



BURNOUT ON THE FRONT LINES

Physicians and Nurses as Servant-Leaders During COVID-19

— REBEKAH ROGERS

Individuals rely on physicians and nurses during some of the most critical moments in their lives. The United States fell victim to a widespread health pandemic in early 2020 caused by the spread of a novel coronavirus (COVID-19) that paralyzed the country and devastated the global economy. The international health crisis thrust first responders to the front lines of an evolving war unlike anything society has seen in a century. As of September 2020, the Centers for Disease Control and Prevention (CDC) reported more than 6.5 million confirmed cases and 194,155 deaths in the United States (CDC, 2020). The cities most affected by the first wave of the pandemic were those in the country's largest metropolitan areas, including New York City, Los Angeles, and Chicago (Muro et al., 2020). These cities represent the three largest metropolitan areas, which together account for 17 percent of the nation's economic activity (Muro et al., 2020).

In the face of COVID-19, the nation's cadre of frontline health care experts have responded to the call to treat highly contagious patients and, in doing so, have exemplified servant-leadership in the most caring way. The purpose of this article is to explore the notion of health care providers; namely physicians and nurses as servant-leaders amidst one of the United States' most momentous economic and health crises in modern history. It will draw connections between



what it means for health care leaders to exhibit selected characteristics of a servant-leader amid a pandemic and the importance of managing the severe risks of burnout during this time. Specifically, this article will address (a) the sweeping impact of COVID-19 on nurses, physicians, and society; (b) an overview of servant-leadership; (c) physicians and nurses as servant-leaders within the contexts of empathy and listening; and (d) the potential implications of burnout for physicians and nurses who operate as servant-leaders during the COVID-19 pandemic.

THE IMPACT OF COVID-19 ON HEALTHCARE PROVIDERS AND SOCIETY

March 2020 marked the beginning of an era the United States had not experienced since the Spanish Flu pandemic that occurred from 1918-1920. The CDC ultimately estimated that the Spanish Flu infected 500 million people, which equated to one-third of the total world population at the time (CDC, 2020). The World Health Organization (WHO) identified the novel coronavirus first began in Wuhan, China, in December of 2019 and is a highly contagious illness with a wide array of symptoms, including a cough, fever, body aches, and shortness of breath (WHO, 2020). There are several controversies and conspiracy theories about the origin of the coronavirus (Brewster, 2020; CDC, 2020; Lau et al., 2020).

The World Health Organization (WHO) and Johns Hopkins University & Medicine had confirmed more than 29 million cases of COVID-19 worldwide and more than 925,000 deaths in 216 countries as of September 2020 with the first wave still underway (Johns Hopkins University & Medicine, 2020; WHO, 2020). The USA has the most confirmed cases of coronavirus in the world, along with Brazil and Russia maintaining high and rapidly increasing numbers (Johns Hopkins University & Medicine, 2020). As noted



earlier, the United States had a total of more than 6.5 million confirmed cases and 194,155 deaths as of September 2020 (CDC, 2020; Johns Hopkins University & Medicine, 2020). The State of New York was originally the hardest hit state in the United States with nearly 400,000 cases and 31,000 deaths by June 2020 (“Coronavirus in the U.S.,” 2020). New York City, in particular, was at the epicenter, with more than 200,000 confirmed cases and 22,000 deaths as of June 2020 (“Coronavirus in the U.S.,” 2020). Two months later, in August, the coronavirus continued to grow at epic proportions throughout the country. California, for example, had almost three times that of what New York City reported in June of 2020 (CDC, 2020). California, Florida, and Texas reported the most confirmed cases in the United States by August 2020 (CDC, 2020). Experts predict the COVID-19 crisis will follow the course of past pandemics with a second wave more deadly than the first, especially if individuals do not follow public health guidance and social distancing recommendations (CDC, 2020; Greene, 2020).

The impact of COVID-19 has spread well beyond the personal health of United States citizens. For example, the novel coronavirus has not only pushed the healthcare system to its brink, but has crippled the state of the economy, forcing the nation into a full-blown financial crisis rivaling that of the Great Depression in 1929. Since the beginning of the coronavirus pandemic, unemployment insurance claims have reached 42 million (Cox, 2020). Skyrocketing unemployment claims are the result of uncertainty about how COVID-19 is transmitted, which has forced the country into a sustained period of lockdown or quarantine, leading to closed businesses, schools, places of worship, public areas, and prohibit public transportation.

Hospitals across the country, especially in the hardest-hit cities, have been flooded with coronavirus patients and strained physical



hospital capacity beyond its maximum capabilities (Velasquez et al., 2020). Many COVID-19 patients have been put on a ventilator due to the intensity of the respiratory illness. Insufficient numbers of Intensive Care Unit (ICU) beds have been reported across the country as well to keep up with the increasing demands for ventilators (Li et al., 2020; Lipsitch, 2020). A recent study that examined the coronavirus outbreak originating in China found that some United States cities may need “4.4 ICU hospital beds per 10,000 adults” (Li et al., 2020, p. 1). Currently, the U.S. has “2.8 ICU hospital beds per 10,000 adults” (Li et al., 2020, p. 4). The reason for the increasing number of ICU hospital beds is because patients with COVID-19 tend to stay in intensive care for a long time, thus overwhelming the system over time (Lipsitch, 2020).

