UNDERSTANDING LEADERSHIP FATIGUE IN EMERGING PHYSICIAN LEADERS:

A QUALITATIVE STUDY OF PHYSICIANS TRANSITIONING INTO EXECUTIVE LEVEL ROLES

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Abstract

Despite increasing attention to physician leadership in contemporary healthcare, leadership fatigue among newly transitioned physician leaders remains poorly understood. This qualitative study sought to illuminate not only the onset but the nuanced developmental contributors to leadership fatigue.

Methods:
Seventeen physician executives across diverse clinical backgrounds, development opportunities, and geographic landscape participated in in-depth interviews, generating narrative rich data subjected to thematic and comparative analysis. The inquiry focused on revealing the lived experiences, hidden stressors, and systemic factors often overlooked in existing literature.

Findings:
Findings suggest that leadership fatigue in physician leaders emerges as a complex, cumulative phenomenon rooted in insufficient institutional support, ambiguous role expectations, and role dissonance. Rather than a singular moment, leadership fatigue reflects an ongoing interplay of repeated, destabilizing incidents. Results expose critical gaps in the prevailing literature, particularly regarding the intersection of role clarity and a lack of support.

Conclusions & Significance:
This research underscores a critical need for a multi-dimensional leadership development appraoch that address support structures, role socialization, and identity transitions for physician leaders. By redefining leadership fatigue as a systemic, rather than individual, outcome, these insights lay the groundwork for evidence-based interventions and future inquiry in physician leadership and organizational well-being with importance beyond healthcare and physician leaders.

Key words: Physician leaders, leadership fatigue, burnout, moral injury, professional identity, organizational support

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As the complexity of healthcare continues to grow, the importance of remaining grounded in evidence-based best practice and the practical considerations of what it means to deliver safe medical care and "do no harm" has become even more paramount. An important voice for representing this perspective is the physician leader, who often serves a critically important role at the nexus of the clinical and business aspects of American healthcare.

The physician leader possesses the unique combination of first-hand, immersive experience and knowledge associated with the practice of medicine and the potential to help translate this into practical and sustainable business practices. Rather than serving only as full-time practicing physician who periodically assists as advisors or clinical consultants to non-physician healthcare administrators, high performing physician leaders can provide dynamic contributions and meaningful perspectives that influence both clinical outcomes and successful business paradigms.

The value of physician leadership does not manifest organically and is borne out of a thoughtful understanding of what type of physician leadership expertise and skills are necessary for a healthcare company's given business needs. The decision to invest in dedicated physician leadership benefits from an intentional approach to setting these leaders up for success and cultivating optimal performance from these valuable resources over time.

In the absence of clear expectations and shared understanding of physician executive accountabilities, physician leaders are often set up to fail (Lord & Schecter, 2016). Their

executive colleagues possess varying perspectives on what they should or should not be doing. Furthermore, navigating potential pitfalls and landmines to maximally contribute value to the organization can be complex, confusing, and demoralizing. The results are often a less than compelling realization of benefits of investing in the physician leader role and physician leader turnover. This is an expensive proposition that could be avoided with a proper understanding of the critical success factors to hire right fit physician leaders, who then are positioned to become valued contributors to the success of the organization.

Purpose

The principle objective of this research is to better understand how and when physicians will experience leadership fatigue as a result of transitioning into leadership roles. There appear to be at least three primary points of potential failure when onboarding a physician executive:

1. Misalignment of Professional Identity: the dissonance between a physician's medical training and clinical skills that historically have defined their personal sense of purpose and individuality versus the transition to embrace the leadership and management skills that are distinct from that sense of self
2. Absence of Intentional Leadership Development: the lack of didactic, mentoring, coaching, and reflection that contributes to the accretive effectiveness of a leader
3. Cumulative Workplace Distress: the collection of workplace occurrences of burn out, moral injury, and/or PTSD that have an adverse impact on the psychological, emotional, and/or physical state of an individual

When these factors, separately and together, are not actively and productively managed, physician leaders, both new and seasoned, are often left adrift in the deep end of the pool with the expectation that they will either sink or swim. The likelihood of success diminishes

significantly, physician leaders fail, and a vicious cycle of non-physician executive colleagues losing faith in the value of physician leadership may ensue.

