). Thus, a self-aware leader who understands their personal connection to burnout is likely better positioned to form and successfully lead others in addressing the systemic issues causing the epidemic of burnout in healthcare.

Summary

Burnout within the healthcare workforce is reaching epidemic levels and requires decisive action by healthcare executives (Kermott et al., 2019; Shanafelt et al., 2020; Shanafelt & Noseworthy, 2017; Wohlever, 2020). If leaders are experiencing burnout, the

organization will also be negatively affected (Siren et al., 2018). Caring for yourself is vital if you are to successfully lead others (Hartney, 2018; Lowney, 2003). The purpose of this study was to offer new knowledge by detailing the essence of the lived experiences of healthcare executives in the context of job burnout.

Specific emphasis was given to explore the self-reflective practices of the healthcare executives. As my research progressed, the world was stricken by the global COVID-19 pandemic. Thus, the context of COVID-19 provided additional background that influenced the lived experiences of the study participants. This context was an important factor; however COVID-19 was not the focus of this research study. The results of this phenomenological study will hopefully offer insight spurring self-reflection and action for healthcare executives in addressing burnout for themselves and their organizations. Finally, this study ideally spurs insights leading to further exploration of this topic via additional research work.

CHAPTER TWO: LITERATURE REVIEW

This section provides a review of the relevant research germane to this study which explored the lived experiences of healthcare executives in the context of job burnout. The purpose of this literature review is to present an overview of the concepts, theories, and relevant research related to burnout, burnout in healthcare, and executive lived experiences in relation to burnout. I will first summarize occupational stress, burnout, and the history of burnout research; second, I will compile a review of burnout within the healthcare industry; and finally, I will offer insight into ways executives might experience burnout and how these experiences inform and influence their leadership.

Occupational Stress

Stress in the work setting is a response to feelings of not being able to cope with work demands or when one feels their well-being is threatened in the context of their workplace (Lazarus & Folkman, 1984). Occupational stress manifests often in two forms: job stress and interpersonal stress (Fiedler, 1992). Job stress derives from the complexity or difficulty of a task alone and is often magnified by contextual operating conditions (e.g. time pressures, working conditions) (Harms et al., 2017). Interpersonal stress comes from unattainable demands made by others or interpersonal conflict with others (Harms et al., 2017). Furthermore, when valued relationships are threatened, stress levels rise (Harms et al., 2017). No matter the stress driver nor form, when people perceive a potential threat to be unpredictable or uncontrollable, they will likely manifest a stress response (Harms et al., 2017). Taken collectively, considerable effort is put forth to reduce stressors or develop coping mechanisms to mitigate stress (Bakker et al., 2007).

Stress can lead to debilitating health problems and has been identified as a major occupational health issue (Quick & Henderson, 2016). Three main categories of stress emerge across the following dimensions: physiological (physical health), psychological (mental health), and behavioral (social health) (Quick & Henderson, 2016; Wiens, 2016). Stress can lead to deleterious effects on one's physical health to include heart disease, cancer, gastrointestinal issues, and musculoskeletal ailments (Freudenberger, 1975; Quick & Henderson, 2016). Psychological issues such as anxiety, depression, and suicidal ideation arise in those who suffer from prolonged stress (Quick & Henderson, 2016; Wiens, 2016). Behavioral or social health issues resultant from prolonged stress include absenteeism, aggression and violence, substance abuse, and workplace accidents (Quick & Henderson, 2016; Wiens, 2016). As stress prolongs without mitigation or when individuals cannot muster the necessary resources to perform their duties, burnout can emerge (Maslach & Jackson, 1981).

Leaders not only establish the vision for action (Bass, 1990), they carry a large part of the responsibility for exerting their influence (Haslam et al., 2011) and setting the direction for others. Quick et al. (2004) suggest that this "exertion of pressure" (p. 363), although often for the common good, is associated with stress; both for the leader and their followers. Harms et al. (2017) contend that leaders play an "outsized role in the lives [and well-being] of their subordinates" (p. 180) and are often the key driver of stress for their followers.

Stress however is not always negative. Stress can produce positive outcomes and moderate levels of stress can prove beneficial (Quick et al., 2004). This is known as good stress or *eustress* and usually results in beneficial outcomes (Quick & Henderson, 2016).

Eustress can help individuals grow, gain competence, and enhance their performance (Lepine et al., 2005; Quick et al., 2004). Moreover, eustress may be a critical component for improved performance over time (Hargrove et al., 2015). Without the proper practice of self-care to mitigate the negative stress (distress) or without the existence of eustress to act as a counter-balance; distress can result in serious consequences for the individual, their families, and their firms (Quick et al., 2004). One relevant consequence of an imbalance between distress and eustress is burnout, which will be explored in the following section.

Burnout

As stress increases and the individual is unable to mount a psychological and physical response to cope with the stress, burnout is likely to occur (Harms et al., 2017). Burnout is a multidimensional, prolonged psychological syndrome arising from a response to chronic pressure and interpersonal job stressors (Demerouti et al., 2001; Maslach et al., 2001; Maslach & Leiter, 2017). Burnout is widely accepted to include the three dimensions put forward by Maslach and Jackson (1981) in their landmark paper to include: emotional exhaustion, cynicism or depersonalization, and decreased feeling of personal accomplishment (inefficacy). Similar to the effects of stress, those suffering from burnout experience physical, psychological, and behavioral issues (McCormack et al., 2017). The following section provides an overview of the history of burnout research and the three dimensions of burnout.

History of Burnout Research

A metaphor describing the experience of mental exhaustion (Schaufeli & Buunk, 2003), burnout was coined and emerged as a syndrome worth further study based in large

part to a landmark publication by Herbert Freudenberger in 1974. Freudenberger (1974) observed and described that after about one year, eager young volunteers working in a free-clinic for drug users in New York City suffered from emotional depletion leading to a loss of energy and conviction to continue with their work. Freudenberger (1975) described feelings of exhaustion and fatigue that lead to physical ailments for those serving the needs of the clients of the clinic. Naming this phenomenon *burnout*, Freudenberger borrowed a colloquial term used to describe the effects of chronic drug abuse within the groups served by the free-clinic (Schaufeli & Buunk, 2003).

About the same time of Freudenberger's work, Christina Maslach was conducting psychology research with human services workers (Schaufeli & Buunk, 2003). She borrowed the term *burnout* used by California poverty lawyers to describe the gradual exhaustion, negative attitudes towards clients, and loss of commitment and professional competence to offer assistance to clients by the study subjects (Maslach & Jackson, 1981; Schaufeli et al., 2009; Schaufeli & Buunk, 2003). Extending the concepts and burnout symptoms described by Freudenberger, much of the foundational understanding of job related burnout stems from the work of Christina Maslach and her many contributors over the last 40 plus years (Schaufeli & Buunk, 2003). Accumulated research supports that the burnout syndrome does indeed emerge across the three dimensions of emotional exhaustion, cynicism, and decreased professional efficacy (Maslach et al., 2018), which will be explored further in the following sections.

Three Dimensions of Burnout

Burnout is not the same as stress; it emerges contextually within one's job as a result of cumulative occupational stressors (Maslach & Leiter, 2008). Originally focused

on human services and educational occupations, the three burnout dimensions have been studied and observed in many other non-human services occupations (Demerouti et al., 2001) and is a widely accepted and studied syndrome in the context of work. The World Health Organization (WHO) includes burnout in its international classification of diseases (ICD-11); however it emphasizes that burnout is contained within the context of work and should not be applied to other life experiences (World Health Organization, 2019). The three burnout dimensions are detailed in the following paragraphs.

Emotional Exhaustion

Exhaustion is the physical and emotional response to stress (Maslach & Leiter, 2008). When exhausted, people feel overextended by work demands and therefore become depleted of the emotional resources necessary to meet performance expectations (Maslach & Leiter, 2008; Siren et al., 2018). Exhaustion is often the first sign of burnout. Additionally, exhaustion is the most often cited symptom when people describe themselves as suffering from burnout; and is the most widely studied burnout component (Maslach et al., 2001; Maslach & Leiter, 2008).

When suffering from emotional exhaustion, some describe themselves as being "stressed out"; drained; or unable to unplug, unwind, or recover (Maslach & Leiter, 1997). Because emotional exhaustion is the most commonly reported element of the burnout syndrome, some posit that the other two dimensions are unnecessary (Shirom, 2003). However, emotional exhaustion is distinct from stress (Iacovides et al., 2003) and even though emotional exhaustion is the stress dimension of burnout, it cannot stand alone as it fails to fully reflect key elements of how people relate to their work (Maslach et al., 2001).

Beyond the context of the work environment, emotional exhaustion manifests similarly to traditional stress factors such as fatigue, depression, and anxiety (Demerouti et al., 2001). Other studies demonstrate an overlap between these stress factors and emotional exhaustion (Schaufeli & Enzmann, 1998). Emotional exhaustion often causes people to disconnect from their work (Maslach et al., 2001), which for a healthcare providers and executives can result in devastating impacts to their patients, themselves, and their organizations (Siren et al., 2018; Studer & Ford, 2015). This disconnection often leads to cynicism and depersonalization (Maslach et al., 2001).

Cynicism or Depersonalization

The second burnout dimension is cynicism or depersonalization. Cynicism is an attempt to distance oneself from various aspects of the job and usually develops in response to overwork and the feeling of exhaustion (Maslach et al., 2001). Manifesting as a behavioral response to the job stress stimulus, people become cynical and disconnected to their work (Maslach & Leiter, 2008). According to Maslach and Leiter (2008), as cynicism develops, people go from giving it their all to doing whatever it takes to get by.

Instead of wanting to engage and lean-in, those suffering from burnout might lose their true north and become disenchanted and cynical. Depersonalization manifests via a withdrawal or cognitive distancing from one's work (Demerouti et al., 2001; Maslach et al., 2001). When suffering from cynicism, people are often negative, callous, and detached from various aspects of the job (Maslach & Leiter, 2008).

Depersonalization can lead to a loss of drive (Maslach & Leiter, 2017) and represents an erosion of engagement (Valcour, 2016). Moreover, those suffering from burnout place distance between others; making other people with whom they work or

serve seem impersonal (Maslach et al., 2001). Within the leadership-follower construct, this then may lead to a high conflict environment and the perception by followers that the burned-out leader lacks fairness and inclusivity in decision making (Valcour, 2016). Taken together, exhaustion and cynicism then often lead to inefficacy – the third dimension of burnout.

Inefficacy

The third burnout component, inefficacy, is the self-evaluation component of burnout and entails a reduction in one's self-described feelings of personal accomplishment (Maslach & Leiter, 2008; Maslach & Leiter, 2017). Feelings of reduced personal accomplishment, incompetence, and being unproductive are symptomatic of a lower sense of self-efficacy (Demerouti et al., 2001; Maslach & Leiter, 2008; Valcour, 2016). This diminished sense of accomplishment that can lead to a loss of confidence and bewilderment (Maslach & Leiter, 2008). One of the more telling fallouts of inefficacy suffered by healthcare caregivers is the emergence of self-doubt on whether they chose the right profession (Maslach & Leiter, 2017). This self-doubt may then manifest into a disregard for themselves and others. Moreover, bewildered caregivers might lose their self-confidence which may lead to depression (Maslach & Leiter, 2017). Burnout thus is a compounding of these three elements. Unmitigated, it can lead to decreased personal engagement (Schaufeli & Bakker, 2004) and a personal career crisis (Maslach & Leiter, 2017) resulting in poor job performance for the individual and for their organization (Maslach & Leiter, 2017; Siren et al., 2018; Studer & Ford, 2015).

Burnout is a major risk factor for impaired health status (de Beer et al., 2016) and can cause individual suffering through strained relationships inside and outside of work

(Fleischhauer et al., 2019). Burned-out healthcare workers who chose a profession aligned with their desire to help others find themselves burdened by their career choice resulting in feelings of sadness and a want to avoid the work altogether (Maslach & Leiter, 2017).

How these three elements of burnout emerge differs amongst individuals (Fruedenberger, 1975; Kobasa, 1979; Sharma, 2007; Swider & Zimmerman, 2010). Of particular interest for this study, one's personality profile has been correlated to executive burnout (Kobasa, 1979). The following section explores the role personality plays in burnout emergence.

Personality Traits and Burnout

Even the earliest foundational articles describing burnout pondered the role of personality in the manifestation of burnout (Fruedenberger, 1975) – where some personality traits might endear a greater risk for the emergence of burnout while other traits might mitigate burnout. Freudenberger (1975) suggested authoritarians, those who were rigid, and those who were negative might be prone to burnout. Using the Five-Factor Model from Goldberg (1990), Swider & Zimmerman (2010) concluded that neuroticism was positively related to burnout while the other four traits within the model (extraversion, agreeableness, conscientiousness, and openness) were negatively related to burnout. Research has shown that Type A personalities are more susceptible to executive burnout (Sharma, 2007). Those in the Type A group typically demonstrate chronic competitiveness, high levels of achievement motivations, impatience and a distorted sense of time urgency, a propensity to multitask, and aggressiveness and hostility (American Psychological Association, n.d.).

Whereas the aforementioned personality traits may be positively related to burnout onset, others such as hardiness and resilience are thought to be negatively related to burnout (Kobasa, 1979; Gentry and Kobasa, 1984). In a landmark study, Kobasa (1979) found that executives who demonstrated higher levels of hardiness, were less likely to become ill when subject to stress. When under increased stress, individuals who manifest attributes such as a greater sense of control and commitment to their lives are hardier than those who feel powerless and alienated (Kobasa, 1979). Years of additional research demonstrate that hardy individuals have better coping strategies than those who are less hardy (Gentry and Kobasa, 1984). Additionally, hardy individuals are more confident in their ability to cope with stress by being proactive and dealing with their problems head-on as opposed to feeling powerless and avoiding issues altogether (Soderstrom et al., 2000). Further research exploring the link between hardiness and stress has shown that hardiness has a more direct impact on overall health than it does in mitigating the effects of stress (Soderstrom et al., 2000).

A key takeaway from these findings linking personality to burnout is that individual-level burnout predictors are as important as occupational- or organizational-level predictors (Swider & Zimmerman, 2010). An additional personality trait that is germane to the exploration of burnout is resilience. Resilience will be explored further in the following section.

Resilience

As cited by Moss-Breen (2018), Dweck (2008) posits that resilience is a mindset that an individual holds enabling them to survive in complex environments. Resilience in individuals is defined as, “one’s ability to rebound from adversity by using previous

experiences to grow cognitively, spiritually, emotionally and physically" (Moss-Breen, 2018, p.12). Resilience is the capacity to deal with job stress that enables the individual to maintain their well-being while achieving their work goals (Mills et al., 2020). Tugade and Fredrickson (2004) suggest that resiliency is the ability to get beyond traumatic and stressful situations with adversity being an antecedent to the emergence of resiliency (Jackson et al., 2007).

Perhaps other elements exists that aid in forming and expressing resiliency. Taleb (2014) suggests that resilience develops as we push ourselves past our limits; emerges as an antidote to fragility; and results in a posture of being prepared to face the reality of being unprepared. Epstein (2017) posits that resilience can be developed over time with practice, especially when individuals focus on meaningful elements of their life that bring them joy. Other researchers suggest that personality and biochemical make-up play a role in the emergence of greater resilience (Cicchetti & Rogosch, 2012).

Deci and Ryan (1985) claim that those who have a greater sense of personal autonomy and confidence often form more lasting and caring relationships with others – all ingredients associated with greater resilience. Southwick and Charney (2012) studied civilians and military personnel who suffered psychological traumas yet very few experienced post-traumatic stress disorders or depression. These individuals had attributes that resulted in their higher levels of resiliency to include: a sense of meaning and purpose, a realistic optimism, a strong moral compass, cognitive and emotional flexibility, and physical and mental fitness (Southwick & Charney, 2012).

Additionally, an individual's genetic make-up plays a role in their resilience levels (Epstein, 2017). Those with greater resiliency tend to have higher levels of positive

hormones (e.g. serotonin, dopamine) and lower levels of stress hormones and seem to have more neuroreceptors attuned to these positive biochemicals (Cicchetti & Rogosch, 2012). This suggests that environmental and social settings affect how an individual's genes are expressed – known as epigenetics.

Just as exposure to primary and secondary trauma triggers expression of genes that code for stress hormones, when individuals are provided time, space, support, and training on resilience – the opposite occurs. Epstein (2017) summarizes work by Johnson et al. (2014) demonstrating an epigenetic example that emerged in a study group of military recruits who had higher gene expression for self-awareness and resilience when immersed in mindfulness programs. This research supports the notion that resilience capacity can be grown. Thus, growing and sustaining one's resiliency is tantamount to keeping burnout at bay as those with higher resilience levels have lower levels of burnout (Mealer et al., 2012; O'Dowd et al., 2018).

Burnout is difficult in any occupation, yet in healthcare, it has been described as reaching epidemic levels (Kermott et al., 2019; West et al., 2016). Interestingly, in the earliest articles describing burnout, Freudenberger (1975) cautioned that physicians, nurses, and social workers (just to name a few) are highly susceptible to burnout given how closely they work with the afflicted and how personally they take their responsibility to help and heal. The following section explores burnout within the healthcare industry.

Burnout in Healthcare

Researchers estimate that half or more of practicing physicians (West et al., 2016) and over one-third of hospital nurses (Bodenheimer & Sinsky, 2014) are experiencing or have experienced burnout. Consequences of this burnout crisis are severe for all

stakeholders of the healthcare industry; patients, caregivers and healthcare provider organizations (West et al., 2009). Some researchers suggest the pressures associated with improving the healthcare system drive the increase in caregiver burnout; thus requiring a reprioritization for caregiver well-being (Bodenheimer & Sinsky, 2014) and a focus on the roles that executive leaders can and should play in addressing the systemic and causal factors contributing to the increase in burnout within the healthcare industry (Shanafelt & Noseworthy, 2017). The following section details effects of burnout in healthcare; to include the negative impact on patients, caregivers, and health provider organizations.

Burnout Impact on Patient Care

When physicians and nurses suffer from burnout, many deleterious effects can materialize such as: the erosion of patient safety, negative patient outcomes, and decreased patient perceptions of care, otherwise known as patient experience (Studer & Ford, 2015). Halbesleben et al. (2008) and Shanafelt et al. (2010) extend this notion to surmise that the quality of care, both outcomes and patient experience, are negatively impacted when caregivers suffer from burnout. Moreover, when suffering from burnout, caregivers often lose their empathy and capacity to successfully motivate patients to take their advice to improve their own health and well-being (Ranjbar & Ricker, 2019) – resulting in less than ideal outcomes for the patient.

Physicians and nurses report having higher self-perceived medical error rates when experiencing burnout (Halbesleben et al., 2008; Schanafelt et al., 2010; West et al., 2009). Research has also shown increased patient mortality in organizations that have higher rates of caregiver burnout (Reith, 2018; Welp et al., 2015). Additionally, the risk for patients acquiring infections while hospitalized increases when caregivers are

suffering from burnout (Reith, 2018). In summary, burned-out caregivers render inferior care and put patients at greater risk of harm.

Burnout Impact on Caregivers

Some physicians suggest the increased pressures to improve the healthcare industry – to deliver on the Triple Aim – has directly led to an increase in burnout (Bodenheimer & Sinsky, 2014; Wohlever, 2020). The term Triple Aim was coined by Donald Berwick, M.D. and his colleagues at the Institute for Healthcare Improvement and suggests the healthcare industry can be improved when the following three performance areas are addressed: improving the experience of care for the patient, improving the health of populations, and reducing the per capita costs of delivering health care (Berwick et al., 2008). Despite its aspirational goals, some in the industry feel the all-out pursuit of the Triple Aim has come at a cost for caregivers in the form of increased burnout (Bodenheimer & Sinsky, 2014; Wohlever, 2020).

A foundational and necessary element required to successfully attain the Triple Aim is the implementation of electronic health record (EHR) systems across the industry; with the ultimate goal being a patient-centered, patient-controlled healthcare record that is portable and available to be used by caregivers wherever patients might seek care (Berwick et al., 2008). However good the intention of achieving a common record across the divergent healthcare system, the acceleration to EHRs has unintended consequences with regard to caregiver well-being and has been linked to increased caregiver burnout (Reith, 2018; Talbot & Dean, 2018). Reith (2018) shares the reflection of a health system CEO who claims that the electronic health record has added hours to a physician's day to include intruding upon their family time.

Bodenheimer and Sinsky (2014) suggest a fourth aim be added beyond the Triple Aim – which is a focus on caregiver well-being. Furthermore, they posit that it now be called the Quadruple Aim and suggest that caregiver well-being be the first of these four aims as the other three are dependent upon caregivers being well and not suffering from burnout (Bodenheimer & Sinsky, 2014). This call for a refocus on putting caregiver well-being at the forefront seems germane to mitigating the negative effects of burnout that impact the entire industry. Moreover, it enriches the context of this study exploring how the healthcare executive participants who were interviewed, appreciate burnout in themselves and within their organizations and how said appreciation therefore informed their leadership practice.

The toll that burnout takes on caregivers can be devastating for the caregiver and those who care about them. When suffering from burnout, caregivers report feeling a disconnection with their spirituality (Ranjbar & Ricker, 2019) and with their families, friends, and social networks resulting in feelings of loneliness and isolation (Rogers et al., 2016). Perhaps losing one's connections to faith, family, and friends contribute to the fact that caregivers who suffer from burnout have higher incidents of substance abuse and broken relationships (Shanafelt et al., 2012). Conceivably the most shocking and sobering evidence of the destructive force that is caregiver burnout is research demonstrating that the burnout syndrome is thought to be a driver of the fact that higher suicidal ideation is found in physicians (Schwartz et al., 2020; Shanafelt et al., 2012) and in nurses (Davidson et al., 2020) than in the general population. Burnout is not only maiming caregivers; it may be leading to their premature death.