Healthcare providers were thrust onto the front lines of this war against COVID-19, which has caused them to put their own lives at risk at the expense of helping others. Stories of healthcare professionals sending their children away with family members while they work on the front lines with COVID-19 patients exhibit the level of commitment they have for their job and their dedication to helping others (Chandler, 2020). Dr. Sabrina Akhtar, a family physician who works at a COVID-19 testing site in Toronto, Canada, admitted that she feels as though there is an “inevitability” that she would contract the virus hence she sent her three young daughters to live with her parents as a “precaution” (Chandler, 2020). However, Dr. Akhtar disclosed that when she comes home from working at the COVID-19 testing site, she feels a “profound amount of emptiness and sadness” without her children being with her (Chandler, 2020). In another example, an emergency medicine physician in Texas chose to live in his children’s outdoor treehouse as a precaution to protect his family from contracting COVID-19 once he had patients



that tested positive for the virus (Today Show, 2020). Healthcare providers take such extreme precautions that demonstrates what it is to be a servant-leader, not only in their profession but also in their homes. The level of sacrifice and commitment by the healthcare professionals during this pandemic has demonstrated their level of care and concern for the wellbeing of others in the face of their own risk of infection. The next section will provide an overview of servant-leadership and describe its importance during these challenging times.

OVERVIEW OF SERVANT-LEADERSHIP

An international health pandemic represents a unique opportunity for physicians and nurses to practice servant-leadership when delivering patient care. This section will describe servant-leadership and highlight two specific characteristics of servant-leaders that may be valuable for health care professionals to exhibit during this unprecedented time.

The term *servant-leadership* was first coined by Robert Greenleaf in his influential 1970 essay, “The Servant as Leader.” Robert Greenleaf’s seminal work on servant-leadership puts into words ideas that were already present. Greenleaf provided a solid foundation for the general understanding of what it means to be a servant-leader and how a leader must be servant first. Greenleaf (1977/2002) provided the following clear, concise, and eloquently worded definition of servant-leadership:

The servant-leader is servant first. It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead. The best test, and difficult to administer, is this: Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And,



what is the effect on the least privileged in society? Will they benefit or at least not be further deprived? (p. 27)

Servant-leadership is a life-long, transformational, and holistic way of being; a constant process—an ever-changing process that aims to create change in society. Spears (1998) noted that the following characteristics are central to the development of servant-leaders: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community (pp. 4-6). Spears also noted that these ten characteristics “serve to communicate the power and promise that this concept offers to those who are open to its invitation and challenge” (p. 6).

Servant-leadership is not marked by a state of doing, but by a state of being (Spears, 2004). Spears (2004) suggested that servant-leadership “offers a means to personal growth—spiritually, professionally, emotionally, and intellectually” (p. 21). The key aspects of servant-leadership start intrinsically within a person; they must have a natural inclination to want to serve. It is something that one must constantly strive for but may often feel as if it is unattainable. Since there is no perfect servant-leader, the process should be a continuance.

The most important purpose for a servant-leader is to serve. To serve effectively, one must be open and vulnerable to others. Autry (2004) said that the servant-leader needs to “project authenticity and vulnerability, be present, be accepting, and see your role as being useful, as being the servant” (p. 61). Too often, people have the mindset that they are overqualified to do certain jobs and let their egos get in the way. Autry (2004) wrote about how the first component of servant-leadership is to recognize that pride can often get in the way. Once it is recognized, an individual must deeply



examine his or her motives, whether it is through meditation, silence, prayer, self-reflection, or some other means. True transformation begins when leaders engage in these spiritual exercises.

Living a life of a servant-leader enables one to a life-long journey of self-discovery, renewal, and learning (Wheatley, 2004). Being a servant-leader involves the process of constantly reflecting on personal life's purpose and meaning. Throughout his writings, Greenleaf discussed how life is about the journey and not the destination. By focusing on the journey rather than the destination, one is able to learn from mistakes, triumph over defeat, and endure the shortcomings along the way. The journey is where true learning occurs and is crucial to the success of the final outcome.

PHYSICIANS & NURSES AS SERVANT-LEADERS WITHIN THE CONTEXT OF LISTENING AND EMPATHY

Listening and empathy represent two central characteristics within servant-leadership that are applicable to the work of physicians and nurses during COVID-19. The following sections will provide detail about these characteristics and then draw connections to physicians and nurses as it applies to servant-leadership and COVID-19.

Listening

Based on Robert Greenleaf's writings, Spears (1998) identified "listening" as the first characteristic of servant-leadership. This section will discuss listening as a trait of servant-leadership and provide concrete examples of how healthcare professionals have exemplified this characteristic amidst the coronavirus pandemic.

Spears (1998) shared Greenleaf's perspective that "leaders have traditionally been valued for their communication and decision-making skills" (p. 13). As Spears indicated, listening is a communication function of the human body that is often easily ignored. Many times, people forget that communication works two



ways: speaking and listening. A person cannot participate in conversation by only speaking; engaging in listening is essential for effective communication to occur.

Without listening to patient needs, healthcare providers are not able to fulfill their roles effectively. Klagsbrun (2001) emphasized the importance of nurses engaging in active listening and focusing as methods of holistically caring for their patients. Shipley (2010) concurred by noting that “listening is not a new skill in healthcare” (p. 125). In fact, she makes the obvious statement that “listening is a key ingredient to nurse-patient interactions and must be present in order for quality care to be provided” (p. 126). Kagan (2008) found that if a patient perceives her healthcare provider to be an effective and active listener, then it will positively impact how the patient feels about her own health and wellbeing. The simple act of a healthcare provider exhibiting active listening can be instrumental in the patient’s perception of the facility they are in, the quality of care they are receiving, and a greater sense of well-being within themselves. However, during COVID-19, many patients cannot speak because they are intubated on a ventilator or are prevented from communicating due to other challenges resulting from the illness. It is important for servant-leaders, physicians, and nurses seek to understand the ideas and thoughts of others in an effort to be able to treat their patients with the best possible care.

