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A diagnosis of well-being: a phenomenological study exploring women resident physicians' perceptions of their personal experiences with occupational burnout and attending physicians' leadership styles

Tabia Graham Richardson

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Pepperdine University
Graduate School of Education and Psychology

A DIAGNOSIS OF WELL-BEING: A PHENOMENOLOGICAL STUDY EXPLORING
WOMEN RESIDENT PHYSICIANS' PERCEPTIONS OF THEIR PERSONAL
EXPERIENCES WITH OCCUPATIONAL BURNOUT AND ATTENDING
PHYSICIANS' LEADERSHIP STYLES

A dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Philosophy in Global Leadership and Change

by

Tabia Graham Richardson

November, 2022

Ebony Cain, Ph.D. – Dissertation Chairperson

This dissertation, written by

Tabia Graham Richardson

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Doctoral Committee:

Ebony Cain, Ph.D., Chairperson

Doug Leigh, Ph.D., Co-Chair/Committee

Robert Vargas, M.D., M.P.H., Co-Chair/Committee

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TABLE OF CONTENTS

	Page
LIST OF TABLES	vii
LIST OF FIGURES	viii
ACKNOWLEDGEMENT	x
VITA.....	xii
ABSTRACT	xiv
Chapter 1: Introduction.....	1
Background.....	1
Medical Residency	4
Resident Physician Occupational Burnout	5
Problem Statement.....	6
Purpose of the Study.....	8
Research Questions	9
Definition of Terms	9
Theoretical Framework	11
Research Methodology	15
Importance of the Study	16
Assumptions of the Study.....	17
Limitations of the Study	18
Delimitations of the Study.....	19
Current Social Implications of the Study	20
Researcher’s Positionality	22
Organization of the Study.....	23
Chapter 2: Literature Review	25
Introduction	25
Literature Review Methodology.....	26
Literature Search	27
Review of the Literature	34
Occupational Well-being.....	41
Residents Physicians and Occupational Burnout	42
Global Impact of Occupational Burnout in Resident Physicians	44
Positive Psychology.....	47
Herzberg’s Two-Factor Theory	49
Coping with Occupational Burnout.....	54
Leadership Styles.....	64

Chapter Summary	68
Chapter 3: Research Design and Methodology	69
Introduction	69
Research Questions	69
Qualitative Research Design	70
Study Inclusion Criteria and Sampling Procedures	70
Data Collection	77
Instrumentation	79
Epoche	84
Data Analysis	84
Trustworthiness in Qualitative Research	87
Chapter Summary	88
Chapter 4: Findings	89
Introduction	89
Participant Recruitment	91
Participant Demographics	92
Data Collection	94
Data Analysis	100
Data Organization	102
Results	106
Trustworthiness	139
Chapter Summary	142
Chapter 5: Findings	146
Introduction	146
Study Summary	147
Key Findings	152
Trustworthiness	166
Data Saturation	168
Study Conclusions	169
Implications for Scholarship	170
Study Limitations	171
Recommendations for Future Research	172
Closing Comments: The Researcher's Perspective	173
REFERENCES	175
APPENDIX A: CITI Certification	186
APPENDIX B: IRB Approval Notice	187

APPENDIX C: Recruitment Script	188
APPENDIX D: Informed Consent Form.....	189
APPENDIX E: Interview Script and Questions	194
APPENDIX F: Leadership Styles Chart.....	198

LIST OF TABLES

	Page
Table 1. Characteristics of Peer-Reviewed Articles.....	29
Table 2. Inclusion and Exclusion Criteria	72
Table 3. Research Questions and Concepts.....	78
Table 4. Interview Flow and Timing.....	80
Table 5. Participant Interview Schedule.....	91
Table 6. Demographics of the Recruited Female Resident Physicians	92
Table 7. Question Categories and Interview Questions	95
Table 8. Emerged Themes and Direct Quotes from Female Resident Physicians	103
Table 9. Leadership Styles Chart.....	126
Table 10. Research Questions and Themes	144
Table 11. Research Questions and Themes	150
Table 12. Leadership Styles Chart.....	159

LIST OF FIGURES

	Page
Figure 1. Procedure of Gathering and Reviewing Literature	28
Figure 2. Herzberg's Two-Factor Theory	52
Figure 3. Data Process	77
Figure 4. Interview Script and Questions	81
Figure 5. IQ3 Coding Results	107
Figure 6. IQ3 Coding Results for Probe 1	107
Figure 7. IQ3 Coding Results for Probe 2	111
Figure 8. IQ3 Coding Results for Probe 3	112
Figure 9. IQ5 Coding Results Bar Chart	115
Figure 10. IQ8 Coding Results Bar Chart	116
Figure 11. IQ9 Coding Results Bar Chart	118
Figure 12. Words Used by Participants Describing Their Feelings	119
Figure 13. More Words Used by Participants Describing Their Feelings	120
Figure 14. IQ12 Coding Results Bar Chart	121
Figure 15. IQ13 Coding Results Bar Chart	122
Figure 16. IQ15 Coding Results Bar Chart	124
Figure 17. IQ23 Coding Results Bar Chart	127
Figure 18. Words Used To Describing Efforts to Address Occupational Burnout	130
Figure 19. IQ17 Coding Results Bar Chart	131
Figure 20. IQ18 Coding Results Bar Chart	132
Figure 21. IQ21 Coding Results Bar Chart	133
Figure 22. IQ22 Coding Results Bar Chart	134

Figure 23. IQ7 Coding Results Bar Chart	136
Figure 24. IQ16 Coding Results Bar Chart	138
Figure 25. Words Described to Address Occupational Burnout by Attendings.....	162

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VITA

EDUCATION

Pepperdine University Los Angeles, CA
 Doctor of Philosophy in Global Leadership and Organizational Management
 Graduate School of Education and Psychology
 PhD Candidate, Final Defense April 2022

Saint Louis University School of Public Health Saint Louis, MO
 Master of Public Health in Community Health: Behavioral Science, Disease Prevention
 and Health Education - Graduation with Distinction

University of Notre Dame Notre Dame, IN
 Bachelor of Arts Degrees in Anthropology and French, Sankofa Scholar

TEACHING EXPERIENCE

California State University – East Bay – School of Business
 Class: Management 314: Leadership and Management Fundamentals – April 2019
 Guest Lecturer

PUBLICATIONS

Martinez-Hollingsworth, A.S., Kim, L., Graham Richardson, T., Angulo, M., Liu, R.,
 Friedman, T. & Choi, K. (March 2021). Supporting "bleeders" and "billers": How safety
 net administrators mitigate provider burnout during the Covid-19 pandemic and beyond.
Journal of Ambulatory Care Management.

Richardson, T. (December 2018). Addressing the Shame Imposed by Healthcare
 Providers on Individuals with HIV/AIDS – Using Change Models and the SPELIT Power
 Matrix to Provide Cultural Sensitivity Training to Physicians and Nurses in Belize.
Journal of Global Leadership, 5.

Richardson, T. (Fall 2008). Cultural Perceptions of Breastfeeding. *Regional Perinatal
 Programs of California – Perinatal Care Matters Newsletter.*

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 Interviewing and Adherence in Hypertensive African Americans. *American Journal of
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PROFESSIONAL TRAININGS AND AWARDS

Above and Beyond Award – Recognition for work as a Regional Perinatal Programs of California Director

University California San Diego Medical Center, Supervisor’s Academy

BOARD MEMBERSHIP

- Parent Teacher Organization Board - President-Cathedral Chapel Elementary Catholic School, 2019 to present
- Parent Teacher Organization Board - Vice President-Cathedral Chapel Elementary Catholic School, 2018 to 2019
- Parent Teacher Organization Member - Cathedral Chapel Catholic Elementary School, 2017 to present
- Our Lady of Victory Catholic School Advisory Board (Member), 2014-2015
- Black Infant Health – San Diego County (Member), 2007 to 2010
- Fetal Infant Mortality Review Board – San Diego County (Member), 2007-2009
- March of Dimes Program Services Board (Member), 2007- 2010
- Perinatal Nurse Leaders Council -San Diego & Imperial Counties (Co-Chair), 2007-2010

ABSTRACT

This qualitative, hermeneutic phenomenological research study explored the shared lived experience of occupational burnout and wellness in female Resident Physicians. The phenomenon was explored to identify if the Residents believed their Attending Physicians' leadership styles ameliorated or exacerbated their feelings of occupational burnout. The theoretical frameworks of Herzberg's Two-Factor Theory (Gardner, 1977) and Positive Psychology (Seligman, 2019) were used to examine the Residents' ability to navigate their workplaces. Virtual, semi-structured interviews were conducted to gain a perspective of the female physicians' residency experience and to learn how each felt their Attendings' leadership styles impacted them. The hermeneutic phenomenological approach identified common themes from the interviews and highlighted the following: (a) their training experience as female Residents, (b) their experience of occupational burnout, (c) their perceptions of leadership styles that alleviated or exacerbated occupational burnout; and (d) the coping strategies and social support they employed when navigating occupational situations that promoted occupational well-being or exacerbated occupational burnout. This research study offered a perspective on how occupational burnout impacts female Residents and how medical leaders, such as Attending Physicians, might help to assuage or prevent this phenomenon from befalling them so early in their medical careers.

Keywords: Resident Physicians, Women Residents, Women Physicians, Attending Physicians, burnout, physician burnout, residency training, phenomenology, wellness, Herzberg's Two-factor Theory, Positive Psychology, leadership, and leadership style.

Chapter 1: Introduction

Background

Psychologist Herbert Freudenberger (1989) first coined the term occupational burnout in the early 1970s, after observing and researching the levels of exhaustion seen in volunteer workers who administered care to substance abuse patients (Chesak et al., 2020). Freudenberger (1989) noticed that the more hours the volunteers worked, the more exhausted they became, and subsequently the more their occupational well-being was compromised. From his observations, he also discovered that an organizational culture that had a lack of leadership could greatly impact the well-being of workers. He believed that the phenomenon he was observing was a direct result of the occupational stress the staff was experiencing. Freudenberger coined the phenomenon of work distress he observed occupational burnout, or a state of being that occurred in work settings where staff felt overwhelmed by their work environments and tasks and subsequently experienced adverse effects to their personal well-being. Maslach furthered Freudenberger's research on occupational burnout and found that not only did it cause employees to feel physically exhausted, but it also had an impact on their psychological well-being (Maslach & Leiter, 2016). Other researchers agreed with Maslach and found that burnout caused people to feel a sense of depersonalization, a sense of emotional detachment, and reduced self-efficacy (Chesak et al., 2020; Maslach & Leiter, 2016).

One profession where occupational wellness is thought to be a commodity, that is prescribed by those who work for the organization rather than an employment benefit, is that of physicians. While physicians work for organizations that promote wellness, it is often thought that they should be able to self-administer wellness (Gazelle et al., 2014; Jennings & Slavin, 2015). However, presumably physicians experience similar occupational challenges as other

workers and therefore they are no more immune to the effects of occupational burnout (Gazelle et al., 2014). In fact, the literature on physician burnout has acknowledged that due to the lofty expectations of their jobs, instances of occupational burnout in physicians is more prevalent than in any other profession.

Various researchers have found that those who practice medicine experience occupational burnout more frequently, for longer periods of time, and more consistently throughout their careers than any other profession (Dyrbye et al., 2014; Eden et al., 2020; Hategan & Riddell, 2020; Kassam et al., 2015; Kinslow et al., 2020). Gazelle et al. (2014) found that the personality traits that are typically associated with physicians is what predisposes them to occupational burnout. These personality traits included compulsion, self-denial, and perfectionism which supposedly increased their predisposition to experience this phenomenon. As these characteristics may not be attributed to all physicians, they are thought to be traits that are modeled by some of their medical leadership and lauded as positive qualities during their medical training. Thus, as early as their first year in medical school, some physicians may have determined that perfectionism and self-denial would afford them a successful career, without realizing that such traits could compromise their overall health as well as occupational well-being (Gazelle et al., 2014; Hategan & Riddell, 2020).

Another trait that some researchers have identified may predispose physicians to occupational burnout is gender (Chesak et al., 2020; McMurray et al., 2000). Historically, gender has always been an underlying factor that prevented women from being seen as equals in the male dominated field of medicine. In the early 19th century, women were not accepted into medical school because they were thought to be intellectually inferior to men (Borst & Jones, 2020). However, in 1849, Elizabeth Blackwell not only fought to be accepted into medical

school but became the first woman in the United States to have ever graduated from an American Medical School (Borst et al., 2020). Although Elizabeth Blackwell was the first female physician, she recognized that her matriculation into medical school did not allow for the admission of large numbers of females into medical school (Borst et al., 2020; Fee et al., 2002).

From 1900 to the present, medical schools in the United States have maintained admitted a steady number of female students (Borst et al., 2020). Presently, in the United States, over half of the student body at American medical schools is female, and women account for the increasing numbers of female medical school graduates who annually become Resident Physicians in the country (Chesak et al., 2020). According to McMurray et al. (2000), the work environments in which female resident physicians work, as well as the impact these environments have on the female residents, has been historically understudied. It is thought that the occupational stressors that impact male physicians also have an impact on female physicians. Researchers have found that some of the stressors that impacted women physicians' occupational well-being included not being satisfied with their careers, being targets of gender discrimination perpetrated by their patients and male colleagues; and pressures associated with maintaining a sense of work-life balance (Borst & Jones, 2020; Chesak et al., 2020; Yeluru et al., 2022). As the number of women physicians, and presumably Residents, increase in the United States, it is necessary to understand how the phenomenon of occupational burnout impacts them individually and collectively.

According to Chesak et al. (2020), it is essential to understand the occupational experiences of female physicians, and it is especially important to identify factors that may contribute to their occupational well-being. In 2021, Kane published an occupational burnout survey. The survey was given to over 12,000 practicing physicians, representing 29 medical

specialties, throughout the United States. Kane (2021) found that in almost all of the 29 specialties represented, approximately 25% to 50% of the physicians surveyed experienced burnout depending upon their practice area. Kane also discovered that of those physicians surveyed, 51% of female physicians reported being or having had experienced occupational burnout compared to their male colleagues.

The female physicians attributed their experiences of occupational burnout to various stressors, such as long work hours, heavy workloads, as well as lack of support from their leaders and organizations for whom they worked (Kane, 2021). Thus, the goal of this research study was to determine if there was a shared experience of occupational burnout, amongst female Resident Physicians, that was believed to be ameliorated or exacerbated by the leadership styles of their Attending Physicians.

Medical Residency

The term Resident Physicians defines medical school graduates or early-career physicians who are in training to become proficient at a medical specialty of their choice (Dyrbye et al., 2014). The training for these physicians can last from 3–7 years depending upon their chosen field of medicine. Every year around July 1 in the United States, most teaching hospitals or hospitals that have residency programs welcome Residents to their organizations to begin their residency training (American Medical Association, 2018). It should be noted that although Resident Physicians are medical trainees, they are also considered employees at the hospitals in which they are being training (Gazelle et al., 2014). Thus, they are held to the same standards as the other physicians on staff, and they are compensated monetarily for the work they perform. For the purposes of this study they are not only seen as medical trainees but as employees, even though they will be in their residency programs for a determined amount of time.

Resident Physicians embark upon the journey of residency with the understanding that this period of their career will include rigorous training that will test their medical knowledge, physical and mental understanding, as well as overall stamina. As Residents, they also know that they will be required to work long hours as they hone their medical skills and administer medical care to patients with various acute and chronic illnesses (Dyrbye et al., 2014; Hategan & Riddell, 2020; Kassam et al., 2015; Kinslow et al., 2020). For some Residents, the rigorous training and tasks associated with the residency experience can be daunting and overwhelming because it can emotionally impact them in ways that are different from what they experienced in medical school (Dyrbye et al., 2014; Monteiro et al., 2020; Tziner et al., 2015; West et al., 2018). As medical students, their focus presumably was primarily on the didactics of medicine; however, during residency they are frontline healthcare providers responsible for many patients' lives (Gazelle et al., 2014). As early-career physicians, their jobs regularly require them to complete taxing and time-consuming clinical and administrative tasks such as manage serious patient care matters, complete copious amounts of paperwork, consult with other physicians, interacting with insurance companies, and performing social welfare activities that take them away from their patient care duties (Gazelle et al., 2014; Kane, 2020; Montiero et al., 2020). The latter can introduce different occupational stressors of which Resident Physicians may not be accustomed (Eckleberry-Hunt et al., 2009).

Resident Physician Occupational Burnout

The increasing rates of burnout among Residents has become a global epidemic (Montiero et al., 2020). According to Montiero et al. (2020), in 2011, 45.5% of American physicians reported feeling burned out. In 2014, 54.4% of all physicians in the United States reported having experienced burnout. Physician authors, Jennings and Slavin (2015) affirmed

that the training that Residents undergo can be harmful to their health and well-being due to the lofty expectations placed on them during the training process and can lead to physician burnout.

This study sought to explore the impact Attending Physicians' leadership style could have on Residents' experiences of occupational burnout and wellness, using the theoretical frameworks of Positive Psychology (Seligman, 2018) and Herzberg's Two-Factor Theory (Alshmemri et al., 2017; Nair et al., 2017) to investigate the latter. The findings from this study also sought to contribute to the literature to highlight the impact medical leadership may have on occupational burnout. For instance, Attending Physicians who directly work with Residents, can share best practices and the importance of risk mitigation based on their own experiences to help Residents in addressing issues which contribute to occupational stressors and burnout earlier in their career (Jennings & Slavin, 2015).

Problem Statement

Physician burnout has reached epidemic levels globally and warrants attention (West et al., 2018). Although the phenomenon of physician burnout is well documented, there are areas of this phenomenon where gaps in the literature exists. One such area in which there is a gap in the literature concerning this phenomenon is the lack of research conducted with female Resident Physicians and their perceptions of how their Attendants' leadership styles may impact their physicians' experiences of occupational burnout (Fee et al., 2002; Kletke et al., 1990; Nair et al., 2017; West et al., 2018).

It should be noted that in the residency training hierarchy, Attending Physicians hold the ultimate responsibility for ensuring that Residents are trained according to residency program standards. In accomplishing the latter, in most teaching hospitals, Residents are trained by their peers such that first-year Residents are trained by second-year Residents, who are all being

trained or who are under the supervisory auspices of a Chief Resident or Resident Physician who has more medical training. At the top of the chain-of-command are the Attending Physicians. Generally, Attending Physicians oversee residency training for all Residents, regardless of how long they have been in residency and are thus considered to be their supervisors.

Another potential gap in the literature related to physician burnout, in addition to the paucity of research on burnout of female Residents, was the relationship female Resident Physicians reported they had with their supervisors, or Attending Physicians (West et al., 2018). As Attending Physicians ultimately oversee all aspects of medical training for Resident Physicians, it could be presumed that the nature of their interactions might contribute to the amelioration or exacerbation of occupational burnout for female Residents (Delmatoff & Lazarus, 2014; Eubank et al., 2012; Gurt et al., 2011; West et al., 2018). Therefore, if the interactions between a Resident and her Attending Physicians are challenged in anyway, the Resident could perceive them to not be conducive to her medical training and occupational burnout could ensue (West et al., 2018).

It is the researcher's ambition that the results of this hermeneutic, phenomenological qualitative study could contribute to the research on physician occupational burnout in two ways:

1. to assist in revealing the shared and lived experience of occupational burnout amongst female Resident Physicians, and
2. to help to identify the leadership styles of Attending Physicians, as perceived by female Resident Physicians, that might aid in ameliorating or exacerbating the occupational experiences of female Residents.

It was thought that such an understanding of this critical phenomenon could assist in mitigating experiences of occupational burnout for female Residents and could offer medical leaders insight

on how to implement policies and procedures to assuage this global phenomenon (Heuser et al., 2018).

Purpose of the Study

The purpose of this research study was to gain a better understanding of the experience of physician occupational burnout in female Resident Physicians and of how their perceptions of their Attendings' leadership styles influenced their experiences. The results of this study provided insight into what female Resident Physicians believed would assist them in mitigating occupational burnout as well as what support they needed from their physician leaders to manage occupational stressors. By utilizing a hermeneutic phenomenological, qualitative approach this study revealed how first, second, and third-year female Residents navigated occupational burnout and to what extent it impacted their residency training. They also shared how their regular interactions with their Attending Physicians helped to alleviate or worsen their experience with this phenomenon.

It was acknowledged that occupational burnout impacts physicians' perceptions of self, of their medical acumen, and it could particularly affect their efficacy to do their jobs (Sochos et al., 2012). One theoretical framework that supported this research was Positive Psychology that espouses that individuals' thoughts of their abilities is predicated on their self-perception of overall well-being. (Seligman, 2019). The other theoretical framework that underpinned this study was Herzberg's Two Factor Theory (Alshmemri et al., 2017). This theory posits that occupational burnout is predicated on workers' perceptions of job satisfaction. For the purposes of this research study, Resident Physicians held a dual role and thus were defined as both medical trainees as well as medical staff at their respective teaching hospitals. Therefore, the

duality of their role allowed for both of the aforementioned theoretical frameworks to support this study.

Research Questions

The research questions that informed this study were used to explore the perceived lived and shared situations faced by female Resident Physicians during their residency training. The following research questions were used to examine their experiences of occupational burnout:

- RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?
- RQ2: What leadership styles do female Resident Physicians perceive their Attending Physicians' exhibit?
- RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?
- RQ4: How do female Resident Physicians cope with occupational burnout?

Through semi-structured, virtual in-person interviews on Zoom, the premises associated with the previous research questions were discussed. The variables examined in the study were the Resident Physicians' beliefs and perceptions, measured in the affective and cognitive domains. Data was collected cross-sectionally during February and March 2022 through. The expectation was that the findings from this study would contribute to the gap in the scholarly literature related to how leadership styles may impact the occupational burnout experienced by female Resident Physicians.

Definition of Terms

- *Attending Physicians or Physician leadership*: A preceptor physician or an experienced physician who supervises the work performed and comprehensive

training experience of Resident Physicians and medical students in hospital and community healthcare settings (Gazelle et al., 2014).

- *Occupational Burnout*: A psychological syndrome or phenomenon that is exacerbated by chronic occupational stressors while in one's work setting (Freudenberger, 1989; Maslach & Leiter, 2017).
- *COVID-19 Pandemic*: clinically known as SARS-CoV-2, is a potentially fatal, pneumonia-like respiratory virus spread through droplet transmission. It became a global pandemic in 2019 that has infected millions of people worldwide and has claimed thousands of deaths daily worldwide (McArthur et al., 2020).
- *Herzberg's Two-Factor Theory*: A two-part theory that delineates categories whereby factors are associated with job satisfactions, leading to motivation and self-determination, and other factors associated with job dissatisfaction, which leads to burnout (Alshmemri et al., 2017).
- *Leadership*: The process by which individuals or groups are influenced and supported by individuals for whom guide them to achieve individual and collective goals (Goleman, 2000).
- *Leadership Styles*: Describes the behavior patterns of individuals who possess leadership positions and how they use their behavior to influence those they lead (Arnold et al., 2015).
- *Physician Burnout*: A phenomenon characterized by a medical provider displaying characteristics such as compulsiveness, guilt, and self-denial, and perfectionism that impact their ability to perform their job to the best of their ability (Gazelle et al., 2014).

- *Positive Psychology*: A field of psychology that studies the wellness and well-being of individuals which is measured by five tenets: Positive Emotion (P), Engagement (E), Relationships (R), Meaning (M), and Accomplishment (A), which is understood as the PERMA model (Seligman, 2018).
- *Residency*: A period of medical training that begins after graduation from medical school. Its duration is dependent upon the medical specialty for which the medical graduate is training and can last from three to seven years (Hategan & Riddell, 2020).
- *Resident Physicians or Residents*: A medical school graduate who is in postgraduate training to specialize in a particular type of medicine (Hategan & Riddell, 2020).
- *Teaching Hospitals*: Hospitals where Resident Physicians are trained to become proficient in a medical specialty during their residency training.

Theoretical Framework

Herzberg's Two-Factor Theory

The primary theoretical framework that underpinned this research study is Herzberg's Two-Factor Theory (Alshmemri et al., 2017). This theory was created in 1959 by psychologist Frederick Herzberg and is used to identify job satisfaction of employees. This theory posited that there are two categories with which job satisfaction is attributed: one category highlights factors that motivated people to work such as achievement, recognition, work, responsibility, advancement in the job, and job growth (Alshmemri et al., 2017; Soliman, 1970). The other category called "hygiene factors" (Alshmemri et al., 2017, p. 12), are denoted factors that could possibly discourage workers and thus contributed to them being dissatisfied with their jobs . Alshmemri et al. (2017), identified hygiene factors to be organizational policies and procedures; in other words, relationships between supervisors and employees or leaders and followers, other

job-related interpersonal relationships amongst employees, and working conditions and compensation (Gardner, 1977; Soliman,1970). The overall premise of the theory was that if the work environment was perceived by workers to provide satisfaction, then motivation for one's job followed. However, if any of the motivating or hygiene factors were perceived by employees to decline, then job satisfaction could be compromised and occupational burnout could prevail (Alshmemri et al., 2017). Thus, this study presumed that if female Resident physicians, in their duality as medical trainees and hired staff at the hospitals, felt as if their work settings promoted a sense of wellness, they could realize a sense of job satisfaction.

Positive Psychology

Another theoretical framework that guided this research endeavor was that of Positive Psychology (Seligman, 2019). The field of Positive Psychology studies human well-being through the five elements of the PERMA model which was introduced by psychologist Martin Seligman (2019). The premise of this theory and the PERMA model was based on individuals' abilities to motivate themselves when they were confronted with challenges. If people perceived themselves to be in situations, such as work environments, where they deemed themselves successful, they were more likely to experience a sense of wellness. Conversely, when individuals felt that they were in environments that were not conducive to their personal growth and productivity, they could feel overwhelmed and less efficacious and presumably being more susceptible to occupational burnout.

Seligman (2019) affirmed that Positive Psychology is predicated on the five elements of the PERMA model:

- Positive Emotion (P),
- Engagement (E),

- Relationships (R),
- Meaning (M), and
- Accomplishment (A).

The first tenet of PERMA is Positive Emotion. The premise of Positive Emotion is the acknowledgement that individuals have the ability to respond to their environments through the expression of positive or negative emotions. Thus, to promote well-being, the environment in general should be one that promotes feelings that encourage a sense of wellness (Brunetto et al., 2016). For instance, in residency environments, this element of PERMA could be supported through the organization's policies, and through its leadership's ability to ensure that the mental and physical well-being of each Resident Physician was supported to mitigate occurrences of occupational burnout.

The second tenet of PERMA is Engagement. As Resident Physicians, they are members of a cohort of physicians-in-training. Thus, multiple researchers have shown that the need for Residents to have positive connections with others in their cohort as well as with their Attendings could be beneficial to their job satisfaction and could contribute to their occupational well-being (Brady et al., 2017; Brunetto et al., 2016; Monteiro et al., 2020; Patrick & Williams, 2009; Ryan & Deci, 2000; Williams & Morrow, 2009).

Relationships, the third tenet of PERMA highlights how important positive relationships with one's colleagues and superiors could enhance one's feelings of job satisfaction (Patrick & Williams, 2009; Ryan & Deci, 2000). In medical environments in which Residents are trained, this third element of PERMA speaks to how social support and mentoring could help to ameliorate well-being and prevent occupational burnout. It is known that when Resident Physicians perceive their work environments to be collaborative and supportive of their

occupational goals, such work settings can promote camaraderie which can increase perceptions of occupational wellness (Brunetto et al., 2016; Chilton, 2017; Patrick & Williams, 2009).

According to Seligman (2019), the fourth tenet of PERMA is Meaning. For Residents, a sense of meaning may be connected with feelings of purpose as it relates to their jobs as physicians (Brunetto et al., 2016). According to Brunetto et al. (2016), identifying a sense of meaning in one's profession could allow individuals to feel a sense of satisfaction concerning their endeavors. Similarly, Dartey-Baah and Amoako (2011) affirmed that when people believe that their professional contributions have a positive impact on a larger purpose, then job satisfaction or occupational well-being could be realized (Brooks et al., 2018). In the case of Resident Physicians, an example of when they might feel the concept of meaning might be positive interaction with a patient,

The last element of PERMA is Accomplishment. According to Brunetto et al. (2016), feeling a sense of accomplishment or achievement is paramount to one feeling as if they are efficacious at their jobs. Presumably, having feelings of professional accomplishment could significantly impact an early-career physician's experience of occupational well-being (Ryan & Deci, 2000; Lianov et al., 2019).

In addition to perceiving one's work environment to assist in promoting job satisfaction and feelings of self-efficacy, another element that can enhance occupational experiences is that of one's supervisor's leadership style (Goleman, 2000). Leaders who exhibit vision-driven leadership styles are thought to value the work of those for whom they lead and are thought to contribute to their occupational well-being (Alshmemri et al., 2017). According to Lianov et al. (2019) when medical professionals were encouraged by their leaders to follow the tenets of PERMA and incorporated positive psychology-related activities in their daily lives such as

exercise, acts of kindness, adhering to stress-reducing or health promotion activities, they saw improvements in their personal outlook on their jobs, and these feelings in turn contributed to positive health outcomes for their patients (Lianov et al., 2019). The objective of this research study was to discover if the female Residents perceived their Attendings' leadership styles to be ones that supported occupational well-being or that contributed to occupational burnout.

Research Methodology

The purpose of this study was to investigate whether female Resident Physicians perceived their Attending Physicians' leadership styles had an impact on their experiences of occupational burnout or well-being (Britzman & Henkin, 1992; Goleman, 2000; Kauppila, 2016). A hermeneutic, phenomenological qualitative study design was selected to guide this investigation because it was hypothesized that perhaps the experiences of the research participants might be one of a shared experience. Of the five types of qualitative study designs, a hermeneutical approach was selected because it espouses the impossibility of separating a phenomenon from the individuals who have experienced it. Thus, in the case of the study population of Resident Physicians, it was thought that their shared understanding of occupational burnout united them in creating a shared experience as early career physicians (Davidsen, 2013).

A hermeneutic, phenomenological qualitative research design was also used because this research methodology permitted the use of descriptive data collection to inform the scientific inquiry (Davidsen, 2013). As the study's ontology followed the concepts of leadership style; and the theoretical frameworks that underpinned the study were Herzberg's Two-Factor Theory (Alshmemri et al., 2017) and Positive Psychology (Seligman, 2018), upon approval of Pepperdine University's Institutional Review Board (IRB), these concepts were investigated through collecting data via in-person, virtual interviews.

Prior to conducting any research activities, the researcher submitted an IRB application at Pepperdine University to gain approval to conduct the research. In keeping with IRB rules, informed consent was obtained from each participant at the time of recruitment. To recruit the Residents to participate in the study, the snowballing method was employed (Eland-Goossensen et al., 1997). This recruitment method allows the participants to refer people for whom they know, who may meet the study's inclusion to contact the researcher to express interest in participating in the study. In short, the researcher asked the first Resident who completed the interview if she knew anyone who might be interested in participating in the study, and if so, to ask that she contact the researcher. Once the second Resident was identified, she was asked to invite another Resident to participate in the study, using the study recruitment flyer, and so on until there were no other female Resident Physicians who expressed interest in participating in the study (Eland-Goossensen et al., 1997; Marcus et al., 2017).

The interviews were conducted using the virtual Zoom platform as well as an interview guide created by the researcher. The interview guide consisted of 26 questions that were created in response to the literature on physician burnout, concept of leadership styles, as well as the theoretical frameworks of Herzberg's Two-Factor Theory (Alshmemri et al., 2017) and PERMA (Seligman, 2019). Each interview was transcribed and upon analyzing the data from the interviews, common themes were identified (Saldaña, 2016).

Importance of the Study

The aim of this research study was to understand the experience and to highlight a group of female Resident Physicians for whom their presence in the literature is somewhat dimmed (Fee et al., 2002). This study was designed under the assumption that women who are Residents could have shared occupational experiences. The occupational experience that was under

investigation in this study was that of the Residents' perceptions of their Attending Physicians' leadership styles having an impact on the amelioration or exacerbation of their personal experiences of occupational burnout.

Studying the experiences of female Resident Physicians is important for a number of reasons. First, it should be acknowledged that there is a gap in the scholarly literature that intentionally discusses how the leadership styles of Attending Physicians impact female Residents. The information collected from the Residents could potentially inform residency training as it relates to how medical leaders mentor early-career physicians. This study is also important because it could perhaps open a dialogue in the healthcare community in regards to leadership and whether enough has been done to teach physicians how to be leaders as well as the importance of them recognizing the leadership styles for which they project, especially if they are Attending Physicians who participate in the medical training of Resident Physicians. This research could potentially contribute to the literature on female Residents in that it may allow them to reflect on the types of leadership styles that are more conducive to their personal training experiences. In doing the latter, if it is recognized that one leadership style resonates more with individual female Residents than another, perhaps she could develop self-coping skills such that she is not as susceptible to debilitating bouts of occupational burnout that put her health and that of her patients in jeopardy.

Assumptions of the Study

One assumption made in this study was that a majority of the female Resident Physicians had actually experienced occupational burnout as it was defined by the research study. Another assumption was that the Residents would want to participate in the study and that their schedules allowed them to do so. It was also presumed that the Residents knew about leadership theory and

could readily identify various leadership styles. The study presumed that the Residents' Attending Physicians' leadership styles had an impact on how they experienced occupational burnout. It was also thought that perhaps the Residents would identify the transformational leadership style as the most effective style to help to ameliorate occupational burnout while there was an assumption that they would identify the transactional and laissez-faire leadership styles as those that would exacerbate the burnout experience.

It was also anticipated that the interview questions used to collect the data aided in exposing the shared experience of the Resident Physicians and that they provided honest, rather than socially desirable, answers to each interview question. It was thought that the Residents who agreed to participate in the study did not have any work conflicts or other time constraints related to the COVID-19 pandemic that would preclude them from participating in a 45–60 minute interview after they had initially agreed to do so. Finally, it was assumed that the researcher's biases, based on her positionality to the research population, would not have a noticeable impact on the study.

Limitations of the Study

The identification of the study population and its subsequent sample size of five participants were limiting factors associated with the study. The recruitment methodology employed, or the snowball recruitment methodology (Eland-Goossensen et al., 1997), may have been a limiting factor of the study in that the researcher was wholly dependent on the Residents to refer and essentially recruit their colleagues to join the study. In short, the researcher was dependent upon strangers to promote the study as well as to recruit for the study.

The small sample size of the study, while it is in keeping with that of phenomenological studies was also a limitation of the study. A sample size of five participants does not suggest that

the results are generalizable to the general population of female Resident Physicians in the United States. There were also limitations associated with the study participants in that they were all Residents who knew each other in some way. Because some of the Residents were familiar with one another, it could be presumed that their professional relationships may or may not have influenced their choice to participate in the study. It could also be argued that because some of the Residents' were colleagues, they chose to participate in the study as a favor to their peers. For instance, if a Resident participated in the study to accommodate the request of their colleague, she may or may not have accurately portrayed her experience of occupational burnout for fear that it would be discovered that she agreed to participate in the study for socially desirable reasons rather than because she had truly experienced occupational burnout.

Another limitation of the study was the time constraint associated with conducting the virtual interviews. For instance, the Residents' work schedules may have precluded some potential research participants from volunteering to partake in a 45-minute interview. As Residents are considered frontline workers administering essential medical care to patients with COVID-19, as well as other patients, there was a possibility that the researcher would not be able to interview a lot of female Residents as anticipated because they were not available (Kwon et al., 2020).

Delimitations of the Study

There were a number of delimitations of this study. For instance, the study population of female Residents was not generalizable to the population of female Resident Physicians in the United States since they were all in residency programs in the Western United States. The study was also not generalizable due to history bias associated with the global pandemic which may

have increased the Residents' experiences of occupational burnout and could be seen as a confounder.

Also, the study's sample was composed of Residents for whom only knew residency training through the lens of the pandemic. It was presumed that they experienced inordinate amounts of occupational burnout thus precluding some potential study participants from choosing to join the study because they may or may not have been interested in discussing the occupational challenges they experienced.

There were also possible delimitations that were associated with the data collection process. For example, qualitative data collection usually occurs in-person; however, due to the COVID-19 pandemic, it was not safe for the data collection to proceed as such. Collecting the data over a virtual, in-person platform like Zoom may have compromised the level of rapport that could be built between the researcher and the participants during the interviews. Another delimitation of the study was the research effect associated with the researcher's general positionality to the research participants. As the researcher has a spouse who is a practicing physician, her positionality was consistently being kept at bay through memoing conducted before, during, and after each interview (Birks et al., 2008).

Current Social Implications of the Study

The COVID-19 Pandemic has highlighted just how valuable healthcare professionals, particularly physicians, are in helping to administer care to the public and the sacrifices they make each day to do so (Kwon et al., 2020). Resident Physicians have been impacted tremendously by the COVID-19 pandemic as they have been a significant part of the frontline workforce that has offered medical care to patients infected by the virus.