Burnout Impact on Healthcare Organizations

Healthcare organizations can be adversely impacted financially and reputationally when patients receive substandard care delivered by clinicians suffering from burnout (Shanafelt et al., 2018). Conservative estimates suggest that in the United States, physician burnout is adding approximately $4.6 billion in costs to the system; principally related to caregiver turnover and reduced capacity to care for patients (Han et al., 2019). Additionally, studies show that physicians who experience burnout are more likely to decrease their work hours or leave the practice of medicine entirely (Shanafelt et al., 2016). Losing experienced physicians not only has high costs for the overall healthcare system due to lost capacity (Han et al., 2019), it threatens a loss of expertise that may negatively impact patient outcomes and organizational reputation (Studer & Ford, 2015).

Specific impacts to an organization's reputation manifests in lower patient experience results when caregivers suffer from burnout (McHugh et al., 2011; Studer & Ford, 2015). Another deleterious outcome of caregiver burnout is an increase in malpractice costs; which increases the costs for all participants across the healthcare system (Balch et al., 2011; Studer & Ford, 2015). Combined, these negative consequences of caregiver burnout threaten the effectiveness and viability of healthcare organizations (Studer & Ford, 2015).

Structural Elements Leading to Caregiver Burnout

When taken together, the aforementioned fallouts from caregiver burnout serve as the bell hammer ringing a clarion call for healthcare executives to address the systemic causal factors underlying the crisis of burnout within the healthcare industry (Shanafelt & Noseworthy, 2017; Talbot & Dean, 2018, Walsh et al., 2019; West et al., 2016;

Wohlever, 2020). Some are imploring healthcare leaders to place more emphasis on the systemic drivers of burnout than focusing on caregiver reactions to burnout (Bodenheimer & Sinsky, 2014; Eschelbach, 2018; Shanafelt et al., 2012; Shanafelt et al., 2018; Talbot & Dean, 2018; Wohlever, 2020). Moreover, some suggest that too much focus is placed on the caregiver fixing themselves and not enough focus is given to addressing the systemic issues leading to burnout (Dean et al., 2019; Talbot & Dean, 2018; Wohlever, 2020). Maslach and Leiter (2017) posit that burnout is more a result of "problematic relationships between employees and their workplaces, and is therefore [more of] a social and organizational issue" (p. 161) than any personal failing on the part of the caregiver. This thinking that burnout is caused more by structural frameworks and elements than issues with individual caregivers will be explored in the next section.

Structural Violence

Many researchers make the point that caregiver burnout is more about the structural elements extant in the industry and less about the weakness of caregivers (Reith, 2018; Shanafelt et al., 2012; Shanafelt et al., 2015; Shanafelt & Noseworthy, 2017; Talbot & Dean, 2018; Wohlever, 2020). Positing that the workplace is the primary driver of the manifestation of burnout in caregivers, Shanafelt et al. (2012) suggest that the emergence of caregiver burnout is grounded in the care delivery structure more than the personal characteristics of the caregivers themselves. Some of these systemic, structural issues include: the burden that the EHRs are placing on caregivers (Tai-Seale et al., 2019; Wohlever, 2020), the increased focus on productivity (Reith, 2018), the mounting pressure to make consistent profits (Talbot & Dean, 2018), and increased governmental and insurance regulations (Wohlever, 2020).

Taken collectively, these systemic, structural issues comprise a context that some caregivers claim goes beyond burnout. Structural arrangements that put people in harm's way or blunt them from reaching their full potential has been described as *structural violence* (Farmer et al., 2006). Johan Galtung (1969) is credited with originating the concept of *structural violence – structural*, as it describes social constructs such as economic, political, legal, or religious frameworks that are embedded in our culture and in our workplaces and *violent* – because it impairs a basic human need or causes an injury of some sort [e.g. the symptoms of caregiver burnout] (Farmer et al., 2006; T. Lenz, personal communication, November 16, 2020). Many of the structural elements described earlier (e.g. EHR, productivity, and regulatory demands) are embedded within the extant healthcare structure and seem beyond the control (Dean et al., 2019) of the caregivers. Perhaps then, the concept of structural violence is an apt description of the epidemic of caregiver burnout within the healthcare industry (T. Lenz, personal communication, November 16, 2020).

Extending this thinking that the systemic, structural issues are root cause elements contributing to the burnout epidemic, some healthcare providers push back on the notion that caregivers are suffering from burnout at all and make the contention that they are actually suffering from moral injury (Ford, 2019). Burnout suggest that there is something wrong with the caregiver (Dean et al., 2019). Conversely, the theory that clinicians are actually suffering moral injury focuses on the systemic issues in healthcare that some claim are not being addressed appropriately by healthcare leaders (Dean et al., 2019; Talbot & Dean, 2018; Wohlever, 2020). Thus, there is a movement afoot within some circles to progress towards a theory of moral injury. Focusing on moral injury

rather than burnout turns the focus from burned-out caregivers to what some in the industry claim to be leadership malpractice on the part of healthcare executives; given the slow and yet ineffective effort to address the underlying systemic causal factors of caregiver burnout (Talbot & Dean, 2018). This concept of moral injury in the context of caregiver burnout is explored further in the following section.

Moral Injury

Johnathan Shay, a psychiatrist working with the United States Department of Veterans Affairs, is credited with developing the concept of moral injury in the 1990s. After two decades of work with military veterans who were deployed in battle, Shay's (2014) vision for moral injury is summarized by "a betrayal of what's right by someone who holds legitimate authority (e.g. a military leader) in a high stakes situation" (p. 183). Shay (2014) explains that this concept came to light when contemplating the stories of the veterans his team treated in relation to Homer's narrative of Achilles in the *Iliad*. Specifically Shay (2014) points to the fact that all the *Iliadic* leaders fail to uphold their fiduciary responsibility to ensure the well-being of the troops under their care and command, in other words, leadership malpractice. Thus, Shay (2014) suggests that leadership malpractice results in a "moral injury – the body codes it as a physical attack, mobilizes for danger and counterattack, and lastingly imprints the physiology every bit as much as if it had been a physical attack" (p. 185). Succinctly, when someone acts in a manner that is counter to their moral beliefs based on direction from a leader, they suffer a moral injury.

Shay (2014) suggests that suffering a moral injury changes the afflicted in dramatic ways. Victims of moral injury suffer a deterioration of their character, their

hopes and ambitions, and their ideals. Additionally, moral injury destroys the afflicted's capacity for trust. When trust is eroded, those suffering moral injury settle for an ongoing expectancy that the harm they are suffering will continue (Shay, 2014).

Extrapolating the concept of moral injury to healthcare, Talbot and Dean (2018) contend that burnout in healthcare is due to the fact that the extant healthcare system is broken. When caregivers are unable to uphold their oath or vocation to heal and serve their patients, they experience a moral injury (Dean et al., 2019; Talbot & Dean, 2018). Dean et al. (2019) suggest that moral injury in the healthcare setting occurs when clinicians know the care their patients need but are unable to render such care due to the limitations of the healthcare system that are beyond their control. Taken collectively therefore, healthcare providers suffer a moral injury when they are unable to fully utilize their knowledge and skills to affect healing because the system keeps them from doing so (Talbot & Dean, 2018). Thus, Dean et al. (2019) claim that the relevant issue at hand is a broken healthcare system, not a broken or burned-out caregiver. Houtrow (2020) extends this by suggesting that focusing only on burnout and not moral injury is equivalent to managing the symptoms of a disease rather than addressing the underlying causal factors.

Some question the equivalency of the experiences of warriors suffering moral injury with the burnout experienced by healthcare caregivers (Asken, 2019). This study did not aim to opine on whether clinicians are suffering from moral injuries or burnout. Having made the point that some are pivoting to claim that healthcare clinicians are suffering from moral injury and not burnout adds further depth to the context of the crisis afoot in healthcare; that caregivers are suffering and healthcare leaders are being called to lead and support efforts to ameliorate the epidemic (Shanafelt & Noseworthy, 2017).

Over time, caregivers have earned a high level of respect within western society (Brusie, 2020; Kmietovicz, 2002). Given this earned political capital and good will, a vanguard of caregivers are exerting their influence to set the agenda (Oc & Bashshur, 2013) related to the epidemic of burnout and impelling healthcare leaders to act (Shanafelt & Noseworthy, 2017). Perhaps healthcare executives might also suffer distress given the structural elements extant in the industry. Thus, my focus for this study was to explore how healthcare executives understand their own lived experiences in the context of the epidemic of burnout within the healthcare industry and how this understanding informed their leadership practice therein.

Healthcare Executives Leading in the Context of Burnout

Perhaps the healthcare executives sampled in this study are not capable of being morally injured given they themselves are the *Iliadic* leader, as described by Shay (2014). Moreover, maybe their personality (Kobasa, 1979; Swider & Zimmerman, 2010) or position provides buffering elements to blunt their own burnout (Sherman et al., 2012). Regardless, I was keenly interested in how the personal burnout journey of healthcare executives informed their leadership and thus their actions to address either burnout or moral injury within their organizations and the healthcare industry at large.

Context plays a critical role in how members of a group (leaders and followers) influence one another and therefore how the group on whole adapts to address a shared problem or opportunity (DeRue, 2011; Kellerman, 2016). Whether the context is moral injury or burnout, executives are more successful in their leadership when they act from a place of personal understanding and care for others (Lowney, 2003). Especially in times

of crisis, leaders who transparently disclose a path forward and do so with courage and enthusiasm aid their teams in dealing with stressors caused by the crisis (Bass, 1990).

Gallup researchers suggest that how leaders treat their employees is a critical element related to the emergence of burnout (Wigert & Agrawal, 2018). Harland et al. (2005) found that employees have higher levels of resilience when they find that their boss is a positive factor in their lives. Additionally, a survey of nearly 3,000 Mayo Clinic physicians found that a one-point increase in the leadership score (on a 60-point scale) of their immediate supervisor resulted in a 3.3% decrease in the likelihood for that caregiver to experience burnout (Shanafelt et al., 2015). Thus, executives are well served to self-reflect on their own experience with burnout and use their personal journey as a source of knowledge to inform their leadership in the context of burnout within the healthcare industry (Shanafelt et al., 2020; Wicks & Buck, 2013) – to help both themselves and front-line caregivers.

As the most senior executive customarily sets the vision and tone within an organization (Bass, 1990), senior healthcare executives are key to making burnout prevention and mitigation a priority for their organizations (Shanafelt & Noseworthy, 2017). Acknowledging that burnout is real and that the well-being of caregivers is a strategic imperative is a first order priority for senior healthcare executives when establishing a plan to address caregiver burnout (Shanafelt & Noseworthy, 2017). When senior executives become more self-aware of their own journey on the burnout spectrum, they develop greater empathy for burnout in others (Hartney, 2018).

Having the self-awareness and self-realization to change one's trajectory on the burnout spectrum well positions the healthcare executive to address the structural

elements at the core of the burnout epidemic in healthcare (Shanafelt & Noseworthy, 2017; Voci et al., 2016; West et al., 2016). Actions that contribute to burnout mitigation and prevention for the senior executive and for their employees are listed in the Table 1. These actions include those that: address structural issues, promote personal well-being, and summarize leadership focus.

Table 1

Senior Leader Areas of Focus in the Context of Burnout

Structural	Well-Being	Leadership
• Set work limits and encourage vacations (Shanafelt & Noseworthy, 2017; Valcour, 2016) • Grant power and control to address burnout to teams closest to the work (Maslach & Leiter, 2008, 2017; Valcour, 2016; Wigert & Agrawal, 2018) • Address structural elements within the executive's company or industry at large that contribut to their work stress and burnout	• Provide resources that promote self-care and resilience (Mealer et al., 2012; Shanafelt & Noseworthy, 2017) • Encourage the participation in exercise programs (Burton et al., 2012) • Enhance community involvement opportunities as a release from work-only life (Maslach & Leiter, 2017)	• Focus on workgroups or particular service areas with greatest burnout risk and/or opportunity (Shanafelt & Noseworthy, 2017) • Promote a culture of reward and appreciation centered on living the mission and values of the organizaiton (Cooperrider & Srivastva, 1987; Maslach & Leiter, 2008; Shanafelt & Noseworthy, 2017)

The following section includes a review of relevant research on how executive leaders experience and respond to their own burnout journey and how that informs their leadership practice.

Lived Experiences of Executives Dealing with Burnout

Having demonstrated many references that suggest burnout in healthcare has reached epidemic levels, so too has stress been declared a 21st century global epidemic by

the World Health Organization (Kermott et al., 2019) as occupational stress can affect workers beyond those in human services roles (Bakker & Demerouti, 2017). Given this context of stress within healthcare and in society in general, executives are not immune to occupational stress (McConnell, 2013; Siren et al., 2018; Wicks & Buck, 2013). Going back to the genesis of burnout research, Freudenberger (1975) warned that burnout can affect the overworked administrator, although perhaps manifesting in a different manner than the manifestation of burnout in front-line workers. One study of senior executives found that more than 50% of the respondents believed that their CEOs were actively experiencing burnout (McConnell, 2013). Interestingly, this study showed that when asked, respondents felt that employees within the organization where even more likely to be suffering burnout than the CEO (McConnell, 2013); thus supporting the position of Harms et al. (2017) who posit that when the boss is stressed, it extends to others.

Harms et al. (2017) suggest that leaders might experience greater levels of stress because they encounter internal and external threats to the organization on a regular basis that can drain their "psychological resources and lead to emotional exhaustion and poorer performance over time" (p.180). Leaders under stress make bad decisions (Thompson, 2010) as stress and burnout can erode a leader's creativity and innovativeness (Moss-Breen, 2018). When a CEO experiences burnout, the firm's performance has been shown to be negatively impacted (Siren et al., 2018). Unmitigated, burnout can lead to decreased personal engagement (Schaufeli & Bakker, 2004) resulting in poor job performance for the individual executive leader and for their organization (Siren et al., 2018).

The often used metaphor of placing your oxygen mask on first before helping others seems appropriate when encouraging executives to practice self-care in the context

of burnout. Becoming aware of and then properly managing stressors, promotes burnout recovery and benefits both mental and physical health (Lee & Cummings, 2008). When an executive undertakes a reflective exploration of their personal burnout experiences; it not only benefits the executive personally – it should enhance their approach when addressing burnout within their organization. Hence, when a CEO promotes a personal and organizational commitment to care for self, burnout is mitigated (Voci et al., 2016).

Self-care

By the nature of the root word "self", a comprehensive description of self-care can be amorphous. Lee and Miller (2013) describe self-care as "a process of purposeful engagement in practices that promote holistic health and well-being of the self" (p. 99). Self-care includes those activities focused on an individual's health and well-being in the context of job stress (Bressi & Vaden, 2017). Additionally, self-care is comprised of activities or programs focused on physical, psychological (mental), emotional, and spiritual well-being (Loehr & Schwartz, 2001; Saakvitne et al., 1996). The aforementioned self-care elements will be reviewed in the following section.

Physical capacity

Loehr and Schwartz (2001) posit that executives can attain and sustain peak performance when they prioritize their self-care and focus on the essential elements of physical, emotional, mental, and spiritual capacity. A comprehensive regimen of physical self-care, including cardiovascular and muscular exercise, combined with good nutrition and sleep hygiene forms the base of the high-performance pyramid as named by Loehr and Schwartz (2001). A real sense of purpose emerges from this focused physical routine, emotional health, and mental acuity (Loehr & Schwartz, 2001). Additionally, activities

that sustain sound physical health also aid in the cultivation of meaningful relationships that aid in the individual's sense of "stability, authenticity, and wholeness", improving their emotional, mental, and spiritual capacity (Wong, 2020, p. 14).

Emotional, Mental, and Spiritual Capacity

Given increasing burnout amongst healthcare workers, emotional well-being was one of the two primary areas of focus outlined by the U.S. Surgeon General in 2016 (Frieden, 2016). Leaders who possess a positive and optimistic attitude focused on helping others are more effective (Bass, 1990; McKee et al., 2006), have lower levels of stress (Poulin et al., 2013: Poulin & Holman, 2013), are more emotionally stable (Loehr & Schwartz, 2001), and have higher levels of resilience often manifest via their hardiness (Mealer et al., 2012; Soderstrom et al., 2000).

The practice of mindfulness and spirituality can provide renewal of one's personal commitment and serve as an energy source (Frederick et al., 2017; McCormack, 2011) and increases mental and spiritual capacity (Loehr & Schwartz, 2001). Moreover, holding the most senior position itself can reduce stress and burnout due in large part to the resultant positional power in holding the top office in a firm (Bakker & Demerouti, 2017; Brown, 2009; Sherman et al., 2012). As a senior leader, it seems one can mitigate burnout by understanding their own strengths and defining traits and by proactively and purposefully taking care of themselves in a holistic manner. This interplay of self-awareness and positional power will be explored in the following section.

Self-awareness and Positional Power

How leaders hoard power and materials or share these social resources can either be a source of stress or a buffer of stress for their followers (Harms et al., 2017). Harms

et al. (2017) found in their meta-analytic review that leaders who put the needs of their employees first helped to lower stress and burnout levels for those employees. It follows then that leaders will be well served to spend time contemplating how their leadership practices are affecting the stress and burnout levels of their followers.

Reflective and self-aware executives monitor their thinking, actions, and learning iteratively to ensure they are poised to improve their leadership practices in order to best respond to challenges and opportunities present within their firms (Finkelstein et al., 2015). In the context of burnout, a senior executive's self-awareness begins with the realization that they have the requisite positional power to set the tone for the organization (Bass, 1990) and declare burnout a strategic priority (Shanafelt & Noseworthy, 2017). Additionally, that same positional power is a bedrock element that lowers stress (Sherman et al., 2012); due in large part to having greater executive control and therefore a higher sense of security (Sherman et al., 2012; Waytz et al., 2015) and perhaps a developed tolerance for stress over time in their executive role (Harms et al., 2017). Thus, positional power provides a means for the executive to lower their own stress levels (Sherman et al., 2012) and conceivably serves as a means to lower stress levels for those with whom power is shared.

In an effort to mount a strong response to the burnout epidemic in healthcare, healthcare executive leaders should take an interpersonal, self-reflective, and mindful approach to understand their own burnout journey (Voci et al., 2016). This focus on self should be coupled with power sharing efforts as a means to decrease the burnout burden of caregivers (Harms et al., 2017) and kick start the necessary work to address the systemic underpinnings of caregiver burnout (Wong, 2020). A systems-focused approach

should include an interdisciplinary collaboration focused on system reforms that improve caregiver working conditions (Wong, 2020). Perhaps as important, sharing power with those in caregiver roles subject to burnout is within the positional power construct of executives (Oc & Bashshur, 2013) and is a suggested best practice to allow caregivers to address their own burnout (Shanafelt & Noseworthy, 2017). Creating an environment whereby the executive shares and grants power to others within the organization (especially those in roles with higher burnout rates), is a recommended best practice towards preventing and mitigating burnout (Shanafelt & Noseworthy, 2017). Therefore, being mindful that you personally have the power to intervene when burnout emerges appears to be a key element to healthcare executives taking action for themselves and for their organizations.

Summary

The focus of this literature review was to help form a relevant theoretical framework for the study (Galvan & Galvan, 2017) and to establish the study context. This review of the literature suggests that a conceptual framework for this study should include a review of burnout and burnout in the healthcare industry leading to an exploration of the lived experiences of healthcare executives in the context of burnout and how these experiences inform their leadership. Extensive research over the last four decades provides a rich understanding of the dimensions and consequences of burnout (Wiens, 2016). Moreover, evidence suggests that burnout has severe ramifications for both the individual and their organizations (Siren et al., 2018) and thus created urgency and agency for this study.

Extending the context to the healthcare setting, research suggests that burnout in healthcare is reaching epidemic levels (Kermott et al., 2019; West et al., 2016). Unmitigated, burnout can manifest serious consequences for caregivers, patients and healthcare organizations. Healthcare governing bodies and senior executives are being called to focus on addressing the systemic and structural causal factors of burnout and making such work a strategic priority (Shanafelt et al., 2018; Shanafelt & Noseworthy, 2017; Wohlever, 2020). Moreover, some recommend focus be given to ensuring the well-being of all professionals in healthcare to include administrators (Rozario, 2019).

Executives are not immune to workplace stress and burnout (McConnell, 2013); especially susceptible are those with strong personalities (Sharma, 2007). When experiencing burnout, CEOs lose their effectiveness (Moss-Breen, 2018) thus extending the negative affects beyond themselves to their firms (Siren et al., 2018). Leaders are well served to gain an understanding of their personality profiles and how those traits relate to burnout. Additionally, investing in a focused self-care program that is well rounded and attentive to physical, emotional, mental, and spiritual needs is a recommended best practice approach (Loehr & Schwartz, 2001). Moreover, leaders play a critical role in setting the tone (Bass, 1990) and providing examples of how important resilience can be when leading through burnout (Mealer et al., 2012). Therefore, exploring how senior executives of healthcare organizations experience and respond to burnout presented a compelling impetus for this study. Having provided this literature review to illuminate the context and the conceptual framework for this study, the following section summarizes the methodological approach employed to answer the research question.

CHAPTER THREE: METHODOLOGY

The purpose of this chapter is to summarize the methodology utilized to inform the evidence-based solution to the real-world problem explored in my study. First, I will summarize the purpose of my study and provide logic on my methodological approach. Second, I will detail the research design to include: participant recruitment and sampling strategies; planned data collection methods and tools; and how the data were analyzed to include an overview of how ensured methodological integrity. This chapter concludes with a discussion of the ethical considerations used in this study.

Establishing that healthcare executives are impelled to address the epidemic of burnout; the purpose of this study was to explore the lived experiences of healthcare executives in the context of job burnout. My focus for the study centered on understanding how the leaders' leadership practice is influenced by their personal journey and their response to burnout. I used a non-probability purposive sampling technique, where I used my own sound judgement (Black, 2010) to arrive at a relevant sample size of nine health executives who hold the title of CEO or President in one of the divisions, markets or hospitals within CommonSpirit Health. This study was designed to answer the following research question:

Research Question

How do senior executives of healthcare organizations experience and respond to burnout?