Physicians are conditioned to work hard throughout their medical school and residency training to keep patient care moving forward. This includes an expectation that when they place an order, an action occurs and an outcome is achieved reasonably quickly and predictably. With administrative medicine, the decisions a leader makes may take weeks, months, or even years to manifest the desired result.

Whereas a patient care plan can be designed and implemented with relative expediency, the analogue of management strategy design and execution can take much longer and is often informed by a complex web of diverse stakeholders. When physician executives experience delayed outcomes, they often compensate by working harder: longer hours, more meetings, and even potentially cutting corners like neglecting critically important relationship cultivation with others. Furthermore, the complexity of knowing which stakeholders to involve and when may be overwhelming compared to navigating medical practice.

This misalignment of professional identity and cumulative workplace distress in the absence of intentional leadership development and mentoring support ultimately results in physician leader burnout, suboptimal human (physical and mental) performance, and often frequent (and expensive) turnover. There appears to be an opportunity to mitigate if not avoid these adverse conditions-by seeking to further understand the root causes contributing to these points of failure.

Research Questions

The researchers are seeking to better understand the leadership development efforts that either contributes to or lessens leadership fatigue among physician leaders. Furthermore, we seek to

determine how quickly leaders will experience leadership fatigue resulting from Cumulative Workplace Distress after transitioning into a formal leadership role.

The combination of a) an absence of intentional leadership development, b) cumulative workplace distress, and c) misaligned professional identity manifest for physician leaders as experiencing a lack of support, role stress, and inadequate role clarity that ultimately increases the risk of leadership fatigue. This has generated the following research questions:

Central question: In the absence of effective development how quickly will physician leaders experience leadership fatigue after promotion into a formal leadership role?

RQ2: How does in adequate leadership development contribute to CWD among transitioning physicians?

RQ3: How soon will physicians experience CWD after transitioning into a formal leadership role?

RQ4: How does a lack of role clarity contribute to CWD as physicians transition to a formal leadership role?

RQ5: How does a lack of role clarity contribute to leadership fatigue as physicians transition into a formal leadership role.

Definitions

Cumulative Workplace Distress: the collection of workplace occurrences of burn out, moral injury, and/or PTSD that have an adverse impact on the psychological, emotional, and/or physical state of an individual.

Formal leadership role: for the purposes of this research, formal leadership role is Director or above.

Intentional Leadership Development: the constellation (or lack thereof) of didactic, mentoring, coaching, time, and reflection that contributes to the overall effectiveness of a leader and adult learning needs.

Physician leadership fatigue: physicians transitioning from clinician to leadership role, in the absence of adequate development who are struggling to stay motivated, passionate, or energetic and/or finding it difficult to motivate, guide, and/or encourage team members, and maybe experiencing Cumulative Workplace Distress (CWD).

Role clarity: a clear and articulated scope of role within any position or role. For the purpose of this study the researchers call out role clarity specifically as a contributor to leadership fatigue.

Role Stress/strain: an umbrella term that refers to a wide variety of feelings of psychological, emotional, and/or physical stress that may be triggered by the stress or strain that can exist within any role.