As this research study was being conducted, the global pandemic had infected over 80 million people and taken the lives of over 2 million. In the United States, COVID-19 had infected over 18 million people and had killed over 300,000 individuals. Thus, the importance of this study was acknowledged as occupational burnout amongst Resident Physicians was presumably felt by the healthcare systems for which the female Residents worked as well as the communities for which they served (Kwon et al., 2020).

The personal and professional sacrifices made by physicians during the pandemic were documented through various news articles (Kwon et al., 2020). Many of the news articles highlighted how the pandemic had exacerbated some physicians' experiences of burnout in ways that had increased their emotional exhaustion, lowered their efficacy, and increased feelings of anxiety and depersonalization. It should also be noted that news articles revealed the mental health repercussions of occupational burnout, including depression, as a result of physicians having had witnessed many deaths in a short time span.

In addition to all of the aforementioned articles that substantiated the levels of burnout experienced by physicians during the pandemic, there were also reports of physicians not feeling supported by their medical leadership. For instance, in the early stages of the pandemic there were multiple news reports highlighting how healthcare systems had not properly equipped physicians with basic personal protective equipment to do their jobs. In short, the pandemic has impacted the medical profession in a myriad of ways that has exacerbated occupational burnout amongst physicians including the female Resident Physicians for whom participated in this research study.

Researcher's Positionality

The investigator's positionality in the study is both personal and professional. She is married to a physician for whom she has known for over 25 years. Due to the longevity of their relationship, the researcher has observed firsthand the successes and challenges one might experience in medical school, throughout residency training, and a myriad of other experiences observed as a spouse of a physician. As a partner of a physician who has successfully completed two different residency training programs in various parts of the country, the researcher has been a participant observer of this experience and has witnessed the successes and challenges that befall Resident Physicians.

Also, for over 20 years the researcher has worked as a Public Health and clinical researcher. She has also worked throughout the United States in teaching hospitals with physicians of various medical specialties. She has formed professional and personal relationships with medical students, Resident Physicians, Attending Physicians, and physician leaders which has afforded her a unique insight on their occupational journeys. Lastly, the researcher has a particular insight into physicians not only because she has spent so much time with them, but also because for most of her life she aspired to go to medical school before entering the Ph.D. Program for which this dissertation culminates and thus holds the medical profession in high esteem. It is because of the admiration she has for the field of medicine and for physicians that she decided to pursue this area of research.

Organization of the Study

Chapter 1 began with a discussion of the scope of medical residency. It then discussed the problem of physician burnout and how its contributing factors impacted the work of Resident Physicians. The chapter continued with a discussion of the two theoretical frameworks that underpinned the study, Herzberg's Two-Factor Theory (Alshmemri et al., 2017) and Positive Psychology (Seligman, 2018). Next, the rationale for the research study was shared through the problem and significance of the study. The chapter concluded with offering definitions for the terms used throughout the study, as well as a discussion of the study's assumptions, limitations, and delimitations. Lastly, the global perspective as it relates to physician occupational burnout during a pandemic and a discussion of the researcher's positionality to the study topic was shared.

Chapter 2 highlighted the literature that supported the two theoretical frameworks that underpin this research study, Herzberg's Two-Factor Theory (Alshmemri et al., 2017) and Positive Psychology (Seligman, 2018). The concepts of leadership style, well-being, social support, and coping were highlighted in the literature to surmise how they impacted the experience of occupational burnout for female Resident Physicians. Chapter 3 discussed the research methodology that guided the study. The rationale for selecting a hermeneutic phenomenological, qualitative research design, rather than a quantitative research design was discussed. The inclusion and exclusion criteria were outlined as well as the demographics of the study population. The study's research questions were identified and the requirements for maintaining confidentiality based on the human protection considerations were emphasized. The procedures for the data collection, data management, and data analysis procedures were also discussed.

Chapter 4 examined the findings from the five qualitative interviews conducted with the female Resident Physicians. The findings included direct quotes from the Resident Physicians' interviews to illustrate the common themes that emerged amongst the cohort. The methodology of the data collection and data analysis was reiterated as it related to the overall hermeneutical, phenomenological approach of the research study.

Finally, Chapter 5 discussed the findings that emerged from the research study. Direct quotes from the Resident Physicians were used to illustrate their self-reports of occupational wellness and burnout. The theoretical frameworks that underpinned the study were discussed to show how they supported the findings as well as how the chosen study design aided in the emergence of the common experiences of the phenomenon of occupational burnout was experienced by each research participant. The chapter culminated with discussing the identified limitations of the study, recommendations for future research, and closing comments from the researcher.

Chapter 2: Literature Review

Introduction

Occupational burnout is a state of being that is exacerbated by workplace stressors that negatively affect workers' job performance and confidence, and can cause physical and mental health issues for them (Freudenberger, 1989; Maslach & Goldberg, 1998). It is a phenomenon that has warranted attention since the term was coined by psychologist Herbert Freudenberger in the 1970s (Freudenberger, 1989). Occupational burnout is known to not only affect workers, but it also has organizational implications. For instance, having overworked employees compromises work performance and thus can have financial implications for organizations.

In all industries there is a potential for burnout to occur; however, the one industry that is known to have the most burnout is that of medicine, particularly as it relates to physicians (Hategan & Riddell, 2020). Over the last several decades, research has focused on the topic of chronic occupational burnout and the impact it had on workers (Freudenberger, 1989).

Physicians experience occupational burnout more than any other profession. If the issue of physician burnout is not addressed early in their careers, presumably in residency, the repercussions of this phenomenon can have long-term effects on them as well as on the patients for whom they serve (Hategan & Riddell, 2020). The need to ensure that physicians are physically and mentally well as they administer care to the public is of paramount importance.

Patients deserve to have physicians who are well enough to make decisions about their healthcare, and more importantly, physicians owe it to themselves to be as healthy as possible when administering care (Gazelle et al., 2014). The high-pressured nature of physicians' jobs has resulted in instances where some of them have practiced medicine when they are not mentally or physically well (Hategan & Riddell, 2020). Research conducted by Wallace et al. (2009) found

that physicians continue to administer healthcare to patients even when they are not at their best. Their research further concluded that physicians view their roles as ones that supersede their personal health and well-being, and therefore often work to the point of burnout or exhaustion. Physicians who perform their jobs when they are unwell are more susceptible to occupational burnout which compromises the organizations for which they work and puts themselves, their patients, and their colleagues at risk (Hategan & Riddell, 2020; Wallace et al., 2009).

Physicians are trained, from the time they enter medical school and well into residency, that they are to take care of the sick even if they are ill themselves (Brady et al., 2017; Brooks et al., 2018). Physician occupational burnout is characterized by cynicism, decreased efficacy, exhaustion, and low job satisfaction (DeChant et al., 2019). Thus, it is thought that occupational burnout in physicians is not only a direct consequence of their choice of profession but that it may also be endemic to the occupational settings in which they work (Jennings & Slavin, 2015). Various national and international studies have identified that the occupational burnout experienced by early-career physicians or Residents is significant with over half of them having acknowledged that at some point in their training they experienced occupational burnout (DeChant et al., 2019).

Literature Review Methodology

A systematic review was conducted to understand how the phenomenon of occupational burnout impacted the training experience of female Resident Physicians. The research study conducted hypothesized that one factor that may have ameliorated or exacerbated their experience of occupational burnout was their Attending Physicians' leadership styles. A gap in the literature exists regarding the latter as the topic of Attendings' leadership styles, in

juxtaposition to the experience of occupational burnout in female Resident Physicians, is limited in the peer-reviewed literature. Various factors associated with physician occupational burnout were conceptualized from the literature including identified stressors, ways in which this phenomenon has impacted female physicians in general and their job satisfaction, and the extent to which the role of leadership and leadership styles have a bearing on this phenomenon.

Literature Search

To investigate occupational burnout as it relates to female Resident Physicians, hundreds of national and international peer-reviewed journals were reviewed. The literature search platforms that were used for this search were: Medline, PubMed, PsycINFO, Scopus, and Business Source Primer. The keywords used to explore the literature for this phenomenon were: Resident Physicians, Women Residents, Women Physicians, Attending Physicians, burnout, occupational burnout, physician burnout, residency training, phenomenology, wellness, Herzberg's Two-factor Theory, Positive Psychology, leadership, and leadership styles. The date parameters for the search terms were not restricted in order to identify as many articles as possible on the topic. At least six searches of the literature were conducted by the researcher from 2020 through 2022.

Over 500 articles met the keyword search criteria and over 150 articles were found to be specifically related to the research topic. Initially, each article's title was scanned to determine its relevance to the study, the abstracts were read, and the articles were categorized according to topic as it pertained to the phenomenon. Thereafter, it was determined that of the 150 journal articles, 60 articles would be included in the systematic review.

The objective of this research study was to contribute to the limited research on the topic of female Resident occupational burnout. The diagram shown in Figure 1 depicted the procedure

the researcher followed for gathering and reviewing the peer-reviewed literature that supported this study. Table 1 displayed the comprehensive list of the literature that was reviewed and used for this study.

Figure 1

Procedure of Gathering and Reviewing Literature



Table 1*Characteristics of Peer-Reviewed Articles*

Author and Year	Study Design or Article Topic	Study Population	Total Number of Participants (Number of Females)	Country	Concept Researched
The Lancet Editorial, 2019	Physician Occupational Burnout	Physicians	N/A	Global	Physician Occupational Burnout
Kletke et al., 1990	Extant data	Physicians	4,000 (not given)	U.S.	Growth Proportions of Physicians over time (1970-1986)
Glenn, 2017	Literature Review	Female Physicians	N/A	U.S.	History of Women in Medicine
Fee et al., 2002	Historical Perspective	Women in Medicine	N/A	U.S.	History of Women in Medicine
Gregersen et al., 2016	Quantitative Study (Self-administered Questionnaires)	Male and Female Healthcare Employees	343 (240)	Europe	Employee Well-being
Skogstad et al., 2014	Quantitative Study	Male and Female Employees	1771 (1320)	Europe	Leadership Style – Laissez-faire
Wallace et al., 2009	Literature Review	Male and Female Physicians	N/A	U.S.	Physician Wellness
Anagnostopoulous et al., 2012	Quantitative Study (Self-administered Questionnaires)	Physicians and patients	30 (13) Physicians and 300 patients	Europe	Physician Occupational Burnout and Patient Satisfaction
Meldrum, 2010	Qualitative Study -Telephone interviews	Physicians	14 (5)	U.S.	Physician Occupational Burnout
Cranley et al., 2016	Quantitative Study (Self-administered Questionnaires)	Resident Physicians – PGY 1-3	38 (20)	U.S.	Resident Occupational Burnout – Stress and Recovery Strategies
Monteiro et al., 2020	Qualitative Study – Focus Groups	Psychiatry Residents	115 (59)	South America	Resident Physicians - Tested

Author and Year	Study Design or Article Topic	Study Population	Total Number of Participants (Number of Females)	Country	Concept Researched
					instrument that could evaluate the work environment.
Hategan & Riddell, 2020	Quality Assurance Pilot Program for Wellness	Psychiatry Residents	22 (18)	Canada	Resident Occupational Burnout
Joaquim et al., 2018	Multi-site, cross-sectional Quantitative Study (Self-administered Questionnaire)	Oncology Residents	118 (87)	Europe	Resident Occupational Burnout
Ahmadpanah et al., 2015	Quantitative	Emergency Department Physicians	100 (29)	Middle East	Physician Occupational Burnout, Personality Type, and Job Satisfaction
Peltzer et al., 2003	A randomized, Quantitative Study	Physicians	402 (163)	South Africa	Identify Symptoms of Occupational Burnout
Guruprakash et al., 2018.	Quantitative Study (Self-administered Questionnaires)	Resident Physicians	68 (12)	India	Occupational Burnout
Rout, 1999.	Quantitative Study (Self-administered Questionnaires)	Physicians	900 (75)	Europe	Occupational stress and Job Satisfaction
Brady et al., 2017	Systematic Review	Physicians	3057 References Reviewed	U.S.	Physician Wellness
Jennings & Slavin, 2015	Wellness Report	Resident Physicians	N/A	U.S.	Resident Wellness
McMurray et al., 2000	Quantitative Study (Self-administered Questionnaires)	Physicians	5704 (735)	U.S.	Identify gender differences in burnout and job satisfaction

Author and Year	Study Design or Article Topic	Study Population	Total Number of Participants (Number of Females)	Country	Concept Researched
Chesak et al., 2020	Descriptive Article to Highlight Phenomenon	Female Physicians	N/A	U.S.	Occupational Burnout Among Female Physicians
Hoff & Lee, 2021	Systematic Review of Literature	Female Physicians	43 Studies Reviewed	U.S.	Occupational Burnout Among Female Physicians
Wallace, 2014	Descriptive Study to Highlight Phenomenon	Physicians	N/A	Canada	Gender and Occupational Social Support
Chilton, 2017	Perspective Paper	Physicians	N/A	U.S.	Social Support
Gazelle et al., 2014	Case Study of Phenomenon of Physician Burnout	Physicians	N/A	U.S.	Physician Occupational Burnout and Coaching
Sochos et al., 2012	Quantitative, Correlational Design (Self-Administered, Web-based questionnaires)	Resident Physicians	184 (111)	Europe	Occupational burnout and stressors; and social support
Kanat-Maymon et al., 2020	Discussion of Leadership Style	N/A	N/A	Israel	Full Range Leadership Theory and its impact on work motivation
Ali et al., 2015	Mixed Methods (Self-administered questionnaires and in-person interviews)	Employees in Business Institutions	100 (45)	U.S.	Identification of which Leadership Styles create an effective work culture
Gregersen et al., 2014	Quantitative	Healthcare Workers	1,045 (742)	Europe	Leadership Behaviors of Healthcare workers to create an environment of employee wellness

Author and Year	Study Design or Article Topic	Study Population	Total Number of Participants (Number of Females)	Country	Concept Researched
Goleman, 2000	Description of Phenomenon of Leadership	N/A	N/A	N/A	Leadership Styles
Shanafelt & Noseworthy, 2017	Discussion of how to Engage Physicians in Helping to reduce Occupational Physician Burnout	Physicians and Hospital Executives	N/A	U.S.	Leadership and Physician Occupational Well-being
Freudenberger, 1989	History of Occupational Burnout	Volunteers at a Free Clinic	N/A	U.S.	Occupational Burnout
Maslach & Goldberg, 1998	Discussion of Prevention of Job Burnout	N/A	N/A	U.S.	Occupational Burnout
Brooks et al., 2018	Quantitative	Physicians	185 (74)	U.S.	Physician Wellness
Alshmemri et al., 2017	Explanation of Herzberg's Two-Factor Theory	N/A	N/A	Australia	Theory of Job Satisfaction
Dartey-Baah & Amoako, 2011	Examination of Herzberg's Two-Factor Theory	N/A	N/A	Africa	Theory of Job Satisfaction
Arnold et al., 2015	Quantitative	Occupational Leaders	205 (80)	Canada	Leadership Styles and Occupational Burnout
Saxena et al., 2017	Qualitative Study – Semi-structured in-person interviews	Medical School Leaders	42 (Not given)	Canada	Leadership Styles
Hildenbrand et al., 2018	Quantitative	Manufacturing Workers	148 (33)	Europe	Transformational Leadership and Occupational Burnout
Stoller, 2017	Leadership Development Program for Physicians	Physician Leaders	18 (Not given)	U.S.	Medical Leadership Development
Ellis et al., 2019	Leader-Member Relationships Related to	Workers from Various Industries	129 (33)	U.S.	Leadership – Occupational Leader and

Author and Year	Study Design or Article Topic	Study Population	Total Number of Participants (Number of Females)	Country	Concept Researched
	Occupational Well-being				Follower Relationships
Dechant et al., 2019	Systematic Review of Literature	Physicians	50 Studies Reviewed	U.S.	Impact of Organizational or Workplace Interventions on Physician Occupational Burnout
Gurt et al., 2011	Quantitative	Male and Female Employees of a business firm	1027 (678)	Europe	The impact leadership practices have on employees' job satisfaction and psychological well-being.
Trépanier et al., 2015	Quantitative Online Survey	Nurses	699 (632)		
Seligman, 2019	N/A	N/A	N/A	U.S.	Discussion of theoretical concepts of Positive Psychology
McClafferty & Brown, 2014	Clinical report of Physician Wellness	Physicians	N/A	U.S.	Physician Wellness
Nair et al., 2017	Quantitative – Online survey	Physicians	297 (101)	India	Work satisfaction, gender, and Occupational Burnout
Kane, 2021	Quantitative Online Survey	Physicians	12,000 (6,120)	U.S.	Occupational Burnout
Heuser et al., 2018	Quantitative Online Survey	Physicians	232 (232)	U.S.	Job Satisfaction
Fainstad et al., 2022	Randomized clinical trial	Female Residents	101	U.S.	Coaching Program to reduce occupational burnout in female Residents

Author and Year	Study Design or Article Topic	Study Population	Total Number of Participants (Number of Females)	Country	Concept Researched
Koressel et al., 2020	Quantitative Study - Survey	Resident Physicians	33 (27)	U.S.	Occupational Burnout, Resilience, perceived stress, and social factors
Eden et al., 2020	Online Survey	Resident Physicians	2176 (1,262)	U.S.	Occupational Burnout and Gender Differences
Yeluru et al., 2022	Discussion of Impact of Occupational Burnout on Female Physicians	Female Physicians	N/A	U.S.	Female Occupational Burnout
Weidner et al., 2018	Quantitative Study - Survey	Physicians	1617 (948)	U.S.	Occupational Burnout
Dillon et al., 2020	Qualitative interviews	Physicians (15) and Medical Executives (2)	17	U.S.	Occupational Burnout
Kern et al., 2015	Quantitative (Self-administered survey)	Students	56 (males)	Australia	Testing the PERMA Model
Msheik-El Khoury et al., 2021	Quantitative (Self-administered survey)	Resident Physicians	95 (57)	Middle East	Relationship between Residency Program Directors and Resident Physicians

Review of the Literature

Women and Medicine

Women first attended medical school in the United States in the 1870s and most of them attended single-sexed schools because they were not allowed admission into the traditional, predominantly male medical institutions. Elizabeth Blackwell was one of the first American

women to become a physician and is regarded as a pioneer in the field (Fee et al., 2002). Since the inception of women in medical schools in the United States, they have been exposed to the same stressors in the medical profession as their male counterparts. However, in some studies, it was noted that being female was associated with a decreased sense of job satisfaction for women who were physicians (Chesak et al., 2020; Kane, 2021).

Some researchers have studied if gender impacts how one experiences occupational burnout. Eden et al. (2020) endeavored to contribute to the gap in the literature concerning the phenomenon of interventions that are designed to support occupational burnout that are tailored to female and male physicians. The objective of their study was to examine whether there are individual and organizational differences in how occupational burnout interventions are instituted for females and males. Eden et al. recruited over 2,000 Family Medicine Physicians to take an online survey. The survey assessed the physicians' level of occupational burnout at the time they took the survey. Results of the survey showed that 55% of the female physicians were experiencing occupational burnout and 50% of male physicians were experiencing it; thus, more than half of the sample were impacted by occupational burnout.

On an individual level, some of the physicians shared that they try to mitigate occupational burnout by adhering to an exercise regimen to reduce stress while others shared that they do mindfulness activities. The female physicians shared that they reduce their work hours as well as talk to therapists when faced with occupational stressors. The male physicians reported, that when faced with occupational stressors, they focus on engaging in activities that are related to their hobbies (Eden et al., 2020). The researchers found that 8% of the sample reported that they do nothing when they feel overcome by occupational burnout while nine percent of the physicians said that they participate in wellness programs to alleviate occupational burnout.

On an organizational level, the physicians reported the types of policies that were implemented to mitigate occupation burnout. A little over one-third (36%) of the physicians said that their organizations ensured that they had enough nursing support to do their jobs. Others said that their organizations offered behavioral services, flexible work hours, and time to complete nonclinical or administrative tasks. Some said that their organizations had formal wellness programs in which they could participate, while other physicians said that their organizations did not offer any occupational wellness programs (Eden et al., 2020).

In terms of the role gender played in addressing occupational burnout, the researchers found that female physicians were more likely to reduce their work hours and focus on personal responsibilities like family. Whereas it was found that male physicians did not reduce their work hours; and that they were less likely to talk to therapists about their experiences of burnout (Eden et al., 2020). It was concluded that the ways in which females and males mitigate occupational burnout are different. One of the biggest differences that also had organizational implications was that female physicians will reduce their work hours and become part-time workers, whereas typically male physicians do not reduce their hours. Thus, this finding has individual implications for female physicians that could explain why their compensation is less than their male counterparts. Therefore, from an organizational level, this may preclude them from advancing in their organizations.

In 2020, Medscape surveyed physicians who practiced in the United States to assess their level of occupational burnout (Kane, 2021). The survey was sent to over 12,000 physicians who practiced in more than 29 medical specialties. The results of the survey showed that occupational burnout for women increased. More than half of the women surveyed reported that they were experiencing occupational burnout at the time the survey was administered.

The phenomenon of gender and physician burnout warrants more investigation in order to determine its impact on female physicians. Chesak et al. (2020) identified that a gap existed in the literature concerning the stressors that exacerbated occupational burnout for female physicians at an individual, organizational, and societal level. The study found that from an individual level, female physicians reported that their experiences of occupational burnout have contributed to their feelings of job dissatisfaction and has impacted their work-life balance. The research also showed that from an organizational perspective, when female physicians experienced occupational burnout, there was a decrease in overall productivity and poor patient outcomes surfaced. It was concluded that the issue of occupational burnout had a significant impact on female physicians as well as on the healthcare system and thus warranted further research.

Hoff and Lee (2021) acknowledged that as a result of the increase in female physicians, there is evidence that they experience higher levels of occupational burnout compared to their male physician counterparts. To examine the latter exertion, the authors conducted a systematic review of the literature generated from the literary databases yielded hundreds of articles on burnout (Hoff & Lee, 2021). Their final review highlighted 43 peer-reviewed articles from 2010 to 2019. Studies highlighted various settings, populations, and sample sizes of female physicians, medical specializations, and study designs. Findings of their exploration yielded articles that included the experiences of occupation burnout of both male and female physicians rather than solely those experienced by female physicians. The majority of the articles reviewed (88%) depicted that burnout was most experienced by physicians who work in hospital settings, with evidence that burnout was also experienced by physicians who worked in other healthcare settings such as government facilities, private practice, or academic settings; and primary care

environments (Hoff & Lee, 2021). A number of the studies also combined medical specialties, thus making it a little more challenging to stratify the female physicians' experiences, and to compare them to other female physicians who practiced the same specialty.

When the authors looked at the data that was generated from the various burnout instruments used to collect data, it was observed that the Maslach Burnout Inventory showed that there existed a statistically significant difference between the male and female physicians for four studies. This indicated that burnout was experienced more by female physicians according to the studies in question. Conversely, results from five other studies showed that gender did not evoke any statistical significance as related to physician burnout (Hoff & Lee, 2021).

The authors also compared the variables of emotional exhaustion as well as professional achievement amongst the genders, both variables that could indicate the presence of burnout amongst physicians (Hoff & Lee, 2021). It was observed that seven of eight studies identified that female physicians had a higher likelihood of having higher emotional exhaustion scores than male physicians, yet the authors confirmed that only three of the eight studies indicated statistical significance for this variable. In short, the review of the extant peer-review literature generated a myriad of data related to the prevalence of burnout as it related to gender thus concluding that female physicians experienced higher levels of burnout related to emotional exhaustion compared to their male colleagues. The authors concluded that future research was needed to determine how gender impacts physician burnout as it could not be concluded from the systematic literature review conducted.

Some studies have found that gender may exacerbate occupational burnout for female physicians (Rout, 1999). In 1999, Rout conducted a study to determine if the phenomenon of physician burnout and its associated occupational stressors affected male and female physicians

differently. A random sample of 900 physicians completed a self-administered survey that asked questions about their perceived job stress, mental and physical well-being, job satisfaction, and personality traits. The survey's response rate was 65%, with 587 of the 900 physicians completing surveys. Of those who returned surveys, over one-third (211) were women. The results showed that male and female physicians similarly felt the occupational stressors of their jobs, particularly as related to patient care responsibilities, workload, long work hours, and work-life balance issues. Thus, Rout concluded that work stress, not gender, exacerbated physician occupational burnout.

Nair et al. (2017) researched how the phenomenon of burnout impacted both male and female physicians. The researchers noted that females had lower job satisfaction than their male counterparts which can lead to feelings of burnout. In reporting their findings, they asserted that while there is limited research on how burnout impacts female physicians, such stressors as personal responsibilities, inflexible work schedules, and the challenges faced at work are known to cause more stress for women physicians than for their male counterparts, thus contributing to their feelings of occupational burnout (Nair et al., 2017).

As physician burnout is a global epidemic (Editorial, 2019), researchers have identified the need for further research concerning how this phenomenon impacts female physicians (Fee et al., 2002; Nair et al., 2017). Since the number of women entering the field of medicine has increased (Glenn, 2017; Kletke et al., 1990), the literature supports the need for further investigation into how gender may influence occupational burnout (Glenn, 2017).

The occupational experiences of female physicians were studied by McMurray et al. (2000) to determine how they managed issues of burnout and job satisfaction. The authors surveyed almost 2,400 female physicians in the United States who practiced medicine. It was

discovered that when they were asked to reflect on their careers, residency training proved to be an experience that greatly impacted how they professionally viewed the field of medicine. For instance, during residency, some of the respondents felt they had little control of their work or personal time, did not always feel supported by their supervisors and colleagues; and they also did not feel that they had adequate resources to perform their jobs. In short, it was concluded that the challenges faced by female physicians contributed to the ways in which they viewed themselves and thus made them more susceptible to occupational burnout.

Studies were conducted to determine how the phenomenon affects male and female physicians and if it may impact them differently (Kane, 2021; Rout, 1999; Wallace, 2014). In short, a number of researchers have investigated whether the two genders experience this phenomenon in similar ways or if their experiences are different. Another study of female physicians was conducted to determine their experiences of occupational burnout to investigate the women physicians' perceived feelings of being accepted as equals in the male-dominated medical field (Wallace, 2014). Questionnaires were mailed to 2,957 physicians from various medical specialties and the researcher received 1,178 completed questionnaires which was a 40% return rate. There were 383 women and 576 men physician respondents, 40% and 60% of the study population; respectively. It was noted that data analysis showed a Chi-squared value of 3.984 with $p = 0.0970$ which indicated that there was statistical significance found in the sample, and more importantly that the responses from the physicians were viewed as representative and generalizable amongst the physicians in the population. It was concluded that the more physicians work the less support they receive from their peers as represented by $b = 0.122$ for emotional support.

Occupational Well-being

Medicine is a field that puts high demands on its physicians, particularly on Resident Physicians, and as a result of the rigorous work environments in which physicians work, occupational burnout may be evident (Gazelle et al., 2014). In order to have a full understanding of the factors that exacerbate occupational burnout for physicians, one must explore the occupational environments in which they work. McClafferty and Brown (2014) reported that the American Academy of Pediatrics Clinical Report on Physician Health and Wellness confirmed burnout is seen more in medicine than in any other profession due to the work environments in which physicians work, the societal expectations that are placed on them, and the overall stress that comes from the type of work they do. The authors also found that pediatricians accounted for approximately 40% of physicians surveyed who reported having experienced burnout. The pediatricians attributed their experiences of burnout to unrealistic personal expectations of endurance, pressure to complete tasks under specified time frames, long work hours that did not allow for full recovery, non-supportive workplaces, and dealing with chronically ill patients. This study posed a number of concerns regarding patient safety, especially since the physicians who acknowledged that they had experienced burnout were those who administer healthcare to the youngest and perhaps most vulnerable of patients, children.

Another study that looked at physicians' work environments was conducted by Brooks et al. (2018). The authors gathered information on the types of workplace wellness initiatives that might appeal to physicians who experience occupational burnout. To investigate the latter, the researchers distributed 185 surveys to physicians. The surveys asked questions about the triggers or signs that precipitated the physicians' occupational burnout, the particular symptoms they felt, as well as any wellness activities that may have helped to mitigate their experiences.

Of the 185 physicians who participated in the study, 111 were men and 74 were women (Brooks et al., 2018). The physician respondents shared that they had obtained mental health care for their feelings of burnout, and it was revealed that 51% were self-referred to a mental health practitioner due to the severity of their burnout experiences. Of the physicians who did not seek care, the reasons shared for not doing so included work schedules (47%), denial of illness (45%), embarrassment (43%), and confidentiality concerns (39%). Some of the physicians also shared that the perceived barriers could have been mitigated if they were aware of workplace wellness programs that focused on such concepts as possible burnout risk factors, physician mentoring and coaching; and being transparent with their colleagues regarding their experiences with occupational burnout without fear of possible reprimand.

The data also showed that if organizational policies were implemented and upheld then physicians might feel encouraged to share their experiences of burnout (Brooks et al., 2018). In addition, they felt that workflow-specific initiatives that encouraged the reduction of paperwork, more physician-patient examination time, personal coaching from colleagues, and the reinstating of safe spaces, such as doctors' lounges, which could help to create an environment of physician wellness rather than occupational burnout. In sum, the environments in which physicians work could assuage the incidence of occupational burnout by promoting climates of wellness that offer them resources and tangible workplace solutions while affording them confidentiality.

Residents Physicians and Occupational Burnout

In the United States, various researchers have studied how the phenomenon of physician burnout and the occupational expectations placed on physicians are ingrained in them as early as medical school and are reinforced during residency (Cranley et al., 2016; Gazelle et al., 2014; McClafferty & Brown, 2014; Wallace & Lemaire, 2009). It is well known that the profession of

medicine requires Resident Physicians to sometimes work as many as 80 hours per week, and some physicians may even work shifts that are 24 to 36 hours long (Cranley et al., 2016). In the 1990s to address the phenomenon of physician wellness the Council for Graduate Medical Education, the entity that governs the training activities for Resident Physicians, imposed work hour restrictions on residency programs throughout the United States in an effort to address physician burnout; however, the latter did not completely assuage the issue.

To investigate the occupational experiences of Residents, Cranley et al. (2016) conducted a study to examine how Resident Physicians reduced stress during and after their work shifts. A sample of 38 Internal Medicine Residents, at various levels of their three-year residency training program, were recruited to attend one of four sessions where they were asked to discuss how they reduce stress during and after their work shifts. It was found that the physicians' work hours precluded them from being able to recuperate from their work shifts. The data showed that approximately 58% of the Residents were not psychologically distancing themselves from their work even though they were physically removed from their work environments which indicated that they were not only stressed at work but that they were bringing the stress home with them. The data also showed that when the Residents were given sufficient breaks, during their shifts for eating or rest, they reported less feelings of occupational burnout.

Cranley et al. (2016) acknowledged that while the sample under study was small, the results highlighted how Residents become accustomed to working long hours does not afford them opportunities to rest which could gravely impact their acuity as well as their personal well-being. The authors also suggested that to assuage this matter, medical leadership might re-evaluate not just the work hour restrictions for Resident Physicians, but the need to offer them

protected time during their shifts that could help them to reduce stress that could make them more susceptible to occupational burnout.

Global Impact of Occupational Burnout in Resident Physicians

While occupational burnout is an issue that affects Residents in the United States, it is a phenomenon that impacts Residents globally as well (Editorial, 2019). Brady et al. (2017) affirmed that occupational burnout is so prevalent amongst physicians, particularly early-career physicians, that occupational burnout has become known as an international crisis. In addition, a number of countries throughout the world have documented that the phenomenon of physician burnout has had deleterious personal and systemic impacts on their medical workforces (Editorial, 2019). In 2018, China reported that approximately two-thirds of its physicians experienced burnout. Similarly in 2019, 80% of Britain's physician workforce felt the impact of this phenomenon. Over the years, it has been documented that the prevalence of this phenomenon has made it an epidemic.

There have been several studies conducted worldwide that focused on the phenomenon of occupational burnout in physicians (Peltzer et al., 2003). A South African study was conducted with 402 general practitioners to determine their level of occupational stress and associated symptoms of burnout. The physicians completed a mailed survey. Approximately 60% of respondents were male while 40% were female. The survey questions were adapted from the Job Stress Survey and the Maslach Burnout Inventory. The results showed that Cronbach's alpha was 0.93 for job stress and 0.8 for lack of colleague support. In terms of Maslach's burnout scales, it was reported that for emotional exhaustion, depersonalization and personal accomplishments the values were 0.90, 0.81, and 0.80; respectively. Thus, both instruments showed that there were significant indications that the physicians had experienced burnout. The results also showed that

there were differences in how female physicians reported their work experience and burnout. For instance, the data showed that female physicians reported having more work stress than their male counterparts with $t = -2.27, p < 0.05$; and they reported having higher rates of perceived lack of organizational support with $t = -4.55, p < 0.01$. While all of the physicians reported having experienced burnout at some point in their careers, it was noted that of those surveyed, the female physicians reported feeling overwhelmed by their experiences of physician burnout because such instances were coupled with a lack of organizational support.

The phenomenon of physician burnout has had an impact in Europe as well, particularly among Medical Residents in Portugal (Joaquim et al., 2018). Joaquim et al. (2018) studied Residents training in oncology, hematology, and radiotherapy programs who care for chronically or terminally ill patients. The study was a one-month multi-site, cross-sectional design. A total of 211 Residents received self-administered questionnaires asking that they offer demographic information as well as answer questions adapted from the Stress Questionnaire for Health Professionals and Maslach's Burnout Inventory. As a result, 118 Residents returned the survey as follows: 58% were oncologists, 26% were hematologists, and 16% were radiotherapists. The results of the survey showed the following: 45.2% of respondents were experiencing burnout at the time the survey was administered. The results further indicated that prevalence scores regarding patient care and workload were two areas that caused the highest levels of burnout for the Residents.

The data also showed that the Oncology Residents rated higher for burnout, particularly for the variable of depersonalization according to the survey's mean scores: The mean for oncologists was 45.42, the mean for hematologists was 34.82, and the mean for radiotherapists was 22.52 (Joaquim et al., 2018). It was also noted that the Residents who scored highest for the

prevalence of burnout, as it related to patient interactions, were the Oncology Residents. It was concluded that while all three groups of Residents experienced burnout, the group that was most at risk were the Oncology Residents who perceived themselves to be overworked and thus were more prone to physician burnout.

Similar to other parts of the world, physicians in the Middle East are not immune to occupational burnout. Ahmadpanah et al. (2015) conducted a research study whose aim was to investigate whether physicians' personality types made them more susceptible to burnout. One hundred Emergency Medicine Physicians, 71 males and 29 females, from eight medical centers in Iran were enrolled in a cross-sectional study for one month where they participated in interviews. The physicians were also asked to complete a self-administered survey which consisted of questions inspired by the Maslach Burnout Inventory and the John Holland Personality Test. The survey assessed occupational burnout using the variables of emotional exhaustion, depersonalization, and work efficacy. The John Holland Personality Test determined which personality trait was best attributed to the physicians of the six identified: (a) realistic, (b) investigative, (c) artistic, (d) social, Enterprising, or (e) conventional. The results showed that 15.4% of the physicians had high rates of burnout for the variable of emotional exhaustion, 14.5% of physicians rated high for depersonalization, and 10% of the physicians rated themselves as not feeling confident in their skills. The data for the study's personality component showed that the physicians' personality types were as follows: 2% were realistic, 41% were classified as social, 35% were investigative, 6% were enterprising, 13% were artistic, and 3% were conventional (Ahmadpanah et al., 2015). In short, the findings concluded that the physicians who experienced the most burnout were those who had the realistic personality type;

and those who were found to have the social personality type had the lowest prevalence of burnout of all three burnout categories.

Positive Psychology

The field of Positive Psychology was introduced by Martin Seligman (2018) a psychologist who studied the benefits of helping people not only identify their psychopathologies, but to identify ways in which they could maintain a sense of psychological well-being (Kern et al., 2015; Seligman, 2019). The Positive Psychology is based on the PERMA model whose tenets promote psychological well-being through five elements. These five elements include: (a) positive emotion, (b) encouragement, (c) relationships, (d) meaning, and (e) accomplishment (Kern et al., 2015). The tenets of this model have been tested in various environments, but particularly in workplace settings where learning or training occurs. Kern et al. (2015) assert that when employed, the PERMA Model's five principles could have a positive impact on psychological well-being and could assist in helping people transcend feelings of negativity in the spaces for which they occupy.

PERMA Model

Positive Emotion. Positive emotion describes the sense of happiness or well-being one feels in a given environment (Kern et al., 2015). For instance, feelings of occupational wellness, may engender feelings of inclusiveness with one's colleagues which could help to increase positive emotion (Seligman, 2019). Research has shown that if members of a workgroup, including the supervisor, show respect to one another, there is a high likelihood that the employees will feel a sense of occupational wellness which could reduce the likelihood of occupational burnout (Kern et al., 2015).