Research Design Overview

Working to achieve the purpose of this study, I used a phenomenological, qualitative framework. Although burnout can be measured quantitatively with valid and

reliable tools (Demerouti et al., 2001; Maslach & Jackson, 1981), my focus was not on measuring relationships between dependent and independent variables or hypothesizing on the causal factors regarding burnout in the study population. Utilizing a qualitative approach provided an opportunity to reveal the rich personal stories of the individuals studied (Creswell & Creswell, 2018) which supported my interest in describing the essence of the phenomenon of executive burnout and how and executive's personal burnout journey informed their leadership in the context of burnout within this sample of healthcare executives. Therefore, the use of an inductive, empirical hermeneutical interpretive phenomenology framework best supported my desire to explore and describe the lived experiences of these healthcare executives in the context of burnout.

Phenomenology

Key to conducting a phenomenology study is to describe, as accurately as possible, the commonality in meaning drawn from exploring the lived experiences of multiple individuals regarding a phenomenon (Creswell & Poth, 2018; Groenewald, 2004). Developed by Edmund Husserl, phenomenology is a method of discovering how an individual perceives their experiences and thus describes those experiences to others (Moustakas, 1994; Pietkiewicz & Smith, 2014; Tan et al., 2009). Two principal types of phenomenology that could have been employed for this study were hermeneutical and transcendental phenomenology. Hermeneutical phenomenology is both a descriptive and interpretive process; where the researcher offers their own interpretation of the meaning of the lived experiences of the study participants (Creswell & Poth, 2018). In transcendental phenomenology, the focus is more on describing and less on interpreting the lived experiences (Creswell & Poth, 2018). My interest centered on describing the

interview texts which resulted in interpretive richness related to other contextual elements of the interviews, to include: the participants' voice inflection, body language, and excitement or reticence shown during the interview. Husserl suggests that *a priori* knowledge, or intuition, also aids in the understanding of the essence of the phenomenon (Tan et al., 2009). Given my own lived experiential understanding of the phenomenon, I chose a hermeneutical interpretive phenomenology and conscientiously and diligently bracketed my experiences so too not unduly bias the findings.

Hermeneutical Phenomenology

Martin Heidegger extended Husserl's work by placing focus on the interpretations of being human or one's lived experiences (Tan et al., 2009). Hermeneutics comes from the Greek, 'to interpret' or 'to make clear' and centers on understanding a person's mindset through the language they use to describe their experiences (Pietkiewicz & Smith, 2014). Grounded in the philosophy put forward by Heidegger, hermeneutical phenomenology is a qualitative methodology that aims to describe and illuminate the central point of the human experience (Crist & Tanner, 2003; Tan et al., 2009). Time and context play a role in hermeneutical phenomenology as the existential relationship the participants have with their surroundings influences their lived experiences and the telling of their stories (Sloan & Bowe, 2014). Hermeneutics, therefore, is an iterative, contextually influenced process where prejudices are set aside to fully appreciate the essence and richness of the lived experiences and stories emanating from the texts produced by those studied (Crist & Tanner, 2003; Moustakas, 1994; Pietkiewicz & Smith, 2014).

Crist and Tanner (2003) suggest that "the philosophy of hermeneutics underpins interpretive methodology" and is the "science of interpreting human meaning and experience" (p. 202). Essential to the hermeneutic interpretive methodology is drawing out the meaning of the practical acts of the lived experiences of the study participants revealed in the telling of their personal life stories (Crist & Tanner, 2003). Moreover, it is in the review and interpretations of the research texts (in this case, the interview transcripts and my research notes and observations during the interviews) that the essence and richness of the lived experiences and research themes emerge via hermeneutical interpretation (Creswell & Poth, 2018; Moustakas, 1994; Pietkiewicz & Smith, 2014; Tan et al., 2009). Elucidating the richness of the phenomenon from the language used by the participants is aided by an iterative process free from predetermined constraints or biases (Crist & Tanner, 2003; Moustakas, 1994; Pietkiewicz & Smith, 2014). I bracketed my preconceptions with the intent of allowing the voice of the respondents to unbiasedly paint the picture of the phenomenon for the reader (Pietkiewicz & Smith, 2014).

Bracketing

Bracketing is a concept put forth by Edmund Husserl, who is noted as "the fountainhead of phenomenology in the twentieth century" (Vandenberg, 1997, p. 11). Husserl's bracketing or epoche (Greek for staying away from or abstaining) is a concept where investigators free themselves from suppositions by setting aside their experiences, as much as possible (Creswell & Poth, 2018; Groenewald, 2004; Moustakas, 1994). Thus, bracketing aims to materialize a fresh and unbiased perspective toward the phenomenon (Creswell & Poth, 2018; Moustakas, 1994). As recommended by Creswell

& Poth (2018), I reflected on my own experiences with the phenomenon then bracketed those views prior to describing the experiences of the study participants.

Hermeneutical Phenomenology Framework

After reflecting on my own experiences with burnout and bracketing those reflections, I collected data via Zoom interviews conducted with a study group drawn from the population of healthcare executives serving as a CEO or President of a CommonSpirit Health division, market, and/or hospital. Working with a ground-up lens (Creswell & Poth, 2018), the interview statements and quotes comprised the material from which emergent, empirical themes were drawn (Babbie, 2017). By focusing on textural (what participants experienced) and structural (how the conditions, situations, or context influenced the participants' experiences) descriptions, I endeavored to convey a deeper understanding (Bengtsson, 2016) of the overall essence of the lived experiences of the study participants (Creswell & Poth, 2018).

Participants

According to Creswell and Creswell (2018), there is no specific answer to how many participants should be included in a qualitative study. Qualitative studies are intended to garner extensive information from a small sample and 3-10 participants can constitute a satisfactory phenomenology study group (Creswell & Creswell, 2018). A relevant sample size of nine (9) participants emerged from the study population of all CEOs and Presidents serving within CommonSpirit Health. Using my own sound judgement as suggested by Black (2010), via a non-probability purposive sampling technique, I was able to garner the interest of nine participants to partake in the study. I did use qualifying parameters in an effort to ensure the respondents had sufficient tenure

in their roles (five or more years). Additionally, I purposefully asked four women to participate with three ultimately agreeing to do so.

Along with gaining IRB approval from Creighton University, I also asked for and received approval from the CommonSpirit Health IRB. I contacted senior leaders within the various divisions to help me contact CEOs and/or Presidents who might be willing to participate in this study. As I also served as a senior healthcare executive within CommonSpirit Health during the study time period, these were my colleagues with whom I had some rapport. I believe that this comradeship helped me garner a sufficient sample willing to participate.

Determining if the sample size is sufficient includes a plan to reach saturation. Once themes were identified, I went back to the transcripts and recordings to ensure there was no new data or information (Bengtsson, 2016; Creswell & Guetterman, 2018). Additionally, I shared major findings and themes with some participants, known as member checking (Creswell & Creswell, 2018), to ensure saturation and accuracy.

Data Collection

As my research collected data from human participants, I complied with and completed all necessary requirements of the Creighton University Institutional Review Board (IRB). Additionally, I complied with all requirements set forth by the CommonSpirit Health IRB as applicable. In using an inductive approach to illuminate detail from the study population, qualitative data was collected via personal interviews geared towards answering the research question.

Data Collection Procedures

My data collection plan was a non-probability purposive sampling approach where I used my own judgement (Black, 2010) to recruit the CEOs and/or presidents who served as study participants. I wrote an introductory letter summarizing my research purpose to include a brief explanation that this work was part of my dissertation for the Creighton Interdisciplinary Leadership Ed.D. I included a small bio of myself for those who do not know me or know me well. Additionally, I provided detail on the interview process, I shared the IRB information with emphasis on the rights of the participant, and I emphasized that data will be de-identified (by using pseudonyms) to protect and ensure anonymity of the participants.

After confirming the nine study participants had sufficient tenure, I contacted the participants and scheduled their interviews. I also provided a primer on time expectations, the general research context, reminded them that their identities will be protected, and that the interviews will be recorded and transcribed. The interviews were conducted via Zoom and recorded on my password protected iPhone. The interviews were scheduled for 90 minutes, yet the actual questions took only 35-50 minutes to complete. The 90-minute window allowed for any logistical issues to be remediated. An interview script comprised of semi-structured questions was used for the interviews. The recordings were transcribed using Rev.com and the data coded utilizing the MAXQDA coding software.

I reviewed the transcripts and categorized the text utilizing summary codes, often using the voice of the respondent, called *in vivo* language (the actual words of the respondent) which is a noted best practice (Creswell & Creswell, 2018; Saldaña, 2009). The data drawn from the transcripts was coded in two cycles resulting in emergent

themes. I will cover methodological integrity later to include a discussion of member checking as a tool to assist validity. The following section details the data collection tools that were utilized in the study.

Data Collection Tools

I conducted interviews with the study subjects to evoke their deep thoughts relative to their interpretation of how their lived experiences relate to the research question (Creswell & Creswell, 2018). An interview protocol and script (see Appendix A) was used to prompt dialogue that illuminated the relevant lived experiences of the participants. The script contained open-ended questions, which is recommended to materialize rich data (Babbie, 2017; Creswell & Creswell, 2018; Jacob & Furgerson, 2012; Leech, 2002). My intention was to explore how these executives experienced burnout, with specific interest on how their journey informed their leadership practices and their self-care practices. Example interview questions included:

> Example Question #1: How have you experienced burnout in your career? In your current role?
>
> Example Question #2: How would you describe yourself when you are burned-out?
>
> Example Question #3: Self-care puts you in a position to be more focused to receive…and build resilience. Describe your self-care practices and how they help you prevent, mitigate, and/or remedy burnout?
>
> Example Question #4: Some have reported that the feelings from burnout come from the structure of the system itself. How do you feel about the structural

system being a contributor to burnout? Can you provide examples of how this might be true?

Example Question #5: How has your burnout journey informed your leadership in the context of the epidemic of burnout in healthcare?

Data Analysis

To further explore the research question, this section provides detail on the approach used for analyzing the qualitative data. This phenomenological study employed an inductive strategy where patterns emerged from the raw interview data to formulate a set of themes (Creswell & Creswell, 2018). Therefore, the emergent themes drawn from the lived experiences of the respondents illuminated insights related to the study phenomenon – how this group of healthcare executives experienced job burnout and how those experiences informed their leadership.

Coding

Coding the data is the initial step along a continuum of analytic rigor and interpretation (Creswell & Creswell, 2018; Saldaña, 2009). Coding is exploratory in nature without a predetermined formula; however, I employed a best practice approach that suggests multiple cycles of coding (Saldaña, 2009). After receiving the transcripts from Rev.com, I uploaded the transcripts into the MAXQDA software program, which is a computer-assisted qualitative data analysis tool. I chose MAXQDA as I had experience using this software program as a doctoral student and found it especially helpful in organizing and coding data. The data analysis process progressed from more specific codes generated in the first cycle of open coding to a more generalized grouping of

summary codes that emerged in during the axial coding process. Additionally, I used *in vivo* language wherever possible.

Using multiple cycles of coding is a noted best practice (Creswell & Creswell, 2018; Saldaña, 2009) and I used two coding cycles during my data analysis. The first cycle of open coding illuminated single words, phrases, sentences, or groups of sentences that resulted in 181 descriptive codes that captured 670 unique coded segments based on relevant and emergent patterns within the transcripts. Employing an axial coding approach, I read the transcripts again and reviewed my coding notes and the open codes which resulted in a grouping of the descriptive codes totaling 15 summary or parent codes. From these summary codes, 12 thematic codes emerged. From the emergent codes, the overarching study themes were revealed that answered the research question.

Methodological Integrity

My lens for reviewing the data was filtered by my understanding of the research related to job burnout. Moreover, as someone who was a President of three hospitals within CommonSpirit Health during the time of the study, I brought subjective experiential filters to the coding work. Mindful of these realities, I endeavored to use *in vivo* language for the codes whenever possible and bracketed my experience.

As a means to ensure validity, I used member checking. Member checking includes the sharing of the emergent themes with select respondents to validate the accuracy of the data (Creswell & Creswell, 2018). Additionally, to mitigate any validity issues, I remained focused on the research purpose (Creswell & Creswell, 2018), which is to illuminate the lived experiences of the study sample and I took care not look to generalize their experience to a broader population. I reviewed my notes taken during the

interviews and coding processes to ensure consistency between my coding and the raw data. In addition to bracketing my burnout experiences, I remained reflexive and self-aware of my biases by journaling my thoughts and reactions throughout each stage of the study process. Each of these – bracketing, reflexivity, and journaling are noted best practices for aiding methodological integrity (APA, 2020; Creswell & Creswell, 2018; Moustakas, 1994).

Ethical Considerations

Prior to submitting a request to the IRB, I completed the Creighton University Collaborative Institutional Training Initiative (CITI) for Research Ethics & Compliance Training (October 2020). As part of the IRB process, I provided an overview of any benefits or risks for the subject participants and provided them with a *Bill of Rights for Research Participants* (see the end of Appendix B for the *Bill of Rights*). I did not solicit anyone where I had a direct reporting relationship. Additionally, participants were informed of their option to withdraw from the study at any time.

I took great care to protect confidentiality and anonymity to include ensuring all recordings, transcripts, and dissertation drafts were stored on password protected devices; to which only I used and had access. When reviewing and analyzing the data, I used pseudonyms (the Greek alphabet) for each participant that provided clarity without jeopardizing confidentiality or anonymity. Additionally, I took great care to refrain from using descriptors related to any participant's job location or other relationships that might have exposed their identities. Finally, when using direct quotes, I scrubbed the quotes and made generic any paraphrases, key words, or examples that risked revealing the identity of the participants (Wiles et al., 2008).

Given that the recalling of these lived experiences regarding burnout might lead to emotional distress for participants, I informed the participants that they did not have to answer a particularly sensitive question. Although it was not necessary, I remained ready to stop the interview if a participant became overwhelmed when recalling any of the details shared in their interviews. Finally, I reminded the participants that they can withdraw from the study at any time, for any reason.

Summary

The purpose of Chapter 3 is to describe the methods I used to answer the research question. A qualitative phenomenology method supported my intended purpose to explore the lived experiences of a select sample of CEOs and Presidents serving within CommonSpirit Health and to describe the essence of the phenomenon of executive burnout within this group. I had particular interest in understanding how the executives' leadership and self-care practices are influenced by their journey and thus a hermeneutical phenomenological approach provided a relevant and germane framework that revealed rich personal stories of the individuals studied (Creswell & Creswell, 2018).

I used an interview protocol and script (see Appendix A) to garner the study data. The interviews were recorded and transcribed using Rev.com. A coding software (MAXQDA) program was used to aid in the multi-cycle coding process to elucidate themes. Steps were taken to ensure validity and rigor to include bracketing, reflexivity, and member checking. Participants were briefed on the research process, provided the Study Participant Information Letter and a bill of rights (see Appendix B), briefed on my efforts to ensure anonymity and confidentiality, and were given an opportunity to disenroll upon request anytime along the way. Coming next in Chapter 4, I present and

discuss my evaluation of the study results. In Chapter 5, I focus on implications for practice within healthcare leadership and discuss implications for future research.

CHAPTER FOUR: RESULTS AND FINDINGS

Within this chapter, a description of the results and findings of this study is presented. As summarized in Chapter One, the purpose of this phenomenological study intended to explore the lived experiences of healthcare executives in the context of job burnout. This chapter is organized to present the results that center on answering the research question: how do senior executives of healthcare organizations experience and respond to burnout? Exploring how the personal journeys of healthcare executives in the context of job burnout informed their leadership, and the data herein provides detail on the personal stories and experiences of the respondents. This phenomenological study used an inductive strategy where patterns emerged from the raw interview data to formulate a set of themes (Creswell & Creswell, 2018) drawn from the lived experiences of the respondents that illuminate insights related to the social phenomenon under study.

As detailed in Chapter Two, the context of this study is the epidemic of burnout in the U.S. healthcare industry. Specifically, this study explores the lived experiences of senior healthcare executives (CEOs and/or Presidents) working at CommonSpirit Health focused on how their experiences and personal burnout journey informed their leadership. Nine people who hold the title of CEO and/or President for a market, hospital or hospitals within CommonSpirit Health comprised the study group. This chapter contains the results of the study, summary information on the study participants, an overview of the data analysis process, detail regarding the findings to include the themes and sub-themes that emerged from the study, a discussion, and a summary section.

Results

By using a hermeneutic interpretive methodology, the meaning of the practical acts of the lived experiences of the study participants was revealed through the telling of their personal life stories (Crist & Tanner, 2003). As discussed in Chapter Three, a ground-up lens (Creswell & Poth, 2018) was used to cull quotes from the interview transcripts that formed the emergent, empirical themes (Babbie, 2017) that comprise the results of this study. The interpretive framework used to illuminate these results was chosen in order to convey a deeper understanding (Bengtsson, 2016) of the essence of the lived experiences of the study participants (Creswell & Poth, 2018). This interpretive framework has two parts: textural and structural elements. Textural elements are the rich personal experiences shared by the participants which are supplemented by my research notes and observations during the interviews. Structural elements are the conditions, situations, and/or contextual components that frame and influence the participants' experiences. This hermeneutical interpretative framework facilitated the discovery of the essence and richness of the lived experiences of the participants and the research results (Creswell & Poth, 2018; Moustakas, 1994; Pietkiewicz & Smith, 2014; Tan et al., 2009).

Participants

According to Creswell and Creswell (2018), there is no specific answer to how many participants should be included in a qualitative study and a small sample of 3-10 participants can constitute a satisfactory phenomenology study group. I employed qualifying parameters in an effort to ensure the respondents had sufficient tenure in their roles (five or more years). Additionally, I purposefully looked to include women in the study and three agreed to participate. Primary data was culled from interviews conducted

with nine healthcare CEOs and/or Presidents, who at the time of the study, were all employed with CommonSpirit Health and who were selected via a non-probability purposive sampling technique, which incorporates my own judgement on how well this group represents the study population (Black, 2010). I connected with senior leaders in the various divisions of CommonSpirit Health to help me contact CEOs and/or Presidents who might be willing to participate in this study. All nine of the participants volunteered to join the study after learning more about the topic and expressing an interest in helping to further research in this space. Three women and six men comprised the study group. The participants ranged in age from their early fifties to mid-sixties. They all have tenure in their current or like roles exceeding five years and none of those surveyed are serving in their first role as CEO or President. Five of the nine have clinical backgrounds and four of the nine have terminal degrees. The interviews lasted on average 45 minutes and were conducted via Zoom and recorded using a password protected smart phone and transcribed via Rev.com. The participants' identities are protected by using the Greek alphabet as pseudonyms (see Table 2).

Data Analysis

As described in the *Data Analysis* section of Chapter Three, a multi-cycle coding process to include both open and axial coding cycles was used to elucidate themes from the raw data within the transcripts. After receiving the transcripts from Rev.com, the transcripts were uploaded into the MAXQDA qualitative data analysis software program. Using a multi-cycle approach, moving from more specific to more general data categories, aided in the synthesis of the information resulting in a more thorough analysis of the data.

Table 2

Participant Pseudonyms

Participant Number	Pseudonym
1	Alpha
2	Beta
3	Gamma
4	Delta
5	Epsilon
6	Zeta
7	Eta
8	Omega
9	Iota

My lens for reviewing the data was filtered by my understanding of the research related to job burnout. Moreover, as someone who was a President of three hospitals within CommonSpirit Health during the time of the study, I brought subjective experiential filters to the coding work. Mindful of these realities, I endeavored to use *in vivo* language for the codes whenever possible, which is a noted best practice (Creswell & Creswell, 2018; Saldaña, 2009). Key findings emerged as a result of my use of an interpretive framework that included textural elements (e.g. rich personal experiences shared by the participants) and structural elements (e.g. conditions, situations, and/or contextual components that frame and influence the participants' experiences).

In the first cycle of coding, the insights gleaned from patterns in the data laid the groundwork for the coding categories used in this analysis. This open coding illuminated single words, phrases, sentences, or groups of sentences that resulted in a 181 descriptive codes that captured 685 unique coded segments based on relevant and emergent patterns within the nine transcripts. In the second cycle of coding, I read the transcripts again and reviewed my coding notes resulting in a grouping of the descriptive codes totaling 15 summary or parent codes. After the cycles of coding were complete, the data were reviewed for larger emergent themes based on my understanding of the relevant burnout research and my reflection on the content within the transcripts. From these summary codes, thematic codes emerged. From these emergent codes, the overarching study findings were reveled suggesting that these nine healthcare executives were not suffering from burnout during the study period. However, they did offer examples suggesting they were suffering from stress and frustration primarily caused by structural elements related to their roles.

Determining if the sample size was sufficient included a plan to reach saturation. Once themes were identified, I went back to the transcripts and recordings to ensure there was no new data or information (Bengtsson, 2016; Creswell & Guetterman, 2018). Additionally, I shared major findings and themes with some participants, known as member checking (Creswell & Creswell, 2018), to ensure saturation and accuracy.

Emergent Themes

Two major emergent theme categories were identified within the study data: A) the study participants did not describe themselves as suffering from burnout during the study period and B) they did state they experienced stress and frustrations related to the

structural elements of their jobs during the study period. Within this chapter, these major emergent themes are detailed to include minor emergent themes and sub-themes within each of the major emergent theme categories. Table 3 provides a summary of the number of references and the number of participants who shared reflections relating to these major themes, minor themes, and sub-themes.