Conceptual Framework

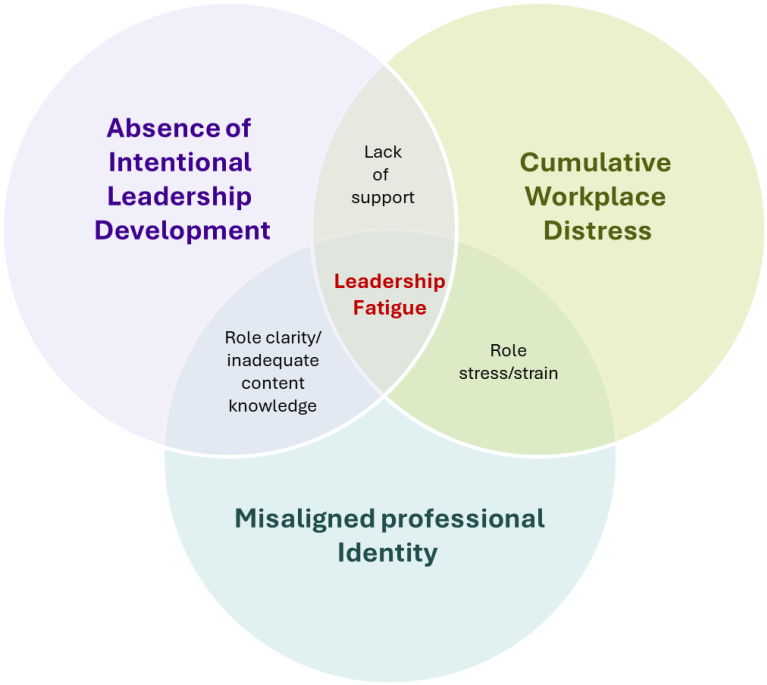
It is commonly known that the role of a physician is demanding. Many work long days, well into the evening or after their scheduled shift completing a litany of documentation and conducting patient follow up. Physicians often feel that they are viewed by the organization as a unit of production, rather than a valued team member. Boundary spanning, for example, is just one way in which physicians have inadvertently played an active role as patient loads continue to increase funding an ever and rapidly changing environment (Ramedani, et al., 2024; Lord & Schecter, 2016).

As the business of healthcare compresses clinics into systems, the physician demand is increasing yet again. With the expansion of physicians into key leadership roles, we see another set of challenges: transitioning the clinician to leader. A shift that is capitalizing on an already diminishing pool of physicians in many specialties.

The framework presented in this research seeks to answer the primary question related to leadership fatigue among physicians transitioning to a formal leadership role: how quickly will physicians experience leadership fatigue as a result of a) an absence of adequate development, b) cumulative workplace distress, and c) mis-aligned professional identify resulting in a lack of role clarity.

Figure 1

Conceptual framework



At the juncture of the framework are three spheres and resulting responses that may contribute to leadership fatigue.

> *Central question: In the absence of effective development how quickly will physician leaders experience leadership fatigue after promotion into a formal leadership role?*

Literature Review

Qualitative research conducted by Lord and Schecter (2016) examined the stress experienced by clinicians as they transitioned from clinician to leader. Results bore testament to the fact that several participants underwent stress, even trauma, during the transition. Developmental time or learning support, a luxury afforded to few, was a repeated expression with 60 occurrences and 97 specific references from 100% of the physician sample. Those who were offered, or went in search of, post-developmental support (i.e., mentoring, coaching), identified it as the key to their success, most reporting it as an out-of-pocket expense. Of the more compelling themes among the participants was the idea that the transition to an executive level position was lonely and confusing. Participants further expressed that the lack of support vis-à-vis the loss of collegial-physician relationships was also a significant forfeiture, especially when combined with limitations to forming new relationships within the executive team. The central purpose of this research is to examine the relationship between the lack of leadership development resulting in Cumulative Workplace Distress (CWD), and loss of professional identity to better understand leadership fatigue among physician leaders.

Intentional Leadership Development

Physicians, considered key subject matter experts, often provide guidance related to quality patient care, reimbursement, compliance, and a reduction in adverse events all within the milieu of a complex environment (Angood & Falcone, 2023). The scope of activities in which physician leaders can contribute value continues to expand to include areas such as business strategy, application and adoption of digital technology, reimbursement, and more. Thus, inciting both the need and demand for physician leaders with diverse subject matter expertise. The

ability to navigate these intricacies presents an often difficult and challenging mental paradigm shift for physicians (Ramedani, et al., 2024). The skills that serve them well in clinical practice may not translate effectively when they assume administrative responsibilities (Theobes, et al., 2023).