Nurses, in particular, must engage in active listening to be effective. Active listening is at the heart of nursing excellence, and it is there that a patient can begin the healing process; sometimes, all a patient needs is to be heard. Imagine how a patient must feel when they are trying to explain to the nurse what is wrong, and they are not given adequate time to express their feelings and ailments. For a patient, there are more variables than just physical symptoms and



that is why nurses must give adequate attention to the whole being of the patient and listen carefully (Jenkins, 2006). Active listening is thought to be superior to merely listen. Mineyama et al. (2007) defined active listening as “a way of listening and responding to another person, which improves mutual understanding” (p. 81). Active listening is not easy and requires intense focus at every moment; it is just as hard as cognitively forming a sentence when speaking. Active listening is a fundamental component of servant-leadership and is especially prevalent in the field of nursing as they relate with their patients. In the circumstances surrounding COVID-19, listening has taken on a new experience for physicians and nurses. It has meant engaging more with patient’s families and required a greater intuition for patient care.

It is the role of the listener to make a conscious choice to be actively engaged and deliberately attentive in the story of the speaker (Shipley, 2010). Further, Shipley stated that “the listener must be committed to hearing, sensing, and understanding the patient’s message to the fullest extent possible” (p. 130). Once the message is fully understood, active listening can then take place. Deep and active listening allows for a special connection between the speaker and the listener to be developed that not only lets the speaker be heard, but allows the listener to think and hear their own inner voice (Wright, 2006). It is by engaging in active listening that the healthcare provider can treat the whole patient with more holistic approach.

Silence is also a quality indicator that effective active listening is taking place. Although silence can be uncomfortable in a conversation, it can prove to the speaker that they are being understood and that the information they are sharing is being absorbed. A healthcare provider’s initial and natural impulse is to react, as opposed to embracing a moment of strategic reflection or



silence (Shipley, 2010, p. 130). Periods of silence provide both the speaker and the listener the opportunity to think critically about their next course of action during the conversation (Shipley, 2010). Periods of silence also disciplines the listener so that he or she can learn the “art of waiting” and only ask the questions deemed most important (Wright, 2006, p. 18). Spears (1998) shared Greenleaf’s insights that “Listening also encompasses getting in touch with one’s own inner voice and seeking to understand what one’s body, spirit, and mind are communicating. Listening, coupled with regular periods of reflection, is essential to the growth of the servant-leader” (p. 13). Reflection is important in communication because it is when both the speaker and the listener can digest the material being presented and pause to internalize what has been said. Additionally, during moments of silence in a conversation, the listener is able to summarize or paraphrase the speaker’s comments to ensure proper understanding. Finally, silence allows the listener to reflect on his or her opinions and offer feedback or guidance, as necessary. When the listener does all of these things listed above, it adds to the assurance of the speaker that the listener is actively engaged in listening.

With COVID-19, medical providers are leaning more on patients’ relatives or emergency contacts to speak for them if the patient is unable to speak, forcing the physician or nurse to learn about them through someone else’s perspective (Today Show, 2020). Since patients have not been able to have family members present in the hospital with them due to the high spread of the virus, the nurses have “had to become the patient’s family” (Today Show, 2020). The nurses in Stonybrook, New York, started a new initiative called “My Story,” where they create posters about each of their patients with COVID-19 who are unable to speak. The nurses have gathered information from the patient’s family and emergency contacts and



put pictures and information about them on their door so that the physician and nurse can understand them as much as possible to treat the whole person (Mears et al., 2020). Some of these measures taken by health care providers take listening far beyond the traditional speaker and listener dynamics. In order to understand their patients holistically, these nurses are eager to find their patient's voice even when they are voiceless.

Empathy

Spears (1998) identified empathy as the second characteristic of servant-leadership from Greenleaf's writings. This section will discuss empathy as a trait of servant-leadership and provide examples of how healthcare professionals have exemplified this characteristic amid today's pandemic with the coronavirus.

According to Spears (1998) "the servant-leader strives to understand and empathize with others" (p. 4). Shipley (2010) defined empathy as "being aware of, and sensitive to, the feelings, thoughts, and experiences of another" (p. 129). Gardenswartz et al. (2008) noted that empathy takes place "where the heart and the mind interact to make powerful connections between people" (p. 120). The authors further suggested that empathy was an attitude of "genuine caring" (p. 120). In practice, exemplifying empathy was said to be the ability to authentically have concern and understanding for others in the rarest form. Spears (1998) highlighted that empathy is a critical quality of servant-leadership and successful servant-leaders are highly skilled in the art of empathetic listening. According to Stickley and Freshwater (2006), empathetic persons attempt to put themselves in the other person's perspective and try to imagine how they would feel if the same happened to them. When individuals are empathetic, they go beyond the normal duties of listening. Persons possessing this



valuable trait let go of their thinking and perspectives and try to imagine the perspective of the other person's experiences.