Table 3

Study Major Themes, Minor Themes, and Sub-Themes

Themes and Sub-Themes	# of References	# of Participants
Major Theme A – Not Suffering Burnout	256	9
Minor Theme A1 – Resilience	62	7
A1a – Health Issues	7	5
A1b – Positive Attitude	16	6
A1c – A Meaningful Connection to One's Purpose and Job	39	7
Minor Theme A2 – Self-awareness and the Need for a Support Structure	194	9
A2a – Cognitive and Emotional Flexibility	32	7
A2b – Having a Great Boss and a Great Work Team	48	9
A2c – Self-care	114	9
Major Theme B – Stressed and Frustrated	103	9
Minor Theme B1 – Structural Violence	103	9
B1a – Positional Control	32	9
B1b – Time in Role	55	5

B1c – Relationships Trump Bureaucracy	16	4

None of the nine study participants described themselves as experiencing any of the three burnout dimensions of emotional exhaustion, cynicism, or inefficacy during the study period. All of the participants agreed that burnout is a problem within the healthcare industry and supported the impetus and importance of this study exploring the lived experiences of healthcare executives in the context of burnout. Although these healthcare leaders did not describe themselves as suffering from burnout at the time of their interview, three participants offered that they believe they likely had experienced burnout in their past while either serving as a frontline caregiver or as a healthcare executive. For example, when recalling their reflections on their former job while in transition between jobs, Gamma said, "Quite frankly…I was a bit naive. I felt like I was bulletproof and that I could push through about anything. I wish it would have happened earlier in my career…just to be better grounded…from a burnout standpoint." One participant (I have chosen to not use the pseudonym here for fear that this information may be too specific and jeopardize the participant's anonymity) offered that they were burned-out when working as a frontline nurse:

> When I was working in intensive care, I was in my 20s. And one day I just realized something's wrong here. And I started thinking about how what was happening for me at work. And what I noticed in reflection was because I was very tired, you know just more tired than usual, because I had a ton of energy back then. You know, and I was running and I think I was taking pretty good care of myself, but I was noticing that I always asked for the sickest patients. And in

> reflection, because I didn't know, I was burned-out…I knew something was different and I needed to make a change.

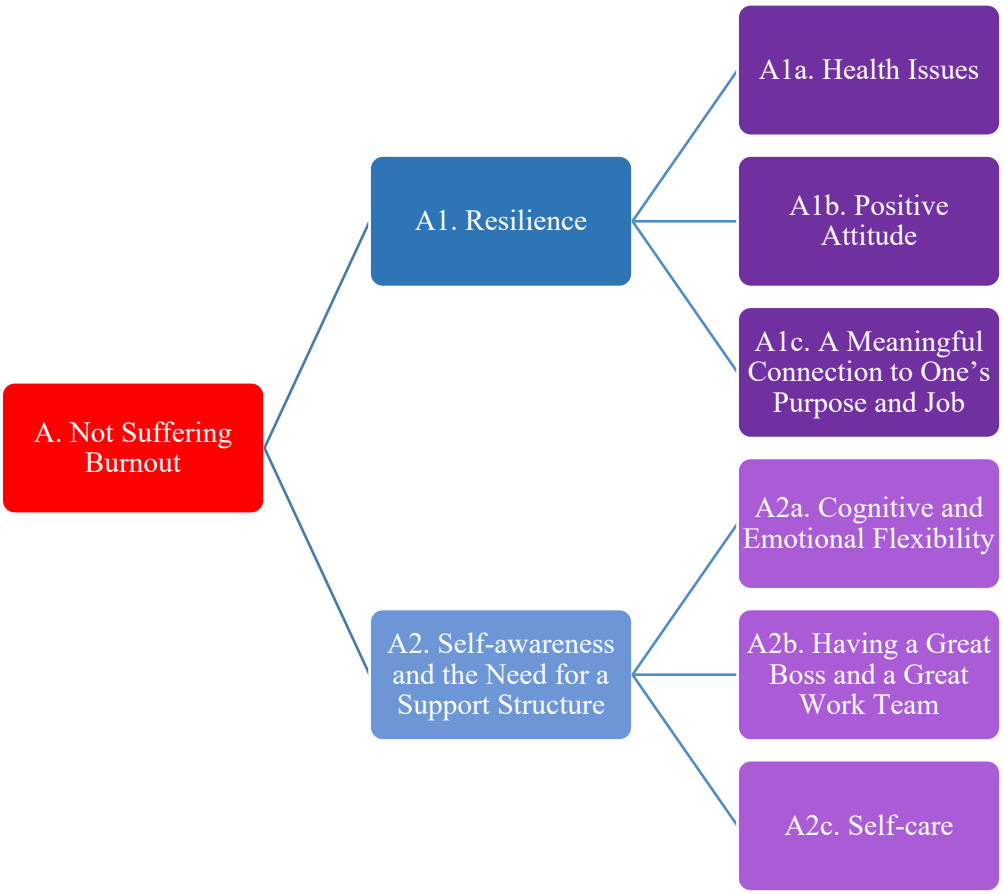
The major emergent theme that these healthcare executives were not experiencing burnout during the study period will be explored in the following section.

Major Emergent Theme A: Not Suffering Burnout

The following sections detail themes and sub-themes that emerged using a textural lens to illuminate the personal experiences of the study participants. The first major emergent theme suggests that these executives did not suffer from burnout during the study period. The minor emergent themes that lend support to the finding that these CEOs were not suffering from burnout include: 1) Resilience and 2) Self-awareness and the Need for a Support Structure. Within the minor theme of resilience there are three sub-themes: 1a) Health Issues, 1b) Positive Attitude, and 1c) A Meaningful Connection to One's Purpose and Job. Within the minor theme of Self-awareness and the Need for a Support Structure there are three sub-themes: 2a) Cognitive and Emotional Flexibility, 2b) Having a Great Boss and a Great Work Team, and 2c) Self-care. The first major emergent theme finding that the participants were not suffering from burnout and the supporting minor emergent themes and sub-themes are detailed in Figure 1.

Figure 1

Major Emergent Theme A - Not Suffering Burnout with its Supporting Minor Themes & Sub-Themes



Major Emergent Theme A: Not Suffering Burnout; Minor Emergent Theme A1: Resilience

"I mean…it's all relative." The preceding quote best describes this emergent theme and is *in vivo* language that connects with the topic of resilience. The *in vivo* language is drawn from the following statement shared by one of the participants (their pseudonym has been removed to ensure their anonymity is protected):

> I mean…it's all relative you know? I have a 15-month old grandchild who's lived their entire first year of life, along with their parents, in a 10x10 hospital room. I have nothing to get burned-out about here.

When the participant shared this sentiment, they did so with a relaxed tone and sat back in their chair in a motion that signaled a real sense of relief and gratitude. This theme of resilience emerged from sub-themes culled from the study group data that support research findings suggesting traumatic life events, a positive and optimistic orientation, and a meaningful connection to one's work help to manifest and build resiliency (Dweck, 2008). The sub-themes of health issues, positive attitude, and a meaningful connection to one's purpose and job will be detailed further in the following sections.

Major Emergent Theme A: Not Suffering Burnout; Minor Emergent Theme A1: Resilience; Sub-Theme A1a: Health Issues. "Maybe [I'm more resilient] because I got to have cancer" (Eta). Five of the nine participants detailed their personal stories of health ailments or trauma that have enhanced their resilience, which has informed their leadership towards dealing with occupational stress. Two of the nine also shared that health issues regarding their family members contributed in similar ways to bolstering their resilience. Delta shared that their work stress may have contributed to their cancer diagnosis:

> When my oncologist sat down with me and said, 'You know all the risk factors. We did the genetics and you don't have a genetic risk. You live healthy, you eat healthy, you take care of yourself and all those things. Your risk is your stress. It's going to kill you.' Stress causes cancer.

Delta seemed subdued when recalling this realization that their occupational stress may have led to their cancer diagnosis yet resolute when they shared "I think there's a framework for me that needs to be different and I'm exploring that… I'm healthy and good (now). I mean, I'm almost two years (cancer free)." Experiencing these life altering events brings a perspective that stress is a causal factor of health ailments and destressing brings relief as Epsilon suggested when saying, "I am much better (at managing my stress) after that experience (getting sick), than I was before."

Perhaps the best way to summarize the hardiness and resilience gained from living through a life changing event is when Eta shared in a most joyful and encouraging manner regarding their perspective as a cancer survivor, "Maybe it's because I got to have cancer and I it's like every time I like have a shot or something…I'm like, I've had cancer. This means nothing!"

Resilience is also the capacity to deal with job stress that enables the individual to maintain their well-being while achieving their work goals (Mills et al., 2020). Beta shared the following while flashing a smile that signaled a sense of peace, "These personal challenges over the last year have been tough, but from a career perspective, I feel really good about where I'm at and what I'm doing."

When sharing their stories of health issues and trauma, the participants seemed upbeat and positive. Their tone and body language suggested a sense of accomplishment when reflecting on these traumatic experiences, manifesting in a sense of optimism and hope. In summary, these participants were upbeat and positive when sharing experiences that might otherwise be perceived as sullen or negative. Thus, having a positive attitude

emerged as a sub-theme within this category of resilience and hardiness and is detailed further in the following section.

Major Emergent Theme A: Not Suffering Burnout; Minor Emergent Theme A1: Resilience; Sub-Theme A1b: Positive Attitude. "We can do this" (Iota). When Iota recalled their experience battling cancer, they emphasized the importance of having a positive and optimistic attitude, which has helped them survive and thrive since. After hearing from their physician that they would have to endure an additional regimen of chemotherapy after thinking only one round would do, Iota shared, "I remember thinking, what the hell! And so your ability to stay positive and manage your mind in difficult times becomes incredibly important." Iota suggested that their journey through difficult times and their resultant reliance and hardiness have "put tools in my toolbox." Iota described their resilience and hardiness as tools that help them lead more effectively by inspiring them to push through their limits. Additionally, Iota suggested that the best leaders have the "ability to bring people together at the very end to say okay, now we can do this, we can go a little bit further, we can go a little bit harder, we can make this happen."

Six of the nine participants suggested that having a positive attitude was a key element for how they approach their jobs and their lives in general and how they keep burnout at bay. Alpha said, "I think it starts with your attitude. I've got a pretty good attitude all the time" and Beta suggested the best tool for dealing with stress is "your attitude." When discussing how they approach their work and its inherent stressors, Eta added, "I think it helps to have kind of a natural[ly] positive attitude". Many of the

participants emphasized that their optimism and positive attitude stems from a personal connection with their work, which will be explored in the following sub-theme.

Major Emergent Theme A: Not Suffering Burnout; Minor Emergent Theme A1: Resilience; Sub-theme A1c: A Meaningful Connection to One's Purpose and Job. An *in vivo* title for this sub-theme might be the following quote from Eta when they emphatically shared, "I love my job!" Within the data, a sub-theme emerged suggesting that perhaps there is a link between a leader's resiliency and how they personally connect to their job and their organization, their job satisfaction. As shown by Epstein (2017), resilience can be developed over time with practice, especially when one focuses on meaningful elements of their life that bring them joy. Seven of the nine participants shared sentiments on how much they enjoy their job. Some used words like love and others blessed to express their connectedness to what they are doing as healthcare leaders. Not only did Eta say they loved their job, but they also added in a joyful, full voice "I've got a great job!" Beta flashed a broad smile with a real conveyance of fulfillment when saying, "this is the job I've always wanted."

When describing their connection to their role as CEO, Gamma said with enthusiasm, "there isn't any greater time in my life." Delta expressed their love for the role they play within an organization that connects with their personal beliefs when they shared the following while opening their arms and leaning into the camera, "I love our organization. I love everything about this job. I love our mission and our values. I love everything we are [about]." Zeta spoke in a collective and humble voice making an effort to speak for me as I also served as a President in the organization, when sharing the following, "We're very blessed I mean to get to do what we do." Omega's quote seems a

good summary for this subsection as they said definitively, “I work for…one of the best, if not the best…places to work.” Zeta reflectively shared that they were not ever expecting to be a CEO, however, they love learning and being in relationship(s) with people and that their job as CEO connects with their personal ‘why’ because, “I get to do so many other kind(s) of interesting things and be involved in so many different things.” Delta expressed how much they feel connected to their work and view it as a vocation and a calling:

> I really believe that God's just been leading me. I never set out to be a president. I never set out and never thought this is in my path. I love our organization. I love everything about [it]...I love our mission and our values I love everything we are.

Beta spoke to how much they feel personally connected to their work when they expressed that their job was more than just making a profit, “When I found Catholic healthcare, I realized, it was something else. And it's more about people. It’s more about doing the right things you know at the right time for the common good.”

In sharing these stories of why they love their jobs and how they connect to their role on a personal level, the participants conveyed humility and a sense of gratitude. Loving your job alone is not a panacea for burnout. Research suggests that the connection between your passion for the work and your motivation makes a difference with regard to job burnout. An employee who loves their job because they feel a sense of obligation, might be subject to overwork and thus burnout. However, when an employee describes their love for their job without a sense of obligation, they can detach themselves from their work and enjoy other parts of their lives (Trépanier et al., 2014). A second minor theme within this major theme category of emerged as the participants shared the

importance of being conscious and self-aware that their attitude and gratitude cannot alone sustain their success in the long run; they need a support structure to include support in finding time away from their work. The sub-theme of self-awareness and the acknowledgement of the importance of a solid support structured is explored in the next section.

Major Emergent Theme A: Not Suffering Burnout; Minor Emergent Theme A2: Self-awareness and the Need for a Support Structure

The majority of participants shared some perspective on how being aware of their stress and then working to alleviate the stress leads to greater success and happiness in their jobs. Some shared examples of differentiating between stressors that are in one's control and those beyond (this will be explored further in the Structural Violence section). Others shared the importance of their boss and their work teams in providing support for mitigating occupational stress. All nine provided detail on their self-care practices. The first sub-theme within this category illuminates how the participants practice self-awareness to inform their thinking in support of their emotional well-being.

Major Emergent Theme A: Not Suffering Burnout; Minor Emergent Theme A2: Self-awareness and the Need for a Support Structure; Sub-theme A2a: Cognitive and Emotional Flexibility. An *in vivo* descriptor that relates to this sub-theme was offered by Iota when they shared, "you have to know yourself." Many participants shared experiences and examples linking self-awareness to mitigating stress and potentially burnout. Alpha suggested a link to self-control as a mitigator to burnout when they shared, "I've worked with people that I felt like…that maybe we're better at dealing with stressful situations and not have that burnout type of feel, they were the ones that

had more self-control." After discussing some of the lessons learned throughout their career, Beta shared the following reflection with a sense of enlightenment and self-realization that they have the power to influence their own thinking and thus their outlook:

> I found out that if I change my thought process on myself personally, I will last a lot longer. And so that's kind of where I'm at now. I feel really good about where I'm at…what I'm doing…[and]how much longer I want to do it.

Iota's sharing illuminates the importance of first knowing thyself and also knowing that your stress can be imparted on others, "I spend a lot of time, making sure I keep myself in check." Iota shared an example of the power of self-reflection and self-awareness when contemplating how one's stress and their ability to mitigate the stress impacts others (Shanafelt et al., 2020):

> So how do you keep that high stress environment from becoming so acute that it impacts your ability to be effective? And, for me, you have to know yourself, you have to know what happens when you get under stress. So what are the attributes that you get…that you express when you're…when you get under pressure that can negatively impact those around you? And each of us have those trigger points and none of us is perfect. And so you just you have to have some self-awareness and quite frankly, in order to be successful, you gotta know when [to] back away. You gotta know when to back away because if you don't know when to back away, you will permanently impair your ability to be effective, and you will damage a number of key relationships oftentimes in a way that you can't repair.

This sub-theme illuminates the participants' experiences and the emphasis they place on the importance of knowing one's self and how that knowing aids in their stress mitigation and overall leadership success. An additional sub-theme emerged within this category suggesting that the participants are self-aware enough to recognize the importance of having a strong group of colleagues at work. The sub-theme of having a great boss and a great work team is explored in the following section.

Major Emergent Theme A: Not Suffering Burnout; Minor Emergent Theme A2: Self-awareness and the Need for a Support Structure; Sub-theme A2b: Having a Great Boss and a Great Work Team. Omega shared a headline quote for this theme when they said, "My boss…is awesome!" Many of the participants expressed the importance of having a great boss and the role that boss plays in helping the leader to be successful and to keep burnout at bay. After sharing that their boss was "awesome", Omega emphatically said, "And I can tell you, I don't know how things might have been different for me over [these last] years if I hadn't had…two fantastic bosses." Epsilon shared the following in a very matter-of-fact and convincing tone, "I'll tell you one thing, I've been very lucky at choosing great bosses… picking the right boss really does help in managing your burnout." Eta shared how they chose to accept their current role because they were recruited by someone with whom they had a strong and trusting relationship, "so it didn't hurt that I completely trusted [the] person who is…my boss." Delta appropriately summarizes this section when they showed some emotion when speaking about their boss who has since passed away, "this [organization]…loved its leader and I love her too." In addition to having a great boss, many of the participants shared the importance of having a strong work team.

Alpha flashed a smile and chuckled when stating the following, “I’ve worked with some really, really good [people]…all around the hospital and…made tons of, say, friends. Some of them are still working [here]…when I run into [them] we have good conversations.” Alpha went on to offer that they spend many hours at work and emphasized the importance of having meaningful relationships with colleagues and having some fun. Alpha smiled and offered, “the best days [are] when you're [doing] your work…but you're also having maybe a little bit of fun with the people you're interacting with.” Beta shared that some of their joy in work comes from the people on their team and how much that resonates with why they enjoy their job and summarized by enthusiastically offering, “I like working with this team!” When recalling a team success, Gamma shared that the team success really “fills my cup” and made “you feel like…feel more part of the team. Yeah, and it's therapeutic for me.” Eta was exuberant when they shared how much they connect with their peer group and those that report to them and how much the people with whom they work contributes to their job engagement and satisfaction:

> We have this great executive team here, and I mean it's like every morning it's just like a love fest you know, everybody checks in on everybody. So yeah, we've got the coolest team ever you know? I’ve got a great job! I love my team!

The study data demonstrate the importance of having a strong work support structure (e.g. a great boss and a supportive work team) in the formation of resilience for the study participants. Research supports that having a strong support structure at work helps to buffer burnout (Eastburg et al., 1994). So too the importance of self-care emerged from the data. A summary of the participants’ self-care practices and

experiences is summarized in the following section detailing the third and final sub-theme of this section, self-care.

Key Finding A: Not Suffering Burnout; Emergent Theme A2: Self-awareness and the Need for a Support Structure; Sub-theme A2c: Self-care. Epsilon offered a quote that connects with this sub-theme when they suggested the following, "We need to be able to have that time to depressurize." As detailed in Chapter Two, self-care includes those activities focused on an individual's health and well-being in the context of job stress to include activities or programs focused on physical, psychological (mental), emotional, and spiritual well-being (Bressi & Vaden, 2017; Loehr & Schwartz, 2001; Saakvitne et al., 1996). Perhaps the *in vivo* term "depressurize" shared by Epsilon best summarizes this sub-theme of self-care. Zeta shared how important it is for them to "turn my brain off and I'm not thinking about work or work stuff. And so you know I mean…I think being very thoughtful and very conscious about that [turning off my brain]." Table 4 contains those activities and practices that helped these executives get away and depressurize; or as Beta shared, to remove themselves from "the fishbowl."

Table 4

Self-care as a Source of Stress Relief and Burnout Mitigation

Self-care Categories	Example quotes
Faith, prayer, & taking a mental pause	*Emotional, Psychological, and Spiritual Dimension*
Participants described the connection they have with their faith and their prayers lives, which served as sources of respite from stress and sources of energy to persevere	"I invest heavily in prayer and people know that about me. There is seldom a day that goes by that I haven't stopped to try to collect myself and get advice [from God], before I move out or move on. And that's a very comforting process to know

	that for me personally in my faith background, I'm not in this alone." (Iota)
Some participants described being "called' to lead and work in Catholic healthcare – it connects with their 'Why'	"I hope that [one day] I'll meet my creator…I think I'll fall down on the ground and cry. But I hope I can say I did everything I was sent here for. That's what I really hope so that's what motivates me and that's really why I do what I do." (Delta)
Six of the nine participants spoke to the importance of having time to purposefully free their minds from their work and its stressors	"If [prayer] is not for you…if you're not religious…I would say, find something [where] you can mentally pause. I would say [do] breathing exercises…something just to stop the world and pause." (Gamma)
Family and friends	*Emotional and Psychological Dimension*
Eight of the nine participants spoke to the importance of family and friends and the role they play as part of their self-care support to relieve stress, mitigate burnout and find joy	"I love time with my family, my kiddos, my [spouse]." (Delta) "I'm just super blessed; I have a great [spouse and] we have awesome kids." (Eta) "My neighbors [are] some of [my] best friends. [They are] a big part of my self-care." (Omega)
Sleep, diet, & laughter	*Emotional, Psychological, and Physical Dimension*
Four of the nine participants spoke to the importance of routine sleep practices and/or a healthy diet. Two participants called out the laughter and humor as important ingredients to proper self-care	"I eat really well. I laugh all the time. I laugh constantly." (Eta) "Humor…I think that's critically important." (Omega) "I think it's a blessing for me…I have eight hours of sleep." (Alpha)

Hobbies and exercise	*Emotional, Physical, Psychological, and Spiritual*
Six of the nine spoke in detail about their hobbies and the importance of having a release from the stressors of the job. Hobbies described include: art & photography, traveling, music, woodworking, running, weightlifting, bicycling, hiking, skiing, golf, tennis, pickle ball, motorsports, yoga, and puzzles	"I'm picking tennis back up. Playing more golf and learning to play pickle ball. (Beta) "I have a workshop. To do it right, you have to have real concentrated time." (Epsilon) "I'm a big exerciser. That's super important to me for [my] self-care." (Delta)

All of the participants shared detail on their self-care practices. The range of activities and practices connected with the well-being and self-care categories of physical, psychological (mental), emotional, and spiritual. Beta and Zeta summarized the essence of self-care practices on whole for the group by describing each of the root words within the term. When contemplating the importance of "self", Beta shared, "I've got to have some me time. I need a little time for myself!" When emphasizing the "care" elements, Zeta connected with the intended outcome of self-care when sharing, "[These] activities that I do, are the times when I can actually turn my brain off and I'm not thinking about work or work stuff."