Engagement. Ryan and Deci (2000) suggested that factors of intrinsic and extrinsic motivation influence people's ability to connect to their environments and thrive in an effort to reach a sense of well-being. If the leader supports this basic employee need, employees flourish in their roles and may feel more engaged in their work. However, if any of the three concepts are perceived to be devalued or diminished by employees, then they will feel disconnected from the leader and the environment and occupational burnout can ensue (Trépanier et al., 2015).

Relationships. It is thought that workers' feelings of occupational well-being or burnout are directly impacted by the work relationships they have with their leaders and colleagues (Goleman, 2000). Resident Physicians are a part of an occupational cohort of physicians-in-training. Thus, they may feel a need to develop and foster positive work relationships. Such relationships could be invaluable as they accomplish various professional successes as well as face expected and unexpected challenges of medical training (Monteiro et al., 2020).

Meaning. Research has shown that when workers believe the work they do has a positive impact on those for whom they serve, they could feel as if their work is purposeful (Kern et al., 2015). In terms of Resident Physicians, it is presumed that by virtue of being healthcare providers, their purpose comes from helping the patients for whom they serve (Brady et al., 2017; Jennings & Slavin, 2015). Thus, when one is successful in their residency endeavors, it is presumed that a sense of well-being is felt (Chesak et al., 2020).

Accomplishment. Autonomy refers to a person's ability to feel a sense of ownership and achievement. In order to feel a sense of accomplishment, there must be a feeling of personal competence which refers to one having a sense of mastery and efficaciousness in their work tasks. In residency programs, this concept could be invaluable because it could help Resident Physicians feel a sense of occupational well-being. In addition, feelings of well-being, efficacy,

and autonomy in the workplace are important for Residents to feel as they master the clinical skills necessary as early career professionals (Gazelle et al., 2014). If for any reason Residents do not feel competent, or they feel less autonomous, they could feel a sense of cynicism toward their jobs (Trépanier et al., 2015).

Herzberg's Two-Factor Theory

Herzberg's Two-Factor Theory, also known as the Motivation-Hygiene Theory, was introduced in the 1950s by psychologist Frederick Herzberg with the thought that it could help to inform work motivation and satisfaction among employees (Alshmemri et al., 2017). The premise of the theory is that when conditions in work settings are optimal employees may feel a sense of job satisfaction, and when conditions are suboptimal, they may experience job dissatisfaction. The theory is comprised of two distinct premises: factors associated with job satisfaction called "Motivators", and factors that contribute to job dissatisfaction called "Hygienes" (Alshmemri et al., 2017; Dartey-Baah & Amoako, 2011). It should be noted that as Residents are considered trainees in their respective residency programs, they are also considered salaried workers at the teaching hospitals in which they train. Therefore, in this study, the Herzberg's Two-Factor Theory was one of the theoretical frameworks that underpinned this research study and helped to assess the Residents' job satisfaction.

The job satisfaction concepts or "motivators" were tenets that could evoke job satisfaction amongst workers such as: (a) advancement, (b) the work itself, (c) the possibility for growth, (d) responsibility, (e) recognition, and (f) achievement (Alshmemri et al., 2017). *Advancement* defined one's ability to obtain a positive status at work. The *work itself* refers to the nature of the tasks one accomplishes at work and whether they are perceived as enjoyable or challenging. The *possibility of growth* referenced the potential for employees to be able to

advance in their workplaces. For instance, the ability for Residents to secure a permanent position at their training hospitals after residency which may be of importance for some of them. The tenet of *responsibility* is defined to speak to the freedom employees are given to work autonomously and to make decisions that impact their work. When employees receive recognition or positive feedback feelings of job satisfaction can increase. The last tenet of job satisfaction is achievement. According to the theory, achievement speaks to the employees' abilities to effectively and efficiently complete challenging tasks (Alshmemri et al., 2017).

The hygiene factors (Dartey-Baah & Amoako, 2011) were the tenets that Herzberg thought could increase job dissatisfaction amongst workers. These factors were:



- interpersonal relations at work with colleagues and supervisors,
- salary or increases in compensation,
- organizational policies and administration or perceptions of organizational fairness as related to policies and procedure,
- supervision or personality and skill of the supervisor, and
- working conditions or the physical state of one's work environment (Alshmemri et al., 2017).

Interpersonal relations described the work relationships employees cultivate with colleagues and supervisors. For some employees, the tenet of salary may reflect that the contributions they make to their organizations are valued. If they believe they are not appropriately compensated for their skills and the work they accomplish that contributes to the organizational goals, their job satisfaction could wane. Thus, for some employees, if they do not receive raises as a positive reinforcement for their contributions, their sense of job satisfaction could decrease. Similarly, the tenet of organizational policies and administration posits that

employees may have feelings of job dissatisfaction if they perceive that their supervisors or organizations promote unfair practices. The next factor, supervision, speaks directly to leadership. Supervision reflects how employees may perceive their supervisors' leadership styles. If they perceive their leadership styles to be incongruent with their perceptions of leadership, their level of job dissatisfaction can surface, and if these feelings persist, occupational burnout could develop. The last factor associated with job dissatisfaction is the work environment. If employees believe their working conditions are subpar, they might lose their motivation (Alshmemri et al., 2017). Figure 2 depicted Herzberg's Two-Factor Theory.

Figure 2

Herzberg's Two-Factor Theory

Motivation factors	Hygiene Factors
<ul style="list-style-type: none"> – Responsibility – Challenging or stimulating work – Recognition – Sense of personal achievement – Opportunity for advancement – Promotion – Growth 	<ul style="list-style-type: none"> – Salaries, wages and benefits – Company policy and administration – Good inter-personal relations – Quality of supervision – Status – Job security – Working conditions – Balance between work and life
When in place, these factors result in:	When in place, these factors result in:
	
<ul style="list-style-type: none"> – High motivation – High satisfaction – Strong commitment 	<ul style="list-style-type: none"> – General satisfaction – Prevention of dissatisfaction

Note. Adapted from “Job Satisfaction Among Swedish Mental Health Nursing Staff: A Cross-Sectional Survey, by C. Holmberg”, I. Sobis, & E. Carlström, (2016), *International Journal of Public Administration*, 39(6), 429–436, <https://doi.org/10.1080/01900692.2015.1018432>
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In keeping with Herzberg's Motivation factors for job satisfaction, Brady et al. (2017) conducted a study on well-being and job satisfaction amongst physicians. They asserted that the well-being of physicians is important as it dictates the quality of patient care they offer. It is thought that patients of physicians experiencing burnout are put at significant risk for having poor outcomes compared to patients whose physicians are not feeling burnout. The researchers noted that patients of physicians who experience a sense of wellness tend to experience better physician-patient interactions and have better patient outcomes. In order to know if the latter was generalizable, the researchers conducted a review of the literature on physician wellness as it related to patient satisfaction. A review of 3,057 articles were initially identified. A final total of 78 articles, dating from 1989–2015, that highlighted physician wellness were reviewed. The results of the review showed that only 14% of them discussed physician wellness. Brady et al. concluded that the well-being of physicians could possibly dictate the quality of patient care they offer. Similarly, if there is a decrease in physician well-being, occupational burnout can become prevalent.

In line with the tenets of Herzberg's theory, Anagnostopoulos et al. (2012) conducted a study on burnout and patient satisfaction and how it impacted physicians' work. The authors sought to show that physician burnout was directly linked to poor patient care outcomes which posed concerns for the provider-patient relationship. The authors identified that, in general, what leads to burnout for physicians was the constant stress associated with their jobs. Thus, it was noted that some of the stress physicians experienced at work came from their perceptions of their supervisors being inefficient leaders, from working long hours, or from regularly caring for chronically or terminally ill patients. The study concluded that physician burnout not only impacts physicians but it also affects patient care and safety.

Coping with Occupational Burnout

Physician occupational burnout is a phenomenon that can occur at any point in physicians' careers and can hinder their ability to effectively perform their jobs and make prudent medical decisions (Brady et al., 2017; Cranley et al, 2016; Meldrum, 2010). According to Meldrum (2010), one way physicians may prevent occupational burnout is by identifying coping strategies that could help them to mitigate burnout. Meldrum researched various strategies that experienced or senior-level physicians, who were renowned in their fields used to address occupational burnout.

Meldrum (2010) conducted a study with physician recipients of the 2007 American Medical Association Foundation's Pride in the Professions Award who were deemed leaders or role models in the field of medicine. Fourteen physicians were interviewed, nine male and five female physicians representing various regions of the United States, as well as medical specialties. The physicians participated in a two-hour telephone interview that asked questions regarding their experience with physician burnout and any advice they might offer to other physicians who may experience this phenomenon. The results of the study highlighted the various strategies the senior physicians used to manage occupational burnout throughout their careers. Some of the strategies identified were participating in daily exercise, setting personal limits in their professional and personal lives that prevented them from feeling overwhelmed, and taking regular breaks during work shifts.

In addition to the strategies offered for preventing occupational burnout, the study's participants also offered suggestions on ways their fellow physicians might monitor feelings of self-doubt or self-criticism. For example, they suggested that their colleagues might focus on the positive aspects of their days or even favorable aspects of their careers rather than harshly

critiquing themselves and their work. It was also suggested that having a sense of humor even through challenging times at work, taking time to do things that they enjoyed with their loved ones, and actively and intentionally having a positive outlook on their careers, in general, were all remedies for mitigating occupational burnout in a profession such as theirs (Meldrum, 2010). The study concluded that to combat occupational burnout physicians might consider regularly using self-help and self-monitoring strategies to promote personal and professional balance in a career where the gravity of the profession at times can be, for some physicians, overwhelming.

Similar to Meldrum (2010), a number of other authors have researched strategies to help physicians handle the daily stressors of their jobs. Guruprakash et al. (2018) studied how postgraduate medical trainees or Residents coped with career stress. To investigate how occupational-induced stress exacerbated burnout in Residents and the strategies they might employ to mitigate occupational burnout, Guruprakash et al. conducted a study of 68 Resident Physicians in various levels of training. The study population consisted of 16 third-year, 25 second-year, and 27 first-year Residents. The demographics of the Resident Physicians were as follows: 56 were males and 12 were females; 86% were married, and 60% of them were over the age of 30. The Residents completed a self-administered questionnaire that assessed their perceptions and experiences with burnout over the previous month. The questionnaire evaluated such variables as perceived stress, coping behaviors, substance use, emotional support, burnout, and depressive-anxiety symptoms. Resident Physicians who had histories of psychiatric disorders were excluded from participating in the study so as to not confound results or exacerbate their mental well-being.

It was found that of the Resident Physicians in the study, the female physicians rated significantly higher than their male counterparts on the perceived stress and general health scales (Guruprakash et al., 2018). Approximately 30.9% of the Residents who scored low on the depression-anxiety scale, reported having experienced burnout while 64.7% of those with moderate scores reported burnout and only 4.4% of those with high depression-anxiety scores reported experiencing occupational burnout. From the findings, the authors concluded that it could be deemed beneficial if Residents, and all physicians who may experience occupational burnout, discuss their experiences with colleagues rather than internalize them because doing so could have deleterious results on them personally and professionally.

Social Support

Sochos et al. (2012) found that physicians experience occupational burnout for a variety of reasons and that one way to possibly address this phenomenon was by identifying how the concept of social support from colleagues might help to assuage this issue. Sochos et al. recruited 184 Resident Physicians, 111 females and 73 males, to participate in their study. The participants were asked to complete self-administered questionnaires via a web-based platform that consisted of questions regarding occupational burnout, work-related stress, and social support. The Maslach Burnout Inventory was used to determine their level of occupational burnout, the Specialist Doctors' Stress Inventory (SDSI) was used to measure their occupational stress, and social support as perceived by the Residents was measured using the Social Support Scale (SSS). The results showed that workplace stress was correlated with occupational burnout and that social support could be a mitigating factor. The findings also showed that the Resident Physicians who participated in the study were prone to experience burnout if they perceived the support from their medical leadership or Attending Physicians was insufficient. Thus, the results

of the study suggested that medical leadership might consider implementing programs tailored to Residents that emphasized the value of social support amongst colleagues and supervisors in order to increase Residents' efficacy for navigating workplace stressors that could possibly lead to occupational burnout.

One way medical leadership could assist with assuaging the phenomenon of occupational burnout amongst physicians is by encouraging them to seek support from their peers (Chilton, 2017). Chilton (2017) referred to the experience of physicians sharing their experiences of occupational burnout with their peers as "Dude – Me Too!" moments (p. 721). As a physician herself, Chilton affirmed that such peer mentoring moments can prove to help decrease work-related stress as well as the feeling of lack of job efficacy amongst physicians because while it is rewarding to be a physician, it is also difficult being one with its long hours, instances of diminished efficacy, and regular encounters with difficult patient care matters. Therefore, allowing physicians the space to be vulnerable with their peers, particularly about professional matters they might not otherwise reveal could allow them the opportunity to see that they are not alone (Chilton, 2017; Lakhani, 2015).

Chilton (2017) acknowledged that the experience of occupational burnout for physicians is unique, and she concluded that only fellow physicians can truly understand. To solidify her point, Chilton shared the following story of a Medical Resident who struggled with his performance and felt overwhelmed by the responsibilities of his job until he experienced a "Dude–Me Too!" moment:

One of my most accomplished colleagues in residency had complimented me on my clinical knowledge. Sick of feeling like a charlatan, I told him about the trouble I was having with collecting clinical data and presenting it in an organized way on rounds. I confessed that I did not think I belonged in the program. He listened thoughtfully, and then uttered the three most beautiful words I had ever heard. Dude–me, too (p. 722)!

The alternative of not having the space for a “Dude–Me too!” moment could lead to such adverse events as medical errors, displays of lack of empathy, and a myriad of other consequences concerning patient safety. Thus, the author argued that the benefits of physicians experiencing such moments could have positive effects on their well-being, efficacy, and ultimately their work performance.

Physician Leadership and Occupational Burnout

Dillon et al. (2020) conducted a study to investigate the perspectives of healthcare leaders and physicians regarding occupational burnout. Fifteen primary care physicians (12 Internal and Family Medicine physicians) and two medical executives participated in the study. To gather information on each participant's perspective of occupational burnout, they conducted individual interviews. The interviews asked about their perceptions and experiences of burnout, ways to mitigate burnout, and what changes were needed to implement wellness for physicians. The researchers found that physicians felt overburdened by administrative tasks such as completing notes in the electronic medical record, their workload, and providing more support to leaders so that they can better support physicians. It was concluded that the information gathered from the interviews suggested that some ways to mitigate occupational burnout were to reduce work hours, decrease the amount of work physicians do with the electronic medical record, and to encourage organizational changes that promote wellness (Dillon et al., 2020).

It has been reported that at least 50% of all physicians in the United States have experienced occupational burnout (Shanafelt et al., 2019). Shanafelt and Noseworthy (2017) discussed the challenge of healthcare leaders engaging physician workforces in order to create solutions for mitigating occupational burnout in an effort to decrease the incidence of this phenomenon. The idea that those who are personally impacted by this situation, which renders

some of them disenchanted about their profession, were being asked to provide viable solutions to fix the issue. The authors acknowledged that the field of medicine poses various challenges for physicians that cannot always be addressed at the micro or individual level. Thus, with a global phenomenon such as physician burnout, they affirmed that the solution to the phenomenon must be addressed systemically. The systemic approach they suggested was that of physician engagement. Although experiences of burnout usually leave people with feelings of disengagement, Shanafelt and Noseworthy hypothesized that if they could create strategies to engage physicians at the organizational level, they could perhaps begin to effectively address this issue. The article highlighted how they introduced nine business strategies at the Mayo Clinic to ameliorate the experience of physician burnout and in exchange, they would increase instances of physician engagement which was beneficial to the overall mission of the organization.

To remedy physician burnout, and increase physician engagement, the authors discussed implementing various organizational strategies (Shanafelt & Noseworthy, 2017). One strategy included evaluating the prevalence of physician burnout so that the executive leadership could effectively address the issue in a way that showed care for the physicians who were impacted. Still, other strategies deployed recruiting leaders to oversee the effective promotion of occupational well-being initiatives and creating innovative interventions to address the various factors that exacerbate physician burnout. As organizational change is a deliberate process, the authors acknowledged creating change at the organizational level, with buy-in from executive leadership, was essential to making the necessary occupational changes to help to decrease the prevalence of physician burnout within healthcare organizations.

Factors that make physicians susceptible to burnout are not only influenced by their behavior, but also by the environments in which they work (Gazelle et al., 2014). One way to

possibly mitigate the incidence of occupational burnout in Residents is to employ the support of their leadership or Attending Physicians (Msheik-El Khoury et al., 2021). Msheik-El Khoury et al. (2021) researched how the relationship between residency Program Directors and Residents impacted the occurrence of occupational burnout for Resident Physicians. The researchers noted that from an organizational perspective, Resident Physicians assume a dual role in hospital settings - they are trainees as well as employees. Thus, they find themselves in a working environment that requires them to adhere to training expectations such as learning how to become clinically astute at patient care matters as well as to follow basic employment rules that are similar to other hospital workers. However, when issues of occupational well-being arise, some Residents, while understanding the duality they possess, do not know or even have a desire to assuage these issues from a residency programmatic or a general hospital organizational standpoint. Thus, leaving Residents to possibly feel that they are in a position where they have to fend for themselves.

Msheik-El Khoury et al. (2021) suggested that, rather than Residents feeling as if they have to manage feelings of occupational burnout on their own, their Program Directors' roles are to intercede such that they have procedures in place to assist the Residents in maintaining or restoring a sense of occupational well-being. To investigate the impact the Program Director-Resident relationship has on the Residents' occupational experiences of burnout, Msheik-El Khoury et al. conducted a research study with 95 Resident Physicians. The aim of the study was three-fold—to investigate the relationship between Program Directors and Residents, to examine how residency program leadership could be instrumental in mitigating occupational burnout for Residents, and to assess Residents' perceptions of the support they receive from their Program Directors as it related to occupational wellness. The Residents ($N = 95$) received a self-

administered survey that had questions about the quality of the Resident-Program Director relationship, perceptions of support offered to Residents, occupational burnout, and patient care.

The researchers found that the Residents' perceptions of their relationships with their Physician leaders were predicated on whether they believed they had a favorable relations with their Program Directors (Msheik-El Khoury et al., 2021). They found that if Residents perceived their relationships with the Program Director to be positive, then they were less likely to be as susceptible to occupational burnout. The results also showed that, when Residents perceived their working relationships to be positive with leadership, they felt less emotionally exhausted, experienced less depersonalization, and thus had better patient care practices and interactions which increased their efficacy. It was concluded that while there may be wellness programs already instituted in teaching hospitals, it could be beneficial for medical leaders and hospital executives to further determine how they might encourage the enhancement of professional relationships amongst Residents and Program Directors in order to promote occupational well-being that could possibly translate into better physician performance, training experiences and ultimately better patient outcomes; all effective organizational outcomes.

Swensen et al. (2016) discussed the importance of hospital systems acknowledging the need to address occupational burnout from a systemic perspective, therefore, the authors created a model called Listen-Act-Develop. The objectives of the Listen-Act-Develop Model are three-fold: (a) to help physicians feel more efficacious in their roles, (b) to reduce occupational burnout, and (c) to increase physicians' overall sense of well-being. The four concepts of the Listen, Act, Develop model are as follows:

- Listen, implores organizational leadership to actively listen to the physicians' concerns regarding occupational burnout and thereafter enact a plan to address the concerns.

- The second step, Act, identifies actions taken by organizational leaders regarding how to offer physicians coaching on how to readily identify and address physician burnout.
- The third step, develop, requires that healthcare systems identify physician leaders who can effectively implement policies to ameliorate the work environment for physicians.
- The fourth and final step, repeat, emphasizes the need to monitor the phenomenon of occupational burnout in physicians by encouraging organizational and medical leadership to offer attention and resources to assuage this phenomenon.

Leadership

Leadership can impact followers in several ways and can be used to legitimize and support organizational norms, culture, and expectations while also influencing the personal interactions between leaders and followers (Gurt et al., 2011). Studies have shown that this relationship is one that not only upholds organizational values, but it also influences the mental, physical and emotional health of employees. For instance, in the medical field, the success of residency training programs is ultimately the responsibility of the Attending Physicians who oversee the programs. Therefore, in their roles as teachers and mentors, Attending Physicians must be able to communicate with Residents in ways that impart knowledge, comradery, and support.

The Full Range Leadership Theory. When leadership is perceived as a byproduct of one's personality, Saxena et al. (2017) argued that the focus of leadership is derived from the personal attributes or behavior of the leader rather than the leader's true leadership skill. Therefore, leadership style is predicated on a leader's ability to connect with followers on an emotional intelligence level. Thus, astute leaders gain their followers' respect and thus are more able to help them to flourish in their roles.

The Full Range Leadership Theory (Kanat-Maymon et al., 2020) is another theoretical framework that was used in this study. The objective of including the Full Range Leadership Theory was to assess if, in fact, the leadership styles of the Attending Physicians were perceived by the Residents to ameliorate or exacerbate their experiences of occupational burnout. Thus, this theory offered a way to identify and understand the various leadership styles: transformational, transactional, and Laissez-faire. Kanat-Maymon et al. (2020) underscore that although the transformational and transactional leadership styles are often perceived as polar opposites, they in fact are not. Rather, the authors affirmed that the Full Range Theory sees these leadership styles as differing in concept and approach yet related in their ability to understand followers' behaviors or responses to them.

The premise of the theory provides an understanding of how leaders interact and motivate followers to work towards common goals in support of the organizational vision (Goleman, 2000). The Full Range Theory thus posits that individuals' leadership styles can encourage or discourage workers from performing at optimal levels. Thus, exhibiting positive leadership is paramount to helping employees experience occupational wellness and job satisfaction. Goleman (2000) alluded that of the three leadership styles, the one that encourages employees to follow the leaders' vision was that of transformational leadership. The transformational leadership style was thought to be effective because it encourages followers to work to their full potential while working toward achieving shared goals.

Leadership Styles

Trépanier et al. (2015) asserted that leaders have one of two leadership styles: autonomy-supportive or controlling. In environments such as residency training settings, the authors acknowledged that if Attending Physicians lead by using an autonomy-supportive approach, Resident Physicians are encouraged to build efficacy and mastery in their chosen medical fields because their leaders are regularly offering them positive feedback about their work. Thus, their intrinsic and extrinsic motivation will be increased and their motivation for doing their jobs most likely would grow. Conversely, the authors concluded that if Attending Physicians' leadership styles are perceived by Residents to be controlling, their intrinsic motivation for doing well at their jobs may decrease and so might their job satisfaction (Britzman & Henkin, 1992; Goleman, 2000; Trépanier et al., 2015).

Stoller (2017) echoed the assertions made by Trépanier et al. (2015) in regards to Residents' perceptions of their leaders' leadership styles, Stoller (2017) acknowledged that the leadership styles of Attending Physicians can either motivate or deter Resident Physicians to work at their optimal levels. It is thought that, in residency training settings where Attending Physicians promote coaching and mentoring as a means to maintain positive work environments, Residents experience are less susceptible to occupational burnout. Whereas if the Attending Physicians' leadership styles are perceived by Residents as being alienating, demeaning, or domineering such perceptions could result in some Residents experiencing occupational burnout. Thus, the implication is that leadership styles can have salient effects on individuals' ability to navigate workplace stressors.

In the medical field, Stoller (2017) affirmed that historically the leadership styles of Attending Physicians were characterized as being one of command-and-control (Stoller, 2017).

The command-and-control style of leadership is considered to be an authoritarian style of leadership whereby Residents would not be encouraged to work in collaboration with Attending Physicians, but instead would work in an environment that created a power differential between leader and subordinate. For some Residents, such a leadership style is incongruent with their perceptions of residency training and collegiality. Thus, Stoller concluded if such a leadership style is possessed, it would behoove medical leadership to be aware that it could compromise the occupational well-being of some Residents and thus precipitate experiences of occupational burnout. The author concluded that the latter leadership style was ineffective and could be attributed to the Resident Physicians' experiences of occupational burnout.

Transformational Leadership

Transformational leadership is said to be a leadership style that focuses on values and long-term goals and objectives through a common vision (Gregersen et al., 2014). A transformational leader coaches followers to do their best, to strive for excellence as they pursue their work; and to understand and agree to attain a shared work vision (Hildenbrand et al., 2018). The transformational leadership style is thought to describe leaders who strive for authenticity through the premise of relational transparency, in which leaders motivate their followers to reach their full potential (Goleman, 2000). A transformational leader is also one who works in unison with followers to create change and promote the progression of that change (Gregersen et al., 2014). In organizational settings, transformational leaders create authentic connections with those for whom they lead, encouraging them to strive for excellence in their tasks, to work as a cooperative team: and imploring them to approach opportunities for change with positive optimism (Goleman, 2000). Attending Physicians with transformational leadership styles could

presumably promote clear communication and offer guidance and support to Residents so that they feel efficacious in their roles (Goleman, 2000; Hildenbrand et al., 2018).

There is a gap in the literature, however, as it relates to the experience of occupational burnout in female Residents as it relates to how the leadership styles of their Attendings might ameliorate or exacerbate their feelings of burnout (Hildenbrand et al., 2018). When considering the leadership styles that may be conducive in medical training environments, one might suggest that transformational leadership might be effective as it takes into account not only the leader's perspective but also that of the followers. In their research, Hildenbrand et al. (2018) showed that when leaders exhibit a transformational leadership style, their workers' productivity is higher than workers who have supervisors who are not perceived to be transformational leaders. Their study also showed that when the leaders exhibited a transactional leadership style the workers' productivity decreased and the likelihood that they experienced burnout was increased. Thus, it was concluded that the workers' experiences of thriving and burnout were directly related to the leadership styles of their Attending Physicians.

A number of researchers have suggested that when a leader has a transformational leadership style it is thought to motivate workers to do their best. Researchers have also affirmed that transformational leadership empowers followers to meet expectations even when dealing with challenging situations such as burnout (Arnold et al., 2015; Goleman, 2000). Transformational leaders are said to promote positive work environments that are perceived to help ameliorate burnout by promoting a climate of collaboration and positive work interactions between leaders and followers so that the followers feel empowered and efficacious in their roles (Goleman, 2000).

Transactional Leadership Style

There are a number of leadership styles that may be perceived as not conducive to the Resident-Attending Physician relationship and according to Stoller (2017). The transactional leadership style is one that can exacerbate occupational burnout as it prescribes to a quid pro quo relationship between leaders and followers that usually benefits the leader more than the follower (Ali et al., 2015; Ellis et al., 2019). Ali et al. (2015) espoused that the transactional leadership style may be seen in work environments in which followers readily acquiesce to their leaders' requests because they may fear that if they do not, they will face corrective action.

Due to their leadership styles, transactional leaders might be viewed as someone who manipulates their workers to complete tasks or to buy into their leadership vision (Ali et al., 2015). Thus, it is presumed that if the exchanges are perceived as favorable by the leader, the follower does not experience stressful events. Conversely, if the relationship is not perceived as favorable by the leader, the interactions between the leader and followers may result in challenging exchanges whereby the followers could feel devalued, overwhelmed, and burned out in their work settings (Ellis et al., 2019).

Laissez-Faire Leadership Style

The laissez-faire leadership style describes leaders who do not lead or offer any guidance to their followers (Skogstad et al., 2014). In short, a leader who exhibits this leadership style is one who prefers to lead by deferring decision-making to his or her followers (Goleman, 2000). Such a leader can induce frustration, mistrust, lowered efficacy, and resentment in their followers (Skogstad et al., 2014).

In terms of the residency experience, a Laissez-faire leadership style could be viewed as suboptimal especially if this style is used with first-year or inexperienced Residents. As trainees,

Residents could perceive this leadership style to be one of indifference concerning their success at learning how to become experienced clinicians (Hildenbrand et al., 2018). Thus, if Residents do not subscribe to this type of leadership style, it could cause frustration as well as job dissatisfaction which could make them susceptible to occupational burnout (Arnold et al., 2015).

Chapter Summary

Chapter 2 highlighted the systematic literature review that was conducted to assess the peer-reviewed literature associated with the phenomenon of occupational burnout experienced by female Resident Physicians and how their Attendings' leadership styles might have an impact on their experiences. Over 150 peer-reviewed articles were reviewed and 60 were included in the literature review. The studies discussed issues associated with the global phenomenon of physician burnout such as gender, occupational stressors, the influence of medical leadership and leadership styles, the theoretical frameworks that underpinned this study, and social support.

The strengths of this literature review included the synthesis of the diverse topics broached by each of the peer-reviewed articles. Each study highlighted the phenomenon of occupational burnout in physicians as well as suggestions for how this matter could be addressed in an effort to ameliorate the experience of occupational burnout for female Residents, thus affording medical leaders a variety of options to employ. The limitations of the systematic literature include the inability to use all published articles on the topic of occupational burnout in physicians, the gaps in the literature regarding the experience of female Residents and how medical leadership impacted their experiences of burnout. The latter was conceptualized by assessing leadership styles in juxtaposition with physician occupational burnout which could be biased through the lens of the researcher.

Chapter 3: Research Design and Methodology

Introduction

A review of the literature highlighted a gap that existed in the research on physician burnout. The gap identified that, in general, the literature on female Resident Physicians was sparse, and that there existed a paucity of literature on how the leadership styles of Attending Physicians impacted the experience of occupational burnout for these Residents. The study's objectives examined the experiences of female Resident Physicians and sought to describe their perceptions of their Attending Physicians' leadership styles and of how these perceived behaviors impacted their experiences of occupational well-being. In this chapter, the design, methodology, and rationale for investigating this phenomenon was outlined.

Research Questions

Upon review of the literature on physician burnout, research questions were created to highlight the unique experiences of female Resident Physicians. The goal of the research questions was to help to uncover each research participant's understanding of occupational burnout as well as to help to elucidate the details of the Residents' personal exposure to the phenomenon. The following research questions informed this study:

- RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?
- RQ2: What leadership styles do female Resident Physicians perceive their Attending Physicians' exhibit?
- RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?
- RQ4: How do female Resident Physicians cope with occupational burnout?

Qualitative Research Design

Burnout is seen across all occupations (Collins, 2004). However, what distinguishes physician occupational burnout from other professions are the potentially grave repercussions this phenomenon has on patient outcomes, the healthcare system, and on physicians themselves (Wallace et al., 2009). In the previous chapter, the peer-reviewed literature summarized the global and national impact of this phenomenon (Editorial, 2019). The literature review also highlighted how physician burnout is thought to affect female physicians differently than their male counterparts (Kane, 2020). Therefore, to further investigate this phenomenon, a qualitative study was proposed to explore the experiences of early-career female physicians.

A qualitative, hermeneutic phenomenological research approach was initiated for this exploration. The study's design allowed the researcher to gain a better understanding of the female Residents' perceptions of the phenomenon, and it allowed for a better understanding of the Residents' exposure to the phenomenon of occupational burnout that contributed to their shared, lived experience. The specific phenomena being studied were the Resident Physicians' perceptions of their Attending Physicians' leadership styles and how they perceived these styles to ameliorate or exacerbate their experiences of occupational burnout. It was presumed that the data gathered from this study would contribute to the literature on physician occupational burnout as it impacts female Residents.

Study Inclusion Criteria and Sampling Procedures

Multiple research articles implied that, in general, physicians do not readily disclose that they are having professional challenges related to occupational burnout (Chilton, 2017; Eckleberry-Hunter, 2009; Gazelle et al., 2014; Jennings & Slavin, 2015). The articles also acknowledged that when physicians experience occupational burnout, they may not tell their

colleagues that they are having feelings of exhaustion, depression, lowered self-efficacy, or feelings of imposter syndrome for fear of being thought of as unprofessional or even unskilled. Chilton (2017), who is a physician, shared that some physicians are not transparent about their experiences with occupational burnout because they possibly believe that they would be judged by some of their colleagues as not being able to handle the pressures of their jobs. Chilton also affirmed that it has been her experience that physicians usually will not voluntarily share their experiences of occupational burnout unless they feel they are in a safe environment for which they can do so. Whether physicians feel comfortable or not about being transparent about their experiences of occupational burnout, it is important to research this phenomenon in order to try to identify strategies to mitigate the consequences of this phenomenon for physicians and those for whom they serve.

Inclusion Criteria

Female Resident Physicians were chosen as the study population because the researcher was interested in investigating the perceptions they had of their Attendings' leadership styles in juxtaposition to their experiences of occupational burnout. It was thought that perhaps their opinions of their Attendings' leadership styles potentially ameliorated or exacerbated their experiences of occupational burnout. Thus, the researcher endeavored to learn what leadership style in particular helped to create work environments whereby female Residents had a sense of occupational well-being and job satisfaction. In sum, female Resident Physicians were chosen as the study population in hopes of possibly narrowing the gap that exists in the scholarly literature, concerning how the phenomenon of occupational burnout affects the occupational experiences of female Residents (Templeton et al., 2019).

Inclusion criteria for this study, as seen in Table 2, included individuals who were self-described as female, who had earned an Allopathic or Osteopathic Medical Degree, who were first, second, or third-year post graduate physicians, were currently participating in a medical residency program in the United States, and who, through self-report, had experienced occupational burnout as a Resident. Additionally, Resident Physicians were chosen as the research population because there was a high probability that, even though they were early in their careers, the rigors of their job made them highly susceptible to the stressors associated with physician burnout (Gazelle et al., 2014).

Table 2

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Self-identified as female • Allopathic Medical Degree (M.D.) or an Osteopathic Medical Degree (D.O.). • First, Second, or Third-Year Resident Physician enrolled in a residency program in the United States. • Through self-report, have experienced occupational burnout at any point during residency. 	<ul style="list-style-type: none"> • Self-identifying as a gender other than female. • Any female who has not earned an MD or DO degree. • Any female who is not currently identified as a Resident Physician in the United States • A female Resident Physician who has not provided, through self-report, that she has ever experienced occupational burnout during residency.

Sample Size. In keeping with the principles of phenomenology, the sample size was not dependent on a calculation of statistical significance, but rather relied on adhering to the qualitative standards of achieving data saturation (Morrow, 2005). However, while the sample size was not a determining factor of significance, it was determined that no less than three female Resident Physicians would be interviewed as data saturation was the objective. In keeping with phenomenology, it was understood that the study's sample size would most likely not be generalizable to all female Resident Physicians in the United States. Nonetheless, the study provided an in-depth exploration of the phenomenon and potentially revealed overarching themes or experiences associated with the topic of occupational burnout experienced by female Residents Physicians and reached a point of data saturation.

Recruitment of Study Participants. To investigate the phenomenon of occupational burnout, the researcher sought to recruit female Resident Physicians in order to hear how this phenomenon had impacted them. As the researcher is not a Resident, and in light of what was learned from the literature concerning the lack of transparency to which this phenomenon is openly discussed, it was determined that the most effective recruitment method was that of snowball sampling (Eland-Goossensen et al., 1997).

Snowball sampling is used when there are challenges associated with contacting a prospective research population because it is thought that they may be reluctant to participate in a research study because they may be hesitant to self-identify as being associated with having experienced a particular phenomenon (Eland-Goossensen et al., 1997). This study used snowball sampling to recruit female Residents through the assistance of their colleagues many of whom were their close friends. The researcher initiated the sampling methodology by asking if the initial Resident who was interviewed, knew a female Resident who might want to discuss her

experience with occupational burnout, and who met the study's inclusion criteria. If the Resident expressed interest in telling a colleague about the study, she was also given a recruitment flyer to give with her colleague with all of the pertinent information about the research study. Once the second Resident was identified and interviewed, the researcher asked her to refer a third person who was willing to participate in the study. The third person then referred one of their Resident colleagues to the researcher, and this procedure was repeated until the researcher had the desired number of participants for whom could partake in the study (Eland-Goossensen et al., 1997).

Upon being identified as potential study participants, the Resident Physicians received an email to confirm their interest in participating in the study. Thereafter, the researcher confirmed that they met the study's inclusion criteria, offered oral consent to participate so that an interview time could be scheduled, and the written consent form was sent to them via DocuSign as well as the demographic questions. The consent information sent to each Resident included detailed information that explained the study, the protections that ensured confidentiality for each participant, as well as the voluntary nature of their participation. After the Resident Physicians chose an interview date, a "Save The Date" email was sent to them to confirm their interview appointment, and the request to return the signed consent form as well as demographic questions was emailed to each Resident as a reminder.

The demographic information collected from the Residents included questions about such personal characteristics as their age, gender, year in the residency program, ethnic background, marital status, and parental status. Collecting demographic data enabled the researcher to gain insight on who the Residents were as well as offered perspective on how the phenomenon of occupational burnout impacted female Resident Physicians of different ages, races, years of residency, and residency specialty.

Due to COVID-19 distancing restrictions, all steps outlined above occurred over email or text. The interviews were conducted over Zoom (<https://zoom.us>), a virtual or cloud-based platform for video conferencing platform. Before the interview, each Resident was asked if she was comfortable having the interview recorded. Once consent was received, the researcher started the Zoom recording and the interview commenced.