When a person is empathetic to another, it shows the speaker that the listener is actively engaged in the conversation, keenly listening to the speaker, and personally understands the story the speaker is trying to convey (Shipley, 2010). Alternatively, when a person is not trying to connect to the speaker or is not exhibiting empathy, it can leave the speaker feeling misunderstood or alienated (Shipley, 2010). Health care providers, such as nurses and physicians, must often embody and exhibit servant-leadership characteristics in this way. For example, nurses are stereotypically characterized as embodying more of a helping spirit and a caretaker's role. Nurses are typically thought of as putting patient's needs first, and this quality matches an obvious value identified by servant-leadership, as see below:

For servant-leadership, the role of the nurse has traditional roots that values taking care of others while traditional physician's roles are as leaders of the health care team. Thus, it may not be surprising that the RNs rated themselves higher as servant-leaders in light of the traditional role of the nurse. (Garber et al., 2009, p. 338)

In essence the servant-leader is focused on the values and caretaking of others thus, nurses thrive in this environment in almost an innate manner. Consequently, it is not surprising that nurses are traditionally viewed as servants first in healthcare.

Nursing and leadership have been researched extensively. According to Dirschel and Klainberg (2010), "leadership in nursing is a goal, vision, and expectation for all professional nurses in any form of practice" (p. 4). In every encounter, all forms of nursing leadership must result in excellent patient's care and outcome. Nurse leaders must also create an environment that supports and



encourages evidence-based nursing practice, which is essential for nursing practice at the cutting edge of recognized standards.

Physicians also represent leaders in the healthcare industry that must embody empathy as a characteristic of servant-leadership. Coulehan and Block (2006) defined physician empathy this way:

Empathy is a type of understanding. It should not be confused with feeling sympathetic or sorry for someone, nor is it the same as the virtue of compassion. Although compassion may well be your motivation for developing empathy with patients, empathy is not compassion. In medical interviewing, being empathetic has a well-defined meaning: listening to the patient's total communication—words, feelings, and gestures—and letting the patient know that you really understand what he or she is communicating. (p. 29)

Being empathetic is often viewed as a trait associated with physicians. Scholars have suggested that the act of empathy must be carefully communicated. For example, Blumgart (1964), described how physicians need to be neutrally empathetic in which the “physician will do what needs to be done without feeling grief, regret, or other difficult emotions” (p. 451). Interestingly, the Merriam-Webster Online Dictionary full definition of empathy reads as follows:

The imaginative projection of a subjective state into an object so that the object appears to be infused with it. The action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner. (Merriam-Webster, n.d.)



Based on the definitions of empathy described above, physicians are trained on implementing this behavior in different ways from the general public. In a sense, physicians are taught to withhold feelings from the patient, when possible, for fear of becoming too emotionally involved and to protect themselves from emotional harm.

Bowden (2000) suggested that the concept of “caring and empathy involves an effort to engage in true moral behaviors in which ethical caring and natural caring are one and the same” (p. 71). Furthermore, “caring can also result from an individual’s instinctive impulse” (Noddings, 2003, p. 81). With this perspective in mind, caring is a moral compulsion in which an individual feels empathy towards the other and is naturally inclined to care for their overall needs (Noddings, 2003). Noddings (2003) firmly contended that the act of caring or being cared for is the “foundation of ethical response” (p. 1).

More specifically, Halpern (2003) used the term *emotional attunement* which “operates by shaping what one imagines about another person’s experience” (p. 671). When a physician listens to a patient’s story, then that medical provider can become emotionally involved in the experience and feelings from past personal situations both positive and negative can surface and impact the physician. Halpern (2003) cautions physicians about interacting with patients in this manner, especially if they are susceptible to the occurrence of burnout. Halpern further wrote: “In clinical practice, the challenge is to use skillful attunement, not in leisurely fantasy, but in multiple, rapid, ordinary clinical interactions” (pp. 671-672). By this, Halpern (2003) was suggesting that the physician be extra observant of every nuance of the patient, physically and emotionally, so that he or she can best serve the patient through careful attunement. These scholars



have suggested that physicians must be objectively empathetic in servant-leadership. In doing so they make an accurate medical diagnosis while also connecting in a meaningful and empathetic way with the patient. It is a challenging juxtaposition when physicians are working to embrace both a servant-leadership mentality and objectively perform their role to warrant the patient's success.

IMPLICATIONS FOR HEALTHCARE PROFESSIONALS WHO PRACTICE SERVANT-LEADERSHIP DURING THE COVID-19 PANDEMIC

The study of healthcare providers as servant-leaders is essential to examine for many reasons, especially during the COVID-19 pandemic. Healthcare leaders inevitably impact the lives of many people, and individuals rely on physicians and nurses during some of the most critical moments in their lives. Effective communication and leadership practices are essential in today's healthcare settings to ensure optimum patient care. People prefer to work for and with others who are skilled in communication and have strong professional and personal leadership qualities, especially qualities such as listening and empathy present in those aspiring to be servant-leaders. Thus, the study of leadership is crucial for the professional, personal, and spiritual growth within individuals.

Practicing servant-leadership is hard work. It requires deep focus, intentional actions, and continual commitment. In this article, the two characteristics of servant-leadership; listening and empathy are noted to be quite taxing on a leader's physical and emotional state. Exemplifying empathy requires the ability to authentically have concern and understanding for others in the rarest form. This action of empathy is critical for a physician, yet when taken to the extreme, such as in a health pandemic, can produce significant emotional exhaustion when dealing with patients.