The participants shared that recharging the body, soul, and mind through hobbies and activities form the foundation of the self-care practices that perhaps keep them from burnout. Although the participants did not describe themselves as suffering from burnout during the study period, they did share their experiences of being stressed and frustrated.

Thus, the second major emergent theme of being stressed and frustrated is detailed in the following sections.

Major Emergent Theme B: Stressed and Frustrated

The second part of the interpretive framework used for this study focuses on structural elements. Conditions, situations, and/or contextual components that frame and influence the participants' experiences are the structural elements that inform this interpretive framework. In using this structural framework, the second major emergent theme details how the CEOs described themselves as being stressed and/or frustrated.

Although these CEOs did not describe themselves as suffering from burnout at the time of the study, all nine did speak to their occupational stress by using words such as stress, frustrated or frustration when answering questions exploring their experiences working in the healthcare industry. Specifically, Eta suggested that she was frustrated and not burned-out when sharing, "Maybe there's a [better] word like frustration." The participants seemed to be avoiding the term burnout and some shared that the term had negative connotations. Iota offered the following that provides some insight as to why these healthcare leaders may be using other words to describe their experiences:

> I don't necessarily like the term burnout. Burnout, I think, to me, implies an end-game and I think there's some real negative connotations around the term burnout. There may be another way to frame [it] that talks about acute stress. In my mind…for me, that feels a better way to articulate what's going on at least in my personal experience.

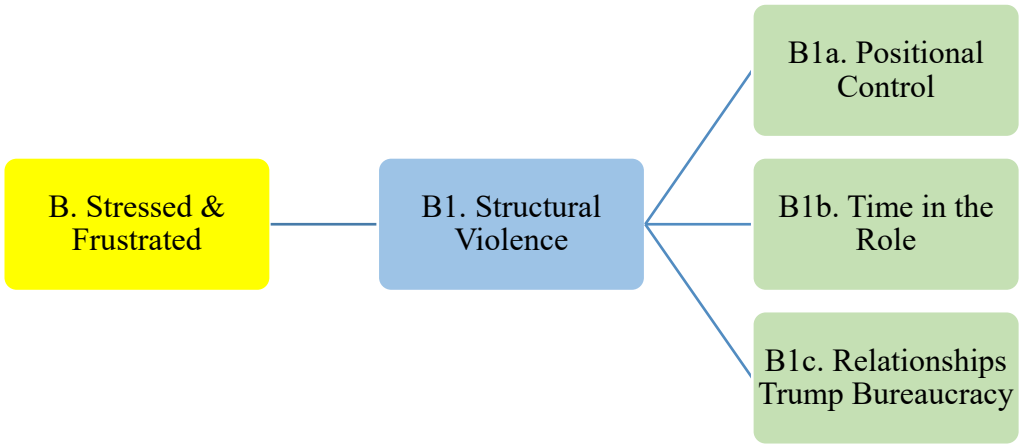
Emergent data supported the finding that the CEOs described that they had experienced and/or were experiencing periods of stress or frustration during the study period. The data

did not support that the participants are experiencing the burnout symptoms of emotional exhaustion, cynicism, or ineffectiveness.

Although perhaps not suffering from burnout during the study period, the study participants did share many experiences of stress and frustration. These data suggested that the stress and frustration experienced by the study participants was caused by factors connected with the structure of their work environments. As described in Chapter Two, research supports the link between burnout in caregivers and the structural elements embedded in the current healthcare systems (e.g. EHR, productivity, regulatory demands, etc.), which seem beyond the control of the caregivers (Dean et al., 2019). These healthcare executives shared experiences, although not exactly the same as caregivers, that connected with the concept of structural issues as causal factors of stress. Thus, a minor emergent theme relating to Structural Violence emerged within the second major emergent theme category. Three sub-themes are contained within this minor emergent theme, which are: B1a) Positional Control, B1b) Time in the Role, and B1c) Relationships Trump Bureaucracy (*in vivo*). The second major emergent theme that the participants suffered stress and frustration and the supporting emergent theme and sub-themes are summarized in Figure 2.

Figure 2

Major Emergent Theme B – Stressed & Frustrated and its Supporting Minor Theme & Sub-Themes



Major Emergent Theme B: Stressed and Frustrated; Minor Emergent Theme B1: Structural Violence

As detailed in Chapter Two, the concept of structural violence emerged in the literature and suggests that causal factors manifesting burnout in healthcare is related to extant structural elements within the healthcare industry and healthcare organizations (Reith, 2018; Shanafelt et al., 2012; Shanafelt et al., 2015; Shanafelt & Noseworthy, 2017; Talbot & Dean, 2018; Wohlever, 2020). All nine of the participants shared their experiences and thoughts regarding the impact that structural elements have on their stress levels and how it impacts members of their teams. A majority of the study participants shared reflections on their experiences suggesting they and some of their teammates, like caregivers, were subject to stress and frustration due to structural elements within their jobs. Most of the participants suggested that structural elements, if

understood and leveraged well, can actually add benefit to their jobs and mitigate stress. One of the nine shared that they are not stressed nor frustrated with structural elements, but see the frustration in others and in members of their team.

As discussed in Chapter Two, stress is not always negative and can have beneficial aspects, known as eustress which can help individuals grow and enhance their performance (Lepine et al., 2005; Quick et al., 2004; Quick & Henderson, 2016). Although the majority of the data relate to negative (stress) impacts of the structural framework, some positive (eustress) aspects did emerge across all three sub-themes and are included in the sub-theme details. The first sub-theme of Positional Control is detailed in the following section.

Major Emergent Theme B: Stressed and Frustrated; Minor Emergent Theme B1: Structural Violence; Sub-theme B1a: Positional Control. Two sides of the same coin emerged within this sub-theme, one that has a more negative connotation and one a more positive connotation. On the negative side, the following quote from Epsilon summarizes the sentiments shared by those in the negative camp, “I have all the responsibility, but none of the levers I used to have in leadership.” On the positive side, Zeta shared, “Let's focus on the things we can control.”

Some researchers posit that CEOs are less prone to burnout because they have greater control, in large part due to their positions as lead executives and decision makers (Bakker & Demerouti, 2017; Sherman et al., 2012; Waytz et al., 2015). The opposite can be assumed to be true when control and or decision making capability and authority are diminished and/or removed. A common thread emerged as many of the participants suggested there was a mis-alignment between the decision making authority at a

corporate level and at a local level. Epsilon shared in a defeated, c'est la vie tone, "the accountability alignment is off." These study data suggested that the mis-alignment of the accountability and decision-making authority is a cause of stress, frustration, and even dissonance for the majority of the participants. This corresponds with literature suggesting the loss or lack of control leads to higher levels of occupational stress and burnout (Bakker & Demerouti, 2017). That said, a minority of the participants did share their reflections and experiences suggesting positive aspects of the structural framework. Both negative (stress) and positive (eustress) aspects of positional control emerged from the data and are detailed in the following section with the negative aspects detailed first.

Negative Aspects of Positional Control. Eta shared that they believe the mis-alignment of accountability and positional control could lead to burnout and/or people leaving their jobs:

> We have much less autonomy in our leadership in things that you would never have guessed would have happened. I mean it's one thing to standardize policies – that's no big deal to me…I think that's awesome. But to have the decision making at the lowest level be taken away…it's so interesting to me and sort of like you know I can't tell you how many times, people are here are saying, 'so why do they need us?' That's a frustration, you know?! I worry we are going to lose our highest talent, because great leaders like to lead. I don't like being put in a bottle and told exactly what to do [on] every move. And so that may not tie into burnout at all, but I worry that it will, or at least [lead to] some signs of it.

Delta suggested that the term structural violence was perhaps too strong of a term, but did agree they experienced stress and frustration that resulted from what they described as structural dissonance:

> I [one] hundred percent believe in the [impact of the] structural [elements]. I would say, structural dissonance or structural barriers that get in the way of an executive being able to move. And I think there [are] bureaucratic challenges, I think there [are] systemic challenges.

Carrying this dissonance between local and national decision making further, Zeta shared, “you can't run a 22-state health system from a corporate office.” Beta shared a similar reflection of this mis-alignment between national and local positional control and decision making authority and the resultant frustration:

> National is taking the decision rights away from us. And they haven't taken the pain away from us necessarily but they've taken the authority in the decision rights away. And so, when you grow up in organizations, where you're used to making decisions, and you have all the accountability all the authority and don’t necessarily have that today. That's a challenge.

Perhaps the best way to summarize the risks that this dissonance between national and local decision control and authority may have on an executive’s stress and potential burnout was offered by Epsilon when they shared the following in a solemn and somewhat exasperated tone:

> When we're focused not on the market and not on our patients but on what corporate wants…that leads to more stress. I spend more time doing that than I do [on] just about anything else in terms of emotional energy.

Despite the emergent stress and frustration caused by losing positional control, some participants discussed the importance of regaining control in other ways and in other aspects of their roles. Omega's sharing connects with this concept when they spoke about having the self-awareness to know that undue worry about things beyond their control creates stress and causes them to be ineffective, "So I can't control, a lot of stuff and you know that circle of influence control etc.; so…when I find myself getting tense and stressed, is when I go to that place of ineffectiveness". When Alpha recalled witnessing others being stressed, they paused and in a tone of revelation shared the following:

> I think one of the drivers for burnout…[is] not having control. You know things aren't going well in your work, for whatever reason. Maybe you've got a lot of stress, maybe you've got too much work and not having the ability to do much about it.

These reflections by Omega and Alpha regarding the loss of control and its impact on burnout is supported by research suggesting that having greater control in one's job increases engagement and lowers burnout (Bakker et al., 2007). Alpha went on to describe an example of someone who might be suffering from the burnout when they shared:

> You know you get in a situation, and I can certainly see how people get in that situation, where they just feel totally overwhelmed. They don't see things getting better and you know…after a while, of course, it depends on the person, how long they can handle that but, after a while anyone is going to - I think all of us are going to start pulling back in[to] our shell.

Focusing on one's personal level of control can serve to mitigate stress and can have a positive influence on helping others to lower their stress (Bakker et al., 2007; Shanafelt et al., 2020; Sherman et al., 2012). The positive attributes of positional control are detailed in the following section.

Positive Aspects of Positional Control. Beta spoke about being self-aware enough to know that they are stressed and their stress might restrict their ability to be effective in their work in the long run, "so I try to be aware of [my stress]. And so, but I think, as you do that and learn to control that I think that's how you can have some longevity in work." Zeta discussed how to get their team to focus on those things that they can control and influence in order to relieve stress:

> We spent a lot of time talking about other things that we can control and really trying to focus on that. And you know we can grieve a little bit [about losing control], but basically get you know we don't control this anymore; we don't really have a lot of influence on [this] anymore…yeah let's bitch about it for 30 minutes and then now let's put that away and let's focus on the things we can control.

Gamma offered a take that fits with scholarship suggesting that higher job control is positively correlated to job satisfaction and negatively correlated to burnout (Bakker et al., 2007; Bakker & Demerouti, 2017) when sharing:

> Control what you can control…when you feel like that, you're overwhelmed that you're stressed beyond belief, more times than not it's the feeling of not being in control and not being able to do something to get you down a better path. So flip the scenario and just even if you have to take a piece of paper and list out a few

> things to focus on that you know you have complete control over for the next few weeks, months, whatever it takes. I know it's completely in my control, I tend to narrow in on those things, and for a period of time, just for my own health, focus on those because I know I can improve those…that it is all on me and I focus in on those things.

The experiences shared by the participants connected with the research that suggests greater executive control and the power derived from being the chief executive serves as a mitigating factor for occupational stress and burnout (Harms et al., 2017; Sherman et al., 2012; Waytz et al., 2015). Conversely, when this executive positional control is lost, it can lead to stress, frustration, dissonance, and perhaps even burnout (Bakker & Demerouti, 2017). As shown in the data, some of the executives emphasized the importance of having the self-awareness and self-realization to focus on those things where one has the greatest control as a means to lower their stress levels. Other stress mitigating factors like positional tenure and relationships emerged within the study data and will be detailed in the following sections.

Major Emergent Theme B: Stressed and Frustrated; Minor Emergent Theme B1: Structural Violence; Sub-theme B1b: Time in the Role. The following quote nicely summarizes a sub-theme that emerged from the data related to the participants' tenure in their role and how near they are to retirement and the resultant influence tenure has on stress and burnout, "different places in your career or different circumstances would cause you to react differently, maybe to the structure or the elements of the structure" **(**Beta).

Two divergent perspectives emerged within this sub-theme where some of the participants suggested that executives who are nearing the end of their careers (i.e. in their final job before retirement) can handle the stress that comes from structural elements better than those who are not nearing retirement. Other participants suggested the opposite; that executives who are earlier in their careers can better handle the more overt structural control emanating from beyond the local level (i.e. national or corporate). Beta shared that they could handle the structural elements better than they might have done earlier in their career because they are in their last job. They also suggested that the younger generation is perhaps better positioned to deal with the structural elements than older executives might have been:

> Now 10 years ago I would be frustrated and probably look for another job. Now that this is the last job that I want to have, I can tolerate it, right? It's like, okay… well I can't do anything about [the structure]. I'm just going to follow the direction and keep the peace, and you know…not buck the system and move on. But 10 years ago I wouldn't do that. Years ago I would have said okay I'm leaving. I think people that have had autonomy in the workplace struggle with [corporate]. If people that are young, that are getting promoted up, that's all they know. And they're fine with that."

Iota supported that perhaps younger executives can handle the stress better, "I think when you're younger in your career, you are more apt to…[you're] better able to tolerate. [You are] more patient…than you are in the second half of your career." Similar to Beta, Eta suggested they can "let it go" when discussing how they mitigate some of the stress of the structural elements because they are nearing retirement, "I actually won't mind retiring, I

have like five more years but [the structure], it's like…so frustrating, but I also have the ability to let it go."

Others shared their thoughts on how structural violence might impact younger executives. Epsilon lamented that the younger generation of healthcare executives may not get to experience the autonomy that Epsilon did when they were a younger executive:

> I feel sorry for a lot of the younger folks because [they're] not going to get as broad of scope as I got. Where people are in their career will make a lot of difference. For me, it's kind of like, I can ride this out. But younger people, they're looking for 'how do I have a career that blends the best of everything?' I think that's a real problem that we're going to have with the people that are mid-career, [who] have another 15-20 years left to go.

Similarly, Eta shared their concern that executives, not in their last job, might be most vulnerable to structural violence:

> Great leaders thrive on being accountable. And if you're not accountable for any decisions, then you're not accountable. I mean, you can't be accountable for the results and not [make] the decisions. I would worry that we would create such frustration for those who are used to being great leaders…getting, great results being responsible and accountable for those [results]. That putting them in such a structured, non-decision making role will just not be satisfying to them.

In support of this theme that those not in their last job might find the decrease of positional power frustrating, Omega, who did not share anything to suggest that they are nearing retirement, said, "And now…it feels like decision by committee. And I found myself thinking, I'm a hospital President. Why can't I make the decision?" Iota shared

that they too believe those who have had greater levels of autonomy earlier in their career, might struggle with a national structure that concentrates decision making at a corporate level:

> If you're not used to it [corporate decision making], then you're going to be stressed to the max because you're going to feel like you've got this top-down structure imposed upon you; that limits your ability to be effective.

In summary, the study data suggested that these participants believe where one is currently on their career timeline and trajectory can influence how they perceive stressors related to their corporate structure. However, not all participants felt that a strong national corporate structure was all bad and the study data suggest there are some positives to such a structure. These positive elements will be explored in the final sub-theme that is titled using *in vivo* language – relationships trump bureaucracy.

Major Emergent Theme B: Stressed and Frustrated; Minor Theme B1: Structural Violence; Sub-theme B1c: Relationships Trump Bureaucracy. The title of this final sub-theme is derived from *in vivo* language shared by Gamma when discussing how to succeed in a national corporate structure:

> I [have] learned that relationships trump bureaucracy. And after a while, if you've got good relationships, you actually get more done in a bureaucratic system then you can in one that's not because most people don't know how to navigate the bureaucracy. And you got the relationships, so you get the capital, you get the…you know, the extra FTE (full time equivalent), you get this, you get that because of your relationships.

Iota shared the importance of relationships when discussing the role of a senior leader in establishing strong trusting relationships as foundation to one's successful leadership practice that leads to high engagement of followers (Holland et al., 2017):

> What I've always talked about with my team is leadership's a relational activity. I mean, you have to have a relationship with the people that you're leading. That does not mean you're going out to dinner three nights a week with them…it (having a relationship) means you; you know them and they know you and there's a trust. That implies that there's a two-way trust in play.

Gamma also suggested that forming relationships within a large bureaucracy is based on building and earning trust with others, "It [building relationships] is a feeling of who can I trust." Additionally, Omega shared that they believe these relationships help by seeking assistance from others, like your boss, who can possibly help you navigate the structure and bureaucracy and support you in advocating for your cause or point of view:

> If you feel like you've discharged your leadership responsibility, it helps you to cope with the infrastructure to just say I did what I could and it's okay, I need to accept what is and help manage it in a positive way.

Iota suggests that once you realize that the national structure includes experts who can be leveraged to help bring about desired outcomes at a local level, success can be achieved "Because…it's a highly matrixed structure. It involves a lot of technical experts at a national and regional level that are available to help improve outcomes. If you use the structure that way."

Although a minority, a few participants shared thoughts and experiences offering a more positive outlook on the benefits of a national corporate structure. Establishing and

then leveraging trusting relationships can manifest positive outcomes for the leader and their organization (Holland et al., 2017). Additionally, finding a way to creatively engage with the bureaucracy via these relationships, one can find joy as Gamma suggests, "You can have some joy out of being creative within a bureaucracy." This positive orientation and motivation in finding creative ways to succeed within the structure of one's work (also called job crafting) has been associated with lower levels of burnout and higher levels of job satisfaction (Bakker & Demerouti, 2017; Tims et al., 2013).

Summary

By using a hermeneutical interpretive framework that included textural and structural elements, this phenomenological study facilitated the discovery of the essence and richness of the lived experiences of the study participants (Creswell & Poth, 2018; Moustakas, 1994; Pietkiewicz & Smith, 2014; Tan et al., 2009). This qualitative approach produced data that illuminated how the study participants were living and leading in the context of burnout in the healthcare industry. All the study participants expressed their support for this study exploring how senior healthcare executives experience stress and/or burnout and how it impacts their leadership. Two major themes emerged that comprise the two key findings of this study. The first key finding was that study participants did not describe themselves as suffering from burnout. The second key finding was that the participants did describe experiences of stress and frustration. The significance of these key findings is summarized in the following sections.

Significance of Major Emergent Theme A: Not Suffering Burnout

Given that none of the nine senior healthcare executives described themselves as burned-out, this was a key finding of this study. This finding was not a complete surprise

as there is very little in the extant literature that explores or suggests there is a crisis of burnout in healthcare executives. Perhaps the participants had a reluctance to use the term burnout as it has negative connotations or suggests "an end-game" as shared by Iota. It is possible that the participants were not burned-out as it is clinically defined (emotional exhaustion, cynicism, inefficacy). It is also possible that the participants were buffered from burnout due to their positive disposition, resilience, and self-awareness regarding the need for a support structure.

Participant resilience emerged as a minor theme supported by experiences suggesting that living through health issues and trauma promote resilience. Additionally, having a positive attitude and a strong connection to one's job enhanced the participants' resilience. The participants shared how important it is to be self-aware and reflective regarding the necessity of having a strong support structure, which emerged as another minor theme within this key finding of not suffering burnout. Some participants discussed being open-minded and flexible in their thinking as a means to mitigate their job stress. Others detailed the significance of having a great boss and a great work team. All nine emphasized the importance of proper self-care and shared detailed examples of how their self-care regimens fill their cups, help them to depressurize, and keep them balanced. Whether buffered from burnout or reluctant to describe themselves as such, the data did support the finding that the study participants experienced stress and frustration in their roles as senior healthcare executives.

Significance of Major Emergent Theme B: Stressed and Frustrated

Despite their reluctance to use the term burnout, the study participants did share experiences using rich examples and language related to stress, frustration, and

dissonance. This second key finding of the study emerged from the interpretive framework exploring structural conditions and contextual components that influenced the participants' experiences. The participants shared detail on how their position and its resultant control influenced their job stress and frustrations. Additionally, many participants discussed the impact that tenure or time in one's role played on stress and frustration levels. Lastly, some participants shared their view that structural elements can be turned into positives with specific focus on the importance of relationships.

Several themes emerged from the study supporting the findings that participants were not suffering from burnout during the study period due to their levels of resilience and self-awareness. Additionally, the importance of having a robust support structure and self-care regime were key ingredients to blunt burnout and stress. Many participants suggested that the term burnout was negative and perpetuated a stigma; perhaps supporting the finding that they were not suffering from burnout during the study period. Although not burned-out, the study findings produced themes that support the conclusion that these executives did suffer periods of stress and frustration. This stress and frustration derived from the structural elements within the study participants' organizational structures. These key findings and supporting themes and sub-themes comprise the foundation for the proposed solution detailed in Chapter Five.

CHAPTER FIVE: PROPOSED SOLUTION AND IMPLICATIONS

This study focused on exploring the lived experiences of healthcare executives in the context of job burnout and how these experiences influenced the leadership practices of the study participants. Contained within this chapter is the study aim statement along with a brief summary of the study. A proposed solution with evidence from the study supporting the solution is detailed along with evidence that challenges the solution. The evidence that supports the solution also serves as a summary of the themes and sub-themes that support the study conclusions. To add some further insight, a section on the science of happiness and how it connects with the study findings is included. The chapter concludes with a section on the implementation of the solution, implications for practice and future research, strengths and limitations of the study, and a summary of the dissertation in practice.