Specific leadership skills including but not limited to change- or relationship-management, conflict resolution, and systems thinking may not be as relevant to a full-time practicing physician. Despite the need for the development of these leadership skills, the education of aspiring physician leaders appears to be more focused on technical business administration and management skills. This includes areas such as operations and finance (Frich, et al., 2015).

Healthcare leadership or the business of healthcare

While hospitals and health systems are restructuring themselves to have a greater focus on physician leaders, it is likely that physicians are being educated in the business of healthcare not the leadership of healthcare. According to Beckers (2025, para. 3) having a standalone physician degree (i.e., DO or MD) is no longer viable, "younger physicians should strongly consider getting a second degree" in Business Administration or Public Health. Further insights from Beckers (2025), notes that many systems are contracting, not expanding, financial support for graduate level programs and/or internal development. Thus, requiring physicians to bear the burden of the additional cost of a Master's degree or transitioning into a leadership role without any development

A Masters in Business Administration (MBA), Public Health, or Informatics provides critical information and knowledge to running the business of healthcare, it differs from leadership and may not develop the necessary competencies to navigate the complex challenges in healthcare (Schwatka, 2024). Management of the business, regardless of the industry, is the ability to carry

out operational activities without the basic elements of leadership (Pruchnicki, et al., 2023). When we compare management and leadership characteristics (Table 1), we can begin to understand the different competencies necessary for leadership in a complex and rapidly changing environment (Frich, et al., 2014).

Table 1

Management vs. leadership tasks

Managing: accomplishing tasks through process	Leading: accomplishing tasks through people
Power base: Position and/or coercive – carrot and stick or fear-based motivation	Power base: influence – finds a way to share power, knowledge, and encourage involvement
Understands organizational goals Creates and prioritizes tasks Assigns tasks Reviewing work output & quality Controls scope of projects Reports on status Accepts and may even encourage conflict	Establishes direction through vision to support the organizational goals Assembles teams Creates shared values and meaning Knows skills and motivational needs of each team member Resolves conflicts by removing obstacles

Lord, D., 2023

Though it should be noted that management and leadership are not always mutually exclusive (Kousez & Posner, 2017). Further, the characteristics of leadership are more closely aligned to the values that physicians most espouse. Wiedman (2023) posits that the inability of healthcare institutions to formally recognize the differences between managing and leading creates further role stress, which will be addressed later.

Individual and organizational learning

Individual knowledge is maintained or re-shaped within the context of an individual's mental model (Senge, 1990). Consequently, individual learning is often over-shadowed by the needs, demands, and limitations of the culture (Ashforth & Saks, 1996). Learning is an individual

event, yet culture is a collective experience. Organizational learning occurs through a collective process of organizational commitment (Pham & Hoang, 2019); differing perceptions, shared understanding, and acquisition of new knowledge (Gnyawali & Stewart, 2003); psychological safety and dialogue (Dixon, 1994; 1996); and shared mental models (Senge, 1990) through a combination of information and interaction.

A comprehensive 2003 literature review by Gnyawali and Stewart describes the framework essential for organizational learning. Organizations have a collective mental model, referred to as a schema. Schemas are the concepts, conceptual relationships, and information contained within the institutional knowledge-bank. In the absence of new information (i.e., lack of knowledge transfer, dialogue) the old schema exists within a vacuum, unable to collectively expand even as new knowledge emerges. It is the lack of dialogue (Dixon, 1994; 1996) that limits any ability for a new schema to develop or for organizational learning to occur. Even as new knowledge or information comes to light it fails to become part of the organizational lexicon, ensuring the long-term existence of the status quo. Culturally this is represented as, *because we've always done it this way*. In the absence of a new schema, it is likely that many sub-schemas will develop creating disorder and confusion (Gnyawali & Stewart) as well as knowledge silos (Senge, 1990).