Burnout is always a challenge experienced by physicians in their line of duty regardless of a pandemic. Therefore, servant-leader can mitigate the situation by creating awareness and helping them cope with the challenges. Recognizing them as servant-leaders can help bring awareness to the work they do on the frontlines. Research by Shanafelt et al. (2012) indicated that “emergency medicine physicians have the highest burnout rate of all medical specialties” (p. 1380). As reported in media reports, health providers are literally on the front lines of COVID-19 patients who experience severe symptoms of the disease (Campbell, 2020). Maslach described burnout as “a syndrome of emotional exhaustion, depersonalization, and lowered sense of personal achievements, which may occur in people working with others in a specific way” (Wilczek-Ruzyczka, 2011, p. 527).

The first symptom, emotional exhaustion, is also referred to as emotional overload. This experience is a common response when individuals feel drained and overwhelmed due to the impact of burnout (Maslach, 2003). Maslach and Leiter (1997) wrote, “Exhaustion is the first reaction to the stress of job demands or major change” (p. 17). When an individual is experiencing emotional exhaustion, they often feel as if they cannot lead and be successful in an effective and meaningful way. Physicians are often prone to face emotional exhaustion daily due to the many difficult decisions they experience, especially in the emergency room. In particular, emergency physicians, encounter stressful scenarios where the life of a patient is literally in the medical provider’s hands.

The second symptom of burnout identified by Maslach and Leiter (1997) is depersonalization, which is an individual’s attempt to initiate a protective feeling as a result of the burnout. Depersonalization is when asymptomatic, burned-out individual



detaches herself and limits interaction with society or, in the case of a physician, from building an emotional connection with the patient; as a byproduct, those individuals often display cynical attitudes when implementing their work (Maslach & Leiter, 1997). Maslach (2003) described an individual experiencing detachment “as though the individual is viewing other people through rust-colored glasses developing a poor opinion of them, expecting the worst from them, and even actively disliking them” (p. 5). Depersonalization is dangerous for both parties being affected—both the individual experiencing burnout and the victim. Maslach (2003) wrote that “the provider may derogate other people and put them down, refuse to be civil and courteous to them, ignore their pleas and demands, or fail to provide the appropriate help, care, or service” (p. 5). Through the acts noted above the burned-out individual is slowly shutting the world out of her life and becoming more and more of a hazard to herself and potentially to others (Maslach, 2003).

The final symptom, as identified by Maslach and Leiter (1997), is reduced personal accomplishment. Individuals may begin to feel inadequate or incapable of fulfilling “normal” obligations and duties in the course of their life (p. 18). Thus, when individuals begin to lose confidence in themselves, begin to view themselves as a failure, and start to think that they are not the right fit for their line of work (Maslach, 2003; Maslach & Leiter, 1997). The burned-out individual starts to believe that they are not strong enough to handle their job and this may cause a great deal of self-doubt about their personal qualities and leadership abilities (Maslach, 2003). Signs that are associated with a sense of ineffectiveness and reduced personal accomplishment include “feelings of apathy, helplessness, hopelessness, increased irritability, and a lack of productivity and poor performance” (Carter, 2011, p. 139). Interestingly, though, Freudenberg (1975) found that “individuals experiencing burnout



also operate as if they can complete their work with a “no one else can mentality” (p. 26). This individualistic approach eventually leads to feelings of hopelessness and defeat because they are not able to withstand the endurance needed. As the symptom of reduced personal accomplishment further develops, it is highly advisable for the burned-out individual to seek professional help and guidance resulting from depression and low self-esteem that has taken over them (Maslach, 2003).

The three burnout symptoms have steered leaders in this field to believe that burnout is a gradual process that evolves over time and is often difficult to diagnose at the outset (Freudenberger, 1975; Maslach & Leiter, 1997). A health pandemic could be the extra challenge that pushes a medical provider over the edge, and into a state of severe burnout—particularly when heightened expectations for long hours. Further, medical providers are leaning more on patients’ families to be their voice, forcing the physician or nurse to learn about his or her patients through someone else’s perspective.

Rodrigues et al. (2012) argued that pressures at work, work overload, interference, limits of intervention/of knowledge, how the work is organized, changes in the profession were the main cause of burnout among physicians. These symptoms can be recognized at any point in the evolutionary process, but when they are ignored or go unnoticed over a period of time, they are capable of causing burnout. It is the culmination of several symptoms over an extended time frame that causes burnout to reach its peak.

When a physician is suffering from symptoms of burnout, it can quickly lead to impairment (Allen & Bowman, 2002). Allen and Bowman (2002) wrote that “Physicians are considered impaired when personal problems interfere with the quality of their medical care, personal life, or well-being” (p. 10). Symptoms of burnout can



increase over time; thus, symptoms may be present over a long period of time before the impaired individual or family and friends even become aware of the situation (Maslach & Leiter, 1997).

Burnout recovery and rehabilitation is a long, complicated process that often requires professionals to treat single symptoms at a time, as there are usually many simultaneous causes of burnout (Karl & Fischer, 2013). In treating a person with burnout, the focus should be solely on the work of the individual (Karl & Fischer, 2013). It is during this effort that one will learn strategies to become more aware of stressors and potential prevention methods. However, in treatment, a person should keep in mind that the causes of burnout are not limited to just one individual person being affected, but the system is affected as well (Maslach & Goldberg, 1998). It is through the implementation of the prevention stages that a person can heal from her burnout and understand the greater complexities of the “system” that led to its occurrence.

Luthans and Avolio (2003) believe that an individual’s ability to become more self-aware is a key piece in their potential for leadership development. It is only through this key medium that self-awareness allows an individual to recognize personal strengths and weaknesses to grow, develop and change her self-concept for the better (Luthans & Avolio, 2003). Allen and Bowman (2002) found that physicians who were more self-aware of their feelings were better able to recognize when they were taking on too much and knew when to re-align to their ideals.