Human Protection Considerations

IRB approval to conduct human subjects research from Pepperdine University was obtained prior to the initiation of any research activities. The IRB approval letter was granted in December 2021. Due to the anticipated progression of the pandemic, oral consent was obtained when the Residents scheduled their interview dates with the researcher and written consent was obtained via DocuSign before each interview. The informed consent form addressed the voluntary nature of participation and indicated that at any time the participant could choose to discontinue her participation. The Residents were also informed that their decision to participate, or to terminate their participation, would not have any bearing on their residency status or relationship with the hospitals where they were employed. The consent form acknowledged that, while this was a minimal risk study, the participants might find some of the interview questions about their experiences with occupational burnout and their Attendings' leadership styles somewhat distressing because the questions might cause them to revisit uncomfortable situations. In the event a participant found the questions to be uncomfortable, the researcher made a list of mental health resources available to each participant should this become an issue.

The consent form also documented the data storage and security measures that were taken to ensure confidentiality. All data collected and other research documentation were kept on a secured research computer that could only be accessed by the researcher. Thus, the

demographic questions, the recorded Zoom sessions, consent forms, transcriptions, and the interview guide were all kept on the secured computer which were housed in a secured, locked file cabinet to which only the researcher had access. All other paper-based documentation such as the copy of the IRB application and approval letter, the researcher's CITI Human Subjects certificate, and any other pertinent study-related materials were locked in the secure file cabinet as well. The participants were assured that at all times, the study and its researcher operated under full transparency. Therefore, the element of deception was not applicable to this study or any of its procedures; and if applicable, any accidental breach of these procedures were promptly reported to Pepperdine's IRB.

The consent form also stated that the participants would not receive any direct benefits as a result of their participation in this study. However, it was shared with them that their participation spoke to their personal sense of altruism as it was associated with the investigation of the phenomenon of occupational burnout amongst female Resident Physicians which was an unintended benefit of study participation. In short, through sharing their residency experiences related to occupational burnout, the Residents were told that they could possibly help other female Residents who might be challenged by this phenomenon.

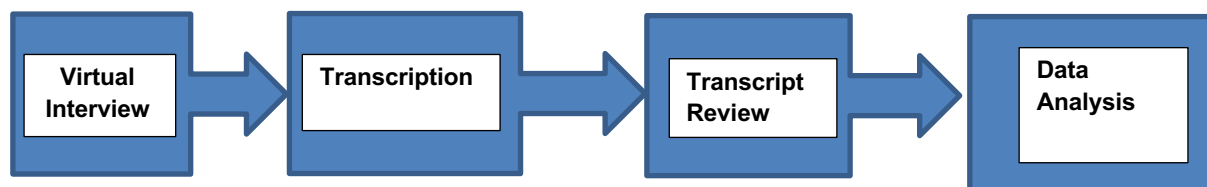
The consent form reiterated to the Residents that their participation in the study would not be afforded any preferential treatment or receive any benefit from the residency program or the hospital for which they worked. In addition, it was acknowledged that any information they shared with the researcher would not affect their status in their residency program. As a gesture of appreciation for their time, participants were sent a thank you email, and an electronic Amazon gift card valued at \$25 which was approved by the IRB.

Data Collection

Data from the female Resident Physicians was collected during February and March 2022, through recorded virtual interviews using the Zoom platform. The data was analyzed at the affective and cognitive levels of measurement to determine if the Residents' perceptions of their Attending Physicians' leadership styles had any effect on their experiences with occupational burnout. Prior to their scheduled interviews, the Residents were given a passcode to enter their respective Zoom interview setting. The researcher ensured that the settings on the Zoom platform were set such that it would not only record, but would also auto-generate the interview transcript after each interview. Once the transcripts were generated, the researcher read each one at least three times to ensure its accuracy; and thereafter began analyzing the data for common themes. The data collection process is detailed below in Figure 3.

Figure 3

Data Process



The Virtual Qualitative Interviews

Qualitative interviews were the primary source of data collection for this study. Each interview lasted no longer than 60 minutes, and each participant had only one interview. The interviews began with the researcher discussing the consent form with the participants, answering their questions, and ensuring that everything was set to record via Zoom the interview. Thereafter, the researcher gave a brief overview of the study, and the recorded interview commenced. The interview questions can be seen in Figure 4.

The objectives of the qualitative interview were two-fold:

- to learn about the Resident Physicians' experiences with occupational burnout, and
- to ask the Resident Physicians their perceptions of their Attending Physicians' leadership styles and whether they believe they ameliorate or exacerbate their experiences of occupational burnout.

The qualitative interviews were semi-structured, open-ended questions about occupational well-being and burnout. The open-ended nature of the interview questions included prompts to encourage the Residents to engage in deeper descriptions of their responses as they related to their residency experiences. Table 3 showed the RQs and concepts that corresponded with the IQs as well as the sources from which these IQs came from.

Table 3

Research Questions and Concepts

Research Question (RQ)	Concept	Interview questions (IQ)	Source of question (cited)
RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?	Perception of occupational wellness	IQ3, IQ5, IQ8-IQ13; and IQ15	Hoff & Lee, 2021; Chesak et al., 2020; McClafferty & Brown, 2014; Yeluru et al., 2022; and Brady et al., 2017.
RQ2: What leadership styles do female Resident Physicians perceive their Attending Physicians' exhibit?	Leadership styles	IQ23	Shanafelt et al., 2019; Msheik-El Khoury et al., 2021; Nair et al., 2017; Stoller, 2017; Shanafelt & Noseworthy, 2017; and Hicks & McCracken, 2011.

Research Question (RQ)	Concept	Interview questions (IQ)	Source of question (cited)
RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?	Perceived impact of Leadership style	IQ14, IQ17- IQ18, IQ21- IQ22	Arnold et al., 2015; Kanat-Maymon et al., 2020; Goleman, 2000; Ali et al., 2015; and Guhr et al., 2019.
RQ4: How do female Resident Physicians cope with occupational burnout?	Coping and Social Support	IQ7 and IQ16	Chilton, 2017; Wallace, 2014; and Gazelle et al., 2014.

Pilot testing of the semi-structured interview questions was conducted with the assistance of physician and qualitative research collaborators. These individuals were given three days to review the questions for clarity and context, namely, to provide feedback on whether each had the potential to elicit robust responses. The feedback contributed to the final formulation of the interview questions that were used for the study. Thus, it was determined that interview questions 1, 2, 4, 6, 19, 20, 24, 25, and 26 were all rapport-building questions that did not relate to any of the four research questions and therefore were kept on the interview script but would not be included in the final data analysis in Chapter 4.

Instrumentation

The goal of an interview guide is to ensure interviews are consistently conducted, and that each participant was asked the same questions in the same order, while allowing for the phenomenon of occupational burnout could be discussed (Kassam et al., 2015). In terms of this study, and because of the researcher's positionality to the subject matter, it was necessary for the researcher to create interview questions that would allow the Resident Physicians to feel comfortable with openly sharing their experiences of burnout without feeling judged. It was the researcher's goal to include the principles of phenomenology studies in the data collection

process for this study because it acknowledged the Resident Physicians' lived experiences of burnout (Sloan & Bowe, 2014). The anticipated structure of the interview experience is seen in Table 4 and the interview script is seen in Figure 4.

Table 4

Interview Flow and Timing

Interview Activity	Interview Question(s)	Allocated Time
Discussion of Informed Consent with Oral Consent Given at time of interview	N/A	2 minutes
Rapport Building and Introduction	#1–2	3 minutes
Start of Interview: Open-Ended Occupational Well-being Questions	#3	10 minutes
Open-Ended Occupational Burnout Questions	#4–15	20 minutes
Pointed Questions: How each Resident has coped with Occupational Burnout and what support mechanisms have been employed	#16	5 minutes
Middle of Interview: Open-Ended Leadership Style Questions and their perceptions of how their Leaders have impacted their residency experience.	#17–24	15 minutes
Closing Questions - General	#25–26	5 minutes
Total Questions: 26		Total Time: 60 minutes

An in-depth review of the scholarly literature as seen in Chapter Two informed the creation of the interview questions. The interview questions were created to address the phenomenon of occupational burnout and were inspired by the Maslach Burnout Inventory (Maslach & Goldberg, 1998) which is considered the gold standard of burnout measures. The interview questions concerning leadership styles were influenced by the Multifactor Leadership Questionnaire (Avolio & Gardner, 2005) as well as by the theoretical framework of the Full-Range Leadership Theory (Alshmemri et al., 2017; Gardner, 1977). Figure 4 depicted the interview script and questions that were asked.

Figure 4*Interview Script and Questions***Interview Script (Creswell, 2013) and Questions****Date:****Participant Number:**

Thank you for taking the time to meet with me today to discuss your experience with being a Resident Physician. I would like to learn about what it is like to be a Resident and my hope is that the information I learn from this research can help to create a positive dialogue, contribute to the literature, and increase the resources available to help mitigate occupational burnout for women Resident Physicians. Let's start by discussing your residency experience in general.

Residency

1. What is your present year of residency?
2. What is your residency specialty?
3. How are you enjoying your residency program? (Ask participants to expand on response if you are given a yes/no answer).
 - If the Resident says she enjoys her residency program, ask:
 - What do you enjoy most about your residency experience?
 - Is residency what you thought it would be?
 - Is it ever stressful?
 - If the Resident says she does not enjoy her residency program, ask:
 - What don't you enjoy about your residency experience?
 - Is residency what you thought it would be?
 - Is it ever stressful?
 - Do you feel you receive support from your fellow Resident Physicians?

Occupational Burnout

I have heard that residency is an exciting time in a physician's life because you are embarking on your career and for many it is the fruition of your lifelong dream of becoming a doctor. You have your own set of patients, and you are fully immersed in medical training. I have also heard; however, that residency can be tough with its long hours, high expectations, and lofty sacrifices of your time.

4. Can you tell me if you have ever known any Residents who have experienced occupational burnout and what did they tell you about their experiences?
5. Have you ever felt burned out during residency?

6. Are you aware of any services or resources that are available for Resident Physicians who experience occupational burnout? Please tell me the services or resources you are aware of.
7. What resources or supports are available for Residents who identify that they are experiencing occupational burnout?
8. Do you think there is a stigma to acknowledging that a Resident has experienced burnout?
9. Do you think occupational burnout is just part of the job of being a Resident Physician?

Women Resident Physicians

Occupational burnout is something that can be quite challenging to deal with for several reasons, but I assume it can be especially challenging for a Women Resident Physician.

10. When you have felt a sense of well-being at work, what are three words you would use to describe how you felt about yourself during those times?
11. What are three words you might use to describe your work performance during times when you have experienced occupational burnout?
12. Do you feel that women Resident Physicians experience occupational burnout differently or more often than their male counterparts? Please explain your answer.
13. Do you feel that when women Residents experience occupational burnout they are treated differently than their male counterparts by their peers and/or Attendings? Please explain your answer.
14. When you have experienced burnout, what kinds of words might describe how you have viewed your Attending Physicians' efforts to address it?
15. Do you think the COVID-19 pandemic has further exacerbated physician burnout for you and your colleagues? If so, please share how.

Social Support

Social support, or the support from one's peers can help them to maintain a sense of occupational well-being as well as ward off occupational burnout. The next set of questions will focus on the social support you have experienced in the workplace.

16. When you have experienced occupational burnout, have you felt that you can seek support from your colleagues?
 - If yes, ask:
 - Please describe the kind of peer support you received.
 - If no, ask:
 - Please tell me why you feel you cannot share your occupational burnout experiences with your colleagues.
 - Please describe the reactions of your peers during these times.
 - Do you feel your Resident colleagues are open to talking about their experiences of occupational burnout?

- Do you feel your colleagues are open to sharing how they maintain a sense of wellness during residency?

Leadership and Leadership Style

Attending Physicians are leaders who can be very instrumental in shaping the overall residency experience. While all Attendings followed the path of medical school to residency, presumably they may have an idea of how to guide the residency experience such that they create a sense of occupational well-being for Resident Physicians. In this part of the interview, we will discuss the leadership styles of your Attending Physicians.

17. Have your Attending Physicians offered information on how to deal with physician wellness? If so, what type of information have they given you?
18. Have your Attending Physicians offered information on how to mitigate occupational burnout? If so, what type of information have they given you?
19. Describe one of your best experiences with an Attending.
20. Describe one of the more challenging experiences with an Attending.
21. Do you feel your Attending Physicians care if you or your colleagues are experiencing occupational burnout?
22. When you have experienced occupational burnout, have you felt that you can seek support from your Attendings?
23. Please look at the chart I am sharing on the screen. What category of words would you say, in general, overall describe your Attending Physicians' leadership styles?
24. Do you think that the COVID-19 pandemic has changed your Attending Physicians' leadership styles? If so, please share how.

Closing Questions

Our interview is coming to an end. Thank you for sharing your Residency experience and your perspective on the various aspects of this experience. I have two more questions for you before we end.

25. Is there anything else you would like to share with me about your experience with physician burnout that was not addressed by any of the previous questions?
26. Is there anything else you may like to share about your Attending Physicians' leadership styles that were not addressed by any of the previous questions?

Thank you for participating in this study. Your time and openness with answering the questions was very much appreciated.

Epoche

In conducting a qualitative research study, it was very important for the researcher to be mindful of the need to enter into the data collection as well as the data analysis phases without preconceived ideas about the research participants or the information for which they share (Moustakas, 1994). The need for implementing bracketing or epoche so that researchers do not insert their experiences with the phenomenon being studied onto the research participants or the research process in general is of paramount importance. Prior to beginning the data analysis process, the researcher reflected on the concept of epoche in an effort to not allow personal preconceptions or positionality of the phenomenon being studied to influence the analysis process. In particular, the researcher was intentional in trying to not impose judgments on any of the information shared by the research participants during their interviews. The researcher also tried to use bracketing when analyzing the data by writing memos throughout the entire process to aid in keeping the researcher's judgments and assertions related to the phenomenon of occupational burnout in female Residents in check (Birks et al., 2008; Moustakas, 1994) so that the analysis could be deemed trustworthy (Korstjens & Moser, 2018).

Data Analysis

The purpose of qualitative data analysis for hermeneutic phenomenological studies is to gain insight on the phenomenon for which was experienced by the study participants. The objective of this study was to determine if the leadership styles of Attending Physicians impacted the experiences of occupational wellness or burnout as experienced by female Resident Physicians. The research design employed in this study was hermeneutical phenomenology as this method is known to highlight the phenomenon of shared, lived experiences (Sloan & Bowe, 2014). Virtual interviews were used to gain a better understanding of the experiences each

Resident had with her Attending Physicians. Upon completion of the interviews and the data collection phase, analysis of the data commenced. As this was a qualitative study, the main objective of the data analysis process was to identify if there were any common themes that emerged from the responses offered by the research participants.

In particular, the qualitative analytic process used in this study followed the five steps for data analysis according to Creswell and Poth (2018). The five steps are:

1. Organizing the data
2. Identifying emergent themes through memoing
3. Creating themes from the codes created from the data
4. Assessing the essence of each interview through interpreting
5. Creating a visual representation of the data

Upon completion of each interview, data analysis began with the researcher reading each of the interview transcripts. As the researcher read the transcripts, notes or memos were taken to ensure that the essence of the interview was captured as well as to identify the first codes associated with the participants' responses (Birks et al., 2008). The researcher read each interview transcript at least three times. The first read was to simply read through the information shared and to ensure that all of the questions were answered and so that the researcher could get a sense of what the data entailed. The second read consisted of the researcher creating memos or significant concepts that became apparent to the researcher upon review of the transcripts. The third read of the transcripts ensured that all of the necessary information was understood by the researcher before codes were identified to interpret the data (Saldaña, 2015).

In Vivo Coding

In qualitative research, one of the most common types of data analysis methods used for coding data is called In Vivo Coding (Saldaña, 2015). In vivo coding describes a style of data analysis whereby codes are created using the exact words or statements generated from qualitative interviews. According to Saldaña (2015), in vivo codes bring the research participants' words alive because the codes are extracted verbatim from the responses offered by the research participants that were captured in the interview transcripts. Ensuring that the codes accurately portrayed the collected data, the researcher organized them into a list of analytic themes that were imported into an Excel spreadsheet so that all of the pertinent data could be captured (Paulus & Lester, 2016; Saldaña, 2015).

Also, while analyzing the data for common themes, a technique the researcher used to ensure that her positionality did not bias the data analysis process was memoing or the act of taking notes while organizing and analyzing the data (Birks et al., 2008). Memoing is a method used by qualitative researchers to ensure that a full picture of the data is created. It allows the researcher to reflect on the information shared by each participant, and it enables the research to objectively view the data. Thus, the act of memoing helped the researcher to become familiar with the qualitative data, while not subjectively imposing her thoughts about the information shared by the Residents. Thus, the researcher made sure to memo before, during, and after each interview as well as throughout the data analysis process in order to not impose upon the data collection or analysis processes.

Sandelowski (2000), asserted that qualitative research allows the researcher to be in close proximity to the data and its findings. To uphold the rigor of the research and its findings, qualitative researchers use the criteria of trustworthiness (Korstjens & Moser, 2018;

Sandelowski, 2000). Trustworthiness is confirmation that the findings that result from qualitative studies are in fact true (Korstjens & Moser, 2018; Leigh & Fowlie, 2014). In this qualitative study, the criteria for trustworthiness are further discussed, in juxtaposition to the findings, in Chapter 4.

Trustworthiness in Qualitative Research

To assess validity of research findings in qualitative studies such criteria as internal and external validity, and generalizability are not used (Korstjens & Moser, 2018). Instead, qualitative studies use trustworthiness to determine if a research study's findings are accurate. According to Lincoln and Guba (1986), trustworthiness for a qualitative study is determined if the following criteria are acknowledged: credibility, transferability, dependability or neutrality; and authenticity or reflexivity. The four criteria that assess a qualitative study's trustworthiness confirm that the research practices were upheld and maintained by the researcher before, during, and after the study.

The trustworthiness criteria of credibility requires the researcher to confirm that the study's data is collected and analyzed in manner that is congruent to the methodology (Korstjens & Moser, 2018; Leigh & Fowlie, 2014). Transferability requires that the data collection and data analysis of a qualitative study can be replicated. This criteria is analogous to the idea of generalizability in quantitative studies (Amankwaa, 2016; Korstjens & Moser, 2018). Dependability or confirmability requires that the research methods are well documented, understandable, and are conducted in a consistent manner (Nowell et al., 2017); and neutrality refers to researcher monitoring their positionality so that it does not interfere with the findings (Korstjens & Moser, 2018). The last trustworthiness criterion is reflexivity (Amankwaa, 2016). Reflexivity refers to the authentic way in which the researcher is required to acknowledge their

positionality, in regards to the research and its findings, so that their subjectivity is not imposed upon the research process (Lincoln & Guba, 1986).

Data Management

Ensuring that the data was properly managed, per IRB standards, was of paramount importance. Therefore, the researcher kept all of the data for this study in a secured research file cabinet. Each of the Zoom interviews, the interview transcriptions, consent forms, and any other study-related documentation was placed in a locked file cabinet and will be kept for a three-year period as required by the IRB. The study participants were also be told that all data would be stored securely so in order to them that their private information would be kept confidential.

Chapter Summary

This chapter discussed the research methodology and practices that guided the data collection and data analysis processes of the hermeneutic phenomenological, qualitative research study. The chapter reiterated the study's objective as well as the study research questions that were the foundation of the inquiry. The goals of the study were identified as being two-fold: to learn the depth of the female Resident Physicians' experiences with occupational burnout, and to understand their perceptions of how their Attending Physicians' leadership styles ameliorated or exacerbated their experiences. Thus, the researcher conducted semi-structured virtual, individual interviews with female Residents to determine if their exposure to the phenomenon being studied created a shared, lived experience amongst the Residents. Other pertinent aspects of the research study that were discussed in this chapter were the inclusion and exclusion criteria of the study population, the sampling criteria employed, the IRB protections to which were adhered, and the data collection and analysis procedures. All of the latter aspects of the study were discussed in this chapter to preface the research findings forthcoming in the Chapter 4.

Chapter 4: Findings

Introduction

Several researchers have identified that the occupational experiences of women who are Resident Physicians are marred with occupational challenges (Brady et al., 2017; Chilton, 2017; Dyrbye et al., 2014; Gazelle et al., 2014; Hategan & Riddell, 2020; Kane, 2020; Nair et al., 2017; Rout, 1999; Sochos et al., 2012). It is thought that these challenges may be exacerbated by familial responsibilities, gender bias, racial predilections, and issues of self-inflicted perfectionism that can color their views of themselves in juxtaposition to their occupational experiences (Nair et al., 2017; Rout, 1999; Wallace, 2014). In addition, researchers have also identified that a Resident Physician's experience may be influenced by those in positions of authority or leadership in their residency programs (Gurt et al., 2011).

It has been reported that female physicians have the highest rates of occupational burnout. In fact, occupational burnout in female physicians is 60% greater than for male physicians (Yeluru et al., 2022). Such a staggering statistic is based on research that shows that female physicians have more emotional exhaustion, higher levels of depersonalization, less opportunities for mentorship and advancement in their fields, as well as a myriad of other factors. Some studies have also shown that occupational burnout impacts female Residents differently than their male counterparts, and that one factor they could positively or negatively impact them is their perceptions of their leadership (Hildenbrand et al., 2018). This phenomenological study examined the shared experiences of occupational wellness and burnout among female Resident Physicians (Dyrbye et al., 2014; Gazelle et al., 2014; Hategan & Riddell, 2020; Wallace et al., 2009).

The purpose of this hermeneutic, phenomenological research study was to discover the shared experience of female Resident Physicians as it related to their occupational burnout as

influenced by their perceptions of their Attending Physicians' leadership styles. The Residents had been in residency training for at least 2 years. Thus, the assumption was that they had sufficient exposure to the residency work culture and physical setting to be able to identify occupational burnout, understand what occupational wellness was for them individually, as well as be able to identify their Attending Physicians' leadership styles.

The theoretical frameworks that underpinned this study were Positive Psychology (Seligman, 2019) which posits occupational wellness and Herzberg's Two-Factor Theory (Alshmemri et al., 2017) which assesses job satisfaction. In addition The Full Range Theory, which highlights Transactional, Transformational, and Laissez-faire leader styles (Kanat-Maymon et al., 2020). The three leadership styles informed the aforementioned theories as they informed the Residents' perceptions of their Attending Physicians' leadership styles The theoretical frameworks also helped to inform the creation of the study's RQs as well as the IQs. Five female Residents participated in individual semi-structured, virtual Zoom interviews. They were asked 26 interview questions that were categorized into eight themes. The interview categories were guided by the study's four RQs:

- RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?
- RQ2: What leadership styles do female Resident Physicians perceive they are Attending Physicians exhibit?
- RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?
- RQ4: How do female Resident Physicians cope with occupational burnout?

Participant Recruitment

The researcher received the CITI certificate on Date (Appendix A). The study received IRB approval (Appendix B) from Pepperdine University's Institutional Review Board in mid-December 2021. Thereafter, the recruitment procedures were initiated and lasted through mid-March 2022. Table 5 depicts the interview schedule for the Residents. The recruitment methodology used for this study was snowball sampling (Eland-Goossensen et al., 1997). This recruitment method is often used when the phenomenon being studied is one where potential research participants may not be readily accessible to the researcher, or the participants may be hesitant to partake in the research because of the topic being studied. Resident Physicians who experience occupational burnout may not readily identify as such, and therefore could be hard to identify as interested research participants (Chilton, 2017; Wallace & Lemaire, 2009).

Table 5

Participant Interview Schedule

<i>Interview Date (Time)</i>	<i>Participant's Name (All names are pseudonyms)</i>	<i>Length of Interview (minutes: seconds)</i>
<i>February 2, 2022 (7pm)</i>	Dr. H	49:25
<i>February 6, 2022 (5pm)</i>	Dr. I	44:33
<i>March 3, 2022 (5pm)</i>	Dr. D	33:46
<i>March 5, 2022 (4pm)</i>	Dr. E	40:06
<i>March 6, 2022 (3pm)</i>	Dr. U	60:00

Participant Demographics

From using snowball sampling, or word-of-mouth recruitment (Eland-Goossensen et al., 1997), the Residents helped the researcher to recruit their colleagues to participate in the study. A recruitment script was approved by the IRB (see Appendix C). As a result of the snowball sampling, five female Residents agreed to share their residency experiences with the researcher. Table 6 detailed the demographics of the five recruited female Residents. Each participant was assigned a pseudonym that is not closely related to their names. In addition, their year in residency is listed as Post Graduate Year (PGY) with the actual year of their training (1, 2, or 3); therefore a second year Resident would be identified as PGY-2.

Table 6

Demographics of the Recruited Female Resident Physicians

Participants	Dr. H	Dr. I	Dr. D	Dr. E	Dr. U
Age	31	31	31	30	No response offered
Medical Specialty	Family Medicine	Family Medicine	Psychiatry	Internal Medicine	Psychiatry
Residency Year	PGY-2	PGY-3 (final year)	PGY-2	PGY-2	PGY-2
Ethnicity/Race	African-American	Caucasian	Caucasian	Chinese American	No response offered
Relationship Status	Committed Partner	Married	Single	Married	Married
Current Clinical Rotation	ICU	Outpatient Surgery Subspecialties	Psychiatric Intake Stabilization Unit	Wards	Internal Medicine
Has a Physician Mentor (Yes/No)	Yes	Yes	Yes	Yes	Yes
Has Co-Resident who offers social support (Yes/No)	Yes	Yes	Yes	Yes	Yes
Experienced Occupational Burnout at time of Interview	Yes, 9 months	Yes, 12 months	No	Yes, 4 months	No

Participants	Dr. H	Dr. I	Dr. D	Dr. E	Dr. U
(Yes/No). If so, for how long?					

Although the sample size was small, the female Residents were quite diverse in several ways. One of the Residents (80%) were in their early 30's and 20% (one) chose not to share their age. The sample was ethnically diverse with 40% (two) identifying as Caucasian, 20% (one) identifying as African- American, 20% (one) identifying as Chinese American, and 20% (one) chose not to share her ethnic background. Three of the participants (60%) were in a relationship while one (20%) of the participants indicated that she was single.

There were no first-year Residents interviewed. Since starting their residency programs, the female Residents had each participated in over 10 clinical rotations and had interacted with several Attending Physicians. Most of the study participants (90%) were in their second year of residency, and one Resident was in her third and final year of residency, although four of the Residents had started residency at the start of the pandemic. Thus, their experience of residency was presumably different than Dr. I's PGY-1 experience that was pre-pandemic. All the Residents indicated that they received social support from their Co-Residents or from their physician mentors who were leaders in their residency programs.

Of note, three out of five participants shared that they were presently experiencing occupational burnout and each confirmed that it was not their first time experiencing occupational burnout during residency. The researcher asked the three Residents if they preferred to not continue with the interview considering what they shared about the state they were in at the time of the interview, however, all three acknowledged that they wanted to proceed with the interview.

Data Collection

Once participants stated their interest in being interviewed, an informed consent form was provided (see Appendix D). The informed consent form was to be signed before the interview was scheduled and conducted. Through semi-structured interviews, the female Resident Physicians graciously and candidly shared their residency experiences of occupational burnout with the researcher. The five Residents participated in interviews that were conducted over a one month period between February and March, 2022. Each interview took place virtually over Zoom and lasted from 45 minutes to 1 hour. There were a total of 26 interview questions (see Appendix E). The questions were categorized into five sections to ensure that the Residents were asked relevant questions that would engender conversation about their experiences of occupational burnout. The categories were: residency, occupational burnout, women resident physicians, social support, and leadership or leadership style.

The study was guided by four research questions. Each of the research questions were used to create interview questions (IQ) that helped to reveal the occupational experiences of the female Resident Physicians. The interview questions were grouped as shown in Table 7 according to their question category. The seven categories on the interview script were: Residency (IQ1-IQ3), Occupational Burnout (IQ4-IQ9), Women Resident Physicians (IQ10-IQ15), Social Support (IQ16), and Leadership and Leadership Styles (IQ17-IQ24), and Closing Questions (IQ25-IQ26). It should be noted that, while the researcher asked each participant 26 questions during the interview, there were nine interview questions that were not included in the data analysis process because it was determined that they were rapport-building questions that did not relate to any of the four research questions. The questions that were omitted from the data analysis process were IQ 1, 2, 4, 6, 19, 20, 24, 25, and 26 and they read as follows:

- IQ1: What is your present year of residency?
- IQ2: What is your residency specialty?
- IQ4: Can you tell me if you have ever known any Residents who have experienced occupational burnout, and what did they tell you about their experiences?
- IQ6: Are you aware of any services or resources that are available for Resident Physicians who experience occupational burnout? Please tell me the services or resources you are aware of.
- IQ19: Describe one of your best experiences with an Attending.
- IQ20: Describe one of the more challenging experiences with an Attending.
- IQ24: Do you think that the COVID-19 pandemic has changed your Attending Physicians' leadership styles? If so, please share how.
- IQ25: Is there anything else you would like to share with me about your experience with physician burnout that was not addressed by any of the previous questions?
- IQ26: Is there anything else you may like to share about your Attending Physicians' leadership styles that were not addressed by any of the previous questions?

Table 7*Question Categories and Interview Questions*

Rapport Building Questions:	
<ul style="list-style-type: none"> • Introductory Questions: These questions were used to identify residency status and overall feeling about being a Resident Physician. • Concluding Questions: Used to ensure that the Resident Physician has shared all information she deems necessary. 	
Question Category	Interview Questions
Introduction: Residency	1. What is your present year of residency? 2. What is your residency specialty?
Rapport-Building Question	4. Can you tell me if you have ever known any Residents who have experienced occupational

Rapport Building Questions:	
<ul style="list-style-type: none"> • Introductory Questions: These questions were used to identify residency status and overall feeling about being a Resident Physician. • Concluding Questions: Used to ensure that the Resident Physician has shared all information she deems necessary. 	
Question Category	Interview Questions
	<p>burnout, and what did they tell you about their experiences?</p> <p>6. Are you aware of any services or resources that are available for Resident Physicians who experience occupational burnout? Please tell me the services or resources you are aware of.</p> <p>19. Describe one of your best experiences with an Attending.</p> <p>20. Describe one of the more challenging experiences with an Attending.</p> <p>24. Do you think that the COVID-19 pandemic has changed your Attending Physicians' leadership styles? If so, please share how.</p>
Conclusion: Final Questions	<p>25. Is there anything else you would like to share with me about your experience with physician burnout that was not addressed by any of the previous questions?</p> <p>26. Is there anything else you may like to share about your Attending Physicians' leadership styles that were not addressed by any of the previous questions?</p>
RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?	
Question Category	Interview Questions
Residency	3. How are you enjoying your residency program?

Rapport Building Questions: <ul style="list-style-type: none"> • Introductory Questions: These questions were used to identify residency status and overall feeling about being a Resident Physician. • Concluding Questions: Used to ensure that the Resident Physician has shared all information she deems necessary. 	
Question Category	Interview Questions
	<p>Probes:</p> <ul style="list-style-type: none"> • What do you enjoy most about your residency experience? • Is residency what you thought it would be? • Is it ever stressful? • If the Resident says she does not enjoy her residency program, ask: <ul style="list-style-type: none"> ○ What don't you enjoy about your residency experience? ○ Is residency what you thought it would be? ○ Is it ever stressful? ○ Do you feel you receive support from your fellow Resident Physicians?
Women Resident Physicians	<p>5. Have you ever felt burned out during residency?</p> <p>8. Do you think there is a stigma to acknowledging that a Resident has experienced burnout?</p> <p>9. Do you think occupational burnout is just part of the job of being a Resident Physician?</p> <p>10. When you have felt a sense of well-being at work, what are three words you would use to describe how you felt about yourself during those times?</p>

Report Building Questions:	
<ul style="list-style-type: none"> • Introductory Questions: These questions were used to identify residency status and overall feeling about being a Resident Physician. • Concluding Questions: Used to ensure that the Resident Physician has shared all information she deems necessary. 	
Question Category	Interview Questions
	<p>11. What are three words you might use to describe your work performance when you have experienced occupational burnout?</p> <p>12. Do you feel that women Resident Physicians experience occupational burnout differently or more often than their male counterparts? Please explain your answer.</p> <p>13. Do you feel that when women Residents experience occupational burnout they are treated differently than their male counterparts by their peers and/or Attendings? Please explain your answer.</p> <p>15. Do you think the COVID-19 pandemic has further exacerbated physician burnout for you and your colleagues? If so, please share how.</p>
RQ2: What leadership styles do female Resident Physicians perceive their Attending Physicians' exhibit?	
Question Category	Interview Questions
Leadership and Leadership Styles	23. Please look at the chart I am sharing on the screen. What category of words would you say, in general, overall describe your Attending Physicians' leadership styles?
RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?	

Rapport Building Questions:	
<ul style="list-style-type: none"> • Introductory Questions: These questions were used to identify residency status and overall feeling about being a Resident Physician. • Concluding Questions: Used to ensure that the Resident Physician has shared all information she deems necessary. 	
Question Category	Interview Questions
Women Resident Physicians	14. When you have experienced burnout, what kinds of words might describe how you have viewed your Attending Physicians' efforts to address it?
Leadership and Leadership Styles	<p>17. Have your Attending Physicians offered information on how to deal with physician wellness? If so, what type of information have they given you?</p> <p>18. Have your Attending Physicians offered information on how to mitigate occupational burnout? If so, what type of information have they given you?</p> <p>21. Do you feel your Attending Physicians care if you or your colleagues are experiencing occupational burnout?</p> <p>22. When you have experienced occupational burnout, have you felt that you can seek support from your Attendings?</p>
RQ4: How do female Resident Physicians cope with occupational burnout?	
Question Category	Interview Questions
Occupational Burnout	7. What resources or supports are available for Residents who identify that they are experiencing occupational burnout?

Rapport Building Questions:	
<ul style="list-style-type: none"> • Introductory Questions: These questions were used to identify residency status and overall feeling about being a Resident Physician. • Concluding Questions: Used to ensure that the Resident Physician has shared all information she deems necessary. 	
Question Category	Interview Questions
Social Support	<p>16. When you have experienced occupational burnout, have you felt that you can seek support from your colleagues?</p> <p>If yes, ask:</p> <ul style="list-style-type: none"> • Please describe the kind of peer support you received. <p>If no, ask:</p> <ul style="list-style-type: none"> • Please tell me why you feel you cannot share your occupational burnout experiences with your colleagues. • Please describe the reactions of your peers during these times. • Do you feel your Resident colleagues are open to talking about their experiences of occupational burnout? • Do you feel your colleagues are open to sharing how they maintain a sense of wellness during residency?

Data Analysis

The objective of a hermeneutic phenomenological study is to analyze the data such that it gives voice to the research participants' lived and shared experiences (Hildenbrand et al., 2018). The purpose of this study was to investigate whether the leadership styles of Attending Physicians impacted the experience of occupational wellness or burnout as acknowledged by the female Resident Physicians. Virtual interviews were conducted with five female Resident Physicians who were at various stages of their residency programs. Each interview was transcribed, and the qualitative data was analyzed to determine if any common themes emerged (Saldaña, 2015).

After each interview, the researcher took handwritten notes regarding impressions of the interview (Birks et al., 2008). The researcher also took copious notes or memos during and after the interviews. The memos included observations of the Residents as they answered each question, the researcher's thoughts of the interviews; and the notes also helped to identify various codes associated with the participants' responses (Birks et al., 2008; Hildenbrand et al., 2018). The researcher also listened to the completed audio recording of each interview at least three times to ensure that the transcription was accurate. The researcher also read each interview transcript at least three times.

In vivo coding was also done as part of the data analysis process. Upon reviewing each transcript, codes were identified and later categorized into themes to further interpret the qualitative data (Saldaña, 2015). The process of manually coding the data not only included identifying common themes, but it also entailed selecting direct quotes that were offered by the research participants that highlighted instances of their occupational wellness and burnout (Paulus & Lester, 2016). An Excel spreadsheet was used to organize the interview data such that each coded variable was identified as it related to the theme (Saldaña, 2015).

The objective of the data analysis was to identify if there was in fact a shared experience between the five female Residents as it related to their experiences of occupational wellness and burnout, and if these experiences were influenced by their perceptions of their Attending Physicians' leadership styles. Thus, upon analyzing the data using In Vivo Coding (Saldaña, 2015), various themes emerged. The eight main themes that emerged were:

- enjoying residency,
- occupational burnout,
- residency is stressful,

- imposter syndrome,
- social support,
- impact of the COVID-19 pandemic,
- overwhelmed by residency, and
- attending support and leadership style.

By conducting further analysis, other sub-themes emerged as a result of the responses offered by the participants during the interviews. All of the data was reviewed and summarized to discuss each of the interview questions that were aligned to the four research questions. The data was also visually depicted using bar charts and word clouds.

Data Organization

The data was organized according to the results generated from the research questions and their corresponding interview questions. Once analyzed, all of the common themes were grouped and the data was summarized. To visually display the data, bar charts were used. The bar charts illustrated the responses that the Resident Physicians offered during their individual interviews. As the sample size was small, five research participants in total, the bar charts did not always represent the frequency of the participants' answers, but instead showed the which each person said individually. Direct quotes said by the Research Participants were included in the data analysis section to offer their perspectives in order to highlight their lived experiences of occupational burnout. The five female Residents who participated in the study were assigned pseudonyms in order to uphold confidentiality.

