As we currently grapple with the international COVID-19 pandemic, it seems highly appropriate to assess and reflect on the effect of leadership qualities and organizational well-being on the practice and delivery of health care. Even before the current health care crisis, physician burnout, mental exhaustion, and depersonalization have affected 40% to 50% of physicians and are increasingly recognized as a collective public health crisis of its own. The future effort required by our academic and practicing communities to successfully fulfill our missions as we emerge from this pandemic is unlikely to lessen the burden of burnout in our care teams.

Effective physician leadership requires numerous executive, managerial, and technical skills, accompanied by emotional intelligence. Meeting all these demands can be challenging for most leaders, who must deal with their own level of burnout and personal stress. Many factors contribute to burnout for leaders and all physicians, including excessive workload, lack of personal autonomy, nonaligned values, perception of unfairness, absence of community, and lack of purpose. Scarcity of social connections has also been associated with burnout and loneliness. High-level leadership can be isolating owing to time demands, competition for institutional resources, and a limited noncompetitive peer group. The increasing trend for working at a distance and social distancing may increase burnout due to reduced social interactions.

As leaders experience emotional exhaustion and depersonalization, it seems likely that the team members they supervise will be adversely affected. Indeed, a leader’s own level of burnout has been shown to adversely influence faculty burnout and professional satisfaction in a previous study by Shanafelt and colleagues. In JAMA Network Open, Shanafelt et al further investigate at a different institution how academic leaders’ perception of burnout was associated with how faculty perceived their leadership behaviors. This study found that approximately 9.8% of the perceived variation in their leader behaviors, including offering encouragement, treating with respect, recognizing accomplishment, empowering team members, communicating organizational decisions, and providing career development, was associated with leader burnout. In contradistinction, higher leader fulfillment and self-evaluation scores were associated with higher scores of leadership behavior.

Clearly, both leadership characteristics and systems realities contribute to the workplace experience. Additional factors that contribute to physician and nursing perceptions of reduced burnout include finding meaning in one’s work, connecting with others to feel renewed, building social and trusting relationships with colleagues and leadership teams, cultivating a positive mentality, performing emotional hygiene, and recognizing one’s uniqueness and special contributions to the team.

The association of self-evaluation with leadership behaviors is an important finding in the study by Shanafelt et al. Having insights and motivation to reflect on personal errors, to grow with experience, and to practice care are critical attributes for successful leadership. These health-promoting leadership styles can reduce workplace stressors and burnout by promoting employees’ health directly (person-focused effect of environmental or workplace stressors [moderating actions]), cultivating health-related shared perceptions (climate control and management), and being a role model (modeling behaviors). Increased emphasis on these personal characteristics should be incorporated into assessment of academic leader appointments, not only to sustain leaders but also for the benefit of the faculty.
Of interest in the study by Shanafelt et al\(^5\) was the finding that the number of hours worked was higher in the age group with the least burnout, suggesting that not the hours worked but rather other factors lead to emotional exhaustion. Distressingly, burnout was higher in the younger, predominantly female faculty, the generation who are expected to mature into future leadership roles. Unfortunately, the scope and size of the study and data generated did not provide sufficient insight into potential differences based on practice discipline, sex, or underrepresented minorities in medicine. In addition, data were not available to ascertain whether female leaders were perceived differently by the faculty they supervise. Efforts to enhance the analysis to draw out some of these specifics would have jeopardized the anonymity of the work. However, each of these areas warrants additional investigation and considerations. Maximizing the full potential of teams within a health care organization requires targeted efforts that enhance equity, diversity, and inclusion. In a review of organizational strategies to reduce physician burnout, Olson et al\(^7\) provide significant insight and suggest goal-directed interventions in these areas, noting: “Remedying inequality, discrimination and exclusion should be an organizational imperative because it undermines well-being and also devalues half the work-force and adversely affects medical decision-making and the patient experience.”

Burnout in medicine is a public health crisis and was so even before the onset of the COVID-19 pandemic. It has been increasingly recognized and linked to compromised patient care, diminished quality and safety, physician and nursing turnover, financial effects on health care organizations, and the personal toll on individuals. The association of leadership behaviors, self-care practices, and role modeling are among many of the important factors to be considered and accounted for in strategies to build and support effective, cohesive health care teams.