Mudrack (2006) found that individuals who are “high self-monitors are keenly aware of moods and reactions and will alter their behavior to elicit others’ approval” (p. 117). The idea of self-monitoring ties into what was previously discussed about self-regulation in that an individual who continually self-monitors their standards of behaviors, thoughts, and actions can self-regulate (Neck



& Houghton, 2006). Self-monitoring would be a useful tool for female physicians to perform intrinsically so that they can better analyze how they are feeling and potentially limit the risks of burnout.

Healthcare providers should also be encouraged to engage in their own reflections and to think about their own mental models and how they want to live. By engaging in this reflective process, it should be helpful for physicians to engage inwardly about their life goals and priorities. This process can allow them to become more aware of how their past and present behavior has influenced their current reality of their own mental models. It may be uncomfortable, but it is necessary. In this process of learning more about themselves, Senge (1990) reminded the reader that personal mastery involves “a lifelong generative learning” (p. 132). One never truly knows himself fully; we must always be striving to learn more about ourselves every day.

Researchers have offered mental imagery as a preventive method for reducing stress (Allen & Bowman, 2002; Carter, 2011). Mental imagery is described when individuals imagine themselves being successful while performing in an effort to help them during the actual performance (Neck & Houghton, 2006; Neck & Manz, 2013). The idea behind Carter’s (2011) notion of mental imagery is having an individual engage with themselves in a way that allows them to relax and imagine they are in a place that makes them feel happy and less stressed (p. 156). Mental imagery is one of the oldest means of practicing relaxation techniques (Allen & Bowman, 2002). Allen and Bowman (2002) wrote that thinking about such images provides “positive feedback messages to the rest of the body which act as cues to relax tense muscles” (p. 19).

Researchers have found that individuals who also engage in



positive self-talk are better able to engage in their own constructive internal dialogue (Neck & Houghton, 2006). Self-talk involves an individual mentally self-evaluating and reflecting on how they are perceived by others (Carter 2011). Carter (2011) identified positive self-talk as any statement a person says to herself that is uplifting that makes her feel more confident and self-assured. Positive self-talk is a method one can practice in order to internally reinforce herself about the work she is doing (Carter, 2011).

Carter (2011) wrote significantly about potential strategies to employ for lowering the chances of burnout. These specified efforts include: journaling, exercise, prioritizing important things, taking a break, reframing, surrounding yourself with more positive people, laughing more often, and considering new friendship opportunities (Carter, 2011). Since female physicians are often considered overachievers, Carter suggested effective ways to alleviate or lessen burnout risks. Some of these targeted strategies include: “extreme vacations, extreme sports, extreme hobbies, extreme workouts, find a cause worth supporting, and challenging their brains” (pp. 161-163).

Meditation practices have also been associated as a method to prevent stress (Allen & Bowman, 2002). Meditation involves an individual focusing on a subject or object over a period of time (Allen & Bowman, 2002). Research has found that engaging in meditation can lead to a “decrease in heart rate, a lowering of blood pressure, and reduction in oxygen consumption” (p. 18). If meditation is practiced regularly, it can greatly reduce prolonged symptoms of stress (Allen & Bowman, 2002). A healthcare provider’s ability to engage in self-awareness through self-monitoring and self-awareness should aid in lowering their likelihood of developing symptoms of burnout. If a healthcare provider is self-aware and noticing symptoms of burnout, then that can prompt them to engage in a variety of remediation such as meditation.



Educating healthcare providers about the risks and threats of burnout is a critical step in minimizing their risk for falling victim to the occurrence. It would certainly be a paradox if the physician is known as the “healer” and is not healthy themselves; therefore, education plays an important role in the work-life balance, burnout, and healthy living effort. Healthcare providers could enhance their wellbeing by becoming knowledgeable about statistics that relate to the likelihood of burnout, as well as learn appropriate coping skills for stress.

CONCLUSION

This article explored healthcare providers—namely physicians and nurses—as servant-leaders amidst one of the United States’ most momentous health crises in modern history. It demonstrated that the Covid-19 pandemic has adversely impacted the lives of the healthcare providers as they sought to lead through this challenging time. This article drew connections between what it means for healthcare leaders to exhibit the servant-leadership characteristics of listening and empathy in an effort to reduce the likelihood of burnout. And finally, this article listed potential implications for healthcare providers who have been operating as servant-leaders during the COVID-19 pandemic.

Throughout this novel coronavirus pandemic, it is critical that healthcare providers understand their higher risk for burnout in general—especially at a time when servant-leadership characteristics like listening and empathy are needed for effective patient care. The more educated healthcare professionals are on what it means to be a servant-leader in their workplace given the unusual stressors associated with the pandemic, the more likely they will become self-aware of their professional environment, set realistic expectations, continue to fulfill their roles, and decrease the likelihood of burnout.



In many ways, physicians and nurses have embodied elements of Greenleaf's concept of servant-leadership through both empathy and listening throughout the COVID-19 pandemic. Accordingly, these leaders must also engage in appropriate self-care strategies to help address and prevent burnout among this critical population, especially during a health crisis.