Explaining further, Gnyawali and Stewart (2003) bring forth the idea of how learning occurs through both information (knowledge) and interaction (dialogue and sharing). Informational learning occurs when organizations acquire, distribute, and interpret information. New information when shared allows for the modification of the existing schema. Interactive learning is the social support among team members. Presenting itself as discussion, storytelling,

knowledge sharing, and experimentation to name a few. In the absence of an evolving schema new information becomes difficult because there is no shared understanding.

This supports Dixon's previous work (1994; 1996) identifying dialogue as the key to successful organizational learning and individual development. In the absence of a supportive organizational community (organizational citizenship, psychological safety, values alignment, leadership support), dialogue is often overlooked or even discouraged. Mistakes, seen as missed opportunities or vulnerabilities, are regarded as crucial missteps rather than learning events.

Effective learning, both individual and organizational, has long been considered a strategic advantage in business. Pham and Hoang (2019) identified a notable relationship among knowledge transfer and organizational commitment. Similarly, Gnyawali and Stewart (2003) explored the relationship between effective learning and organizational citizenship. Citing that organizational learning was positively related to organizational citizenship when there were opportunities for a) collegial interactions and b) a reduction in formalized rules. As described in Senge's (1990) influential work, The Fifth Discipline, organizations function at their peak when it is able to overcome the very obstacles that limit learning.

Learning support

A 2021 study Shanafelt, et al., identified a notable association to physician burn-out and the lack of a supportive or learning environment, as did Chew, et al., (2022). Physicians need to develop the competencies that allow them to act on knowledge transfer in order to support complex change within a complex system (Schwatka, et al., 2024), which according to Theobes, et al., (2023) are based in differing motivators and efficacy between physicians and administrators.

Healthcare is not immune from the rapid pace of change; in fact, it may be argued that changes in healthcare far outpace that of traditional business. Policy, regulatory, finance, technology, are just a few of the changes that are constantly evolving healthcare (R. Hamilton, MD, Personal Communication, 1/21/2025). This means there is often considerably less tolerance for learning in an environment with an increasing need for ambiguity, as there is an unwritten expectation and demand of speed and adaptability. This is especially true as the trend for physician leadership is experiencing an increase in demand, speed, and adaptability.

Humans naturally develop patterns of behavior based on observable events (Goleman & Boyatzis, 2008). In a non-supportive culture, learned or outdated behaviors are rarely questioned. In a toxic, or fast-paced environment common within healthcare, these behaviors, even dysfunctional ones become emulated over time through the socialization process (Jackson-Lord, 2007; Lord & Schecter, 2016) and mirror-neurons (Goleman & Boyatzis).

Managerial and leadership support. Effective managers, as defined by Luthans, (1988) are those who develop their team using time, tools, and support. Humans are complex; there exists a wide variety of learning needs, temperament preferences, and motivators. For individual and organizational learning to occur, managers must understand the unique learning needs of each individual (Galema, 2022). Further, as acknowledged by both Chew, et al., (2022) and Shanafelt, et al., (2021), leadership style and managerial effectiveness were noted to be in direct relationship to burn out and turnover intent (Martinussen, et al., 2020), role clarity (Zheng, et al., 2013), institutional supportive learning and professional identity (Luchinger, et al., 2024), leader emotional intelligence (Considine, et al., 2023), professional relationships (Yikilmaz, et al, 2024), and ability to dialogue (Dixon, 1994; 1996).

In the fast-paced, competitive environment, the value of time to learn is often underestimated (Lord & Schecter, 2016). As noted by one physician-leader, "Even once I took this role, there was no focus on development. There was a long learning curve, it was mostly on the job training…being thrown into situations that you were not trained for" (p. 31).