The interview consisted of 26 interview questions. As mentioned previously in the data collection section, there were five interview questions that were not analyzed because they were either introductory or conclusion questions or they did not relate to any of the four research

questions. The main themes generated from the semi-structured interviews as well as the seen in Table 8 were: (a) enjoying residency, (b) occupational burnout, (c) residency is stressful, (d) imposter syndrome, (e) social support, (f) impact of the Covid-19 pandemic, (g) overwhelmed by residency, and (h) attending support and leadership style.

Table 8

EmergEd Themes and Direct Quotes from Female Resident Physicians

EmergEd Theme	Participants				
	Dr. H	Dr. I	Dr. D	Dr. E	Dr. U
Enjoying Residency	What I enjoy most the positive connections that I make with patients because that's why I went into medicine and went into Family Medicine.	I like learning from each other.	Overall, I am really enjoying my residency program.	I like being able to use the knowledge I've learned to serve patients.	I am now enjoying residency.
Occupational burnout	You fear telling certain leadership that you are burned out.	I was over fatigued and I felt shame and guilt because I thought I should be able to control my feelings better	I feel really guilty that I feel tired and frustrated about going to work.	You don't wake up excited to go to work.	I knew I was stressed out and just beyond burned out because I would wake up in the middle of the night panicked about work.
Residency is stressful	The biggest stress I've realized is trying to fit in a lot of patient visits in a short amount of time.	Feeling like I don't have any time off. Feeling like my time is sometimes not their own.	Not feeling supported by your Attendings or Program Director is very stressful as well as feeling tired of the responsibilities that they have.	The time commitment definitely adds to the stress of residency.	Residency is very stressful.

Emerged Theme	Participants				
	Dr. H	Dr. I	Dr. D	Dr. E	Dr. U
Imposter Syndrome	I am trying to quiet the Imposter Syndrome voice. I try to remind myself that I am capable.	I have questioned my career path almost every day to several times per day.	Since the start of residency, I say to myself daily, 'I am a worthy person independent of who I am as a physician'.	I think that anecdotally imposter syndrome seems to be more common in female physicians than male women physicians	When I first started residency, I didn't feel like I belonged. I didn't feel like I was worth it. I didn't feel like I deserved to be in residency and wondered, 'how did I sneak in and fool them...what did they see in me?'.
Social Support	I lean on my family and friends when I need social support or want to vent about work.	Working together and feeling like we're all in it together as Residents as a collective unit is great.	In my residency program the Residents, for the most part, try to work together as a group. We help each other.	When I need to vent, I ask one of my colleagues to go for a walk so we can check in.	My colleagues are very supportive.
Impact of the COVID-19 pandemic	The COVID pandemic has definitely added another layer of stress in terms of patient care especially if the patient is COVID positive.	I question whether medical training is forever changed because of the COVID pandemic.	I think COVID has changed the cohesiveness of our community and the support system kind of forcing everything to be much more isolated and virtual.	COVID has prevented us from being able to socialize with each other outside of work.	I think, residency hasn't been as clinically engaging or stimulating because a lot of focus is on COVID, but there are so many other clinical aspects of training we could focus on.
Overwhelmed by residency	Residency is tough, just the time	Residency kind of bleeds into	Residency has been most stressful when I	There are times when you're on 24-	There are times when you must

Emerged Theme	Participants				
	Dr. H	Dr. I	Dr. D	Dr. E	Dr. U
	commitment of residency can be hard.	and takes over everything else in your life.	was doing rotations in a field that I didn't feel confident in my skills like when a patient coded in internal medicine or in the emergency department.	hour call and I think that's hard.	bring work home, like finishing the Inbox. The Inbox is like an email that patients use to message you, and you must answer the messages in a certain time frame. The messages can pile up and then you're working late to finish then while you're at home. It can sometimes be the worst part of residency.
Attending support and Leadership Style	Some Attendings like to remind us Residents of the importance of moving our bodies and taking the time to walk outside and get fresh air during our shifts.	Our Attendings take the time to get to know you as a person. Sometimes they ask me about my family. I appreciate that they take the time to do that.	We each have a faculty mentor, and I would feel very safe going to him to discuss burnout.	They don't set expectations	They may offer time off if they notice you are looking burned out. Some of them have said to me, 'Do you need anything? Do you need to be off from clinic today? Do you need to switch your call schedule?'

Results

Research Question 1

RQ1 asked, how do women who are Resident Physicians describe their experiences of occupational well-being? To assess how the participants described the phenomenon of occupational wellness as related to residency training, they were asked nine questions associated with RQ1. Those questions were:

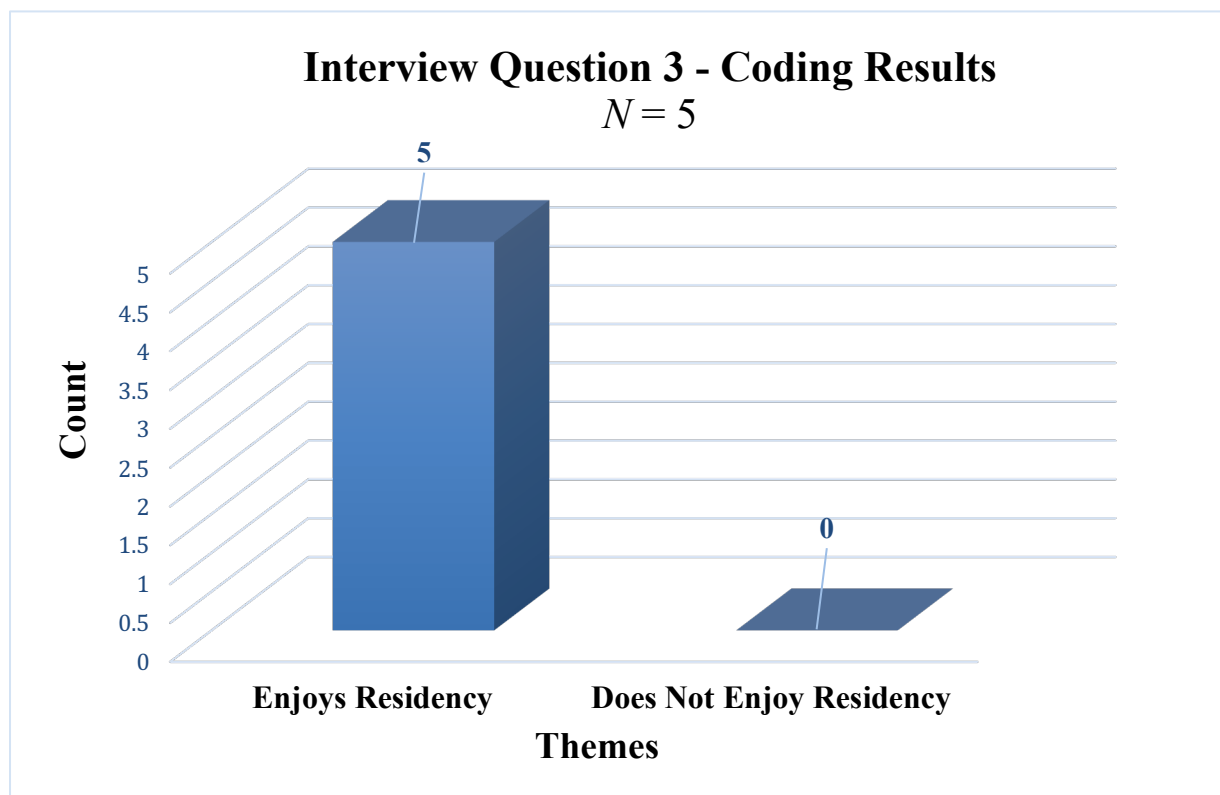
- IQ3: How are you enjoying your residency program? The following probes for IQ3 were used to generate conversation:
 - What do you enjoy most about your residency experience?
 - Is residency what you thought it would be?
- IQ5: Have you ever felt burned out during residency?
- IQ8: Do you think there is a stigma to acknowledging that a Resident has experienced burnout?
- IQ10: When you have felt a sense of well-being at work, what are three words you would use to describe how you felt about yourself during those times? The answers offered by the Residents were analyzed and grouped to identify a common theme.
- IQ11: What are three words you might use to describe your work performance when you have experienced occupational burnout?
- IQ12: Do you feel that women Resident Physicians experience occupational burnout differently or more often than their male counterparts? Please explain your answer.
- IQ13: Do you feel that when women Residents experience occupational burnout, they are treated differently than their male counterparts by their peers and/or Attendings? Please explain your answer.

- IQ14: Do you think the COVID-19 pandemic has further exacerbated physician burnout for you and your colleagues? If so, please share how.

Interview Question 3 (IQ3). IQ3 asked the Residents, how are you enjoying your residency program? All five of the female Resident Physicians answered this question affirmatively. The Residents were asked the three exploratory questions from IQ3 to elicit more dialogue. Three themes emerged from asking the probe questions: (a) enjoying residency, (b) residency is what I expected, and (c) residency is stressful. Figure 5 depicted the bar chart of the coding results, showing that either the female Residents enjoyed residency, or did not enjoy residency. Both “enjoying residency” and “residency is what I expected” on the bar chart shows all five under the “enjoying residency” theme.

Figure 5

IQ3 Coding Results



Enjoying Residency. The female Residents acknowledged that they enjoyed their residency experience, although it was challenging. In fact, not one of the five Residents who participated in the study shared that she did not enjoy her residency experience. The theme of enjoying residency was identified as a shared experience amongst all the study participants. The following responses highlight the various reasons the female Residents shared for their enjoyment of residency training. According to Participant Dr. D, “Of course, residency as you know it has its challenges, but overall I would say that I'm enjoying my experience.”

Residency is What I Expected. When asked if residency training met their expectations and if it were what they expected, three Residents said that the residency experience was what they expected (60%), and two Residents said that it was not what they expected (40%).

Residency is Stressful. While 100% of the female Residents said initially that they enjoyed residency, all of them also said that it could be a stressful endeavor. Participant, Dr. U expressed why she felt residency was stressful, “I find it to be very stressful a lot of the time. The expectations you put on yourself during residency are a lot, and the expectations the residency program puts on you makes it very stressful.”

In addition, Participant Dr. E stated,

For me, when I get off of work I sometimes want to dive deeper into looking up different medical diagnosis and clinical management, but I also want to take time to care for myself and get sleep so it can be stressful to continue to think about work when you are at home because you feel like you always have to be working.

Also, Participant Dr. H added,

It's stressful when patients come in with over 5 medical problems or concerns they want you to solve, and some come in with baggage from a prior experience they had with another clinician, and you feel like you have to be a therapist and doctor all at the same time in order to help them navigate through all of that. It can be very stressful. Then on top of that the stress of patient care, you also have to deal with an in-basket which are the patient messages.

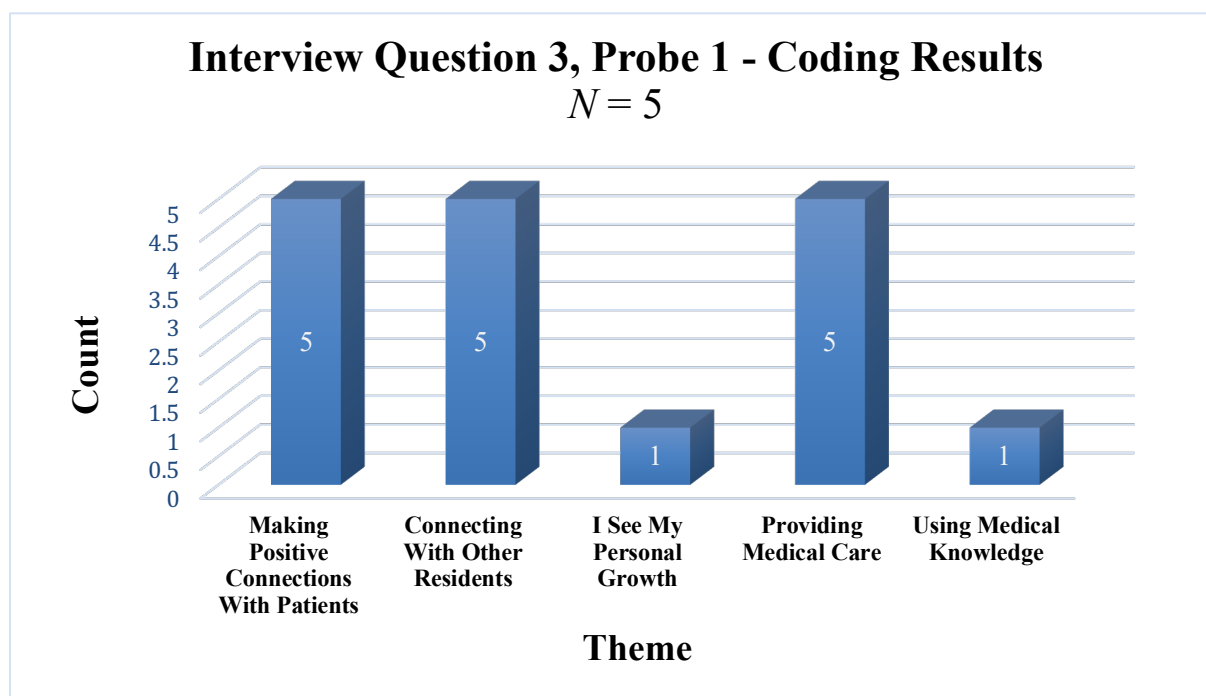
Two more participants stated they were tired of always coming to work. For instance, Participant Dr. H said, “I was tired of coming into work every day, and there were times when I would be driving to work and be in tears because I just really didn't want to go in.” Also, Participant Dr. E stated, “You dread going to work, and you come home exhausted from the stress.” Finally, Participant Dr. D added,

Knowing that you no longer are happy going into work every day is stressful. You know, you fear or dread going into work, especially with the long shifts and the long hours we have as Residents, then you find yourself not enjoying working with patients.

Probe Question 1. The researcher asked, What do you enjoy most about your residency experience? From this question, five themes emerged due to multiple responses: (a) making positive connections with patients, (b) connecting with other Residents, (c) I see my personal growth, (d) using medical knowledge, and (e) providing medical care. Figure 6 depicted the bar chart which showed the themes.

Figure 6

IQ3 Coding Results for Probe 1



Making Positive Connections With Patients. All of the Residents shared that they decided to be physicians to help patients. Sixty percent (60%) of the study participants were primary care physicians and the other 20% were considered non-primary care physicians. The majority of the participants see their patients regularly and shared that the frequency for which they administer patient care to the same individuals allows for them to make positive connections with their patients which they valued. One of the participants, Participant Dr. H shared, “It’s been a joy being a part of my patients’ lives. I’ve enjoyed being able to help them reach their health goals has been great.”

Connecting With Other Residents. All of the Residents voiced how imperative it was for them to establish and maintain good relationships with their Co-Residents. They acknowledged that they see their colleagues as a great source of support as well as people for whom help them through the residency experience. One Resident, Participant Dr. H said, “What I enjoy most about residency is the community of Residents and faculty I work with.”

I See My Personal Growth. One Resident said that although residency has been a challenging experience for her, she has had moments where she has noticed how her clinical skills have increased. Participant Dr. I told the researcher, “I’m enjoying residency now because I’m recognizing that I am in the place where I need to be and want to be. I think I’m enjoying it because I can see myself grow.”

Providing Medical Care. All of the physicians have spent many years studying to become physicians. Thus, if a physician exclaimed that after all of the preparation and studying it took her to get to residency, Participant Dr. H stated, “I really enjoy providing medical care.”

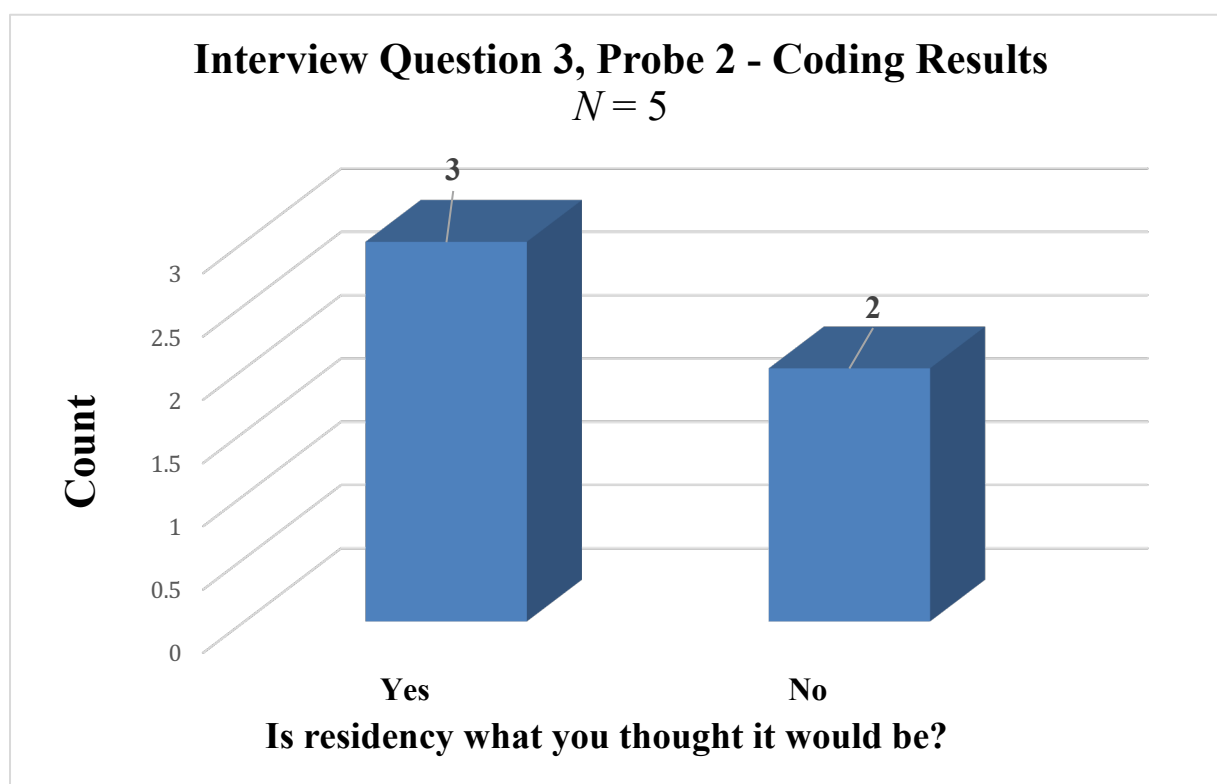
Using Medical Knowledge. Although their daily work comes with its successes and challenges, one of the female Residents shared with the researcher that it is great validation of

the time she spends at work as well as studying clinical diagnoses while not at work because as Participant Dr. E shared, “I like being able to use the knowledge I’ve learned to serve patients.”

Probe Question 2. The second probing question asked, is residency what you thought it would be? The question provoked a dichotomous answer of yes or no. Three of the female Residents said that residency is not what they expected, and two of the Residents responded that residency training was what they expected (see Figure 7).

Figure 7

IQ3 Coding Results for Probe 2

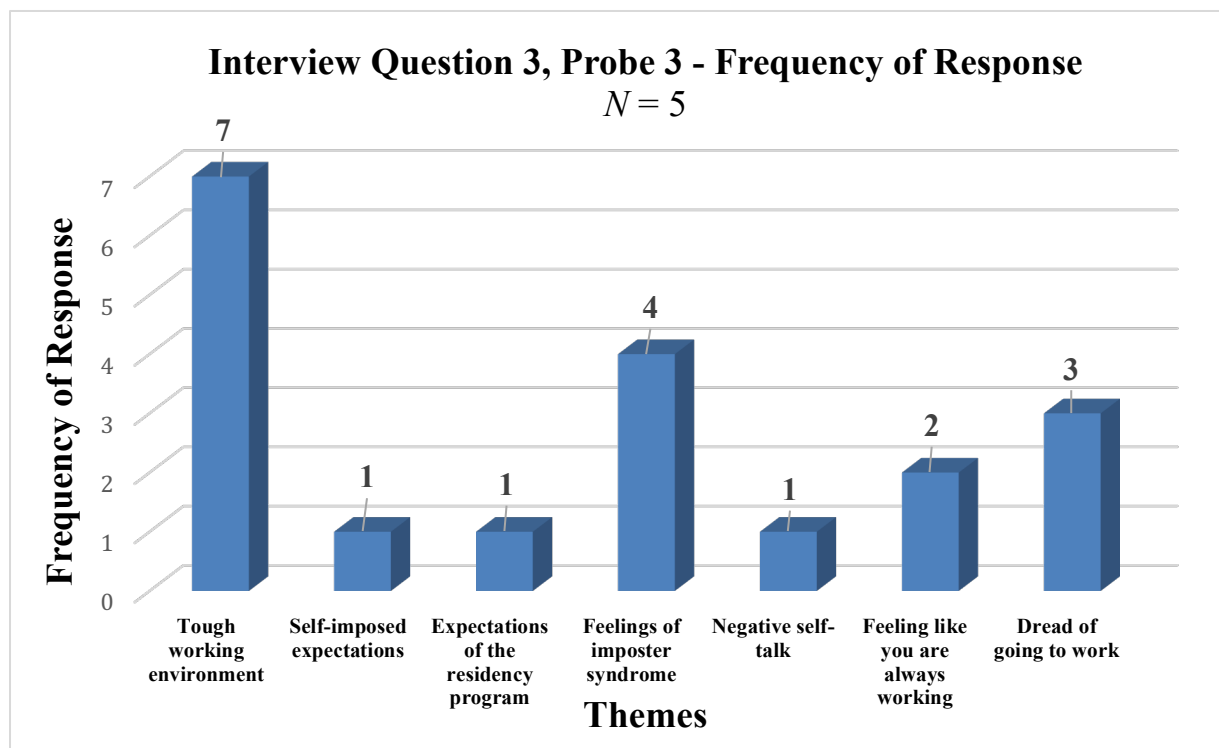


Probe Question 3. The last probing question asked, is it ever stressful? All of the Residents answered this question affirmatively, that residency training was in fact stressful. The Residents provided multiple response for this questions. Some of the common responses for why residency is stressful included: (a) tough work environment, (b) self-imposed expectations,

(c) expectations of the residency program, (d) feelings of imposter syndrome, (e) negative self-talk, (f) feeling like you are always working, and (g) dread of going to work. Figure 8 showed the responses the Residents shared in a bar chart.

Figure 8

IQ3 Coding Results for Probe 3



Tough Work Environment. Being in a hospital with sick patients, even for physicians can be a tough environment to work in on some days especially during a pandemic. Dr. H shared, “The COVID pandemic has definitely added another layer of stress in terms of patient care especially if the patient is COVID positive.” She mentioned to the researcher that the pandemic, especially during the early days of the pandemic when everything was more precarious, caused her and some of her colleagues to worry for their own lives which was not expected.

Self-Imposed Expectations. Some researchers have suggested that, generally speaking, people who pursue medical careers are goal-driven and thus can be self-critical of their skills

(Gazelle et al., 2014). Thus, one of the participants shared with the researcher that she often judges her abilities harshly as a physician and that criticism is reflected sometimes in how she sees herself as a person. She said that when she realizes that she is being too self-critical she tells herself, “I am a worthy person independent of who I am as a physician.”

Expectations Of The Residency Program. All participants (100%) shared that sometimes the expectations of their residency programs can be taxing. They mentioned that the patient schedules, the need to check Inbox messages after a long work day, and the long hours they are required to work are all expectations that, at times, can be quite daunting.

Feelings of Imposter Syndrome. Four of the participants (80%), shared that they often struggles with Imposter Syndrome. Each of the Residents who have experienced Imposter Syndrome told the researcher that the question of whether they truly belong in medicine is something they have thought about often during medicine, particularly during times when they feel stressed or are experiencing occupational burnout. Dr. H shared with the researcher the following: “I am trying to quiet the imposter syndrome voice. I try to remind myself that I am capable.” Similarly, Dr. I shared, “I have questioned my career path almost every day to several times per day.”

Negative Self-Talk. One Resident shared that she has had negative thoughts about herself as a physician when she experiences occupational burnout, or if she has not performed her best during a clinical occurrence with a patient. She mentioned to the researcher that in those moments she is trying to learn to not have negative self-talk or to berate herself harshly after the experience because she realizes that while she is a physician she is still fallible, thus, she is not perfect.

Feeling Like You Are Always Working. Two of the Resident Physicians discussed that they often feel like they can have down time, even when they are not physically at the hospital working. They shared that they often have to reply to patients' messages because they did not have protected time during their shifts to do so. One of the Residents also said that she felt as if she always had to read articles about various clinical diagnoses because she did not want her colleagues or Attendants to think she was not prepared for work. She felt that "Residency kind of bleeds into and takes over everything else in your life."

Dread Going To Work. Three participants (40%) shared in depth how they sometimes dread going into work. One physician shared, "There were times I would be driving to work and be in tears because I really did not want to be there." Another told the researcher that COVID made her work environment "A less inviting environment to work in because everyone seems to be incredibly stressed." One Resident, Dr. E., told the researcher that on some days,

I don't want to go into work because I am not as motivated about being a physician or as excited about it as I was as a medical student. Sometimes I find enjoyment in some of the interactions I have, but the stress of being a Resident can outweigh the joy of those interactions sometimes.

All of the aforementioned themes came from the Residents having experienced occupational burnout. Thus, it is imperative for medical leadership to not only be able to readily identify the signs of occupational burnout, but to also be able to offer the physicians various resources to assuage this phenomenon, especially because when they feel as described in the previous themes, they are treating patients while they are not well themselves (Gazelle et al., 2014).

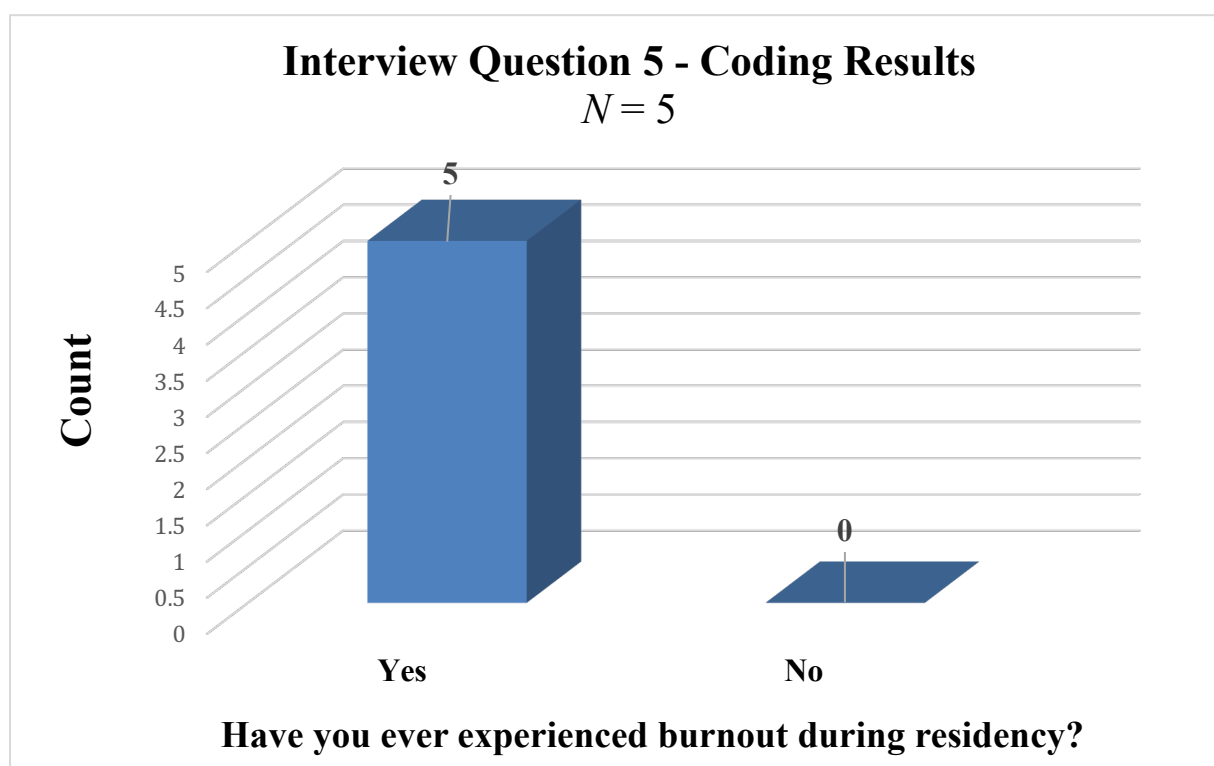
Interview Question 5. IQ5 asked, have you ever felt burned out during residency. The Residents all answered that question affirmatively. The overarching theme from IQ5 was occupational burnout. One prevalent theme that came from IQ5 was the idea that the experience

of occupational burnout could cause Residents to “feel on edge.” Figure 9 showed the coding results as a bar chart. One of the Residents, Dr. H, shared the following thoughts about residency:

I just returned from vacation recently, but before I went on vacation I talked to my mentor about the struggles I was having in residency particularly because I felt on edge. I was tired, bitter, and I wondered if I should continue with residency because of the stress.

Figure 9

IQ5 Coding Results Bar Chart



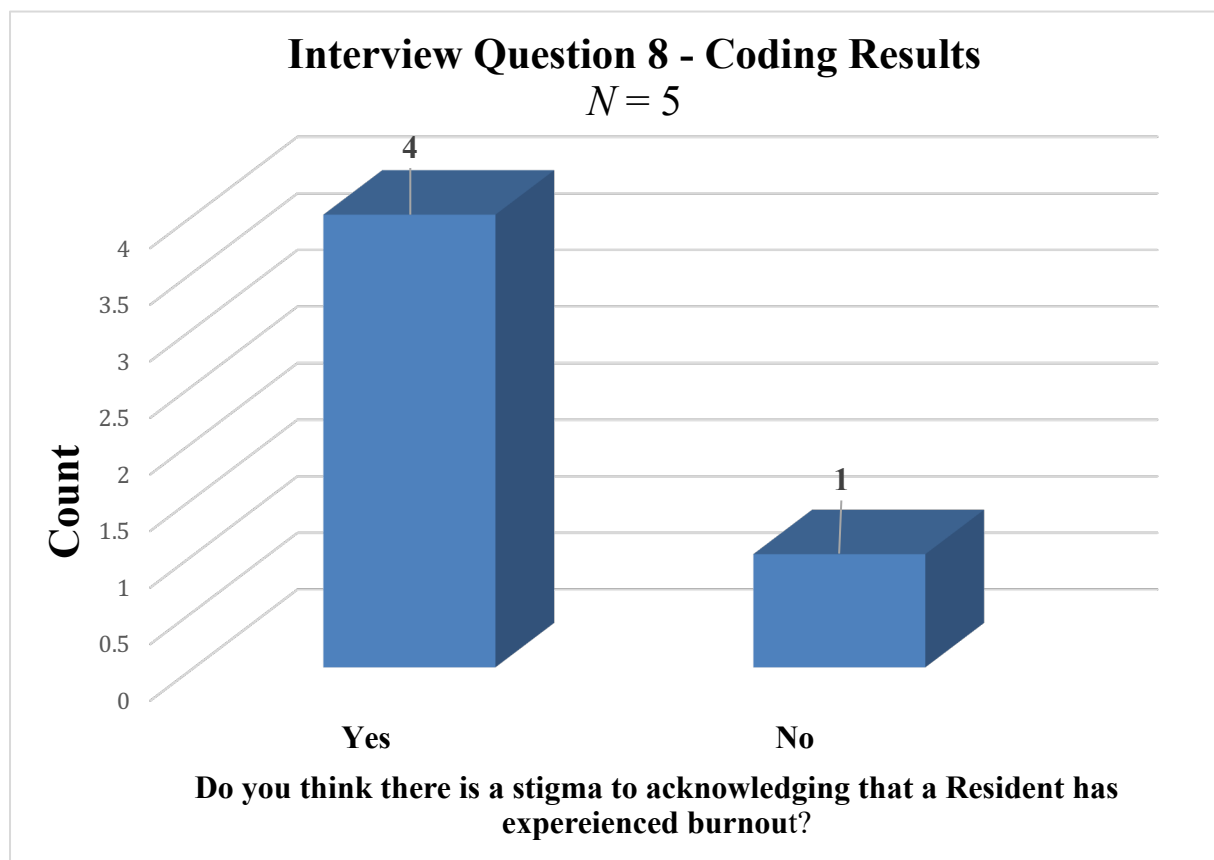
Feel on Edge. The phenomenon of occupational burnout is something that can alter the way a person feels in their work environment. Sometimes when people experience stressful situations can may feel irritable, frustrated, and a host of other feelings that could be described as feeling on edge. For other people, a perceived decrease in efficacy could cause some people to experience occupational burnout that could lead to a lack of job satisfaction (Jennings & Slavin, 2015). Thus, the predominant response to IQ5 as it related to occupational burnout highlighted

the need for Residents to have resources readily accessible, be it printed resources of human resources, to engage during times they experience occupational stress.

Interview Question 8. IQ8 asked, do you think there is a stigma to acknowledging that a Resident has experienced burnout? The responses received from the Residents are seen in the bar chart below. In short, 80% of the participants said they thought there was a stigma to saying that a Resident has occupational burnout while 20% of participants or one participant disagreed with the other Residents. The main theme that derived from this interview question was “stigma of admitting occupational burnout.” Thus the participants had much to say about the theme. Figure 10 depicted the participants’ responses as a bar chart.

Figure 10

IQ8 Coding Results Bar Chart



Participant Dr. E stated the following:

I have a fear of sharing that I have experienced burnout with certain faculty members or Attendings because I think they will think I don't have what it takes to be a doctor, or that I can't handle residency, and then they will look at me differently.

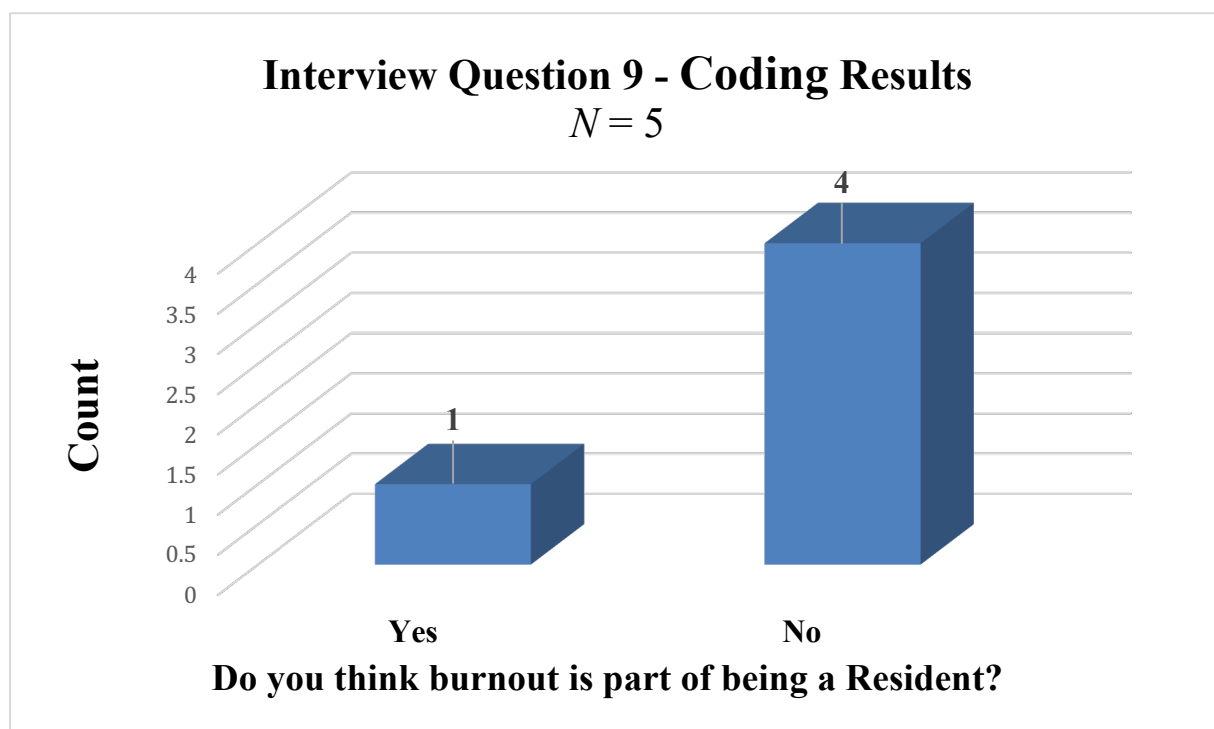
In addition, Dr. I said, "Yes, there is a stigma with telling people in your residency that you are feeling burned out. I don't want them to think I can't handle this."