References

- Allen, D., & Bowman, M. (2002). The stress of our profession. In M. A. Bowman, E. Frank, & D. I. Allen (Eds.), *Women in medicine: Career and life management* (3rd ed.; pp. 4-11). Springer-Verlag.
- Autry, J. A. (2004). Love and work. In L. C. Spears & M. Lawrence (Eds.), *Practicing servant-leadership: Succeeding through trust, bravery, and forgiveness* (pp. 47-69). Jossey-Bass.
- Blumgart, H. (1964). Caring for the patient. *New England Journal of Medicine*, 270, 449-456.
- Bowden, P. (2000). Ethic of care. In L. Code (Ed.), *The encyclopedia of feminist theories* (p. 71). Routledge.
- Brewster, J. (2020, May 24). A Timeline of the COVID-19 Wuhan Lab Origin Theory. *Forbes*.
<https://www.forbes.com/sites/jackbrewster/2020/05/10/a-timeline-of-the-covid-19-wuhan-lab-origin-theory/>
- Campbell, L. (2020, April 21). What it's like to be a nurse working on the front lines of COVID-19. <https://www.healthline.com/health-news/what-its-like-to-be-a-nurse-working-on-the-front-line-of-covid-19>.
- Carter, S. (2011). *High-octane women: How superachievers can avoid burnout*. Prometheus Books.
- Center for Disease Control (CDC). (2020). COVID data tracker.
<https://www.cdc.gov/covid-data-tracker/>
- Chandler, J. (2020, March 26). Health-care workers worry about bringing COVID-19 home to their kids. *CBC Radio*.
<https://www.cbc.ca/radio/thecurrent/the-current-for-march-26-2020-1.5510576/health-care-workers-worry-about-bringing-covid-19-home-to-their-kids-1.5510850>
- Coronavirus in the U.S.: Latest map and case count. (2020, March 03). *The New York Times*.
<https://www.nytimes.com/interactive/2020/us/coronavirus-us->



- cases.html
- Coulehan, J., & Block, M. (2006). *The medical interview: Mastering skills for clinical practice* (5th ed.). F. A. Davis Company.
- Cox, J. (2020). Jobless claims, total unemployment level worse than expected. *CNBC*. <https://www.cnbc.com/2020/06/04/weekly-jobless-claims.html>
- Dirschel, K. M., & Klainberg, M. (2010). *Today's nursing leader: Managing, succeeding, excelling*. Jones and Bartlett Publishers.
- Freudenberger, R. (1975). The staff burnout syndrome in alternative institutions. *Psychotherapy: Theory, Research, and Practice*, 12(1), 73-82.
- Garber, J. S., Madigan, E. A., Click, E. R., & Fitzpatrick, J. J. (2009). Attitudes towards collaboration and servant-leadership among nurses, physicians, and residents. *Journal of Interprofessional Care*, 23(4), 331-340.
- Gardenswartz, L., Cherbosque, J., & Rowe, A. (2008). *Emotional intelligence for managing results in a diverse world*. Davies-Black Publishers.
- Greene, D. (2020, May 06). Former CDC official warns of 2nd COVID-19 wave: Most Americans are still susceptible. *National Public Radio*. <https://www.npr.org/sections/coronavirus-live-updates/2020/05/06/851190730/a-majority-of-americans-are-still-susceptible-to-coronavirus-khan-says>
- Greenleaf, R. K. (2002). *Servant leadership: A journey into the nature of legitimate power and greatness* (L. C. Spears, Ed.; 25th anniversary ed.). Paulist Press. (Original work published 1977)
- Halpern, J. (2003). What is clinical empathy? *Journal of General Internal Medicine*, 18(8), 670-674. <https://doi.org/10.1046/j.1525-1497.2003.21017.x>
- Jenkins, A. (2006). Holistic listening. *Nursing Standard*, 20(27), 30. <https://doi.org/10.7748/ns.20.27.30.s36>
- Johns Hopkins University & Medicine. (2020, July 20). Coronavirus resource center. <https://coronavirus.jhu.edu>
- Kagan, P. (2008). Feeling listened to: A lived experience of humanbecoming. *Nursing Science Quarterly*, 21(1), 59-67.
- Karl, D., & Fischer, M. (2013). Prevention and Communication: A most effective tailored treatment strategies for burnout. In S. Bahrer-Kohler (Ed.), *Burnout for experts: Prevention in the context of living and working* (pp. 185-200). Springer Science + Business Media.
- Klagsbrun, J. (2001). Listening and focusing: Holistic health care tools for nurses. *Nursing Clinics of North America*, 36(1), 115-130.
- Lau, S., Luk, H., Wong, A., Li, K., Zhu, L., He, Z....Woo, P. (2020).