Development time. Development is the intentional process of fostering specific knowledge, skills, abilities, and competencies to support new behaviors and perceptions, knowledge transfer, and practice requiring time and effective role models. The lack of adequate development time and resources was cited as a contributing factor to physician leadership fatigue (Chew, et al., 2022; Lord & Schecter, 2016). This is further supported by Luchinger, et al., (2024), who noted that physicians are often promoted on academic or clinical achievements rather than their leadership or management efficacy. Further, many fail to receive clear development goals (Haruta, et al., 2020) or role clarity directly impacting engagement (Lord, 2024).

While there is little support in the literature to sustain the claim, it is likely that many physicians are put into formal leadership roles with little preparation. Anecdotally, however, the researchers have observed that physicians are placed into key leadership positions with little, if any, evaluation or assessment of critically important leadership skills. This extends to customized learning such as assessments that would inform an intentional approach to closing the knowledge gap or understanding specific individual needs. Luchinger, et al. (2024) revealed similar findings.

Nevertheless, administrative leaders are frequently provided with a developmental pathway known as a succession plan. Succession planning is an intentional process of identifying key individuals with strong leadership skills. According to D. Benny, a leadership development professional with years of succession planning experience, succession planning among

administrative leaders, is not only a common practice, but includes multiple factors such as, a detailed individual development plan, specific competency goals, multiple assessments, evaluation, coaches and mentors, and coursework over a multi-year period (Personal Communication, 4/9/2025). Leadership development among physicians has been limited to lectures and seminars, lacking the necessary elements for leadership competency development (Frich, et al., 2015; Schwatka, et al., 2024), and limited in developmental feedback (Zheng, et al., 2013). Long-term exposure to healthcare operations, in a succession planning style, as identified by Ramedani, et al., (2024) could help to bridge the learning gap and clarity as well as increase future physician-administrator collaboration.

Socialization

The socialization process can be considered an essential, albeit informal, learning activity. Employee or role socialization is the process of examining the contextual, content, and social needs of employees, preparing them for an experience that ensures a greater degree of cultural integration. It can be specific to employees moving into a new role, i.e., Chief Medical Officer, and extends into entire professions, i.e., physicians, nurses, engineers, across industries. During such time, the notion of professional identity often manifests into a strong professional bond.

Organizational or institutional socialization is the method that is considered more inclusive than its individual counterpart of individual socialization (Ashforth & Saks, 1996; Jackson-Lord, 2007), often referred to as on-boarding. Hence, ensuring that individuals have a "shared experience with purposeful activities in a defined structure during a specified period of time, and socialized with a mentor designed to build on existing skills." (Jackson-Lord, p. 59). Institutional socialization is considered to be more supportive of newcomers while reducing role

stress (Ashforth & Saks, 1996; Galema, et al, 2022, Jackson-Lord, 2007, 1996; King & Sethi, 1998) and increasing or sustaining engagement (Lord, 2024).

The lack of effective socialization is a significant contributor to both role stress and strain and burn out. An examination of socializing healthcare professionals revealed that veteran nurses reported significant role stress when they transitioned to new nursing roles (Jackson-Lord, 2007) physicians taking on executive level --primarily CMO-- roles experienced role stress and strain, specifically when there was considerable ambiguity in the role description (Lord & Schecter, 2016). Social workers, finance professionals, and even engineers experienced role stress and a loss of engagement as a result of inadequate socialization (Lord, 2024).

Content Knowledge. Content knowledge is the information, skills, and overall experience that empowers employees to effectively perform their duties. It is one of the three key elements of role strain from inadequate socialization. Nurses identified a lack of adequate content knowledge as a key indicator in role stress (Jackson-Lord, 2007). Physicians are no less prone to the stress as it relates to transitioning from clinician to leader. According to Ramedani, et al., (2022) physicians often struggle to differentiate the goals associated with healthcare operations and patient interactions.