Aim Statement

The aim of this study was to provide evidence-based leadership best practices in the context of job burnout oriented towards leaders of healthcare organizations. The study was intended to spur further exploration and research regarding how healthcare executives personally deal with burnout and how that influences their leadership on the topic. Furthermore, this study focused on illuminating insights for leaders beyond CommonSpirit Health who might be dealing with burnout personally or who are leading their organization’s response to burnout within their workforces.

Summary of the Study

Nine CEOs or Presidents who served in their roles for five years or more at CommonSpirit Health were selected via a non-probability purposive sampling technique,

which incorporated my own judgement on how well this group represented the study population (Black, 2010). All participants agreed to partake in a single, 90-minute Zoom interview. The participants answered open-ended, semi-structured questions focused on a textural and structural interpretive framework prompting them to share their rich lived experiences as senior healthcare leaders in the context of burnout. Upon completion of multi-cycle coding and data analyses, two major themes, three minor themes, and nine sub-themes emerged. These themes served to answer the research question and are supported by academic literature. The following research question guided this qualitative study:

> **Research question:** How do senior executives of healthcare organizations experience and respond to burnout?

Proposed Solution

Each of the nine study participants agreed that healthcare leaders play an important role in the work to address the epidemic of burnout in healthcare. Based on the findings of this study and the supporting academic literature, I contend that perhaps the best way to begin the work necessary to address burnout in their firms is for senior healthcare executives to do the following:

1. acknowledge the problem of burnout in healthcare and make the recognition, treatment and mitigation of burnout a strategic priority for the organizations these executives lead (Shanafelt et al., 2018; Shanafelt & Noseworthy, 2017; Wohlever, 2020),
2. spend the requisite time in reflection, recovery, and mitigation regarding their own burnout journey and the ways they remain resilient in the face of structural

elements that cause them stress and frustration (Boyatzis et al., 2002; McKee et al., 2006; Voci et al., 2016),

3. promote a culture where caregivers and executives transparently share their burnout journeys while emphasizing the power of resilience, which can be grown (Epstein, 2017) and should be a focus of the learning and development programs of healthcare organizations, and
4. share their positional power and collaborate with those nearest the work to address the systemic, structural causal factors underlying burnout while promoting resilience training to blunt the epidemic of burnout (Harms et al., 2017; Houtrow, 2020; Oc & Bashshur, 2013; Shanafelt & Noseworthy, 2017; Talbot & Dean, 2018; Walsh et al., 2019; West et al., 2016; Wohlever, 2020).

Evidence that Supports the Solution

The following major themes, minor themes, and sub-themes emerged from the study to answer the research question: How do senior executives of healthcare organizations experience and respond to burnout? The following section details how these themes lend evidence to support the proposed solution.

Not Suffering Burnout

All of the study participants agreed that burnout has reached epidemic levels within healthcare and acknowledged the importance of this study. Many also supported the importance of making burnout recognition and mitigation a strategic priority for their organizations. Not one of the nine said they were suffering from burnout during the study period but did share experiences of stress and frustration stemming from the structural elements extant in their jobs. It appears that the term burnout equates to a stigma or

portends an “end game” (Participant Iota) and thus, has a negative connotation for this group. The fact that these senior healthcare executives refrained from using the term burnout connects with recent research regarding caregiver burnout that aims to erase the stigma that burned-out caregivers are weak (Wohlever, 2020). In an effort to emphasize the importance of the phenomenon of burnout, healthcare executives who share this position that burnout is a negative term will do well to explain their position and acknowledge that burnout is a strategic priority and the term should not bring shame to those suffering burnout.

Resilience (Health Issues). Perhaps these executives did not suffer from burnout because they possessed greater levels of resilience as a product of their lived experiences and their resultant hardiness. The stories of personal struggle and trauma across the majority of the study participants is supported by research suggesting that resilient people are able to move beyond their trauma and stress because they have built resiliency derived from their experiences with adversity (Jackson et al., 2007; Tugade & Fredrickson, 2004). These executives seemed more in-tuned to how their traumatic experiences awakened their realization that they control their response to stress. This greater sense of control and commitment to their lives manifested a hardy disposition and better coping strategies (Gentry and Kobasa; 1984; Kobasa, 1979). Additionally, these executives demonstrated a confidence in their ability to cope with stress by being proactive and dealing with their problems head-on as opposed to feeling powerless and avoiding issues altogether (Soderstrom et al., 2000). Research supports the notion that resilience capacity can be developed and those that grow and sustain their resiliency have lower levels of burnout (Epstein, 2017; Mealer et al., 2012; O’Dowd et al., 2018).

Resilience (Positive Attitude and A Meaningful Connection to One's Purpose and Job). Most participants spoke to the importance of having a positive attitude. Possessing a positive attitude connects with research suggesting that individuals with greater resiliency tend to have genetic compositions (higher levels of positive hormones like serotonin and dopamine, and lower levels of stress hormones) and underlying personalities that are more positive and optimistic (Cicchetti & Rogosch, 2012; Mealer et al., 2012; Soderstrom et al., 2000). Additionally, individuals who are connected on a personal level with their work have greater resiliency (Epstein, 2017).

Self-awareness and the Need for a Support Structure (Cognitive and Emotional Flexibility, Having a Great Boss and a Great Work Team, and Self-care). The participants shared the importance of being self-aware enough to know that optimism and positivity can be sustained and enhanced through strong relationships inside and outside of work. Additionally, a consistent and focused self-care regimen emerged as a key component to mitigating burnout in this group. The study participants shared how important it was for them to monitor their thinking to remain reflective and self-aware as a key practice to remain connected with and responsive to their teams and to best lead their organizations. This self-awareness and reflectiveness is supported by literature suggesting that self-aware and reflective leaders improve their leadership practices in order to best respond to challenges and opportunities present within their firms (Finkelstein et al., 2015). Moreover, when a leader practices self-awareness and self-reflection regarding their own stress, they aid in the mitigation of stress for others (Shanafelt et al., 2020). Research supports the importance of how leaders treat their employees; as this relationship between employee and their boss plays a critical role in

burnout emergence and mitigation (Wigert & Agrawal, 2018). Additionally, research suggests that employees have higher levels of resilience when their boss is a positive factor in their lives (Harland et al., 2005). As demonstrated in the literature, when a CEO promotes a personal and organizational commitment to self-care, burnout is mitigated across the organization (Voci et al., 2016).

Stressed and Frustrated (Structural Violence)

The participants did share that they suffer stress and frustrations in their jobs and emphasized the interplay between the corporate or organizational structure and their stress levels and stress management approaches. The majority of the participant connected with the concept of structural violence, which results from structural frameworks embedded in culture and/or the workplace that impair a basic human need leading to a state of moral distress or injury (Farmer et al., 2006; T. Lenz, personal communication, November 16, 2020). Although some participants balked at the term and suggested that the language might be softened to something akin to "structural dissonance or structural barriers" (Participant Delta), the word violence emphasizes the moral distress that comes from these structural elements and garners attention.

Positional Control. Many participants connected the concept of positional control and power to a greater level of stress and frustration (lack of control and power) or as a mitigant to stress and frustration (focusing on things within ones control). This aligns with research suggesting a link between one's positional power and control, and their stress levels (Sherman et al., 2012). When one is a senior executive, the greater control derived from their position provides an increased sense of security (Sherman et

al., 2012; Waytz et al., 2015) and aids in their development of tolerance to stress over time (Harms et al., 2017).

Time in Role and Relationships Trump Bureaucracy. Another sub-theme that emerged from the study suggests that the participants believed there is a link between where one is on their career path (i.e. near or far from retirement) and their ability to handle their stress levels. An additional sub-theme suggested that those who have strong relationships can excel in a bureaucratic structure, which is supported by research suggesting the same (Jafari et al., 2020). When a leader invests the time and energy to create trusting relationships, they can then leverage those relationships to manifest positive outcomes for themselves and their organization (Holland et al., 2017).

Perhaps these CEOs did not claim to be suffering from burnout during the study period because they are happy. Research suggests that happy people are more creative and productive at work, have strong and more long-lasting relationships, are healthier and live longer, more resilient when exposed to stress and trauma, and are better leaders (Lyubomirsky, King, & Diener, 2005). The following section explores the connection to the findings of this study and the concept of happiness as a means of successfully mitigating burnout for these study participants.

Happiness Science

Thematic qualities expressed by the study participants such as feeling connected to their work, being called to serve, having a purpose, and a having a positive attitude match with themes found in happiness science. Additionally, the resilience formed from the study participants' life experiences, which bolsters their positive dispositions, also likely protected them from burnout. Emerging from the framework of positive

psychology, happiness can be explored by understanding one's positive emotion or how pleasant their life, their engagement, and their purpose or meaning in life may be (Seligman, 2008). Happiness research suggests that a person's happiness is comprised of heritable elements or genes (50%), one's daily actions (40%), and one's environment or those areas that are further beyond one's control (10%) (Lyubomirsky, Sheldon, & Schkade, 2005). More recent research suggests that how people actually live their lives plays the largest role in sustaining their well-being (Sheldon & Lyubomirsky, 2019). Despite some pushback on the original notion that one's genetic composition comprises the largest influence on happiness, this interplay between genetic composition and life experience is supported by epigenetic research (Brown & Rohrer, 2020; Cicchetti & Rogosch, 2012; Epstein, 2017). Perhaps these study participants were protected from burnout due to a combination of their genetic compositions (their positive proclivities and perspectives) and their life choices and experiences.

As detailed in Chapter Four, many study participants had an aversion to the term burnout and suggested that it portended a negative "end-game" (Iota). Additionally, the participants shared the importance of having a positive attitude, strong social connections with their work teams (and their bosses), and how grateful they were to have their roles. Happiness research supports the finding that happy people are more optimistic, grateful, and engage in more prosocial behavior (Lyubomirsky, 2001). Moreover, the study participants shared the importance of their self-awareness regarding staying positive and properly balanced through a meaningful and consistent self-care regimen. Research supports this finding suggesting that intentional focus on positive aspects of one's role or positive activities bolsters well-being by satisfying one's basic psychological needs of

autonomy (control), competence (efficacy), and having meaningful relationships (Lyubomirsky & Layous, 2013; Vaillant & Mukamal, 2001).

Evidence that Challenges the Solution

Without proper prioritization, the cause for mitigating burnout might fall short while competing with other priorities vying for the attention of healthcare executives. Making the well-being of employees the highest priority in an organization requires intense work to: educate stakeholders on the science of occupational stress, burnout, and well-being (e.g. employees, trustees, patients, the community at large), conduct the requisite research to iteratively measure the status of well-being within the workforce (periodic engagement surveys), and muster the needed resources and time to fully diagnose and treat burnout amongst employees. Addressing the stigma of the term burnout may be a high-hurdle to overcome to gain the necessary engagement of all stakeholders. Specifically, many (like these executives) might hesitate or refrain from describing themselves as suffering from burnout, and thus be hesitant to participate in necessary fact-finding endeavors to measure burnout within the workforce. Addressing burnout within the healthcare industry is a complex problem and one that will not simply be solved with these proposed steps. However, the power of leadership and the power of influence when burnout is made a strategic priority, does play a large role despite these real challenges.

Implementation of the Proposed Solution

The following is an example of a team that has been charted at CHI Memorial (my place of work during the study period) using the four aforementioned recommendations.

Structural Violence and Physician Well-being Committee

As President and COO of CHI Memorial, I, in concert with the Vice-President of Medical Affairs, chartered a group focused on making physician well-being a strategic priority in the organization. Table 5 summarizes the members of the team. The team stemmed from a desire to address the stress and frustration that comes from navigating the electronic health record (EHR, in this case the Epic system). Epic was implemented in November 2019, and after more than a year practicing with the new EHR, a wellspring from the medical staff emerged with suggestions to improve the record.

Table 5

Members of Structural Violence and Physician Well-Being Committee

Title	**Profession**
President/COO	Administrator
Vice-President of Medical Affairs	Physician – Neurologist
Medical Director – Surgical Services	Physician – Urologist
Medical Director – Specialty Services	Physician – Infectious Disease
Vice Chief of Staff	Physician – Pathologist
Market Director – Clinical Informatics	Pharmacist
Director – Performance Excellence	Industrial Engineer

The first task of the committee was to declare that the frustrations caused by the EHR and resultant loss of joy in practicing was an issue within the organization and a cause of burnout, as supported by research (Reith, 2018; Talbot & Dean, 2018). The Medical Executive Committee (MEC – a formal group charted by the Board of Directors to administer and lead the professional practice of medicine within CHI Memorial) gave

its support to this committee as did the Board of Directors. Because the EHR at CHI Memorial is shared with another organization within CommonSpirit Health (CHI St. Luke's Health in Texas), any changes to the EHR must be vetted by a shared governance group comprised of members of CHI Memorial and CHI St. Luke's.

Working within this governance structure can present frustrations as the decisions to change the EHR are not local, but shared nationally. As suggested in my recommendations, I conveyed my own experience navigating the national decision-making structure within CommonSpirit Health. I shared that I too get frustrated with the shared-governance at times, but focus on those things that can be accomplished. Although it can be frustrating at times, just as was recommended by the study participants, the key to achieving the goals within a shared-structure is to leverage relationships and control the things that you can control. Given this context, the committee worked to garner feedback from members of the medical staff on the things within the EHR that could be changed rather quickly and those that were similar at CHI St. Luke's, thus mitigating any potential roadblocks. One of the most important outcomes of the committee structure and work was congruent with the final point of my recommendations – to empower physicians to identify priorities and make decisions on how to allocate resources to improve elements within the EHR.

The overall effectiveness of this committee cannot be judged at present as the work is still underway as of this study publication. However, the early feedback from the committee members and physicians who have shared frustrations has been positive. The existence of this committee and its focus on navigating the corporate structure to enhance and improve the provider experience with the EHR is a key step in helping to mitigate

burnout by addressing structural violence and moral injury that can occur because of issues within the EHR.

Implications

Practical Implications

This committee has been well received by physicians and caregivers who have been engaged in the process. By declaring the importance of addressing these systemic issues within the EHR a strategic imperative, the necessary trust to produce breakthrough solutions and sustain the effort has been established. Early remedies of nagging issues further aided the trust building and garnered participation of those who were more in the "I'll believe it when I see it" camp. This trust avails further iterations of the work that will tackle more complex systemic issues. As suggested by the study participants, focusing on things within one's control can produce the wins necessary to build momentum for addressing more difficult and complex issues.

Implications for Future Research

Several future research possibilities exist given the findings of this study. First, this study did not quantitatively measure the actual burnout of the participants, which is something that can be measured using reliable instruments. If this study were to be repeated looking at different participants from this study population, perhaps a burnout measurement instrument might help to confirm the findings or offer additional insights.

Second, the emergence of resilience as a theme might be something to be explored in future research. As the majority of the participants had life experiences that influenced their development of resilience, a future study might explore these life experiences and how it correlates, if at all, to becoming a CEO.

A third research approach might explore how the positive dispositions of these study participants emerge over time. Specifically, focusing on how the genetic and psychological profiles of the participants along with their daily living or daily activities influence the emergence of happiness and resilience. Furthermore, it would be interesting to explore how genetics and daily activities impact one's ascendancy up the corporate ladder and the emergence of burnout or lack thereof. Is it genetics or daily activities or perhaps a combination of both?

A fourth line of inquiry might be to explore how burnout emerges or is mitigated at different stages of one's career based on the study findings suggesting that perhaps tenure influences one's burnout manifestation.

Finally, a research study could explore how some executives thrive in corporate structures while others may struggle. For those that do struggle, focusing on the role burnout played in them leaving their job as a CEO.

Implications for Leadership Theory and Practice

Whether these healthcare executives suffered burnout – or not, or were stressed or frustrated – or not, their experiences informed their leadership in the context of burnout in the healthcare industry. The leaders shared their feelings on whether the word burnout itself is appropriate and suggested other ways to describe how they experienced stress in their roles. Perhaps the hesitance to use the word itself and a positive disposition and orientation towards being happy buffered the participants as they were attuned to preventing the onset of emotional exhaustion, cynicism, or inefficacy. Perhaps their genetic composition, their life experiences (all are aged 53 or older), and their experiences as senior healthcare executives (each has served five years or more in their

current role or an equivalent role) served as burnout mitigants bolstered by their accumulated resilience and self-awareness. Perhaps a focus on cultivating happiness within themselves, their teams, and their organizations should be a keen focus for healthcare executives leading in the context of burnout.

Evidence from this study suggests that leaders will be more successful leading in the context of burnout if they: cultivate a positive and realistic attitude for themselves and others; practice self-control; focus on those things within their control; seek mentors and serve as mentors for others; and practice self-care and emphasize the importance of self-care in their organizations. The majority of the participants shared the importance of having a positive and realistic attitude for themselves and for those on their leadership teams. Additionally, many participants shared the importance of having self-control and not letting their frustrations spill over to their teams. In fact, several participants emphasized the importance of focusing on the things that they and their teams can control. The study participants discussed the importance of having great leader mentors and serving themselves as exemplars for others. Each of the nine shared details on how they practiced self-care and how they encouraged and supported the self-care practices of their teammates and the caregivers within their organizations.

Strengths

By focusing on the lived experiences of senior healthcare executives in the context of burnout, this study provided a portal into a group that plays an important role in establishing the recognition, treatment, and prevention of occupational stress and burnout as a strategic priority for healthcare organizations. The use of a hermeneutical phenomenological framework consisting of textural and structural elements using open-

ended interview questions led to rich data that materialized relevant themes which convey a deeper understanding of the study participants lived experiences. The study findings align with research suggesting that CEOs may be less inclined to experience burnout because of their positional power, levels of resilience, self-awareness, positive attitudes, self-care practices and robust support structures (Sherman et al., 2012). The study findings also align with recent literature suggesting there is a stigma regarding the term burnout as used in the healthcare setting; connotating weakness (Wohlever, 2020). Finally, the study findings show that structural elements play a role in manifesting and mitigating stress within this study group.

Limitations

As detailed in Chapter One, this study does have limitations. The purposeful sampling strategy and small sample size do not support making generalizations of the study findings beyond this group of senior executives working at CommonSpirit Health. Moreover, the timing of the study (February – March, 2021) and the fact that the data come from self-reported reflections culled from a single interview, with no guarantee of truthfulness or completeness, are additional limitations with regard to making generalizations. Another limitation is that the participants have served at least five years as a CEO, thus, their experiences seasoned them and perhaps provided them some resilience and hardiness to avoid and mitigate burnout. Thus, these limitations support novel findings of this study that are bound by this purposefully sampled group during this period of time and should not be broadly generalized.

Summary of the Dissertation in Practice

Burnout in healthcare is an epidemic and how CEOs of healthcare organizations respond and lead in this context is of great consequence to the many stakeholders within the healthcare system (Kermott et al., 2019; Shanafelt et al., 2020; Shanafelt & Noseworthy, 2017; West et al., 2016, Wicks & Buck, 2013; Wigert & Agrawal, 2018). The purpose of this phenomenological qualitative study focused on exploring how the personal lived experiences of healthcare executives informed their leadership thinking and approach in the context of job burnout. The following research question guided the study: How do senior executives of healthcare organizations experience and respond to burnout?

Nine senior executives who served as CEOs or Presidents of organizations within CommonSpirit Health comprised the study group. Interviews were conducted and transcripts were coded in a multi-cycle approach to garner emergent themes. Major themes and minor themes support the two key research findings. First, the participants did not describe themselves as being burned-out during the study period. Second, the participants did detail stressors and frustrations stemming from structural elements of their jobs. Table 6 displays the major, minor, and sub-themes.

Perhaps these senior healthcare executives were not burned-out because they have burnout buffers born from their life experiences, such as: their high levels of resilience, the benefits derived from their positional control, their relationships and self-care regimens, or their positive and optimistic dispositions that make them happier people. These variables and their causal relationships provide ample material for further investigation. Given the study participants were not suffering burnout during the study

period, this state of well-being suggested they are best positioned to lead a response to caregiver burnout within the healthcare industry. Moreover, as these executives suffered stress and frustrations emanating from their corporate structures, this empathetic understanding might serve them well when leading efforts to address structural elements causing moral injury and burnout amongst caregivers.

Table 6

Major, Minor, and Sub-Themes

Themes and Sub-Themes
Major Theme A – Not Suffering Burnout
Minor Theme A1 – Resilience
A1a – Health Issues
A1b – Positive Attitude
A1c – A Meaningful Connection to One's Purpose and Job
Minor Theme A2 – Self-awareness and the Need for a Support Structure
A2a – Cognitive and Emotional Flexibility
A2b – Having a Great Boss and a Great Work Team
A2c – Self-care
Major Theme B – Stressed and Frustrated
Minor Theme B1 – Structural Violence
B1a – Positional Control
B1b – Time in Role
B1c – Relationships Trump Bureaucracy

A practical solution is included in this dissertation and serves as an example recommendation on how senior healthcare leaders might leverage their optimism, resilience, experience, and their positions to formulate a strategic response to address burnout within their organizations.

This study focused on illuminating the lived experiences of healthcare executives in the context of burnout in the healthcare industry. These findings and the resultant suggestions for practice and research amplify the importance of the role the CEO plays in prioritizing the issue of burnout within the field. In an effort to blunt the epidemic of burnout in healthcare, I hope that this study serves as a prompt for CEOs to take this issue to heart and make it a strategic priority. Inspired by Chris Lowney's (2003) summary of heroic leadership, CEOs leading in the context of burnout would do well to remain self-aware of their own journey, be heroic and courageous by sharing their personal journey and their positional power with others, be ingenious in thinking of novel ways to thwart this epidemic, and do all of this with a loving heart, optimism, and passion for alleviating suffering and elevating the common good for all who serve in healthcare and all those who are served by healthcare workers.