- Possible bat origin of severe acute respiratory syndrome coronavirus 2. *Emerging Infectious Diseases*, 26(7), 1542-1547.
<https://doi.org/10.3201/eid2607.200092>
- Li, R., Rivers, C., Tan, Q., Murray, M. B., Toner, E., & Lipsitch, M. (2020). Estimated demand for US hospital inpatient and intensive care unit beds for patients with Covid-19 based on comparisons with Wuhan and Guangzhou, China. *JAMA Network Open*, 3(5), 1-9.
<https://doi.org/10.1001/jamanetworkopen.2020.8297>
- Lipsitch, M. (2020). More ICU capacity still needed in U.S. for COVID-19 patients. <https://www.hsph.harvard.edu/news/hsph-in-the-news/more-icu-capacity-still-needed-in-u-s-for-covid-19-patients/>
- Luthans, F., & Avolio, B. (2003). Authentic leadership development. In K. S. Cameron, J. E. Dutton, & R. E. Quinn (Eds.), *Positive Organizational Scholarship* (pp. 241-258). Berrett-Koehler Publishers.
- Maslach, C. (2003). *Burnout: The cost of caring*. ISHK.
- Maslach, C., & Goldberg, J. (1998). Prevention in burnout: New perspectives. *Applied and Preventive Psychology*, 7, 63-74.
- Maslach, C., & Leiter, M. (1997). *The truth about burnout: How organizations cause personal stress and what to do about it*. John Wiley & Sons.
- Mears, B., Cruz, J., Fletcher, K., & Knight, K. (2020). Stony Brook nursing initiative gives a voice to the voiceless.
<https://news.stonybrook.edu/homespotlight/stony-brook-nursing-initiative-gives-a-voice-to-the-voiceless/>
- Merriam-Webster. (n.d.). Empathy. In *Merriam-Webster.com dictionary*.
<https://www.merriam-webster.com/dictionary/empathy>
- Mineyama, S., Tsutsumi, A., Takao, S., Nishiuchi, K., & Kawakami, N. (2007). Supervisors' attitudes and skills for active listening with regard to working conditions and psychological stress reactions among subordinate workers. *Journal of occupational health*, 49, 81-87.
- Mudrack, P. (2006). Understanding Workaholism: The case for behavioral tendencies. In R. J. Burke (Ed.), *Research companion to working time and work addiction* (pp. 108-130). Edward Elgar Publishing Limited.
- Muro, M., Maxim, R., & Whiton, J. (2020). The places a COVID-19 recession will likely hit hardest. <https://www.brookings.edu/blog/the-avenue/2020/03/17/the-places-a-covid-19-recession-will-likely-hit-hardest/>
- Neck, C., & Houghton, J. (2006). Two decades of self-leadership theory and research: Past developments, present trends, and future possibilities. *Journal of Managerial Psychology*, 21(4), 270-295.
- Neck, C., & Manz, C. (2013). *Mastering self-leadership: Empowering yourself for excellence* (6th ed.). Pearson Education.



- Noddings, N. (2003). *Caring: A feminine approach to ethics and moral education* (2nd Ed.). University of California Press.
- Rodrigues, A., Campos, E., & Valente, G. (2012). Quality of life and burnout in physicians. In A. Rossi, P. Perrewe, & J. Meurs (Eds.), *Coping and prevention* (pp. 147-172). Information Age Publishing.
- Senge, P. (1990). *The fifth discipline: The art and practice of the learning organization*. Doubleday.
- Shanafelt, T., Boone, S., Tan, L., Dyrbe, L., Sotile, W., Satele, D., Oreskovich, M. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine, American Medical Association*, 172(18), 1377-1385.
- Shipley, S. D. (2010). Listening: A concept analysis. *Nursing Forum*, 45(2), 125-134.
- Spears, L. C. (1998). Introduction: Tracing the growing impact of servant-leadership. In L. C. Spears (Ed.), *Insights on leadership: Service, stewardship, spirit, and servant-leadership* (pp. 1-14). Wiley.
- Spears, L. C. (2004). The understanding and practice of servant-leadership. In L. C. Spears & M. Lawrence (Eds.), *Practicing servant leadership: Succeeding through trust, bravery, and forgiveness* (pp. 9-24). Jossey-Bass.
- Stickley, T., & Freshwater, D. (2006). The art of listening in the therapeutic relationship. *Mental Health Practice*, 9(5), 12-18.
- Today Show. (2020, June 15). How these nurses connect with patients silenced by COVID-19. <https://www.today.com/video/how-these-nurses-connect-with-patients-silenced-by-covid-19-85064261516>
- Velasquez, J., Choi, A., & Gonen, Y. (2020, March 28). Hospitals nearing ICU bed limits as COVID-19 surges in NYC. <https://www.thecity.nyc/health/2020/3/28/21210412/hospitals-nearing-icu-bed-limits-as-covid-19-surges-in-nyc>
- Wheatley, M. J. (2004). The servant-leader: From hero to host [Interview]. In L. C. Spears & M. Lawrence (Eds.), *Practicing servant leadership: Succeeding through trust, bravery, and forgiveness* (pp. 241-268). Jossey-Bass.
- Wilczek-Ruzyczka, E. (2011). Empathy vs. professional burnout in health care professionals. *Journal of US-China Medical Science*, 9(82), 526-532.
- World Health Organization. (2020, July 20). Coronavirus disease: COVID-19 pandemic. <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>
- Wright, S. (2006). The beauty of silence. *Nursing Standard*, 20(50), 18-20.



Dr. Rebekah Rogers is a researcher and scholar in the interdisciplinary field of leadership studies. Her dissertation research explored burnout among female emergency medicine physicians within the context of self-leadership and authentic leadership. Dr. Rogers writes and speaks frequently on the concept of leading and communicating in the healthcare industry. She is currently an adjunct faculty member within the School of Integrative Studies at George Mason University (GMU) and teaches a course titled Leadership Theory and Practice. Dr. Rogers also served in an adjunct faculty role within the Department of Communication at GMU and taught a wide array of courses, including: Introduction to Communication, Public Speaking, and Intercultural Communication. Before relocating to the Washington DC Metro Area, Dr. Rogers served as an instructor in the Department of Communication at East Carolina University (ECU) and in the Division of Arts and Sciences at Pitt Community College in Greenville, North Carolina. In addition to her academic teaching assignments, Dr. Rogers provided direction and oversight for ECU's Office of the Leadership Collaborative and served on a research team at the Center for Creative Leadership in Greensboro, NC. She is a native of Greensboro, North Carolina and currently resides in Alexandria, Virginia with her husband, Dr. Philip Rogers, and their two young sons, Grayson and Dean.