Stigma Of Admitting Occupational Burnout. The majority of Residents (80%) who participated in this study acknowledged that they believed there was in fact a stigma to sharing that they had occupational burnout with individuals in their work environments such as their colleagues or leadership. Their acknowledgement of the latter, if it is thought to be a pervasive perspective in their field, requires medical leadership to intervene. As previously mentioned, over half of the participants of this study were primary care physicians who regularly administer healthcare to patients of various ages who have a myriad of acute and chronic medical conditions. Thus, having physicians administer clinical care to people, when they are impaired by occupational burnout yet may not feel comfortable sharing that they are impacted by this phenomenon, is not beneficial to the physicians nor the patients for whom have entrusted them with their medical care.

Interview Question 9. IQ9 asked, Do you think occupational burnout is just part of the job of being a Resident Physician? Four of the five Residents (80%) said that occupational burnout was not part of the job, however, one Resident (20%) said that she thought that occupational burnout was a part of the job. Figure 11 depicted their responses in a bar chart.

Figure 11

IQ9 Coding Results Bar Chart



As stated previously, one of the Residents said occupational burnout was not part of the job. For instance, Dr. I shared:

No, I don't believe that burnout is just a part of the job because I feel it would be unfortunate for our system and profession to look at residency like that. I feel to acknowledge that burnout is a part of the job means that we as doctors have accepted that and are somewhat trying to say that being burned out is ok. To say it's a part of the job is almost normalizing burnout which I think is an issue.

In addition, Dr. E added, "I feel like it shouldn't be thought of as a part of the job, but unfortunately, it is I think."

Interview Question 10. IQ10, asked the participants, when you have felt a sense of well-being at work, what are three words you would use to describe how you felt about yourself during those times? All five of the Resident Physicians answered this question. Four out of five (80%) Residents offered three words while one out of five (20%) Residents offered two words

because she could not think of a third word to describe how she felt when she had a sense of well-being at work. Figure 12 displayed a graphic depiction of the words offered by the Residents to illustrate how they felt when they had a sense of well-being at work.

Figure 12

Words Used by Participants Describing Their Feelings

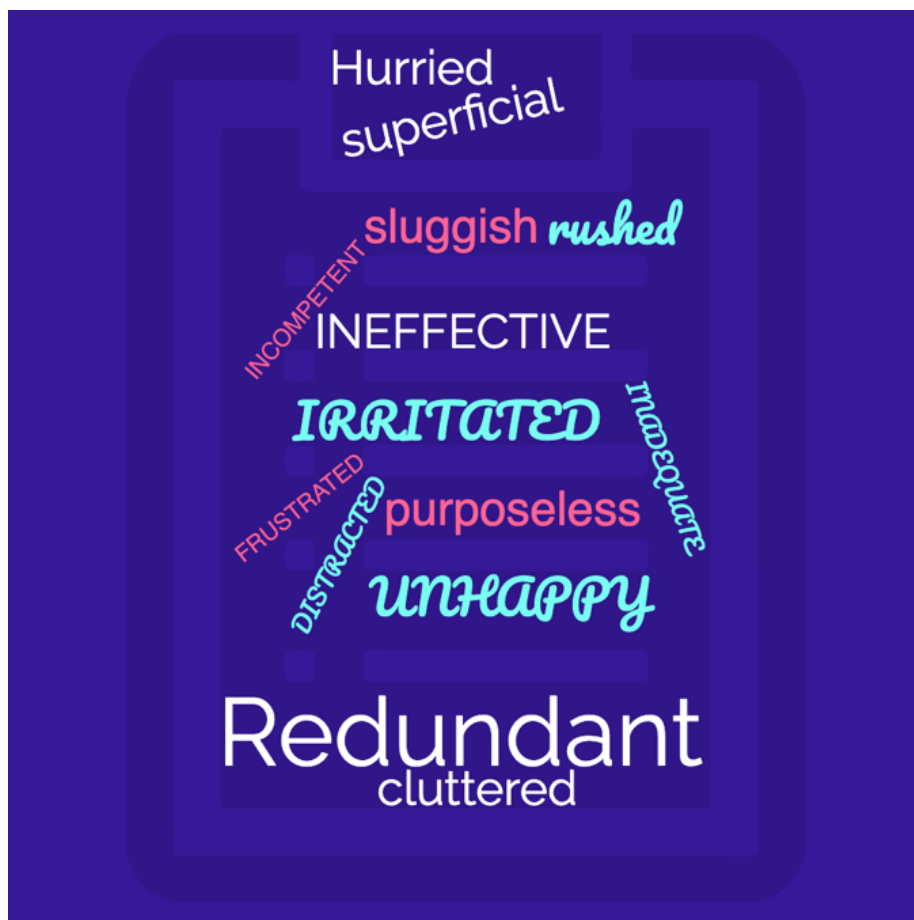


Interview Question 11. IQ11 asked the participants, what are three words you might use to describe your work performance when you have experienced occupational burnout. Four of the female Resident Physicians (80%) offered three words to capture their perceptions of their work performance when they have experienced occupational burnout while one Resident offered only two words because she could not think of an additional word. The graphic depiction seen in

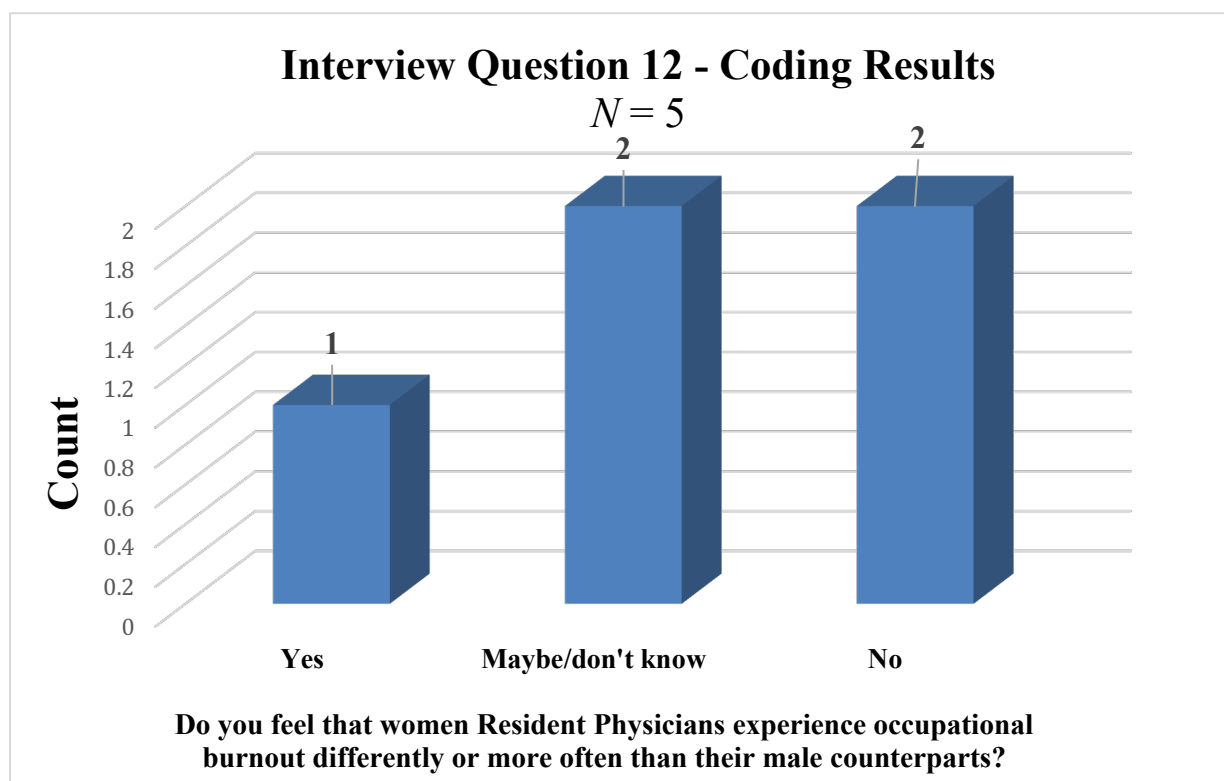
Figure 13 shared the words they used to describe their perceptions of their work performance when they experienced occupational burnout.

Figure 13

More Words Used by Participants Describing Their Feelings



Interview Question 12. IQ12 asked the Residents, do you feel that women Resident Physicians experience occupational burnout differently or more often than their male counterparts? Please explain your answer. The main theme from this interview question was gender differences in occupational burnout. As shown in Figure 14, the participants answered “yes,” “no,” or, “maybe/I don’t know.”

Figure 14*IQ12 Coding Results Bar Chart*

In light of this theme, Dr. I stated:

I think that burnout is just so ubiquitous. I would be hesitant to say that women experience more burnout than men. I do think that women in medicine may get judged more than their male colleagues which may impact burnout, but I am not sure.

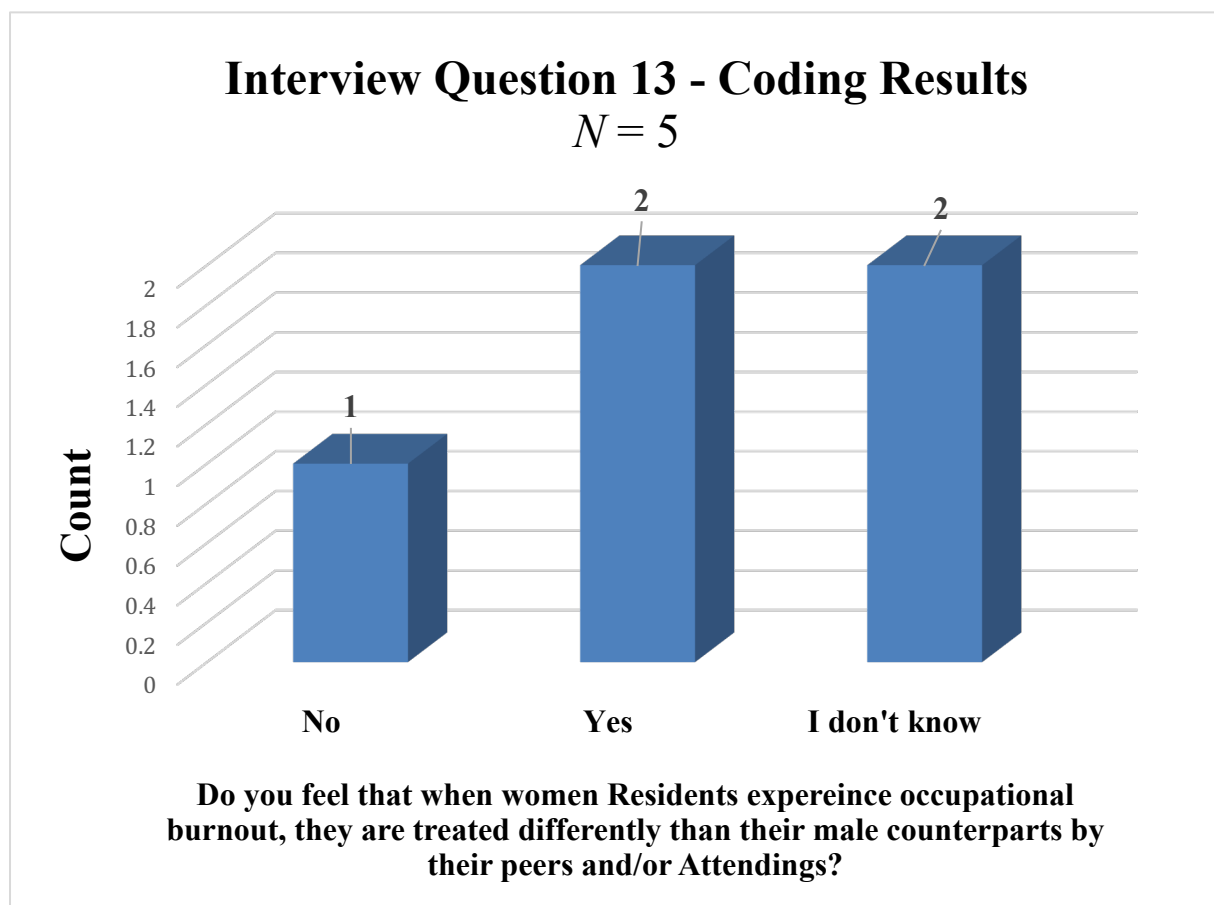
Additionally, Dr. D stated, “My colleagues who are female who have experienced burnout, they usually are carrying a heavy emotional load at home, they are taking care of family members, and they have to deal with residency.” Finally, Dr. E explained, “I am in a program where most of the Residents are female so I don’t know. I never thought about that.”

Interview Question 13. IQ13 asked, do you feel that when women Residents experience occupational burnout, they are treated differently than their male counterparts by their peers and/or Attendants? Please explain your answer. Similar to IQ12, the main theme from this

interview question was gender differences in occupational burnout. The responses offered by the Residents could be seen in Figure 15.

Figure 15

IQ13 Coding Results Bar Chart



Gender Differences in Occupational Burnout. To summarize both IQ12 and IQ13, the Residents shared their opinions regarding whether they thought their female and male colleagues experienced occupational burnout differently (IQ12). They also were asked if they felt that the female Residents were treated differently by peers and Attendings once they have shared that they are experiencing this phenomenon (IQ13).

From the responses given for IQ12, 40% responded yes, that their female and male colleagues experience the phenomenon of occupational burnout differently, and 40% responded

that they were not sure how gender impacted their colleagues' experiences of the phenomenon; 20% said no, that they did not think that gender impact how their colleagues experienced occupational burnout. In terms of IQ13, 40% of the Residents (two people) said they believed female Residents were treated differently by colleagues and leadership once they revealed they had occupational burnout. One Resident (20%) said they believed female Residents were not treated differently, and another 40% of participants (two people) said they did not know if female Residents were treated differently by their peers or Attendings if they confirmed having experienced occupational burnout.

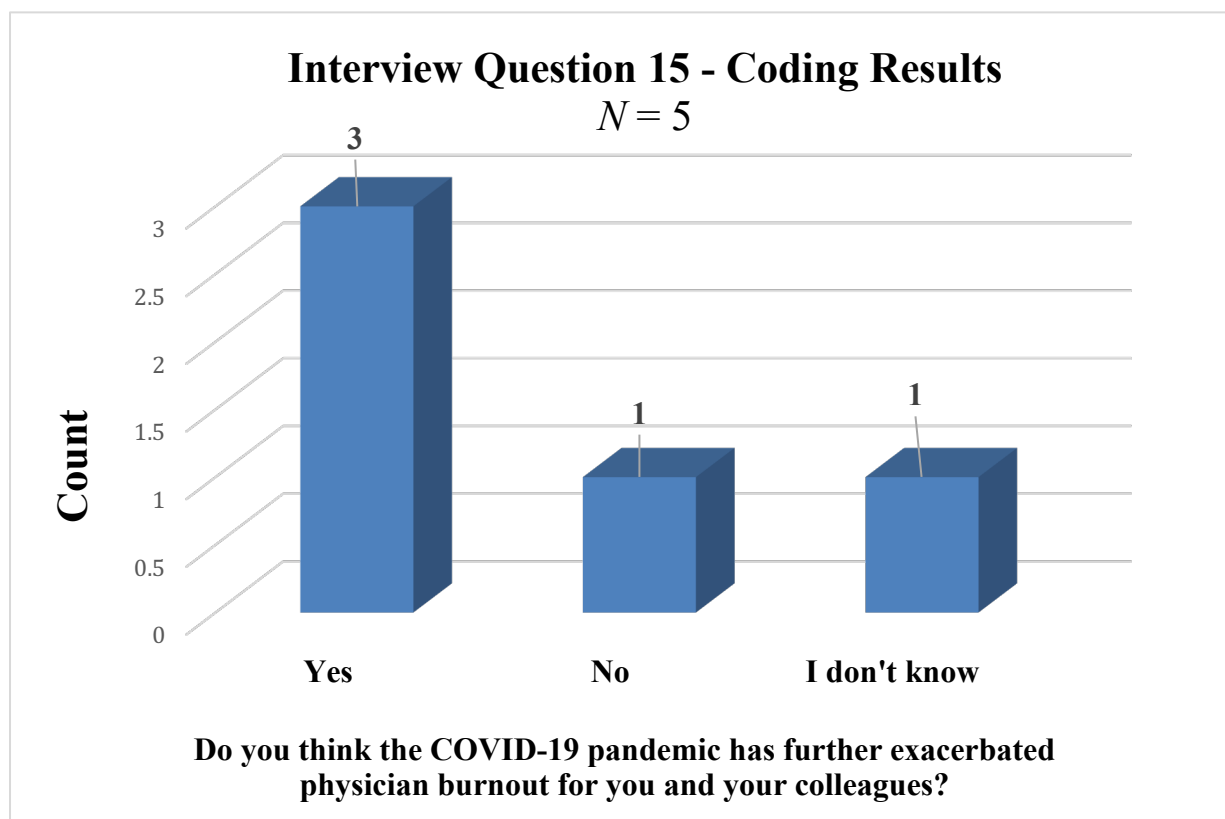
A similar perspective, to what was seen from the responses given for IQ12 and IQ13, might be seen in the peer-reviewed literature. Some of the research on physician occupational burnout suggests that female Residents' experiences and treatment by peers and Attendings differs from their male counterparts once it is known that they have experienced occupational burnout. Chapter 2 of this study highlighted how a number of research studies have considered physician occupational burnout to be a universal matter that impacts all physicians without specifically highlighting how it impacts the different genders (Meldrum, 2010). Other studies have discussed gender and physician occupational burnout in terms of participant demographics rather than to compare the impact of the phenomenon on gender (Joaquim et al., 2018), while a more limited number of studies have examined the phenomenon by tailoring the research to female physicians (Chesak et al., 2020). Thus the gap in the literature as it relates to how this phenomenon impacts female Residents Physicians, might help to explain why this issue has not been fully addressed and resolved.

Interview Question 15. The last interview question, IQ15, associated with RQ1 asked, do you think the COVID-19 pandemic has further exacerbated physician burnout for you and

your colleagues? If so, please share how. The theme for this interview question was the COVID-19 pandemic and Figure 16 showed the themes in the bar chart.

Figure 16

IQ15 Coding Results Bar Chart



According to the theme on whether or not the COVID-19 pandemic further exacerbated physician burnout, three participants (60%) said “yes,” one participant (20%) said “no,” and one participant (20%) said they were not sure or they did not know. One of the Residents, Dr. I stated, “I don’t know if COVID had exacerbated physician burnout for Residents? I started residency when the pandemic was already in full swing, so I don’t know any different.” Dr. E shared:

I think that COVID has exacerbated physician burnout because we, as Residents, have not been able to have the same social connections with our colleagues as we did before the pandemic. During my first year of Residency my colleagues and I were able to meet

up to discuss our days and challenges in residency. The pandemic has prevented us from coming together socially.

COVID-19 Pandemic. The global pandemic has impacted many different industries over the last several years. However, the industry some would say has been most affected is that of medicine as physicians have been on the frontlines of the pandemic. One group of physicians who have administered healthcare throughout the pandemic are the early-career physicians also known as Residents. Some might suggest that with the long hours that Residents have traditionally worked, the global pandemic has increased those hours and in some cases has made Residents even more susceptible to occupational burnout. As the pandemic continues, it would behoove medical organizations to continue to ascertain ways in which to mitigate the prevalence and incidence of this phenomenon such that it does not have major professional and personal repercussions for Resident Physicians.

Summary of RQ1

The purpose of the RQ1 was to examine how the female Residents described theirs and their female colleague's experiences of occupational wellness. A total of nine interview questions were asked to gain an understanding of their perceptions about occupational well-being. After analyzing the responses from the nine interview questions, 19 themes emerged. The themes were as follows: (a) enjoying residency, (b) residency is what I expected, (c) residency is stressful, (d) making positive connections with patients, (e) connecting with other Residents, (f) I see my personal growth, (g) using medical knowledge, (h) providing medical care, (i) tough work environment, (j) self-imposed expectations, (k) expectations of the residency program, (l) feelings of imposter syndrome, (m) negative self-talk, (n) feeling like you are always working, (o) dread of going to work, (p) feel on edge, (q) stigma of admitting occupational burnout, (r) gender differences in Occupational Burnout, and (s) COVID-19 pandemic.

Research Question 2

RQ2 asked, what leadership styles do female Resident Physicians perceive they are Attending Physicians exhibit? To assess their perceptions of their Attendings' leadership styles, the participants were shown a chart on the screen (Table 9) and were asked the following IQ:

- IQ 23: Please look at the chart I am sharing on the screen. What category of words would you say, in general, overall describe your Attending Physicians' leadership styles?

Interview Question 23. IQ23 required that the participants look at the Leadership Styles Chart on the screen during their Zoom meeting (see Appendix F). As shown in Table 9, the Residents were asked to identify the column of words they would attribute, in general, to their Attending Physicians' leadership styles. Four of the Resident Physicians identified their Attending Physicians' Leadership Styles as Transformational and one Resident said that she would rate the leadership styles of the Attending Physicians she worked with as Laissez-faire. Thus, the theme that emerged from IQ23 was Leadership and Leadership styles.

Table 9

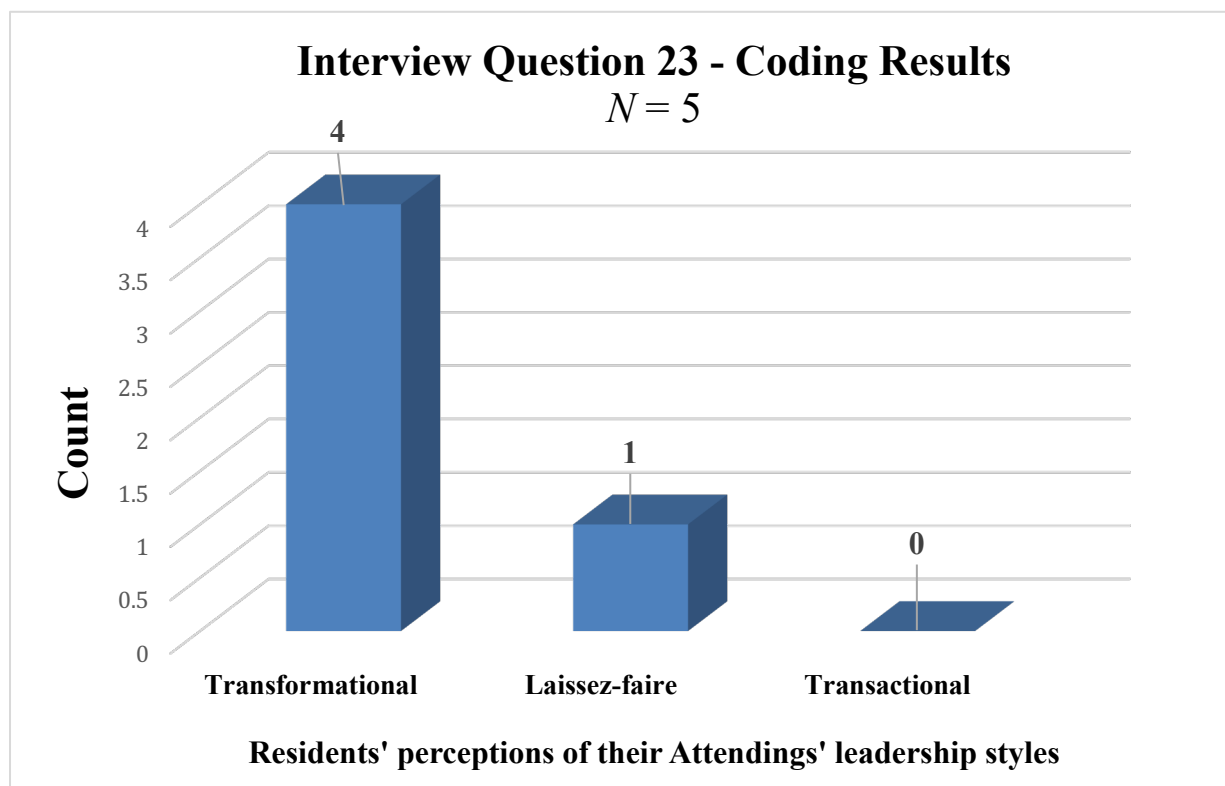
Leadership Styles Chart

Transactional Leadership Style	Transformational Leadership Style	Laissez-Faire Leadership Style
<ul style="list-style-type: none"> • Leader issues rewards based on personal ideal of performance • Micromanagement • Not Supportive • Not a Mentor • System of Negative Reinforcement • Penalizes growth 	<ul style="list-style-type: none"> • Mentors and coaches staff • Identifies a shared Vision • Offers encouragement/motivation • Encourages Growth • Vision focused • Positive feedback 	<ul style="list-style-type: none"> • Absence of leadership • Lack of leadership vision • No regular feedback is given • Not interested in growth or development of staff • No accountability • Indecisive

In addition, Figure 17 depicted the Residents' perceptions of their Attendings' leadership styles.

Figure 17

IQ23 Coding Results Bar Chart



Leadership and Leadership Styles. It is thought that a leader's leadership style can have an influence on those for whom he or she leads. In this study, the Residents leaders were defined as their Attending Physicians. The participants were asked questions about their leadership as well as about their leaders' leadership styles to gain a better understanding of the perceptions the Residents held about their Attendings. The leadership styles were determined based upon the participants' perceptions as well as the objective of this research study was to explore if the Attendings' leadership styles ameliorated or exacerbated the female Resident Physicians experience of occupational burnout.

Summary of RQ2

The purpose of Research Question 2 was to explore the Residents' perceptions of their Attending Physicians' leadership styles. The one theme that emerged from RQ2 was leadership and leadership style. Four of the female Resident Physicians affirmed that their Attendings' led using a transformational leadership style where one Resident said that she felt her Attendings led with a Laissez-faire leadership style. In general, the Residents who identified their Attendings' leadership style as transformational offered answers related to their Attendings favorably while the Resident who perceived her Attendings to have a Laissez-faire style answered questions tepidly regarding her opinions of how the Attendings cared for the occupational well-being of the Residents in her program as well as her residency program in general.

Research Question 3

RQ3 asked the female Resident Physicians, in what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout? To examine the participants' beliefs regarding how they perceived their Attending's leadership may ameliorate or exacerbate their experiences of occupational burnout, five interview questions were asked. From the analysis of the responses from the five interview questions the prevailing theme that emerged was Residents' perceptions of Attendings.

- IQ14: When you have experienced burnout, what kinds of words might describe how you have viewed your Attending Physicians' efforts to address it?
- IQ17: Have your Attending Physicians offered information on how to deal with physician wellness? If so, what type of information have they given you?
- IQ18. Have your Attending Physicians offered information on how to mitigate occupational burnout? If so, what type of information have they given you?

- IQ21: Do you feel your Attending Physicians care if you or your colleagues are experiencing occupational burnout?
- IQ22: When you have experienced occupational burnout, have you felt that you can seek support from your Attendings?

Interview Question 14. IQ14 asked, when you have experienced burnout, what kinds of words might describe how you have viewed your Attending Physicians' efforts to address it? This was the one question that seemed to cause all of the participants to pause as they tried to recall a time when they had experienced occupational burnout and the words their Attendings said to them to try to assuage the situation. In fact, two of the Residents could not recall a time when they spoke to an Attending about this matter. The other three participants offered a mixture of words and phrases they believed their Attendings might use to address if they shared that they were experiencing occupational burnout. The words that the three Residents offered were as seen in Figure 18.

Figure 18

Words Used To Describing Efforts to Address Occupational Burnout

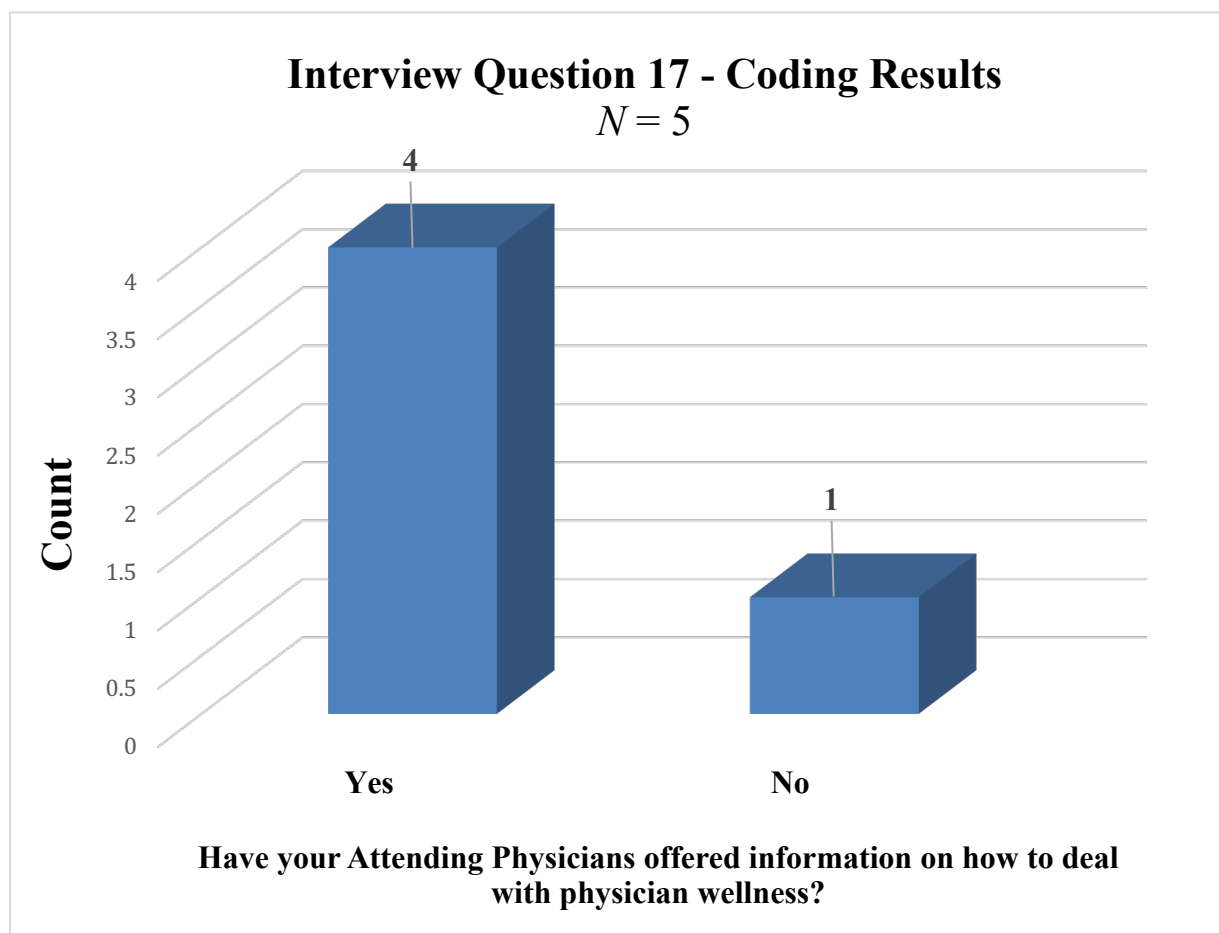


Interview Question 17. IQ17 asked the Residents, have your Attending Physicians offered information on how to deal with physician wellness? If so, what type of information have they given you? Four of the Residents stated that they have had periodic conversations with some of their Attendings about the importance of stress management activities such as exercising, mindfulness, and having self-care practices that induce wellness. Some of the participants also mentioned that their residency programs sometime offer Residents didactic

sessions on occupational burnout. The responses to IQ17 can be seen in Figure 19 which shows the bar chart with the themes.

Figure 19

IQ17 Coding Results Bar Chart



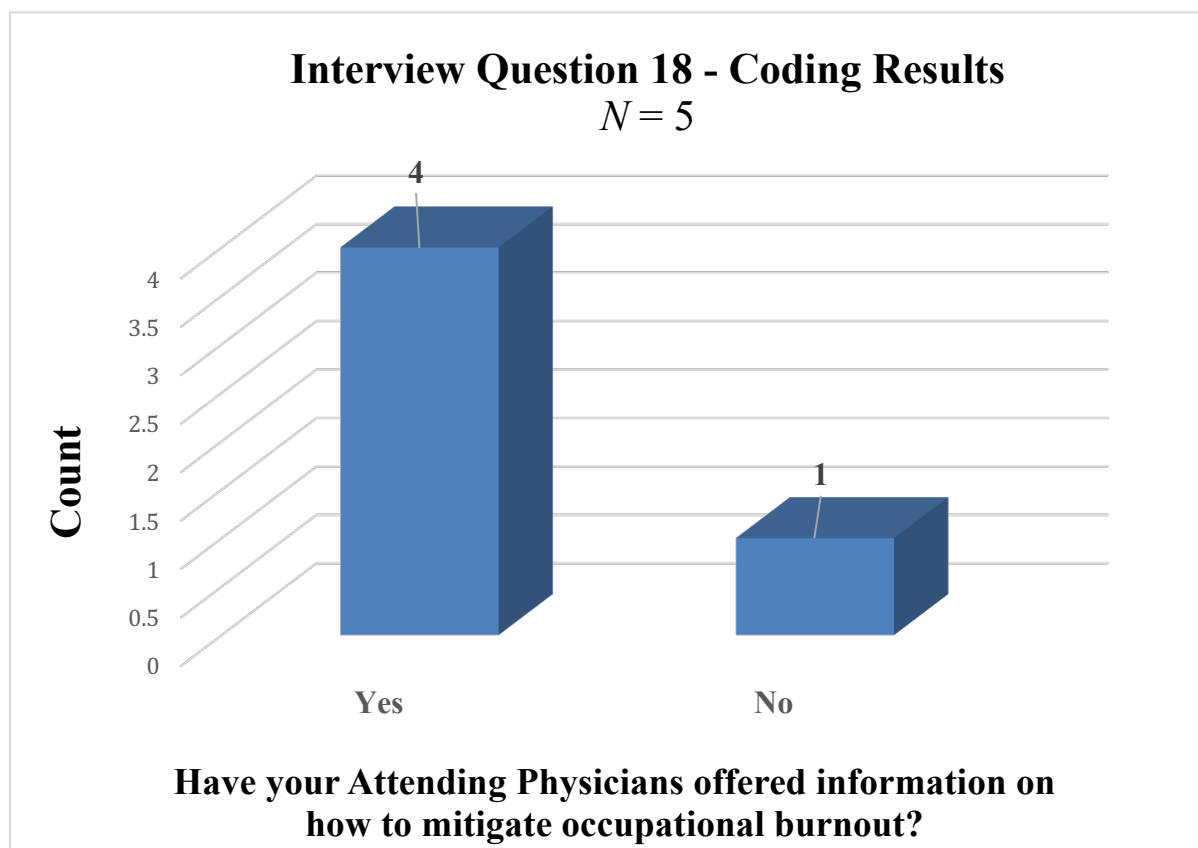
Based on the themes, Dr. D shared, “Some of my Attendings have share information on physician wellness but not all of them. They usually don’t offer a lot of information on physician wellness nor do they share how they personally handle their own wellness.”

Interview Question 18. The second interview associated with RQ3 asked the participants, have your Attending Physicians offered information on how to mitigate

occupational burnout? If so, what type of information have they given you? Figure 20 depicted the coding results as a bar chart.

Figure 20

IQ18 Coding Results Bar Chart



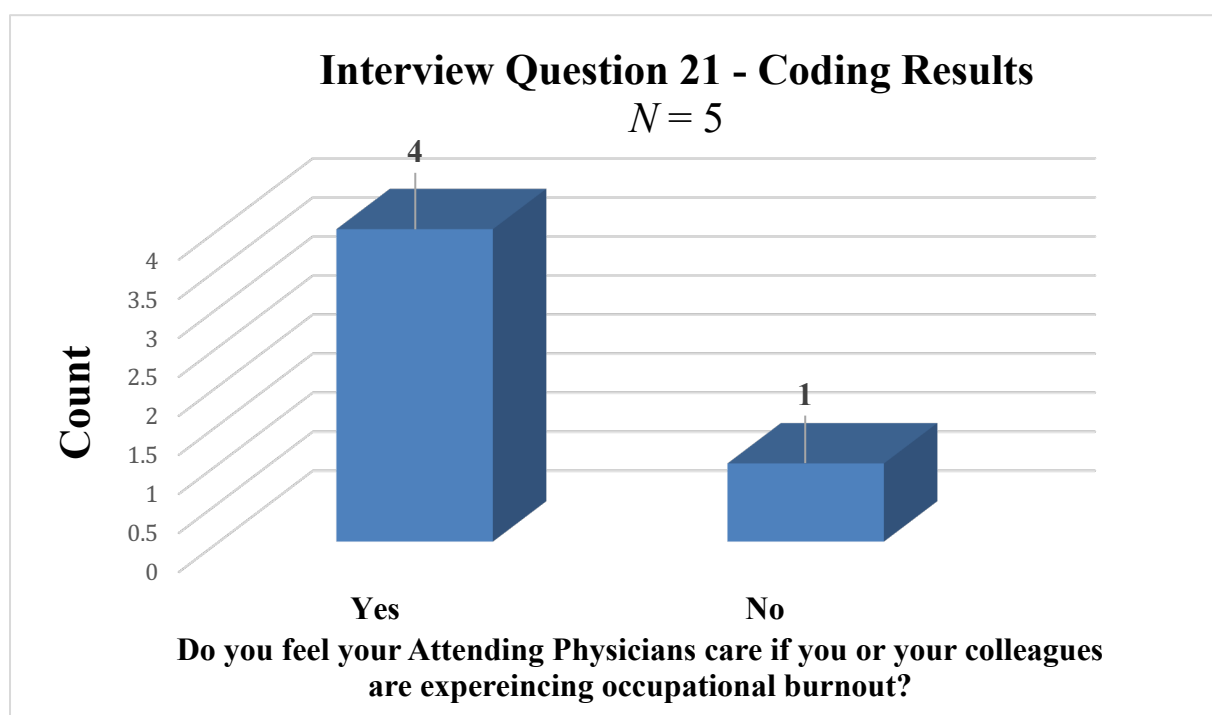
Dr. I stated, “No, they don’t offer information per se on how to mitigate burnout, they just usually deflect by saying, ‘we’ve all experienced burnout’ as if they is a rationale for it happening to us Residents.” Dr. U mentioned that the information she received from her Attendings regarding information about mitigating occupational burnout was in the annual institution-wide online, mandatory hospital wellness training. Dr. U shared:

Our Attendings encourage us each year to complete the mandatory hospital online training about wellness. The training talks about the signs associated with burnout, how many hours we should sleep each night for good health, and topics like that to build awareness.