References

American Psychological Association (n.d.). Type A personality. In *APA dictionary of psychology*. https://dictionary.apa.org/type-a-personality

Asken, M. J. (2019). Physician burnout: Moral injury is a questionable term. *BMJ, 365*, I2375. https://doi.org/10.1136/BMJ.L2375

Babbie, E. (2017). *The basics of social research* (7th ed.). Cengage Learning.

Bakker, A. B., & Demerouti, E. (2017). Job demand-resources theory: Taking stock and looking forward. *Journal of Occupational Health Psychology, 22*(3), 273-285. https://doi.org/10.1037/ocp0000056

Bakker, A. B., Hakanen, J. J., Demerouti, E., & Xanthopoulou, D. (2007). Job resources boost work engagement, particularly when job demands are high. *Journal of Educational Psychology, 99*, 274–284. https://dx.doi.org/10.1037/0022-0663.99.2.274

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.

Bass, B. (1990). *Handbook of leadership* (3rd ed.). Free Press.

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *NursingPlus Open 2*, 8-14. https://dx.doi.org/10.1016/j.npls.2016.01.001

Benson, H. (1974). Your innate asset for combating stress. *Harvard Business Review, 52*(4), 49-60.

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs, 27*(3), 759-769. https://doi.org/10.1377/hlthaff.27.3.759

Black, K. (2010). *Business statistics: Contemporary decision making* (6th ed.). John Wiley & Sons.

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *Annals of Family Medicine, 12*(6), 573-576. https://doi.org/10.1370/afm.1713

Boyatzis, R., McKee, A., & Goleman, D. (2002). Reawakening your passion for work. *Harvard Business Review, 80*(4), 87-94.

Bressi, S. K., & Vaden, E. R. (2017). Reconsidering self-care. *Clinical Social Work Journal, 45*, 33-38. https://doi.org/10.1007/s10615-016-0575-4

Brown, C. J. (2009). Self-renewal in nursing leadership: The lived experience of caring for self. *Journal of Holistic Nursing, 27*(2), 75-84. https://doi.org/10.1177/0898010108330802

Brown, N. J. L., & Rohrer (2020). Easy as (happiness) pie? A critical evaluation of a popular model of the determinants of well-being. *Journal of Happiness Studies, 21*, 1285-1301. https://doi.org/10.1007/s10902-019-00128-4

Brusie, C. (2020, January 7). *Nurses ranked most honest profession 18 years in a row*. Nurse.org. https://nurse.org/articles/nursing-ranked-most-honest-profession/

Burke, K. F., & Burke-Sullivan, E. (2009). *The Ignatian tradition: Spirituality in history*. Liturgical Press.

Burns, J. M. (1978). *Leadership*. Harper Torchbooks.

Burton, J. P., Hoobler, J. M., & Scheuer, M. L. (2012). Supervisor workplace stress and abusive supervision: The buffering effect of exercise. *Journal of Business & Psychology, 27*, 271-279. https://doi.org/10.1007/s10869-011-9255-0

Cicchetti, D., & Rogosch, F. A. (2012). Gene x environment interaction and resilience: Effects of child maltreatment and serotonin, corticotrophin releasing hormone, dopamine, and oxytocin genes. *Development and Psychopathology, 24*(2), 411-427. https://doi.org/10.1017/S0954579412000077

CommonSpirit Health. (n.d.). About Us. https://www.commonspirit.org/about-us

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage.

Creswell, J. W., & Guetterman, T. C. (2018). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (6th ed.). Pearson.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage.

Crist, J. D., & Tanner, C. A. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing Research, 52*(3), 202-205. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=ovftf&NEWS=N&AN=00006199-200305000-00011.

Cooperrider, D. L., & Srivastva, S. (1987). Appreciative inquiry in organizational life. In W. Pasmore & R. Woodman (Eds.), *Research in organization change and development* (pp. 129-169). JAI Press.

Davidson, J. E., Proudfoot, J., Lee, K., Terterian, G., & Zisook, S. (2020). A longitudinal analysis of nurse suicide in the United States (2005–2016) with recommendations for action. *Worldviews on Evidence-Based Nursing, 17*(1), 6-15. https://doi.org/10.1111/wvn.12419

Dean, W., Talbot, S., & Dean, A. (2019). Reframing clinician distress: Moral injury not burnout [Editorial]. *Federal Practitioner, 36*(9), 400-402.

de Beer, L., Pienaar, J., & Rothmann, S. (2016). Work overload, burnout, and psychological ill-health symptoms: A three-wave mediation model of the employee health impairment process. *Anxiety, Stress, & Coping, 29*(4), 387-399. https://doi.org/10.1080/10615806.2015.1061123

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior.* Plenum Press.

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resource model of burnout. *Journal of Applied Psychology, 86*(3), 499-512. https://doi.org/10.1037/0021-9010.86.3.499

DeRue, D. S. (2011). Adaptive leadership theory: Leading and following as a complex adaptive process. *Research in Organizational Behavior, 31*, 125-150. https://doi.org/10.1016/j.riob.2011.09.007.

Duval, S., & Wicklund, R. A. (1973). Effects of objective self-awareness on attribution of causality. *Journal of Experimental Social Psychology, 9*(1), 17-31. https://doi.org/10.1016/0022-1031(73)90059-0

Dweck, C. S. (2008). *Mindset: The new psychology of success*. Random House Digital, Inc.

Eastburg, M. C., Williamson, M., Gorsuch, R., & Ridley, C. (1994). Social support, personality, and burnout in nurses. *Journal of Applied Social Psychology, 24*(14), 1233-1250. https://doi.org/10.1111/j.1559-1816.1994.tb00556.x

Epstein, R. (2017). *Attending: Medicine, mindfulness, and humanity*. Scribner.

Eschelbach, M. M. (2018). A proposed review and fix for burnout. *American Association for Physician Leadership*, *5*(6), 46-51.

Farmer, P. E., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PLOS Medicine, 3*(10), e449. https://doi.org/10.1371/journal.pmed.0030449

Fiedler, F. E. (1992). Time-based measures of leader experience and organizational performance: A review of research and a preliminary model. *The Leadership Quarterly, 3*, 5-23. https://doi.org/10.1016/1048-9843(92)90003-X

Finkelstein, L. M., Costanza, D. P., & Goodwin, G. F. (2015). Do your high potentials have potential? The impact of individual differences and designation on leader success. *Personnel Psychology, 71*, 3-22. https://doi.org/10.1111/peps.12225

Fleischhauer, M., Miller, R., Wekenborg, M. K., Penz, M., Kirschbaum, C., & Enge, S. (2019). Thinking against burnout? An individual's tendency to engage in and enjoy thinking as a potential resilience factor of burnout symptoms and burnout-related impairment in executive functioning. *Frontiers in Psychology, 10*(420), 1-13. https://doi.org/10.3389/fpsyg.2019.00420

Ford, E. W. (2019). Stress, burnout, and moral injury: The state of the healthcare workforce [Editorial]. *Journal of Healthcare Management, 64*(3), 125-127. https://doi.org/10.1097/JHM-D-19-00058

Frederick, T. V., Dunbar, S., & Thai, Y. (2017). Burnout in Christian perspective. *Pastoral Psychology, 67*, 267–276. https://doi.org/10.1007/s11089-017-0799-4

Freudenberger, H. J. (1974). Staff burnout. *Journal of Social Issues, 30*(1), 159-165. https://doi.org/10.1111/j.1540-4560.1974.tb00706.x

Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions. *Psychotherapy: Theory, Research & Practice, 12*(1), 73–82. https://doi.org/10.1037/h0086411

Frieden, J. (2016, April 10). *Surgeon General concerned about physician burnout: If physicians aren't happy, they can't heal others*. MedpageToday. https://www.medpagetoday.com/PublicHealthPolicy/GeneralProfessionalIssues/57280

Galtung, J. (1969). Violence, peace, and peace research. *Journal of Peace Research, 6*(3), 167-191. https://doi.org/10.1177/002234336900600301

Galvan, J. L., & Galvan, M. C. (2017). *Writing literature reviews: A guide for students of the social and behavioral sciences.* Routledge.

Ganns, G. E. (1991). *Ignatius of Loyola: The spiritual exercises and selected works*. Paulist Press.

Geger, B. T. (2014). Cura personalis: Some Ignatian inspirations. *Jesuit Higher Education: A Journal, 3*(2), 6-20.

Gentry, W. D., & Kobasa, S. C. (1984). Social and psychological resources mediating stress-illness relationships in humans. In Gentry, W. D. (Ed.), *Handbook of behavioral medicine* (pp.87-113). Guilford Press.

Goldberg, L. R. (1990). An alternative "description of personality": The big-five factor structure. *Journal of Personality and Social Psychology, 59*, 1216-1229. https://doi.org/10.1037/0022-3514.59.6.1216

Grandy, G., & Silwa, M. (2017). Contemplative leadership: The possibilities for ethics of leadership theory and practice. *Journal of Business Ethics, 143*, 423-440. https://doi.org/10.1007/s10551-015-2802-2

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1), 42–55. https://doi.org/10.1177/160940690400300104

Halbesleben, J. R. B., Wakefield, B. J., Wakefield, D. S., & Cooper, L. B. (2008). Nurse burnout and patient safety outcomes: Nurse safety perception versus reporting behavior. *Western Journal of Nursing Research, 30*(5), 560-577. https://doi.org/10.1177/0193945907311322

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*, 784-790. https://doi.org/10.7326/M18-1422

Hargrove, M. B., Becker, W. S., & Hargrove, D. F. (2015). The HRD eustress model: Generating positive stress with challenging work. *Human Resource Development Review, 14*(3), 279-298. https://doi.org/10.1177/1534484315598086

Harland, L., Harrison, W., Jones, J. R., & Reiter-Palmon, R. (2005). Leadership behaviors and subordinate resilience. *Journal of Leadership & Organizational Studies, 11*(2), 2-14. https://doi.org/10.1177/107179190501100202

Harms, P. D., Credé, M., Tynan, M., Leon, M., & Jeung, W. (2017). Leadership and stress: A meta-analytic review. *The Leadership Quarterly, 28*, 178-194. https://doi.org/10.1016/j.leaqua.2016.10.006

Hartney, E. (2018). A three-step model of stress management for health leaders. *Healthcare Management Forum, 31*(3), 81-86. https://doi.org/10.1177/0840470417751157

Haslam, S. A., Reicher, S. D., & Platow, M. J. (2011). *The new psychology of leadership: Identity, influence and power.* Psychology Press.

Holland, P., Cooper, B., & Sheehan, C. (2017). Employee voice, supervisor support, and engagement: The mediating role of trust. *Human Resource Management, 56*(6), 915–929. https://doi.org/10.1002/hrm.21809

Houtrow, A. J. (2020). Addressing burnout: Symptom management versus treating the cause [Editorial]. *The Journal of Pediatrics, 224*, 18-19. https://doi.org/10.1016/j.jpeds.2020.04.068

Iacovides, A., Fountoulakis, K. N., Kaprinis, S., & Kaprinis, G. (2003). The relationship between job stress, burnout and clinical depression. *Journal of Affective Disorders, 75*(3), 209-221. https://doi.org/10.1016/S0165-0327(02)00101-5

Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review. *Journal of Advanced Nursing, 60*(1), 1-9. https://doi.org/10.1111/j.1365-2648.2007.04412.x

Jacob, S. A., & Furgerson, S. P. (2012). Writing interview protocols and conducting interviews: Tips for students new to the field of qualitative research. *The Qualitative Report, 17*(42), 1-10. http://www.nova.edu/ssss/QR/QR17/jacob.pdf

Jafari, M., Ghasemvani, S., Sadeghifar, J., Shams, L., & Naderimanesh, K. (2020). Relationship between organizational citizenship behavior and social capital: Survey from hospital setting. *Hospital Topics, 98*(3), 81-88. https://www.doi.org/10.1080/00185868.2020.1784813

Johnson, C. E. (2018). *Meeting the ethical challenges of leadership: Casting light or shadow* (6th ed.). Sage.

Johnson, D. C., Thom, N. J., Stanley, E. A., Haase, L., Simmons, A. N., Shih, P. B., Thompson, W. K., Potterat, E. G., Minor, T. R., & Paulus, M. P. (2014). Modifying resilience mechanisms in at-risk individuals: A controlled study of mindfulness training in Marines preparing for deployment. *American Journal of Psychiatry, 171*(8), 844-853. https://doi.org/10.1176/appi.ajp.2014.13040502

Johnson, W., & Humble, A. (2020, April 28). To take care of others, start by taking care of yourself. *Harvard Business Review*. https://www.hbr.org/2020/04/to-take-care-of-others-start-by-taking-care-of-yourself

Kellerman, B. (2016). Leadership – It's a system, not a person! *Daedalus, Journal of the American Academy of Arts & Sciences, 145*(3), 83-94. https://doi.org/10.1162/DAED_a_00399

Kermott, C. A., Johnson, R. E., Sood, R., Jenkins, S. M., & Sood, A. (2019). Is higher resilience predictive of lower stress and better mental health among corporate

executives? *PLOS ONE, 14*(6), Article e0218092. https://doi.org/10.1371/journal.pone.0218092

Kmietovicz, Z. (2002). R.E.S.P.E.C.T. – Why doctors are still getting enough of it. *BMJ, 324*(7328), 11. https://10.1136/bmj.324.7328.11

Kobasa, S. C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. *Journal of Personality and Social Psychology, 37*(1), 1-11. https://doi-org.cuhsl.creighton.edu/10.1037/0022-3514.37.1.1

Lazarus, R. L., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer.

Lee, H., & Cummings, G. G. (2008). Examining relationships between director leadership practices and manager worklife and burnout. *Journal of Leadership Studies, 2*(2), 47-62. https://doi.org/10.1002/jls.20061

Lee, J. J., & Miller, S. E. (2013). A self-care framework for social workers: Building a strong foundation for practice. *Families in Society, 94*, 96–103. https://doi.org/10.1606/1044-3894.4289

Leech, B. L. (2002). Asking questions: Techniques for semistructured interviews. *Political Science and Politics, 35*(4), 665-668.

Lepine, J. A., Podsakoff, N. P., & Lepine, M. A. (2005). A meta-analytic test of the challenge stressor-hindrance stressor framework: An explanation for inconsistent relationships among stressors and performance. *Academy of Management Journal, 48*(5), 764-775. https://doi.org/10.5465/amj.2005.18803921

Loehr J., & Schwartz, T. (2001). The making of a corporate athlete. *Harvard Business Review, 79*(1), 120-129. https://hbr.org/2001/01/the-making-of-a-corporate-athlete

Lowney, C. (2003). *Heroic leadership: Best practices from a 450-year-old company that changed the world*. Loyola Press.

Lyubomirsky, S. (2001). Why are some people happier than others? *American Psychologist, 56*, 239-249. https://doi.org/10.1037/0003-066X.56.3.239

Lyubomirsky, S., King, L., & Diener, E. (2005). The benefits of frequent positive affect: Does happiness lead to success? *Psychological Bulletin, 131*(6), 803-855. https://doi.org/10.1037/0033-2909.131.6.803

Lyubomirsky, S. & Layous, K. (2013). How do simple positive activities increase well-being? *Current Directions in Psychological Science, 22*(1), 57-62. https://doi.org/10.1177/0963721412469809

Lyubomirsky, S., Sheldon, K. M., & Schkade, D. (2005). Pursuing happiness: The architecture of sustainable change. *Review of General Psychology, 9*(2), 111-131. https://doi.org/10.1037/1089-2680.9.2.111

Manney, J. (2017). *Ignatian spirituality: A to Z.* Loyola Press.

Martin, J. (2010). *The Jesuit guide to (almost) everything: A spirituality for real life*. HarperOne.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior, 2*(2), 99-113. https://doi.org/10.1002/job.4030020205

Maslach, C., Jackson, S. E., & Leiter, M. P. (2018). *Maslach burnout inventory (MBI): Manual* (4th ed.). Mind Garden.

Maslach, C., & Leiter, M. P. (1997). *The truth about burnout: How organizations cause personal stress and what to do about it.* Jossey-Bass.

Maslach, C., & Leiter, M. P. (2008). Early predictors of job burnout and engagement. *Journal of Applied Psychology, 93*(3), 498-512. https://doi.org/10.1037/0021-9010.93.3.498

Maslach, C., & Leiter, M. P. (2017). New insights into burnout and health care: Strategies for improving and alleviating burnout. *Medical Teacher, 39*(2), 160-163. https://doi.org/10.1080/0142159X.2016.1248918

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*, 397-422. https://doi.org/10.1146/annurev.psych.52.1.397

McConnell, S. (2013, August 27). *C-suite burnout survey 2013, summary: Understanding causes of burnout among US executives and senior managers.* Arielle Executive. https://arielle.com.au/c-suite-burnout-survey-summary/

McCormack, E. (2011). Leading from within: The Ignatian practice of deep listening. *Health Progress, 95*(5), 36-40.

McCormack, L., Abou-Hamdan, S., & Joseph, S. (2017). Career derailment: Burnout and bullying at the executive level. *International Coaching Psychology Review, 12*(1), 24-36. http://shop.bps.org.uk/publications/international-coaching-psychology-review-vol-12-no-1-march-2017.html

McHugh, M. D., Kutney-Lee, A., Cimiotti, J. P., Sloan, D. M., & Aiken, L. H. (2011). Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs, 30*(2), 202-210. https://doi.org/10.1377/hlthaff.2010.0100

McKee, A., Johnston, F., & Massimilian, R. (2006). Mindfulness, hope, and compassion: A leader's road map to renewal. *Ivey Business Journal, 70*(5), 1-5.

Mealer, M., Jones, J., Newman, J., McFann, K. K., Rothbaum, B., & Moss, M. (2012). The presence of resilience is associated with a healthier psychological profile in ICU nurses: Results of a national survey. *International Journal of Nursing Studies, 49*(3), 292-299. https://doi.org/10.1016/j.ijnurstu.2011.09.015

Mills, J., Ramachenderan, J., Chapman, M., Greenland, R., & Agar, M. (2020). Prioritising workforce wellbeing and resilience: What COVID-19 is reminding us about self-care and staff support. *Palliative Medicine, 34*(9), 1137-1139. https://doi.org/10.1177/0269216320947966

Moss-Breen, J. (2018). Designing an organization that builds resilient leaders. In R. Elkington, M. van der Steege, J. L. Glick-Smith, & J. M. Breen (Eds.), *Exceptional leadership by design: How design in great organizations produces great leadership* (pp.143-169). Emerald Publishing Limited. https://doi.org/10.1108/978-1-78743-900-920181010

Moustakas, C. (1994). *Phenomenological research methods*. Sage.

Oc, B., & Bashshur, M. R. (2013). Followership, leadership and social influence. *The Leadership Quarterly, 24*(6), 919-934. https://doi.org/10.1016/j.leaqua.2013.10.006

O'Dowd, E., O'Connor, P., Lydon, S., Mongan, O., Connolly, F., Diskin, C., McLoughlin, A., Rabbitt, L., McVicker, L., Reid-McDermott, B., & Byrne, D. (2018). Stress, coping, and psychological resilience among physicians. *BMC Health Services Research, 18*(730), 1-11. https://doi.org/10.1186/s12913-018-3541-8

Olson, A. K., & Simerson, B. K. (2015). *Leading strategic thinking: Four ways effective leaders gain insight, drive change, and get results*. John Wiley & Sons, Inc.

O'Malley, J. W. (1993). *The first Jesuits*. Harvard University Press.

Owens, K. M. (2020). Moving forward to nurture workforce resilience in crisis. *Frontiers of Health Services Management, 37*(1), 14-19. https://doi.org/10.1097/HAP.0000000000000094

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretive phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne-Psychological Journal, 20*(1), 7-14. https://doi.org/10.14691/CPPJ.20.1.7

Popper, M. (2004). Leadership as relationship. *Journal for the Theory of Social Behavior, 34*(2), 107-125. https://doi.org/10.1111/j.0021-8308.2004.00238.x

Popper, M. (2011). Toward a theory of followership. *Review of General Psychology, 15*(1), 29-36. https://doi.org/10.1037/a0021989

Poulin, M. J., Brown, S. L., Dillard, A. J., & Smith, D. M. (2013). Giving to others and the association between stress and mortality. *American Journal of Public Health, 103*(9), 1649-1655. https://ajph.aphapublications.org/doi/epub/10.2105/AJPH.2012.300876

Poulin, M. J., & Holman, E. A. (2013). Helping hands, healthy body? Oxytocin receptor gene and prosocial behavior interact to buffer the association between stress and physical health. *Hormones and Behavior, 63*, 510-517. https://doi.org/10.1016/j.yhbeh.2013.01.004

Quick, J. C., & Henderson, D. F. (2016). Occupational stress: Preventing suffering, enhancing wellbeing. *International Journal of Environmental Research and Public Health, 13*(459), 1-11. https://doi.org/10.3390/ijerph13050459

Quick, J. C., Mack, D., Gavin, J. H., Cooper, C. L., & Quick, J. D. (2004). Executives: Engines for positive stress. In P. L. Perrewe & D. C. Ganster (Eds.), *Research in occupational stress and well being: Vol. 3. Emotional and physiological processes and positive intervention* (pp. 359-405). Elsevier Ltd.

Ranjbar, N., & Ricker, M. (2019). Burn bright I: Reflections on the burnout epidemic (part one of a two-part series) [Editorial]. *The American Journal of Medicine, 132*(3), 272-275. https://doi.org/10.1016/j.amjmed.2018.09.036

Reith, T. P. (2018). Burnout in United States healthcare professionals: A narrative review. *Cureus, 10*(12), e3681. https://www.doi.org/10.7759/cureus.3681

Roberts, C., & Hyatt, L. (2019). *The dissertation journey: A practical and comprehensive guide to planning, writing, and defending your dissertation*, (3rd ed.). Corwin.