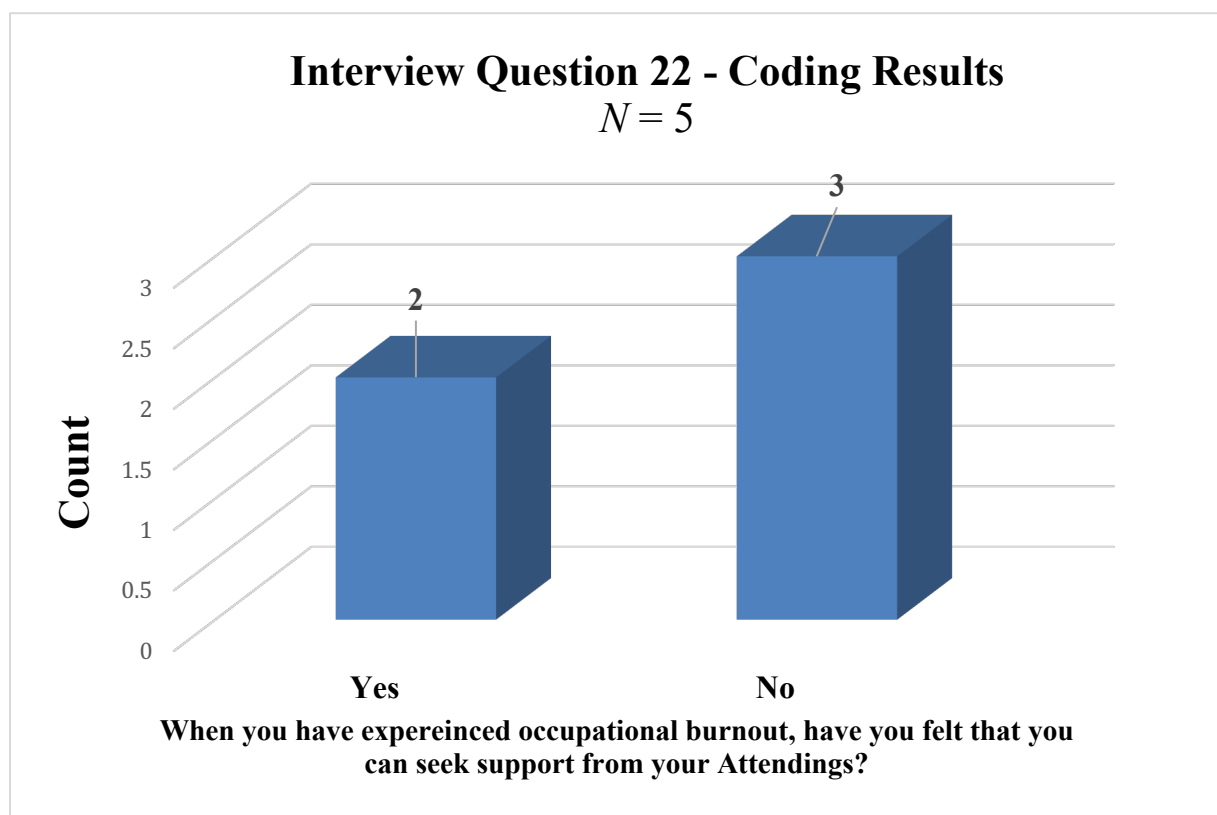
Interview Question 21. IQ21 asked each of the participants, do you feel your Attending Physicians care if you or your colleagues are experiencing occupational burnout? For instance, Dr. I shared, “I think my Attendings care. I think they are really trying to help the Residents maintain their wellness and I don’t think all residency programs try hard to do that.” The Residents’ responses to this question is seen in Figure 21.

Figure 21

IQ21 Coding Results Bar Chart



Interview Question 22. IQ22 asked the Residents, when you have experienced occupational burnout, have you felt that you can seek support from your Attendings? Two of the Residents responded yes and three of the Residents said that they did not feel like they could seek support from their Attendings when they have experienced occupational burnout. Figure 22 reflected the Residents’ responses in the form of a bar chart.

Figure 22*IQ22 Coding Results Bar Chart*

Residents' Perceptions of Attendings. Ultimately, Attending Physicians are responsible for the final medical decisions each Resident Physician makes as it relates to the clinical care of patients even though there may be a more senior Resident who may assist them as well. Thus, in terms of the leadership hierarchy the Attendings are the ones who ensure that the Residents are providing appropriate medical care. The Attending is seen as the leader over all Residents under their clinical service. As Residents understand the hierarchy they may see the Attending as not only the lead for their clinical service but also a mentor and someone for whom can provide advocacy, support, and mentorship during times of when they experience occupational burnout.

Summary of RQ3

The purpose of RQ3 was to ask female Resident Physicians their views on whether their female Resident colleagues believed their Attending Physicians' leadership styles had an impact on their experiences of occupational burnout. The researcher thought that this question might offer insight into whether the Residents believed that their Attendings leadership styles or lack thereof had any influence on how they felt at work, particularly as it related to occupational burnout. To ascertain the latter, five interview questions were asked whose purpose was to assess the Residents' opinions of how their Attendings addressed issues such as occupational burnout, the information they offered about the phenomena of wellness and burnout, as well as words they would use to describe how they view their Attending leaders. The theme that was generated from the five interview questions associated with RQ3 was Residents' perceptions of Attendings.

Research Question 4

RQ4 asked, how do female Resident Physicians cope with occupational burnout? The participants were asked two questions (IQ7 and IQ16) related to RQ4. The pervasive themes associated with the two interview questions were occupational burnout and social support. The two questions were:

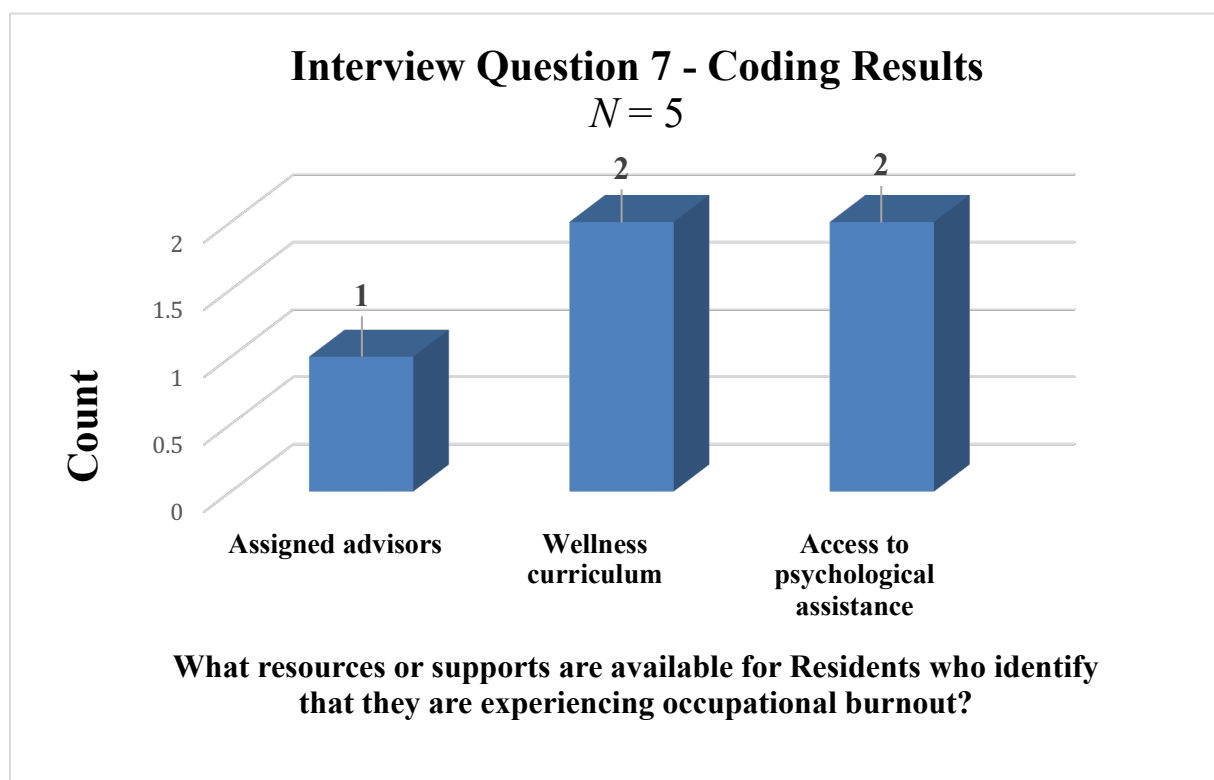
- IQ7: What resources or supports are available for Residents who identify that they are experiencing occupational burnout?
- IQ16. When you have experienced occupational burnout, have you felt that you can seek support from your colleagues?

Interview Question 7. IQ7 asked the Residents to comment on, what resources or supports are available for Residents who identify that they are experiencing occupational burnout. Overall, the participants discussed the resources they were given by the leadership of

their residency programs. Common themes were: (a) assigned advisors (one response); (b) wellness curriculum (two responses), and (c) access to psychological assistance (three responses). The bar chart in Figure 23 depicted the common themes received from the responses from IQ7.

Figure 23

IQ7 Coding Results Bar Chart



The following was information shared by two of the Residents regarding the resources or support their residency programs offered: Dr. H shared how the Residents at her program are assigned advisors:

Our program assigns us advisors or mentors who can help guide us through residency. If you're lucky, you will get an advisor who you feel comfortable talking to about your residency experience, but everyone may not feel comfortable talking to their assigned mentor.

Dr. H continued by stating that her program has a wellness curriculum:

Our residency program has developed a great wellness curriculum with a psychologist who moderates the sessions and helps to develop wellness resources. The problem is that most of us Residents do not have protected time in our daily schedules that would allow us to participate in the residency's wellness sessions. For instance, if we are on the medical wards, the sessions are from 12:30–1:30pm, and none of us can take one hour out of our schedules to attend the sessions nor does the residency program adjust our schedules so that we can do so.

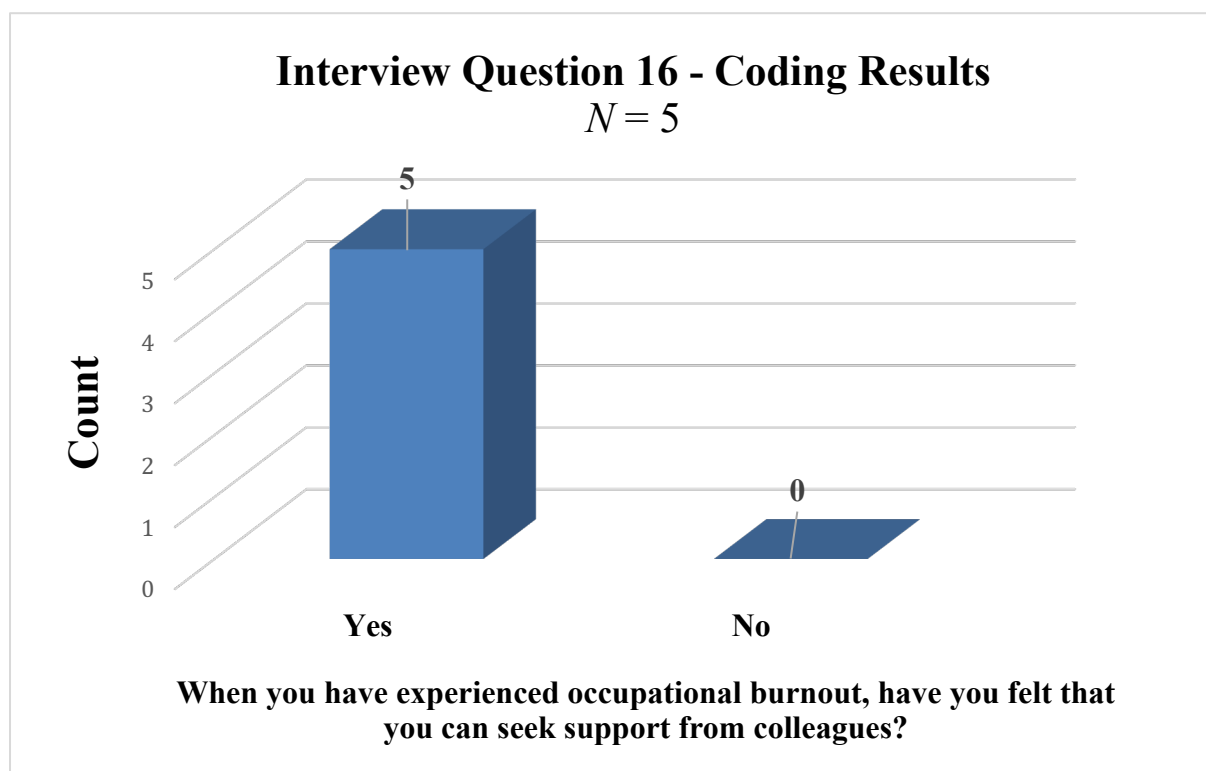
Dr. I shared that her residency program offered Residents access to psychological assistance:

I think my program lets Residents know that we have access to psychological assistance, but I have not used it when I've felt burned out because it's never really felt 100% safe to access the services because I don't want my Attendings to find out that I needed the services.

Interview Question 16. IQ16 asked, when you have experienced occupational burnout, have you felt that you can seek support from your colleagues. Probes were also included with IQ16, to generate conversation, in the event the researcher received a dichotomous “yes” or “no” answer. If the answer was “yes,” the Residents were asked, please describe the kind of peer support you received. If their response to IQ16 was “no,” they were asked to answer the following probe questions:

- Please tell me why you feel you cannot share your occupational burnout experiences with your colleagues.
- Please describe the reactions of your peers during these times.
- Do you feel your Resident colleagues are open to talking about their experiences of occupational burnout?
- Do you feel your colleagues are open to sharing how they maintain a sense of wellness during residency?

All five female Resident Physicians responded “yes” to IQ16 in that they were able to seek support from their colleagues when they experienced occupational burnout during residency. Figure 24 showed the Residents' responses to IQ16 as a bar chart.

Figure 24*IQ16 Coding Results Bar Chart*

Some of the direct quotes generated from IQ16 are listed below, and the themes from the responses are as follows: (a) talking to supportive colleagues, (b) understand our unique experience, and (c) knowing that I am not alone.

The comment Participant Dr. I shared illustrated the theme talking to supportive colleagues by stating the following:

My colleagues always offer to listen to me when I have feeling burned out. It's nice to know you have people who will just listen to you when you need them to. My colleagues know the residency experience so they understand this unique experience and won't judge me.

Dr. I continued by saying the following which elicited the theme understand our unique experience:

My colleagues always offer to listen to me when I have feeling burned out. It's nice to know you have people who will just listen to you when you need them to. Unlike other

people, my colleagues know the residency experience so they understand our unique experience and won't judge me.

Dr. H's responded as follows which highlighted the theme of knowing that I am not alone:

I appreciate being able to talk about what I'm feeling with my Co-Residents and knowing that I'm talking to someone who is not going to judge me or stigmatize me. They will validate the way I'm feeling and they will let me know that I'm not alone—that I'm not the only one having these thoughts.

Summary of RQ4

The purpose of RQ4 was to investigate the participants' insights on how female Resident Physicians cope with occupational burnout. The Residents were asked two questions related to RQ4. After the researcher analyzed the interview transcripts, it was identified that five pervasive themes emerged. The themes were: (a) occupational burnout, (b) social support, (c) assigned advisors, (d) wellness curriculum, and (e) access to psychological assistance.

Trustworthiness

The degree to which a qualitative research study is authentic or has a level of trustworthiness is dependent upon the extent to which a researcher transparently discussed the findings of the study so that they can be deemed valid or trusted (Korstjens & Moser, 2018). The four criteria by which render the findings of a qualitative study trustworthy are credibility, transferability, dependability, and confirmability (Connelly, 2016; Leigh & Fowlie, 2014; Lincoln & Guba, 1986; Morrow, 2005). This qualitative study's findings suggest its trustworthiness as verified by the criteria of credibility, transferability, dependability, or neutrality; and authenticity or reflexivity (Lincoln & Guba, 1986).

According to Lincoln and Guba (1986), credibility is defined as the confidence one has that the results and data generated from a study are in fact truthful (Lincoln & Guba, 1986). This criterion was met in this study through the strategies of prolonged engagement and persistent

observations (Korstjens & Moser, 2018). According to Korstjens and Moser (2018), prolonged engagement is a test of study rigor whereby the researcher's engagement as the qualitative interviewer is in question (Korstjens & Moser, 2018; Morrow, 2005). For instance, this criterion requires that the interviewer helps to elucidate the participants' responses by ensuring that they offer comprehensive answers to the interview questions. To ensure the latter, the interviewer would ask probing, clarifying, or reflective questions to encourage the research participant to offer examples or clarifying information to support their answers thus allowing for more robust data collection (Korstjens & Moser, 2018).

The strategy of persistent observations requires that the researcher adheres to a data analysis procedure whereby once the data is collected, the researcher promptly begins analyzing it. In the case of this study, after each interview was completed, the researcher promptly transcribed the audiotaped interview. The researcher also re-listened to the interviews and read and re-read the transcripts at least three times. While doing the latter, the notes and codes were written in the margins of the transcripts and were analyzed (Connelly, 2016; Korstjens & Moser, 2018; Leigh & Fowlie, 2014).

The second criteria of trustworthiness is transferability. This concept questions whether the study's finding can be transferred to other research settings (Korstjens & Moser, 2018; Leigh & Fowlie, 2014). For instance, only five female Resident Physicians participated in this study, thus, the transferability of the study may could be questioned if it were not for the fact that the researcher offered clear descriptive data regarding the participants, the sampling method, research setting, inclusion and exclusion criteria, and interview procedures such that the study could most likely be replicated by other researchers (Korstjens & Moser, 2018), and could

perhaps receive similar findings to those of this study of female Residents (Leigh & Fowlie, 2014).

Dependability is a criteria of trustworthiness that speaks to the whether the study's findings can be considered consistent (Korstjens & Moser, 2018; Leigh & Fowlie, 2014). In this study that examined the experiences of occupational burnout in female Residents and their perceptions of how their Attendings' leadership styles ameliorated or exacerbated their experiences, this test of study rigor dictates that for the findings to be trustworthy, the procedures used to generate the findings must be consistent with data collections methods used in hermeneutical, phenomenological studies.

In addition, to the study having a level of dependability it must also include the aspect of confirmability or neutrality for trustworthiness to exist (Korstjens & Moser, 2018; Leigh & Fowlie, 2014). In short, confirmability or neutrality requires that the researcher does not allow their positionality or opinions and perceptions of the phenomenon being studied to interfere with any of the research procedures (Korstjens & Moser, 2018). In accomplishing the latter, the researcher must ensure that their research notes before, during, and after such research procedures are comprehensive and outline all study activities in a transparent matter. In this study to adhere to neutrality, the research used memoing to maintain neutrality throughout the course of the study (Birks et al., 2008). Korstjens and Moser (2018) referred to the transparent nature of the research notes as helping to create an audit trail whereby any decisions that were made during the process of data collection or analysis are documented and readily understood.

As qualitative research usually requires that the researcher interacts in-person with the research participants, trustworthiness dictates that the interaction be one of authenticity or reflexivity (Connelly, 2016; Korstjens & Moser, 2018). This concept of trustworthiness requires

that the researcher does not include their positionality, opinions, or perceptions to dictate the findings of the research. The trustworthiness criterion of authenticity or reflexivity is a check and balance of sorts on the researcher's human inclination to subjectively offer their perspective which would compromise the trustworthiness of the research findings (Connelly, 2016; Korstjens & Moser, 2018).

Chapter Summary

Chapter 4 discussed the purpose of the hermeneutical, phenomenological qualitative research study which was to investigate whether female Resident Physicians perceived their Attending Physicians' leadership styles to ameliorate or exacerbate their experiences of occupational wellness and burnout. To examine the latter phenomenon, five female Resident Physicians were recruited to participate in a single, virtual semi-structured interview using the Zoom conferencing platform. The following four research questions guided the data collection process:

- RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?
- RQ2: What leadership styles do female Resident Physicians perceive they are Attending Physicians exhibit?
- RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?
- RQ4: How do female Resident Physicians cope with occupational burnout?

The demographic information for each Resident was shared, the interview questions are outlined as well as the data collection methods, and the findings associated with the five female Residents' experiences with occupational burnout are highlighted. Data collection was

accomplished through conducting semi-structured, virtual interviews with the Residents. The interview script consisted of 26 questions, and each interview lasted for no longer than 60 minutes. After each interview, the data was analyzed and was grouped according to the corresponding research and interview questions. Thereafter, the themes emerged from 17 of the original interview questions as it was determined by the researcher that the purpose of nine of the interview questions was to build and maintain rapport with the participants throughout the interview and therefore did not render data that was specific to any of the four research questions.

Upon collecting all of the qualitative data, the researcher transcribed the interviews and manually conducted in vivo coding to ascertain if there were any themes that emerged from the data (Saldaña, 2015). From the interviews eight overall themes emerged as follows:

- Enjoying Residency
- Occupational burnout
- Residency is stressful
- Imposter Syndrome
- Social Support
- Impact of the COVID-19 pandemic
- Overwhelmed by residency
- Attending support and Leadership Style

Upon collection reflection of the data, the data analysis process revealed that there are 19 specific themes were produced from the interview questions associated with each of the four research questions. The themes are listed in Table 10. The themes and all pertinent data generated from the study was displayed throughout the chapter using graphic illustrations. Upon

completing the data analysis process, the researcher deemed that data saturation was reached as the participants' responses to the interview questions began to repeat themselves, and that trustworthiness had been reached (Morrow, 2005). In sum, the study's data analysis process acknowledged and substantiated the study's hermeneutical approach as the data depicted the shared, lived experience of occupational burnout and wellness experienced by the five female Resident Physicians.

Table 10

Research Questions and Themes

RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?	RQ2: What leadership styles do female Resident Physicians perceive they are Attending Physicians exhibit?	RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?	RQ4: How do female Resident Physicians cope with occupational burnout?
<ul style="list-style-type: none"> • Enjoying residency • Residency is what I expected • Residency is stressful, making Positive connections with patients • Connecting with other Residents • I see my personal growth • Using medical knowledge • Providing medical care • Tough work environment • Self-imposed expectations 	Leadership and Leadership styles	Residents' perceptions of Attendings	occupational burnout social support assigned advisors wellness curriculum access to psychological assistance.

RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?	RQ2: What leadership styles do female Resident Physicians perceive they are Attending Physicians exhibit?	RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?	RQ4: How do female Resident Physicians cope with occupational burnout?
<ul style="list-style-type: none"> • Expectations of the residency • Feelings of imposter syndrome Negative self-talk • Feeling like you are always working • Dread of going to work • Feel on edge • Stigma of admitting occupational burnout • Gender differences in Occupational Burnout • COVID-19 pandemic. 			

Chapter 5: Findings

Introduction

Female physicians have the highest rates of occupational burnout (Yeluru et al., 2022). In fact, occupational burnout in female physicians is 60% greater than for male physicians. Such a staggering statistic is predicated on research that shows that female physicians have more emotional exhaustion, higher levels of depersonalization, less opportunities for mentorship and advancement in their fields, as well as a myriad of other personal and familial factors. With the increase of female students at medical schools in the United States, it is thought that there will be an increase in female physicians in residency. Thus, the need to understand why women face more occupational burnout in the field of medicine than their male counterparts is imperative (Borst & Jones, 2020; Chesak et al., 2020; Yeluru et al., 2022).

The purpose of this hermeneutical, phenomenology qualitative study was to determine if female Resident Physicians perceived the leadership styles of their Attending Physicians to ameliorate or exacerbate their experiences of occupational burnout. The study's findings evaluated the Residents' perceptions of occupational burnout and wellness, their perceptions of their residency training experience, the juxtaposition of gender and occupational well-being, leadership style, and social support. The objectives of this qualitative study were two-fold:

- to contribute to the limited literature that discusses the need to maintain work environments of wellness for female Resident Physicians,
- and the paucity of leadership literature dedicated to exploring the leadership styles of Attending Physicians that are conducive to creating a sense of well-being in medical training environments.

Study Summary

The aim of this research study was to gain an understanding of the female Resident Physicians' perceptions of their Attending Physicians' leadership styles and whether or not they believed the leadership styles of the Attending Physicians exhibited, ameliorated or exacerbated their experiences of occupational burnout. To investigate this phenomenon, a qualitative, hermeneutic phenomenological research approach was initiated for this exploration which allowed the researcher to gain a better understanding of the female Residents' perceptions of the phenomenon. It was presumed that the data from this study would contribute to the literature on physician occupational burnout as it impacts female Residents. It was also presumed that the study's findings would allow for a better understanding of the Residents' experiences of occupational burnout.

The theoretical frameworks that underpinned this study were Seligman's theory of Positive Psychology (Seligman, 2019) and Herzberg's Two-Factor Theory (Alshmemri et al., 2017; Dartey-Baah & Amoako, 2011; Soliman, 1970). The theory of Positive Psychology was used because of its focus on personal psychological well-being as influenced by the theory's PERMA tenets, which were (a) positive emotion, (b) encouragement, (c) relationships, (d) meaning, and (e) accomplishment (Kern et al., 2015). Herzberg's Two-Factor Theory (Alshmemri et al., 2017) was the second theoretical framework that guided this study because it posited that workers' perceptions of their work environment can impact their professional effectiveness, job satisfaction, and can have an influence on their experiences of occupational wellness or burnout. Thus, as Resident Physicians have a dual role in their work environments of being medical trainees of the residency program, yet they are also seen as full-time employees at the hospitals for which they train the latter theory was deemed appropriate for this exploration of

occupational well-being. Lastly, the concepts of the Full Range Theory also was used to inform the leadership component of the study as it consist of the transactional, transformational, and Laissez-faire leadership styles (Kanat-Maymon et al., 2020).

The theoretical frameworks as well as the scholarly review of the literature associated with the phenomenon of occupational burnout were used to inform the creation of the study's research questions as well as its interview questions. The study's four research questions were as follows:

- RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?
- RQ2: What leadership styles do female Resident Physicians perceive their Attending Physicians' exhibit?
- RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?
- RQ4: How do female Resident Physicians cope with occupational burnout?

Prior to conducting any research activities, the study was submitted to the IRB at Pepperdine University for review and approval of the research. Upon receiving IRB approval, recruitment of the research participants began in February 2022. To recruit the Residents to the study, the snowballing method was employed (Eland-Goossensen et al., 1997). This recruitment method allowed the Residents to refer other female Residents for whom they knew who were interested in joining the study. Those interested in participating in the study contacted the researcher, they were told about the premise of the study, and it was determined whether they met the study's criteria such that they could schedule an interview with the researcher. In keeping with the snowball sampling methodology, after the first Resident was interviewed the

researcher asked her if she knew anyone who might be interested in participating in the study, and if so, she could email the researcher to express her interest. Once the second Resident was identified she was asked to invite another Resident to participate in the study, and so on until there were no other female Resident Physicians who expressed interest in participating in the study (Eland-Goossensen et al., 1997; Marcus et al., 2017). In keeping with IRB protocol, written informed consent was obtained from each participant at the time of recruitment.

To collect the data for the study, the five female Residents each participated in a virtual, semi-structured interviews using the Zoom conferencing platform. Prior to the residents' scheduled interview date, they were sent an IRB approved consent form using DocuSign. Before starting each interview, the researcher asked the participants for their verbal consent and asked their permission to record the session. The interviewer also shared with each Resident that she could determine whether to put her Zoom camera on or not, however for purposes of transparency and to build rapport and trust, the researcher always had her camera on. Each Resident participated in a single, semi-structured interview where they were asked 26 questions. The interviews lasted no longer than 60 minutes. For participating in the interview, after the interviews conclude, each participant was emailed a thank you notes as well as an electronic \$25 Amazon gift card.

After each interview concluded, it was transcribed using the Zoom transcription function. Thereafter, the transcription was exported to Microsoft Word and printed. After each interview, the researcher also listened to the recorded audio from the interviews at least three times, while referencing the transcribed document to ensure that the audio and the transcription matched. While listening to the audio of the interview, the researcher also took additional notes to ensure that the essence of the interview was accurately captured. Upon analyzing the data from the

interviews, common themes were identified. A total of 19 themes emerged. Table 11 depicted the themes that were associated with each research question.

Table 11

Research Questions and Themes

RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?	RQ2: What leadership styles do female Resident Physicians perceive they are Attending Physicians exhibit?	RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?	RQ4: How do female Resident Physicians cope with occupational burnout?
<ul style="list-style-type: none"> • Enjoying residency • Residency is what I expected • Residency is stressful • making Positive connections with patients • Connecting with other Residents • I see my personal growth • Using medical knowledge • Providing medical care • Tough work environment • Self-imposed expectations 	Leadership and Leadership styles	Residents' perceptions of Attendings	occupational burnout social support assigned advisors wellness curriculum access to psychological assistance.

RQ1: How do women who are Resident Physicians describe their experiences of occupational well-being?	RQ2: What leadership styles do female Resident Physicians perceive they are Attending Physicians exhibit?	RQ3: In what ways do women who are Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout?	RQ4: How do female Resident Physicians cope with occupational burnout?
<ul style="list-style-type: none"> • Expectations of the residency • Feelings of imposter syndrome Negative self-talk • Feeling like you are always working • Dread of going to work • Feel on edge • Stigma of admitting occupational burnout • Gender differences in Occupational Burnout • COVID-19 pandemic. 			

Key Findings

Results for RQ1

The first research question asked the participants share how they think female Residents describe their experiences of occupational burnout. From analyzing this research question 19 themes emerged.

Discussion of RQ1. The study's first research question asked the participants to reflect on how female Residents describe occupational burnout. Nine interview questions were posed to the Residents to address RQ1. From analyzing the responses from the interview questions, the following 19 themes that emerged which are discussed below: (a) enjoying residency, (b) residency is what I expected, (c) residency is stressful, (d) making positive connections with patients, (e) connecting with other Residents, (f) I see my personal growth, (g) using medical knowledge, (h) providing medical care, (i) tough work environment, (j) self-imposed expectations, (k) expectations of the residency program, (l) feelings of imposter syndrome, (m) negative self-talk, (n) feeling like you are always working, (o) dread of going to work, (p) feel on edge, (q) stigma of admitting occupational burnout, (r) gender differences in Occupational Burnout, and (s) COVID-19 pandemic.

Enjoying Residency. Residency is the when Residents hone their clinical skills in their chosen medical specialty. According to the participants in the study, it is also a time where they are given their own patient load and assume the role of a full-fledge physician which is the culmination of the hard work they accomplished in medica school coming into fruition. Thus, 100% of the study participants affirmatively stated that they were enjoying their residency training.

Residency is What I Expected. What some of the Residents expected their residency experience to be, was not their actual reality. In fact, three of the participants shared that Residency was exactly what they expected. They expected to work long hours, have little time for anything other than residency, and knew that at times it would be challenging, whereas 40%, or two participants said that their experiences of residency were not at all what they expected. Thus, while all of the Residents shared whether residency was or was not what they had initially expected, they all agreed that it was in fact an experience that only fellow Residents could truly understand.

Residency is Stressful. The time after medical school graduation and that of becoming a fully trained clinician is called residency (Heuser et al., 2018). All five of the study participants agreed that residency is stressful. They said that on some days, residency training can also be rewarding when they have positive patient outcomes, have positive interactions with their peers; and on days when they feel efficacious at the clinical tasks they performed. A number of researchers have asserted that the stress of residency training can become so significant that it could make Residents susceptible to occupational burnout and thus cause some Residents to become dissatisfied with the job and sometimes less confident about their medical skills (Brady et al., 2017; Heuser et al., 2018).

Making Positive Connections With Patients. All of the Residents shared that they wanted to be physicians in order to help patients. Three of the Residents, or 60% stated their specialty was primary care medicine while 40% of the participants were Psychiatry Residents. Research has shown that when Residents perceive the interactions, they have with patients to be productive and positive, they view themselves as providers whose ability to connect with patients is a direct relationship to how well they perform their jobs and may serve as validation that they

chose the correct profession that could highlight their skills as such (Chesak et al., 2020; Jennings & Slavin, 2015).

Connecting With Other Residents. The participants told the researcher that residency is a time for them to hone their clinical skills, but it is also a time for them to build professional and personal rapport with other Residents. Thus, establishing and maintaining positive rapport with those for whom one works is essential in establishing occupational wellness (Chesak et al., 2020).

I See My Personal Growth. As mentioned, residency is a time for Resident Physicians to hone their clinical skills. Thus, the participants were either in their second or third years of residency. Therefore, one of them shared with the researcher how she can see how much clinical knowledge she had attained during her training.

Providing Medical Care. The participants shared that one of their main reasons for going into medicine was so that they could provide medical care to people. Thus, in residency training, each of the participants said that they each had completed at least 10 clinical rotations during residency training.

Using Medical Knowledge. The Residents shared that on a daily basis they are called upon to use their medical knowledge whether it be during a patient visit, on rounds (or presenting patient diagnosis to Co-Residents), or ordering medications, they enjoy being able to utilize their medical knowledge.

Tough Work Environment. Some of the Residents admitted that working in a hospital setting can be a daunting experience at times. One Resident mentioned that during the early part of the pandemic it was tough to work in a setting where she did not know if she could transmit the virus to someone at home. She also mentioned that during the pandemic it has sometimes

been difficult to work at her hospital because she was regularly administering care to very ill patients.

Self-Imposed Expectations. Gazelle et al. (2014) have researched physicians and found that the characteristics that are typically attributed to physicians such as being goal-driven and self-critical can cause Residents to place unrealistic goals on themselves which can make them susceptible to occupational burnout. A female Resident shared that she regularly imposed expectation on herself that sometimes led her to being successful during residency training and at other times made her susceptible to occupational burnout.

Expectations Of The Residency Program. All of the participants (100%) shared that sometimes the expectations of their residency programs can be taxing. They mentioned that the patient schedules, the need to check Inbox messages after a long workday, and the long hours they are required to work are all expectations that, at times, can be quite daunting. Research supported what the Residents shared regarding their thoughts on the expectations that are placed on the by their residency programs. For instance, Yeluru et al. (2022), conducted a study with female Physicians and found that many of them acknowledged that the clinical and non-clinical demands of their job can be challenging at times to navigate. Their research highlighted that one expectation of most hospitals is that physicians use the electronic medical record or EMR. While this innovation was thought to streamline physicians' workflows and maintain patients' records, for some physicians is it viewed as an extra expectation that competes with their direct patient care responsibilities. Yeluru et al. found that the EMR greatly increased the amount of work for physicians by adding to their non-clinical tasks. It was affirmed that for every hour of direct patient care physicians completed, with the introduction of the EMR, they spent approximately two hours doing administrative tasks for the with whom were associated they had schedule

patient appointments. The administrative tasks that Yeluru et al. identified greatly increased the time and effort physicians offered to non-clinical tasks included ordering patients' medications, answering Inbox messages, and writing medical notes for patient care visits, all of which are expectations of their jobs.

Feelings of Imposter Syndrome. Eighty percent (80%) of the study participants said they have dealt with feelings of Imposter Syndrome while in residency. Some of them spoke of not feeling like they were capable of being in a Resident Physician. Others mentioned that they often wondered if they were smart enough to be the sole clinician administering care to patients. Chen (2020) identified in her research that over 30% of all female Residents and medical students have experienced this phenomenon which is gone unchecked could make them susceptible to occupational burnout.