Rogers, E., Polonijo, A. N., & Carpiano, R. M. (2016). Getting by with a little help from friends and colleagues: Testing how residents' social support networks affect loneliness and burnout. *Canadian Family Physician, 62*(11), e677-e683.

Rozario, D. (2019). Burnout, resilience and moral injury: How the wicked problems of health care defy solutions, yet require innovative strategies in the modern era. *Canadian Journal of Surgery, 62*(4), E6-E8. https://doi.org/10.1503/cjs.002819

Saakvitne, K. W., Pearlman, L. A., & the staff of the Traumatic Stress Institute (1996). *Transforming the pain: A workbook on vicarious traumatization*. W. W. Norton.

Saldaña, J. (2009). *The coding manual for qualitative researchers*. Sage.

Schaufeli, W. B., & Bakker, A. B. (2004). Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study. *Journal of Organizational Behavior, 25*, 293–315. https://doi.org/10.1002/job.248

Schaufeli, W. B., & Buunk, B. P. (2003). Burnout: An overview of 25 years of research and theorizing. In M. J. Schabracq, J. A. M. Winnubst, & C. L. Cooper (Eds.), *The handbook of work and health psychology* (2nd ed., pp. 383-425). John Wiley & Sons, Ltd.

Schaufeli, W. B., & Enzmann, D. (1998). *The burnout companion for research and practice: A critical analysis of theory, assessment, research, and interventions*. Taylor & Francis.

Schaufeli, W. B., Leiter, M. P., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International, 14*(3), 204-220. https://doi.org/10.1108/13620430910966406

Schwartz, R., Shanafelt, T. D., Gimmler, C., & Osterberg, L. (2020). Developing institutional infrastructure for physician wellness: Qualitative insights from VA physicians. *BMC Health Services Research, 20*(7), 1-9. https://doi.org/10.1186/s12913-019-4783-9

Seligman, M. E. P. (2008). Positive health. *Applied Psychology, 57*, 3-18. https://doi.org/10.1111/j.1464-0597.2008.00351.x

Shanafelt, T. D., Balch, C. M, Bechamps, G., Russell, T., Dyrbye, L., Satele, D., Collicott, P., Novotny, P. J., Sloan, J., & Freischlag, J. (2010). Burnout and medical errors among American surgeons. *Annals of Surgery, 251*(6), 995-1000. https://doi.org/10.1097/SLA.0b013e3181bfdab3

Shanafelt, T. D., Boone, S., Tan, L., Dyrbye, L. N., Sotile, W., Satele, D., West, C. P., Sloan, J., & Oreshovich, 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., Gorringe, G., Menaker, R., Storz, K. A., Reeves, D., Buskirk , S. J., Sloan, J. A., & Swenson, S. J. (2015). Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clinic Proceedings, 90*(4), 432-440. https://doi.org/10.1016/j.mayocp.2015.01.012

Shanafelt, T. D., Makowski, M. S., Wang, H, Bohman, B. Leonard, M., Harrington, R. A., Minor, L., & Trockel, M. (2020). Association of burnout, professional fulfillment, and self-care practices of physician leaders with their independently rated leadership effectiveness. *JAMA Network Open, 3*(6), e207961. https://doi.org/10.1001/jamanetworkopen.2020.7961

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., & Noseworthy, J. H. (2017). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clinic Proceedings, 92*(1),129-146. https://doi.org/10.1016/j.mayocp.2016.10.004

Shanafelt, T. D., Swensen, S. J., Woody, J., Levin, J., & Lillie, J. (2018). Physician and nurse well-being: Seven things hospital boards should know. *Journal of Healthcare Management, 63*(6), 363-369. https://doi.org/10.1097/JHM-D-18-00209

Sharma, R. R. (2007). Indian model of executive burnout. *Vikalpa: The Journal for Decision Makers, 32*(2), 23-38. https://doi.org/10.1177/0256090920070203

Shay, J. (2014). Moral injury. *Psychoanalytic Psychology, 31*(2), 182-191. https://doi.org/10.1037/a0036090

Sheldon, K. M., & Lyubomirsky, S. (2019). Revisiting the sustainable happiness model and pie chart: Can happiness be successfully pursued? *The Journal of Positive Psychology, 16*(2), 145-154. https://doi.org/10.1080/17439760.2019.1689421

Sherman, G., Lee, J., Cuddy, A., Renshon, J., Oveis, C., Gross, J., & Lerner, J. (2012). Leadership is associated with lower levels of stress. *Proceedings of the National Academy of Sciences of the United States of America, 109*(44), 17903-17907. https://doi.org/10.1073/pnas.1207042109

Shirom, A. (2003). Job-related burnout: A review. In J. C. Quick & L. E. Tetrick (Eds.), *Handbook of occupational health psychology* (pp. 245–264). American Psychological Association. https://doi.org/10.1037/10474-012

Silvia, P. J., & Duval, T. S. (2001). Objective self-awareness theory: Recent progress and enduring problems. *Personality and Social Psychology Review, 5*(3), 230-241. https://doi-org.cuhsl.creighton.edu/10.1207/S15327957PSPR0503_4

Siren, C., Pankaj, C. P., Ortqvist, D., & Wincent, J. (2018). CEO burnout, managerial discretion, and firm performance: The role of CEO locus of control, structural

power, and organizational factors. *Long Range Planning, 51*, 953-971. https://doi.org/10.1016/j.lrp.2018.05.002

Sloan, A. & Bowe, B. (2014). Phenomenology and hermeneutic phenomenology: The philosophy, the methodologies and using hermeneutic phenomenology to investigate lecturers' experiences of curriculum design. *Quality & Quantity, 48*(3), 1291-1303. https://doi.org/10.1007/s11135-013-9835-3

Soderstrom, M., Dolbier, C., Leiferman, J., & Steinhardt, M. (2000). The relationship of hardiness, coping strategies, and perceived stress to symptoms of illness. *Journal of Behavioral Medicine, 23*(3), 311-328. https://doi.org/10.1023/A:1005514310142

Southwick, S. M., & Charney, D. S. (2012). *Resilience: The science of mastering life's greatest challenges. Ten ways to weather and bounce back from stress and trauma.* Cambridge University Press. https://doi.org/10.1017/cbo9781139013857

Studer, Q., & Ford, G. (2015). *Healing physician burnout: Diagnosing, preventing, and treating*. Fire Starter Publishing.

Swider, B. W., & Zimmerman, R. D. (2010). Born to burnout: A meta-analytic path model of personality, job burnout, and work outcomes. *Journal of Vocational Behavior, 76*, 487-506. https://doi.org/10.1016/j.jvb.2010.01.003

Tai-Seale, M., Dillon, E. C., Yang, Y., Nordgren, R., Steinberg, R. L., Nauenberg, T., Lee, T. C., Meehan, A., Li, J., Chan, A. S., & Frosch, D. L. (2019). Physician well-being linked to in-basket messaged generated by algorithms in electronic health records. *Health Affairs, 38*(7), 1073-1078. https://doi.org/10.1377/hlthaff.2018.05509

Talbot, S. G., & Dean, W. (2018, July). Physicians aren't 'burning out.' They're suffering from moral injury. *Stat*. https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/

Taleb, N.N. (2014). *Antifragile: Things that gain from disorder*. Random House.

Tan, H., Wilson, A., & Oliver, I. (2009). Ricoeur's theory of interpretation: An instrument for data interpretation in hermeneutic phenomenology. *International Journal of Qualitative Methods, 8*(4), 1-15. https://doi.org/10.1177/160940690900800401

Thompson, H. (2010). *The stress effect: Why smart leaders make dumb decisions-and what to do about it.* Jossey-Bass.

Tims, M., Bakker, A. B., & Derks, D. (2013). The impact of job crafting on job demands, job resources, and well-being. *Journal of Occupational Health Psychology, 18*, 230–240. http://dx.doi.org/10.1037/a0032141

Trépanier, S. G., Fernet, C., Austin, S., Forest, J., & Vallerand, R.J. (2014). Linking job demands and resources to burnout and work engagement: Does passion underlie these differential relationships? *Motivation and Emotion, 38*(3), 353-366. https://doi.org/10.1007/s11031-013-9384-z

Tugade, M. M., & Fredrickson, B. L. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of Personality and Social Psychology, 86*, 320-333. https://doi.org/10.1037/0022-3514.86.2.320

Vaillant, G. E., & Mukamal, K. (2001). Successful aging. *The American Journal of Psychiatry, 158*(6), 839-847. https://doi.org/10.1176/appi.ajp.158.6.839

Valcour, M. (2016). Beating burnout. *Harvard Business Review, 94*(11), 98-101. https://hbr.org/2016/11/beating-burnout

Vandenberg, D. (1997). Phenomenological research in the study of education. In D. Vandenberg (Ed.), *Phenomenology & education discourse* (pp. 3-37). Heinemann.

Voci, A., Veneziani, C. A., & Metta, M. (2016). Affective organizational commitment and dispositional mindfulness as correlates of burnout in health care professionals. *Journal of Workplace Behavioral Health, 31*(2), 63-70. https://doi.org/10.1080/15555240.2015.1047500

Walsh, G., Hayes, B., Freeney, Y., & McArdle, S. (2019). Doctor, how can we help you? Qualitative interview study to identify key interventions to target burnout in hospital doctors. *BMJ Open, 9*, e030209. https://doi.org/10.1136/bmjopen-2019-030209

Waytz, A., Chou, E. Y., Magee, J. C., & Galinsky, A. D. (2015). Not so lonely at the top: The relationship between power and loneliness. *Organizational Behavior and Human Decision Processes, 130*, 69-78. https://doi.org/10.1016/j.obhdp.2015.06.002

Welp, A., Meier, L. L., & Manser, T. (2015). Emotional exhaustion and workload predict clinician-rated and objective patient safety. *Frontiers in Psychology, 14*(5), 1573. https://doi.org/10.3389/fpsyg.2014.01573

West, C. P., Dyrbye, L. N., Erwin, P. J., & Shanafelt, T. D. (2016). Interventions to prevent and reduce physician burnout: A systemic review and meta-analysis. *Lancet, 388*, 2272-2281. https://doi.org/10.1016/S0140-6736(16)31279-X

West, C. P., Tan, A. D., Habermann, T. M., Sloan, J. A., & Shanafelt, T. D. (2009). Association of resident fatigue and distress with perceived medical errors. *JAMA, 302*(12), 1294-1300. https://doi.org/10.1001/jama.2009.1389

Wicks, R. J., & Buck, T. C. (2013). Riding the dragon: Enhancing resilient leadership and sensible self-care in the healthcare executive. *Frontiers of Health Services Management, 30*(2), 3-13. https://journals.lww.com/frontiersonline/Abstract/2013/10000/Riding_the_Dragon__Enhancing_Resilient_Leadership.2.aspx

Wiens, K. J. (2016). *Leading through burnout: The influence of emotional intelligence on the ability of executive level physician leaders to cope with occupational stress and burnout* (Publication No. 10158565) [Doctoral dissertation, University of Pennsylvania]. ProQuest Dissertations and Theses Global.

Wigert, B., & Agrawal, S. (2018, July 16). *Employee burnout, part 2: What mangers can do.* Gallup. https://www.gallup.com/workplace/237119/employee-burnout-part-2-managers.aspx

Wiles, R., Crow, G., Heath, S., & Charles, V. (2008). The management of confidentiality and anonymity in social research. *International Journal of Social Research Methodology, 11*(5), 417-428. https://doi.org/10.1080/13645570701622231

Wohlever, A. S. (2020). Burnout in the workplace: Strategies, omissions, and lessons from wounded healers. *American Journal of Health Promotion, 34*(5), 568-571. https://doi.org/10.1177/0890117120920488c

Wong, A. M. F. (2020). Beyond burnout: Looking deeply into physician distress. *Canadian Journal of Ophthalmology, 55*(3S1), 7-16. https://doi.org/10.1016/j.jcjo.2020.01.014

World Health Organization (2019, March 28). *Burn-out an "occupational phenomenon": International Classification of Diseases*. https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases

Zhao, X., Qu, H., & Liu, J. (2014). An investigation into the relationship between hospitality employees' work-family conflicts and their leisure intentions. *Cornell Hospitality Quarterly 55*(4), 408-421. https://doi.org/10.1177/1938965513517171

Appendix A

Interview Protocol

Interview Protocol: Exploring the lived experiences of healthcare executives in the context of burnout.
Time of Interview:
Date:
Place:
Interviewer: Anthony A. Houston, Jr.
Interviewee:
Position of Interviewee:
Proposed sample: The proposed sample for my DIP is a sufficient number of the approximately 140 CEOs or Presidents within CommonSpirit Health. The persons I plan to interview for this assignment are peers and colleagues with whom I serve. They will be other CEOs/Presidents in different markets (I serve as a President for three of these 140 hospitals in the Tennessee/Georgia market).

Thank you for agreeing to sit down with me. As part of my work to complete my doctorate in Interdisciplinary Leadership at Creighton University, I have developed the following interview protocol for my dissertation in practice work to explore the lived experiences of executives leading healthcare organizations in the context of burnout.

Specifically, I am curious to understand your lived experiences related to job burnout. As a reminder, your comments will remain confidential and anonymous. The form I have placed in front of you is a consent form. Please review and append your signature. The interview should take no more than 45-60 minutes. Please let me know if you need a break along the way and if you have any questions. You can refuse to answer any question for any reason. We can stop the interview at any time if recalling these experiences distresses you in any way. Lastly, after reviewing the interview transcript, I may contact you for further clarity or follow-up.

Do you have any questions?

Are you ready to begin?

Questions:

1. Please share a brief, one minute or less bio of yourself and conclude with a summary of your current role.
    a. How long have you served in this or an equivalent position?
    b. How long have you worked for CommonSpirit Health (or the legacy organizations)?

2. What about your personal life's journey connects you to your work as a healthcare executive?

3. How have you experienced burnout in your career? In your current role?

4. How would you describe yourself when you are burned-out?

[Clarifying questions if needed]
   a. What was that like to be burned-out?
   b. How did it impact your relationships in and out of work?
   c. In the context of your own burnout journey, how do you get to a better place?

5. Self-care puts you in a position to be more focused to receive…and build resilience. Describe your self-care practices and how they help you prevent, mitigate, and/or remedy burnout?

[Clarifying question if needed]
   a. What is different when you feel at your best at work?
   b. If you had a recipe for keeping burnout away, what would be the ingredients?

6. Some have reported that the feelings from burnout come from the structure of the system itself. How do you feel about the structural system being a contributor to burnout? Can you provide examples of how this might be true?

7. How has your burnout journey informed your leadership in the context of the epidemic of burnout in healthcare?

8. Do you have anything else to add that we didn't discuss about burnout or your self-care practices?

Additional prompts for depth and breadth to the above questions:
- Would you expound on that?
- Tell me more.
- How would you describe that in a different way?
- I would like to hear more about that.
- Would you clarify that for me?
- What was the effect of that incident?
- What were the consequences?
- What was your reaction to that behavior?
- Take me through your thought processes during that time.

Closing script:

Thank you again for agreeing to share your burnout journey. Please remember that your answers are confidential and anonymous. After reviewing this interview, I may have follow-up questions. Additionally, as I conduct the analysis of the data, I will select a few participants to review the themes. This is known as member checking to ensure I have

data saturation and validity in the findings. Would you be willing to participate in this process if asked? Lastly, you can withdraw at any time during the study process.

Appendix B

Study Participant Information Letter

Creighton
UNIVERSITY

January 28, 2021

Dear Participant:

Greetings! I trust this correspondence finds you well. I am contacting you to gauge your interest in participating in a research study exploring the lived experiences of CEOs and/or Presidents in the context of burnout. I am a doctoral candidate in the Interdisciplinary Doctor of Education in Leadership program at Creighton University. I currently serve as the President and COO at CHI Memorial in Chattanooga, Tennessee. Prior to arriving in Chattanooga in January 2019, I served as the president at CHI St. Vincent Hot Springs from 2014-2019.

Throughout my career, I myself have experienced burnout and it has and continues to inform my leadership. Burnout is reaching epidemic levels within healthcare and much of the current research is rightly focused on caregiver burnout. I believe there is room to explore how senior executives, specifically CEOs and Presidents, experience burnout with emphasis on understanding their self-care practices and ultimately how their burnout journey informs their leadership within the context of healthcare burnout.

I serve as the project's principle investigator and will conduct one, 45-60 minute, individual interviews via Zoom with approximately 7-10 CEOs and/or Presidents within CommonSpirit Health. Study participant names and identifying information (e.g. the ministry name and/or location) will remain anonymous and will be removed in the reporting of the data.

I am eager to illuminate the lived experiences of CEO/Presidents within CommonSpirit Health – in the hopes it will better inform our leadership in the context of burnout in healthcare and provide insight for others similarly positioned.

Important things to know:

- Taking part in research is voluntary. You can choose not to be in this study, or stop at any time.
- If you decide not to be in this study, your choice will not affect your relationship with me, the primary investigator of this study. There will be no penalty to you.

If you agree to participate in this study:

- The participant group will comprise females and males who serve in the role of President or CEO within CommonSpirit Health.
- All participants involved in the study will be over 19 years of age.
- One (1) interview visit (via Zoom) is required of each participant.

- There will be no compensation for the interviews.
- These interviews will last between 45-60 minutes (the block schedule will be for 90 minutes to allow for any technical set-up or issue resolution).
- The potential benefits of participating in this study is to assist a colleague in the completion of their doctoral degree and contributing to new knowledge on the research topic.
- The potential risks to be in this study are minimal. Perhaps the largest risk is some emotional distress upon recalling experiences of stress and burnout. If you experience these feelings during the interview, know that we can stop immediately and resume when you feel ready. Additionally, you can refuse to answer any questions for any reason and you can withdraw from the study at any time for any reason.

Confidentiality and Anonymity:

- I will do everything I can to keep your records confidential. However, it cannot be guaranteed. I may need to report certain information to agencies as required by law. I intend to take care to protect confidentiality and anonymity to include ensuring all recordings, transcripts, and dissertation drafts are stored on password protected devices; to which only I use and have access. Records that identify you may be looked at by others. The list of people who may look at your research records are:
  - My dissertation committee and support staff within the Creighton Interdisciplinary Leadership program, and
  - The Creighton University Institutional Review Board (IRB) and other internal departments that provide support and oversight at Creighton University
- We may present the research findings at professional meetings or publish the results of this research study in relevant journals. However, we will always keep your name and other identifying information private.
- When reviewing and analyzing the data, I plan to use pseudonyms (the Greek alphabet corresponding to the interview order, i.e. interview 1 = pseudonym Alpha). I will refrain from using descriptors related to your job location or other relationships that might expose your identity. Finally, when using direct quotes, I will scrub or make generic any phrases, key words, or examples that might reveal your identity.

If you are interested in being interviewed for this research project, or know another colleague who might be interested, please contact me at AnthonyHouston@creighton.edu or Anthony_Houston@memorial.org or 630-464-3337.

Thank you for your consideration.

Sincerely,

Anthony A. Houston, EdD (c), FACHE

Creighton University

Attachment: Creighton University Bill of Rights for Research Participants

Bill of Rights for Research Participants

As a participant in a research study, you have the right:

1. To have enough time to decide whether or not to be in the research study, and to make that decision without any pressure from the people who are conducting the research.
2. To refuse to be in the study at all, or to stop participating at any time after you begin the study.
3. To be told what the study is trying to find out, what will happen to you, and what you will be asked to do if you are in the study.
4. To be told about the reasonably foreseeable risks of being in the study.
5. To be told about the possible benefits of being in the study.
6. To be told whether there are any costs associated with being in the study and whether you will be compensated for participating in the study.
7. To be told who will have access to information collected about you and how your confidentiality will be protected.
8. To be told whom to contact with questions about the research, about research-related injury, and about your rights as a research participant.
9. If the study involves treatment or therapy:
    a. To be told about the other non-research treatment choices you have.
    b. To be told where treatment is available should you have a research-related injury, and who will pay for research-related treatment.

Appendix C

IRB Approval Letter

Creighton
UNIVERSITY
Office of the Provost
Research Compliance

DATE:	January 25, 2021
TO:	Houston, Anthony
FROM:	Social / Behavioral
PROJECT TITLE:	New Protocol Created for Anthony Houston on 18-Dec-2020 11:11 AM EXPLORING THE LIVED EXPERIENCES OF HEALTHCARE EXECUTIVES IN THE CONTEXT OF BURNOUT: A PHENOMENOLOGICAL STUDY
REFERENCE #:	2001759-01
SUBMISSION TYPE:	Initial Application
ACTION:	APPROVED
APPROVAL DATE:	January 25, 2021
EXPIRATION DATE:	January 24, 2022
REVIEW TYPE:	Expedited

Thank you for your submission of Response to IRB Requests materials for this project. The following items have been reviewed with this submission:

- Creighton University HS eForm
- Response to IRB Requests for Amendments to the Protocol
- REVISED - Study Participant Information Letter (Consent)
- REDLINE- Dissertation in Practice Ch. 1-3 with appendices

You have satisfied the concerns of the Board as expressed in the letter dated January 19, 2021 from the IRB. Therefore, this project is fully approved. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission. The requirement for a signed consent has been waived.

1. Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding (signature requirement is waived). Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

2. Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.
3. All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.
4. All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.
5. If this project has been determined to be a Minimal Risk (risks no greater than one would encounter in daily life) project it will require continuing review by this committee on an **annual** basis. The Annual/Continuing Review/Project Termination form must be received with sufficient time for review and continued approval before the expiration date.

If you have any questions, please contact the IRB Office at 402-280-3208 or irb@creighton.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained in Creighton University's IRB-01 Biomedical IRB records

Institutional Review Board
T 402.280.2126 | T 402.280.3200
Dr. C.C. and Mabel L. Criss Health Sciences Complex I
2500 California Plaza Omaha, NE 68178

creighton.edu
creighton.edu/researchservices/rcocommittees/irb