Negative Self-Talk. Negative self-talk often goes hand-in-hand with the previous theme of Imposter syndrome. One Resident shared that she is often conscious of her negative self-talk as it relates to her clinical knowledge. She attributed the negative self-talk to the rigors of residency training which could cause a physician to question themselves.

Feeling Like You Are Always Working. It is well-known that Resident Physicians work long hours and can often work 24–36 hour shifts at a time (Gazelle et al., 2014). Thus, some of the Residents shared with the researcher that they always felt as if they were only working and that was it. In addition, one Resident stated that by virtue of being a physician she felt as if she must read clinical diagnosis and other clinical articles, even when she is not at work. She felt that if she did not keep abreast of various clinical information, she could be unprepared for work and thus was worried about how she would look in front of her Co-Residents and supervisor.

Dread Going To Work. Due to the rigors of residency training, three participants admitted that they dread going to work someday, and one of them shared that her dread has gotten to the point that she has considered whether medicine is still in line with her career goals. Ryan and Deci (2000) acknowledged that people feel most efficacious at their jobs when they experience a sense of accomplishment or a sense of occupational well-being. If either characteristic is compromised then job dissatisfaction or dread can become prevalent.

Feel on Edge. Occupational burnout can cause a person to feel on edge. It is a phenomenon whereby people may feel overwhelmed and not prepared for their jobs. If these feelings are exacerbated, one can feel as if she is on edge and thus may be susceptible to occupational burnout (Jennings & Slavin, 2015).

Stigma Of Admitting Occupational Burnout. When asked if the Residents thought that an admission of occupational burnout was viewed as a stigma, 80% of the Residents said that they perceived admitting that one is experiencing occupational burnout is a stigma. Their response to this question might possibly offer some insight on why the phenomenon of physician occupational burnout is said to be a global matter (Editorial, 2019). Perhaps, it has reached global levels because there may be a perception that if a Resident or Attending Physician is impacted by occupational burnout then that person is incapable for doing their jobs (Gazelle et al., 2014).

Gender Differences in Occupational Burnout. Kane (2020) affirmed that gender does influence the incidence of occupational burnout and it manifests itself differently for men and women. Kane also stated that the impact occupational burnout has on female physicians may cause them to feel less self-efficacious at their jobs, cause decreased feelings of job satisfaction; and can also impact their physical and mental health.

COVID-19 Pandemic. The global pandemic has had a tremendous toll on the medical profession. Two groups of clinicians who have felt the brunt of the ramifications of COVID are Resident Physicians as well as primary care physicians (Kwon et al., 2020). All of the research participants commented during their interviews on how the COVID-19 pandemic has impacted their residency training. Some of them shared that because of COVID, they have administered care to very ill patients, that they have noticed how it has changed the scope of the residency curriculum, and others said that because of the seriousness of the pandemic their overall work climate has induced more stress than normal. In addition to all of the other potential factors that could impact the residency training environment, the Residents shared with the researcher that COVID has in fact been one of the main occupational stressors that has induced occupational burnout.

Summary of RQ1. Studies have shown that occupational burnout can impact female Residents differently than their male colleagues (Chesak et al, 2020). It is thought that the phenomenon of occupational burnout may manifest itself differently according to gender because the stressors that may induce occupational burnout in female Residents may be different than those that produce occupational burnout in their male counterparts (Chesak et al., 2020; Yeluru et al., 2022). Therefore, this study's first research question's objective was to try to understand how female Residents described their colleagues' as well as their own experiences of occupational wellness and burnout. Nine interview questions were asked to garner responses. After analyzing the responses, a total of nineteen themes emerged for RQ1. The themes highlighted the various descriptions offered from the female Residents. As the themes were generated through the lens of the Residents it became apparent the some of them identified the same stressors, while some identified different ones. The findings suggested that similar to the

literature outlined in Chapter 2, the factors associated with this phenomenon are vast , and therefore require individual, organizational, and systemic strategies to ameliorate, rather than exacerbate, occupational burnout for female Resident Physicians.

Results for RQ2

The second Research Question assessed the Residents' ability to identify the leadership styles their Attending Physicians exhibit. From the analysis of this research question, one theme emerged: Leadership and Leadership Style.

Discussion of RQ2. According to Stoller (2017), the leadership styles of Attending Physicians can have a tremendous impact on the training experiences of Resident Physicians which can have a lasting impact on their careers. RQ2 asked the Residents to reflect on the concept of leadership as it related to the Attending Physicians with whom they worked. In particular, the researcher was interested in learning which of the three leadership styles, transactional, transformational, or Laissez-faire, they attributed to their Attending Physicians. The Residents were asked to review the characteristics listed in Table 12, and to determine which column contained words that best described how they perceive their Attendings' leadership. Four out of five (80%) Residents said that their Attendings led by using Transformational Leadership.

Table 12

Leadership Styles Chart

Transactional Leadership Style	Transformational Leadership Style	Laissez-Faire Leadership Style
<ul style="list-style-type: none"> • Leader issues rewards based on personal ideal of performance • Micromanagement • Not Supportive • Not a Mentor 	<ul style="list-style-type: none"> • Mentors and coaches staff • Identifies a shared Vision • Offers encouragement/motivational • Encourages Growth • Vision focused • Positive feedback 	<ul style="list-style-type: none"> • Absence of leadership • Lack of leadership vision • No regular feedback is given • Not interested in growth or

Transactional Leadership Style	Transformational Leadership Style	Laissez-Faire Leadership Style
<ul style="list-style-type: none"> • System of Negative Reinforcement • Penalizes growth 		<ul style="list-style-type: none"> • development of staff • No accountability • Indecisive

Summary of RQ2. The following theme summarized the answers found for RQ2.

Leadership And Leadership Styles. Having leaders for whom can extrinsically motivate their followers to succeed at their tasks are thought to be support of occupational environments that support wellness (Bono et al., 2007; Shanafelt & Noseworthy, 2017). In terms of Attending Physicians, the participants of this study shared that leaders who were identified as those who led using a transformational leadership style, offered the Residents information about occupational wellness and burnout and were perceived as caring about the Residents well-being. The Resident who perceived that the majority of the Attendings she interacted with led using the Laissez-faire leadership style, saw her Attendings as not showing the kind of interest she deemed appropriate of leaders who were interested in the occupational growth and well-being of Residents.

After analyzing the data regarding the participants' views about their Attending Physicians' leadership styles, it bears to mind that just because someone has a role that is indicative of leadership does not mean that they are a true leader. For instance, in some hospitals Attending Physicians hold leadership titles, however, they may not have what some people perceive to be leadership skills. Thus, the leadership styles they exhibit with those for whom they lead may not be optimal or even effective. On the other hand, there are a number of physicians for whom hold leadership roles who are consummate, authentic leaders. These physicians are those who are self-aware and have an understanding or vision that enables those for whom they lead to thrive.

Results for RQ3

The third Research Question's objective was to examine whether the female Residents' believed their Attending Physicians' leadership styles could contribute to their occupational burnout. From the analysis of this research question, one theme emerged, and this was the Residents' perceptions of Attendings.

Discussion of RQ3. RQ3 asked each Resident to offer her opinion of their Attending Physicians' leadership styles and if she thought the leadership styles proved to ameliorate or exacerbate female Residents' experiences of occupational burnout. Five interview questions were asked to assist in garnering the participants' thoughts. From analyzing the participants' responses, the theme, Residents' perceptions of Attendings, emerged.

Residents' Perceptions Of Attendings. The Residents were asked to offer their perceptions of their Attendings' leadership styles focused on their personal interactions with them. For instance, they were asked to share the words they would use to describe the ways in which their Attendings offered their support when they addressed matters of occupational burnout or wellness. The graphic in Figure 25 displayed the words offered by the three Residents who offered a response to the question.

Figure 25

Words Described to Address Occupational Burnout by Attendings



Summary of RQ3. The words that the Residents offered were ones of support and encouragement thus sharing that the Attendings genuinely wanted to help them to maintain a sense of occupational wellness, or even to alleviate feelings of occupational burnout. Although the Residents were able to identify positive words to describe their perceptions of how their Attendings' addressed occupational burnout, they had some difficulty expressing a time when they recalled feeling comfortable approaching their Attendings when they needed support when they experienced occupational burnout. In fact, 40% of the respondents, or two Residents, shared that they had not ever approached an Attending to seek support when they felt challenged in their

work environments or were experiencing occupational burnout. Conclusions cannot be drawn from the latter as it is unclear if the Residents felt uncomfortable because they preferred to keep their feelings private and not share them at work. If they did not feel as if they knew the Attending well enough to share their feelings with them, or if their work responsibilities precluded them from taking the time to have a discussion with their Attending, this could be a reason. Thus, the responses offered may not be a true reflection of the Attending being unapproachable, nor can it be seen as a commentary necessary of how the Resident truly perceived the Attending. It could perhaps be merely a circumstance of what was transpiring at the time which prevented the Resident and Attending Physicians from communicating with one another through the necessary channels.

Results of RQ4

The fourth research question's aim was to surmise the various coping strategies the female Resident Physicians during times when they experienced occupational burnout. From this research questions, five distinct themes emerged: occupational burnout, social support, assigned advisors, wellness curriculum, and access to psychological assistance. Each of the five themes generated by RQ4 are discussed below.

Discussion of RQ4. The study's last research question asked the participants to reflect on the types of coping mechanism they and their female Co-Residents used to mitigate the effects of occupational burnout. Two interview questions were posed to Residents to assess the resources they used as well as the social support they employed when they experienced occupational burnout. The themes that emerged from analyzing the responses from the interview questions were: (a) occupational burnout, (b) social support, (c) assigned advisors, (d) wellness curriculum, and (e) access to psychological assistance.

Occupational Burnout. McClafferty and Brown (2014) acknowledged that the well-being of Residents is imperative to their productivity at work. When Residents are overcome with occupational burnout, research has shown that not only are the Residents directly impacted by this phenomenon, but the patients for whom they administer healthcare are, unknowingly, and directly impacted by it as well. According to McClafferty and Brown, research has shown that an observed effect of occupational burnout could result in poor patient outcomes.

Social Support. Having the support of one's peers could be instrumental in helping to overcome challenges as well as help them to maintain a sense of wellness. Sochos et al. (2012) affirmed the latter through their research on physician wellness where they found that when physicians identified colleagues for whom they could garner social support they were less likely to experience occupational burnout. Thus, the participants of this study shared that knowing that their Co-Residents offered them social support during times when they felt burned or overwhelmed gave them comfort. All of the Residents who participated in the study stated that their peers proved to be sources of social support for them often; and a number of the participants said that it was the comradery they established with their cohort of Residents that has made the experience of residency more tolerable.

Assigned Advisors. One of the female Residents shared that her residency program assigns Residents an advisor. The advisors are also physicians, and they are seen as mentors to the Residents. The advisors are randomly selected for the Residents therefore it is not guaranteed that the Resident and physician advisor will build the type of rapport that would afford the Residents the necessary comfortability for them to feel as if they can share that they are experiencing occupational burnout. On the other hand, the Resident shared that she and her advisor had formed a relationship whereby she felt she could share both professional and

personal successes and challenges. She mentioned that she felt fortunate to have someone at work, who was more senior in their career than she, to talk to and for whom she could receive feedback or guidance if needed.

Wellness Curriculum. A participant mentioned that the hospital where she worked issued an annual, mandatory online wellness curriculum. She mentioned that it was considered an institutional policy for all staff in the hospital to take this training, so it did not seem tailored to Resident Physicians. She shared that while she thought it was a good idea to have such a training for hospital workers, because anyone could be susceptible to occupational burnout, she would prefer to have a resource that was specialized to the occupational stressors found in residency training.

Access to Psychological Assistance. Two of the Residents stated that their residency programs offered sessions with a psychologist for Residents who were experiencing the effects of occupational burnout. They shared that initially they thought that this resource was an effective way of helping the Residents. However, as they experienced occupational burnout themselves, they found that they could not schedule sessions to speak to the psychologist because their work schedules precluded them from doing so. They shared that although the residency program offered this resource, it was not offered at times when Residents could use the service. They also said that the residency program did not create protected time for Residents to meet with the psychologists. Resources are more helpful for those for whom need to utilize them if they are available for to them and from what the Residents shared the latter was often not the case.

Summary of RQ4. The participants were asked to share how they handle the impact of occupational burnout. They were asked to identify the type of resources or social support they

found to be helpful during those times. The predominant themes that emerged were: occupational burnout, social support, assigned advisors, wellness curriculum, and access to psychological assistance. The shared that when experiencing occupational burnout, they have found that their Co-Residents, both male and female, have helped them to feel better or even distract them temporarily from the stressors that were bothering them. They identified that their Co-Residents were vital to helping to assuage their feelings of occupational burnout because they felt that their colleagues understood what they were going through because they all were in the same proverbial boat. They found comfort in knowing that at times when they were feeling the stress of their work, there were people for whom got it and understood exactly what they were experiencing. The responses the Residents offered were congruent with those found in the literature discussed in Chapter 2 concerning Residents and social support. In short, a number of articles in the literature review highlighted how when Resident Physicians feel a sense of comradery with their Co-Residents, research has found that they have an increased sense of occupational wellness as well as feel more efficacious in their roles (Chilton, 2017; Kern et al., 2015; McClafferty & Brown, 2014; Monteiro et al., 2020).

All of the Residents shared that their family members provided them with support. They shared with the researcher that they valued being able to speak to their family members for whom they knew where some of their biggest fans so to speak and knew them for who they were rather than for what profession they held. In short, in times when they felt the stress of being a physician, they shared that their families offered them unconditional love and support.

Trustworthiness

In qualitative research, trustworthiness supports the authenticity of the research procedures as well as the extent to which the study's findings can be considered valid (Korstjens

& Moser, 2018). This qualitative study used the following criteria of trustworthiness can be used to verify the study's findings: credibility, transferability, dependability, or neutrality; and authenticity or reflexivity (Connelly, 2016; Leigh & Fowlie, 2014; Lincoln & Guba, 1986; Morrow, 2005). The findings have credibility through the concepts of prolonged engagement and persistent observations, thus the researcher ensured that some of the interview questions incorporated probes or clarifying questions as well as reflective questions to elicit data and to ensure that the participants offered full responses (Korstjens & Moser, 2018; Morrow, 2005). The criteria of transferability was also incorporated in this study to ensure trustworthiness. Transferability measures for the study included clear descriptions of the study's methodology, procedures, sample, and findings such that the study could be replicated with the same or a similar population (Korstjens & Moser, 2018; Leigh & Fowlie, 2014).

Dependability is a criterion of trustworthiness that guided the study to ensure that the findings were consistent (Korstjens & Moser, 2018; Leigh & Fowlie, 2014). In this study the experiences of occupational burnout shared by the female Residents as well as their opinions of their used a data collection method, the semi-structured interviews, that were consistent with qualitative, hermeneutic, phenomenological research methods and thus established trustworthiness for the study. The study could also be deemed to have dependability because it had neutrality or confirmability due to the memos the researcher wrote before, during, and after each interview to were detailed and comprehensive as trustworthiness was established and maintained throughout the data collection and analysis processes (Korstjens & Moser, 2018). Lastly, trustworthiness was maintained because the researcher ensured that her positionality did not interfere in the research process (Korstjens & Moser, 2018).

Data Saturation

The hermeneutic, phenomenology qualitative study was designed such that the data collection method was in-person, virtual interviews. There were five research participants, or five female Resident Physicians, who participated in the study. One semi-structured interview was conducted with each Resident. The interview script had 26 questions and the questions consisted of probes to garner complete and robust responses. All of the interview questions were asked of each participant, and there were not any questions omitted from the script. Therefore, all five Residents answered all of the questions.

Upon analyzing and coding the responses from the interviews, 19 themes emerged, and it was noted by the researcher that many of the responses offered by the five Residents were the same if not similar in scope, thus it was observed that the codes were being replicated due to the duplication of the responses (Fusch & Ness, 2015). According to Fusch and Ness (2015), data saturation as it relates to qualitative research studies is not dependent on the quantity but the quality of the data nor the sample size. If the data is able to be replicated, and there no new themes or codes are produced from the analysis, then the data has reached saturation.

After each of the interviews concluded, the researcher transcribed the recorder session and begin to analyze the data. After the transcript of the fourth transcribed interview was coded and analyzed, the researcher noticed that the emergence of themes had declined. By the time the fifth interview transcript was analyzed, the researcher determined that the qualitative study had reached data saturation as observed by the duplicative responses offered by the Residents (Fusch & Ness, 2015). Thus, data saturation for this hermeneutic, phenomenological qualitative research study was reached with a sample size of five participants.

Study Conclusions

The lack of literature on occupational burnout experienced by female Residents warrants a deeper investigation on their training experience. In addition, the gap in the literature concerning how female Residents perceive their Attendings' leadership styles may contribute to their overall experience of occupational wellness or burnout is also needed. Therefore, a qualitative, hermeneutic, phenomenological, cross-sectional study was conducted to determine if in fact there was a shared experience amongst female Resident Physicians as it relates to this phenomenon. From this study three conclusions were drawn:

- Female Resident Physicians' experiences of occupational well-being are similar due to the occupational settings in which they occupy.
- Women who are Resident Physicians who train in the western United States have similar experiences of occupational well-being.
- Some of the ways that female Resident Physicians believe their Attending Physicians' leadership styles impact their experiences of occupational burnout include: sharing information with them concerning resources to mitigate occupational burnout, creating safe spaces for them to share that they experience occupational burnout; and creating protected time during their work shifts to seek help.
- Female Resident Physicians cope with occupational burnout by connecting with individuals from their social network such as Co-Residents, family members, and Attending Physicians who they have been identified as being receptive to offering the needed assistance.

Implications for Scholarship

The results of this research study are congruent with the literature in Chapter 2 that espoused that occupational burnout for female Residents is not only prevalent but that it can have a great impact on them professionally and personally (Brady et al., 2017; Gazelle et al., 2014; Rout, 1999). In Chapter 2, the literature review discussed the implications associated with this phenomenon in general as well as how Attending Physicians might assuage or intensify the phenomenon of burnout. Lastly, the literature in Chapter 2 discussed the positive impact social support had on the phenomenon of occupational well-being and burnout for physicians (Chilton, 2017; Gurt et al., 2011; Stoller, 2017), which was echoed by all five of the study participants. In general, all of the Residents mentioned that it was their family, friends, and Co-Residents who they considered offered them the most social support as they navigated through residency. Thus, the results from this study may be used to further research the impact social support has on the residency experiences of female physicians.

An unexpected result from this study, that warrants further research, was the acknowledgement of some of the research participants of having experienced Imposter Syndrome as physicians (Chen, 2020). While this syndrome was described by the Residents as the reason they questioned their skills, intelligence, and professional acuity, the literature in Chapter 2 gave a very different portrayal of the physician persona that led to occupational burnout. In short, the literature in Chapter 2 acknowledged that feelings of perfectionism, not that of feelings of being an imposter in their field, is what was attributed to their experiences of occupational burnout (Brooks et al., 2018). In fact, the literature reviewed shared that physicians were often thought to be very astute in their knowledge regarding the delivery of healthcare (Cranley et al., 2016; Wallace et al., 2009), yet this was not how some of the female study

participants characterized themselves. In fact, some of the research participants acknowledged that even prior to having experienced occupational burnout, they questioned their skills and intelligence as physicians. Thus, the results from this study indicate that there is an opportunity for further research on the topic of female Resident Physicians and Imposter Syndrome, and of how this psychological phenomenon impacts female Resident Physicians on a larger scale.

Study Limitations

With all research studies, there are limitations, and this study is no different. It could be surmised that the limitations of this qualitative study were as follows:

- The small sample size for the study was a sample size of five. In the United States, the number of female Resident Physicians is in the thousands (Kane, 2020). Therefore, the most apparent study limitation is that the small sample size does not render the results of this study generalizable to the overall population of female Residents.
- The Residents who participated in the study happened to all be in residency programs in the Western United States. Thus, the assumed regional similarity that exists between the study participants, might be thought to limit the data that may be gathered on the phenomenon being investigated. Presumably, enrolling Residents in the study from different regions of the country would make for a more diverse sample.
- The pandemic could also be considered a limitation to the study because it may have impacted the more Residents from participating in the study, thus contributing to the aforementioned small sample size.

- As the topic of physician occupational burnout is still somewhat taboo, the manner in which the data was collected, through virtual interviews, may have precluded some Residents from participating who may have preferred to remain anonymous. Therefore, perhaps a limitation might be the qualitative design of the study. It could be argued that more data may have been collected had the researcher designed a quantitative study that used an anonymous survey to gather the data.

Recommendations for Future Research

Investigating occupational wellness and burnout in female Resident Physicians is a topic where a gap in the literature exists. Therefore, the ability to conduct both quantitative and qualitative research studies on this phenomenon is endless. Some recommendations for future research would include the following:

- Researching the differences in experiences of occupational burnout between female Residents who began residency before the pandemic and those who started residency during the pandemic to determine if there exists a difference in the Residents' experiences of occupational burnout.
- Researching various self-care activities that are conducted to maintain a sense of wellness amongst female Resident Physicians during training.
- Conducting a qualitative study of female Residents who self-identify as women of color and what their experience of residency has entailed.
- Investigating Attending Physicians' perceptions of their personal leadership styles and how they perceive their styles to impact the training experience of Residents.
- Researching the differences in experiences of occupational burnout and wellness amongst female Residents by specialty.

Closing Comments: The Researcher's Perspective

Occupational burnout is said to be a symptom of poor organizational management of human resources rather than poor personal management on the part of those resources. After having researched this topic for some time, I would have to agree with the previous statement. The thought that over 50% of all practicing physicians in the United States have occupational burnout is not only a national issue, but also a healthcare crisis that requires attention at the systemic level (Shanafelt & Noseworthy, 2017), and as a consumer of healthcare, it is frightening to know that occupational burnout is so prevalent.

The research espouses that many of the strategies employed to mitigate burnout are focused on the individual. Rather I understand the rationale for the latter, I might propose that perhaps taking an individual, organizational, and a systemic approach might yield more options for addressing this phenomenon. It is a plausible solution to try to resolve occupational burnout by assuaging the factors that may have contributed to Residents' personal experiences of the phenomenon. It may also be plausible to create organizational solutions to mitigate the repercussions of this issue however to merely tackle this global issue from the aforementioned standpoints may not yield the anticipated results. For instance, to try to resolve the matter from an organizational approach may not yield a comprehensive solution for all teaching hospitals but may just for those who have Residents who identify similar occupational stressors that perhaps precipitated the decrease in their occupational well-being that may be incongruent with another organization.

Thus, to create solutions to mitigate this phenomenon systematically, meaning through the national healthcare system, may be more beneficial, yet a daunting task, however, necessary. According to Fainstad et al. (2022), no solution has produced longevity in assuaging this matter.

Hospitals and other organizations in which employ physicians have tried to offer them better salaries, flexible or reduced hours, and promises of less paperwork and interaction with the electronic medical record, yet this phenomenon not only persists but has increased exponentially.

It was a wonderful learning experience to interview the five female Resident Physicians. For them to have shared their stories with me, a stranger, was a gift. Being a physician, let alone a female Resident Physician, is no small undertaking that requires skill, dedication, and selfless quality that many people would not for their jobs. It was hoped that the results of this hermeneutic, phenomenological qualitative study could contribute to the research on physician occupational burnout in two ways:

- to assist in highlighting the shared and lived experience of occupational burnout amongst female Resident Physicians, and
- to help to identify the leadership styles of Attending Physicians, as perceived by female Resident Physicians, that might aid in ameliorating or exacerbating the experiences of occupational burnout and wellness for female Residents.

It was thought that such an understanding of this critical phenomenon could perhaps assist in mitigating experiences of occupational burnout for female Residents and could offer medical leaders insight on how to implement policies and procedures to assuage this global phenomenon.

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APPENDIX A
CITI Certification



Completion Date 16-Jun-2020
Expiration Date 14-Jun-2030
Record ID 36795799

This is to certify that:

Tabia Richardson

Has completed the following CITI Program course:

Human Research
(Curriculum Group)
Biomedical Investigators and Key Personnel.
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Cedars-Sinai Medical Center - Los Angeles, CA

Not valid for renewal of certification through CME.



Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wc3af21db-389e-4950-8c9f-da49497a9d6a-36795799

APPENDIX B

IRB Approval Notice

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: December 07, 2021

Protocol Investigator Name: Tabia Richardson

Protocol #: 21-06-1615

Project Title: A Diagnosis of Wellness or Burnout: A Phenomenological Study Exploring Women Residents' Perceptions of Their Personal Experienced with Occupational Well-being and their Attending Physicians' Leadership Styles,

School: Graduate School of Education and Psychology

Dear Tabia Richardson:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today December 07, 2021, and expires on December 06, 2022.

The consent form included in this protocol is considered final and has been approved by the IRB. You can only use copies of the consent that have been approved by the IRB to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond December 06, 2022, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research

APPENDIX C

Recruitment Script

Dear [Name],

My name is Tabia Richardson, and I am a doctoral student in the Graduate School of Education and Psychology at Pepperdine University. I am conducting a research study examining the experience of burnout in Women Resident Physicians and you are invited to participate in the study. If you agree, you are invited to participate in a virtual Zoom interview.

The interview is anticipated to take no more than 45 minutes to 1-hour.

Participation in this study is voluntary. Your identity as a participant will remain confidential during and after the study. To protect your confidentiality, your name and all data collected will be de-identified and will be assigned a non-identifying participant number. All data will be securely stored on a password protected computer that will only be accessed by the researcher. If you have questions or would like to participate, please contact me by email.

Thank you for your participation,

Tabia Richardson
Pepperdine University
Graduate School of Education and Psychology
Doctoral Student

APPENDIX D

Informed Consent Form

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES**IRB #: 21-06-1615**

Participant Study Title: A Diagnosis of Wellness or Burnout: A Phenomenological Study Exploring Women Residents' Perceptions of their Personal Experiences with Occupational Well-being and their Attending Physicians' Leadership Styles

Authorized Study Personnel

Principal Investigator: Tabia Richardson, MPH

Key Information:

If you agree to participate in this study, the project will involve:

- Women between the ages of 19-90.
- One virtual, Zoom interview. Each Zoom interview will require a passcode to enter into the virtual interview platform.
- The virtual interview will take no longer than 1-hour, and a break will be given at the 30-minute mark of the interview.
- Should a participant experience fatigue, she will be asked if she would like to take a break in the interview process and/or if she would like to discontinue the interview all together.
- Minimal risks associated with this study
- You will be paid a \$25 Amazon gift card for your participation
- You will be provided a copy of this consent form

Invitation

My name is Tabia Richardson and I am a doctoral student at Pepperdine University. I am conducting a qualitative study titled, A Diagnosis of Wellness or Burnout: A Phenomenological Study Exploring Women Residents' Perceptions of their Personal Experiences with Occupational Well-being and their Attending Physicians' Leadership Styles. You are invited to take part in this research study if you are 19 years of age or older, self-identify as a women, have graduated from a school of medicine with either an MD or DO degree, are currently a Resident Physician, and have identified that you have experienced occupational burnout as a result of being a Resident. The information in this form is meant to help you decide whether or not to participate. If you have any questions, please ask.

Why are you being asked to be in this research study?

You are being asked to be in this study because you are a Resident Physician who has identified that you have experienced occupational burnout as a result of training in a medical residency program.

What is the reason for doing this research study?

The purpose of this research study is to better understand physician burnout as experienced by Women Resident Physicians and if they perceive their Attending Physicians' leadership style may have a positive or negative impact on their personal experience with burnout. The results of this study will contribute to the limited information on how residency training impacts Women Residents.

What will be done during this research study?

You will be asked to complete a virtual Zoom interview with the researcher that will be no longer than 1 hour. At the 30-minute mark in the interview, you will be asked if you would like to take a break. You will be asked to complete a brief demographics questionnaire prior to the interview.

How will my data be used?

Results from this study will be used to contribute to the limited research on Women Residents' experience with burnout. It will also share the experiences they may have with their Attending Physicians and the perceived leadership styles the Residents believe are most helpful in assuaging and mitigating burnout, and the perceived leadership styles that may exacerbate burnout. As this is a minimal risk study, it is anticipated that the benefits will outweigh the risk, and the contribution it will make will be notable.

Your data will not be sent to researchers outside of Pepperdine. Any personal information that could identify you will be removed and will not be shared.

What are the possible risks of being in this research study?

This research presents minimal risk. Fatigue or boredom are risks of participation, therefore, half way through the interview (at the 30-minute mark) the researcher will ask if you would like to take a break and/or if you would like to discontinue your participation in the interview.

Additionally, recollecting experiences of burnout or unpleasant residency experiences may cause you to feel emotional and/or psychological distress because the surveys involve sensitive questions about your work experience. In case of any emotional and/or psychological distress, the following telephone numbers of mental health services are provided:

National Alliance on Mental Health (NAMI) Hotline

1-800-950-NAMI (6264)

www.nami.org

Substance Abuse and Mental Health Services Administration

1-800-662-HELP (4357)

www.samhsa.gov/find-help/national-helpline

National Suicide Prevention Lifeline

1-800-273-TALK (8255)

www.suicidepreventionlifeline.org

Crisis Text Line (Mental Health Services) – 24/7 Help Line

Text SUPPORT to 741-741

Breach of confidentiality is another possible risk, however, the researcher will take every possible precaution to ensure that confidentiality is kept.

What are the possible benefits to you?

You may not get any direct benefit from being in this research study.

What are the possible benefits to other people?

The benefits of this study are of an altruistic nature. Your participation will assist in gaining a better understanding of physician burnout and how it impacts Women Physicians. Results of this study may impact how residency programs create policies and procedures to mitigate burnout

What are the alternatives to being in this research study?

The alternative to participating is non-participation. In addition, at any time you may decide not to participate in the study. If you decide not to participate in the study, it will not impact your residency status.

What will being in this research study cost you?

There is no cost to you to be in this research study.

Will you be compensated for being in this research study?

You will receive an electronic Amazon gift card worth \$25 for completing the interview and for your participation in this study.

What should you do if you have a problem during this research study?

Your welfare is the major concern of the researcher. If you have a problem as a direct result of being in this study, you should immediately contact her. Her contact information is listed at the beginning of this consent form.

How will information about you be protected?

Reasonable steps will be taken to protect your privacy and the confidentiality of your study data. All data will be stored in a password protected computer that only the researcher can access.

The data will be stored in a locked cabinet in the investigator's office and will only be seen by the researcher during the study and for 3 years after the study is complete.

The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person, agency, or sponsor as required by law. The information from this study may be published in scientific journals or presented at scientific meetings but the data will be reported as group or summarized data and your identity will be kept strictly confidential.

What are your rights as a research subject?

You may ask any questions concerning this research and have those questions answered before agreeing to participate in or during the study.

For study related questions, please contact the investigator(s) listed at the beginning of this form. For questions concerning your rights or complaints about the research contact the Institutional Review Board (IRB):

Phone: 1(310)568-2305

Email: gpsirb@pepperdine.edu

What will happen if you decide not to be in this research study or decide to stop participating once you start?

You can decide not to be in this research study, or you can stop being in this research study or withdraw at any time before, during, or after the research begins for any reason. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator or with Pepperdine University or your residency program.

You will not lose any benefits to which you are entitled.

Documentation of Informed Consent

You are voluntarily making a decision whether or not to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study. You will be given a copy of this consent form to keep.

Participant Feedback Survey

To meet Pepperdine University's ongoing accreditation efforts and to meet the Accreditation of Human Research Protection Programs (AAHRPP) standards, an online feedback survey is included here: <https://forms.gle/nnRgRwLgajYzBq5t7>

Participant Name:(Name of Participant: Please print)

Participant Signature: Signature of Research Participant

Date: _____

Signature of Person Obtaining Consent _____ Date: _____

APPENDIX E

Interview Script and Questions

Date:

Participant Number:

Thank you for taking the time to meet with me today to discuss your experience with being a Resident Physician. I would like to learn about what it is like to be a Resident and my hope is that the information I learn from this research can help to create a positive dialogue, contribute to the literature, and increase the resources available to help mitigate occupational burnout for women Resident Physicians. Let's start by discussing your residency experience in general.

Residency

1. What is your present year of residency.
2. What is your residency specialty?
3. How are you enjoying your residency program? (Ask participant to expand on response if you are given a yes/no answer).
 - If the Resident says she enjoys her residency program, ask:
 - What do you enjoy most about your residency experience?
 - Is residency what you thought it would be?
 - Is it ever stressful?
 - If the Resident says she does not enjoy her residency program, ask:
 - What don't you enjoy about your residency experience?
 - Is residency what you thought it would be?
 - Is it ever stressful?
 - Do you feel you receive support from your fellow Resident Physicians?

Occupational Burnout

I have heard that residency is an exciting time in a physician's life because you are embarking on your career and for many it is the fruition of your lifelong dream of becoming a doctor. You have your own set of patients, and you are fully immersed in medical training. I have also heard; however, that residency can be tough with its long hours, high expectations, and lofty sacrifices of your time.

4. Can you tell me if you have ever known any Residents who have experienced occupational burnout and what did they tell you about their experiences?
5. Have you ever felt burned out during residency?

6. Are you aware of any services or resources that are available for Resident Physicians who experience occupational burnout? Please tell me the services or resources you are aware of.

7. What resources or supports are available for Residents who identify that they are experiencing occupational burnout?

8. Do you think there is a stigma to acknowledging that a Resident has experienced burnout?

9. Do you think occupational burnout is just part of the job of being a Resident Physician?

Women Resident Physicians

Occupational burnout is something that can be quite challenging to deal with for several reasons, but I assume it can be especially challenging for a Women Resident Physician.

10. When you have felt a sense of well-being at work, what are three words you would use to describe how you felt about yourself during those times?

11. What are three words you might use to describe your work performance during times when you have experienced occupational burnout?

12. Do you feel that women Resident Physicians experience occupational burnout differently or more often than their male counterparts? Please explain your answer.

13. Do you feel that when women Residents experience occupational burnout they are treated differently than their male counterparts by their peers and/or Attendings? Please explain your answer.

14. When you have experienced burnout, what kinds of words might describe how you have viewed your Attending Physicians' efforts to address it?

15. Do you think the COVID-19 pandemic has further exacerbated physician burnout for you and your colleagues? If so, please share how so.

Social Support

Social support, or the support from one's peers can help them to maintain a sense of occupational well-being as well as ward off occupational burnout. The next set of questions will focus on the social support you have experienced in the workplace.

16. When you have experienced occupational burnout, have you felt that you can seek support from your colleagues?

If yes, ask:

- Please describe the kind of peer support you received.

If no, ask:

- Please tell me why you feel you cannot share your occupational burnout experiences with your colleagues.
- Please describe the reactions of your peers during these times.
- Do you feel your Resident colleagues are open to talking about their experiences of occupational burnout?
- Do you feel your colleagues are open to sharing how they maintain a sense of wellness during residency?

-

Leadership and Leadership Style

Attending Physicians are leaders who can be very instrumental in shaping the overall residency experience. While all Attendings followed the path of medical school to residency, presumably they may have an idea of how to guide the residency experience such that they create a sense of occupational well-being for Resident Physicians. In this part of the interview, we will discuss the leadership styles of your Attending Physicians.

17. Have your Attending Physicians offered information on how to deal with physician wellness? If so, what type of information have they given you?

18. Have your Attending Physicians offered information on how to mitigate occupational burnout? If so, what type of information have they given you?

19. Describe one of your best experiences with an Attending.

20. Describe one of the more challenging experiences with an Attending.

21. Do you feel your Attending Physicians care if you or your colleagues are experiencing occupational burnout?

22. When you have experienced occupational burnout, have you felt that you can seek support from your Attendings?

23. Please look at the chart I am sharing on the screen. What category of words would you say, in general, overall describe your Attending Physicians' leadership styles?

24. Do you think that the COVID-19 pandemic has changed your Attending Physicians' leadership styles? If so, please share how so.

Closing Questions

Our interview is coming to an end. Thank you for sharing your Residency experience and your perspective on the various aspects of this experience. I have two more questions for you before we end.

25. Is there anything else you would like to share with me about your experience with physician burnout that was not addressed by any of the previous questions?

26. Is there anything else you may like to share about your Attending Physicians' leadership styles that were not addressed by any of the previous questions?

Thank you for participating in this study. Your time and openness with answering the questions was very much appreciated.

APPENDIX F

Leadership Styles Chart

Table F1*Participant Leadership Styles Chart*

Category A	Category B	Category C
<ul style="list-style-type: none"> • Leader issues rewards based on personal ideal of performance • Micromanagement • Not Supportive • Not a Mentor • System of Negative Reinforcement • Penalizes growth 	<ul style="list-style-type: none"> • Mentors and coaches staff • Identifies a shared Vision • Offers encouragement/motivational • Encourages Growth • Vision focused • Positive feedback 	<ul style="list-style-type: none"> • Absence of leadership • Lack of leadership vision • No regular feedback is given • Not interested in growth or development of staff • No accountability • Indecisive