The rapidly changing healthcare environment requires a unique skill set not normally afforded to physician practice. The skill set of leaders requires change management, team dynamics, conflict resolution, collaborative partnerships, performance improvement, and much more (Lord & Schecter, 2016; Frich, et al., 2015). Hence, physician leaders require a significant mental model shift in perspective that may contradict with their perceived priorities i.e., patient care (Galema, et al, 2022; Ramedani, et al., 2024). Equally important is the need to transition

physician leaders from autonomous decision makers to collaborative ones (Luchinger et al, 2024).

Consider the difference between the content specific knowledge of physicians and business leaders as part of their graduate level business education most associated with administrative leaders. Business education frequently requires collaborative team type of interactions, thus enhancing the employee's ability to work with others. These skills are further enhanced once the student enters the workspace as multi-operational teams work in partnerships across the organization. In the silo-approach of contemporary health systems, however, the ability to learn through collaboration is limited.

Figure 2

Physician vs. organizational-leader competencies

Physicians	Organizational leaders
Autonomous decision makers	Collaborative decision makers
Reactive problem solvers	Proactive problem solvers
Focus on detail	Focus on the system
Analytical - linear thinkers	Creative - intuitive thinkers'
Little tolerance for ambiguity	High tolerance for ambiguity
Patient - centered	Organization/strategic - centered

Lord & Schecter, 2016

It has been suggested that physician only leadership development programs may be ideal for developing a physician support structure, however, it potentially limits the ability of content sharing (Frich, et al., 2015; Ramedani, et al., 2022; Schwatka, et al., 2024). Furthermore, the hierarchical structure of the physician at the top may limit the willingness of others to question a perceived order or abut up against long-held professional practices. Yet, as noted by Thoebes, et

al., (2023) learning needs and styles varied significantly among administrators (traditional organizational leaders) and physicians.

Successful leadership development requires a structured process, effective interaction, as well as time, that allows for learning to occur. These are the fundamental antecedents afforded to administrative, executive leaders across industry but do appear to be extended to transitioning physicians.

RQ2: How does inadequate leadership development contribute to CWD among transitioning physicians?

Cumulative Workplace Distress among physician leaders

The researchers have identified the collection of psychological workplace occurrences of burn out, moral injury, and PTSD as Cumulative Workplace Distress (CWD). These are the known, various stressors that build up overtime. They may occur as a single incident or compound and present in multiples. As it is well established within the literature that each of these has an effect on physicians, for the context of this study, they will be combined, addressed a cluster of variables rather than three unique ones.

PTSD

Boitet, et al., (2023) identified moral distress as a significant and ubiquitous factor of PTSD among healthcare workers in general. PTSD is defined as a psychological incident that occurs after a traumatic event. Though more dramatic than its counterparts, PTSD in the workplace is not uncommon. While physical abuse is not a normal occurrence, emotional and/or mental abuse in the workplace is. This has widely been associated with the 1950s Asch Conformity Studies, 1960's Milgram experiment, as well Stockholm syndrome (1973) highlighting that colleagues

and co-workers can influence conformity through psychological incidents and even physical violence.

When we consider the standard definition of trauma as “repeated and prolonged instances of interpersonal events” (retrieved 9/20/2024 from https://www.bing.com/search?q=trauma%20defintion&FORM=ARPSEC&PC=ARPL&PTAG=30532071) we can begin to reframe our mental model of trauma that extends well beyond an event, and realize that by this definition it occurs daily in healthcare, in both clinical and cultural settings. Novilla, et al., (2024) identifies this as type II trauma, defining it as complex trauma. Complex trauma is prolonged, recurring, multiple, and repetitive, often involving an interpersonal relationship. Little research addresses PTSD in isolation, rather it is addressed in conjunction with moral injury and burn out.

Moral injury

Moral injury or moral distress is becoming more widely acknowledged as a significant challenge in healthcare. Shanafelt, et al., (2021), identified moral injury or distress as an occurrence when physician values are misaligned, especially when associated with quality of patient care. Byrne (2024) also addresses moral injury currently affecting healthcare providers. Defining it as a part of something that goes against your values, is ordered by somebody superior, and has high stakes. This is particularly evident among physicians transitioning to a leadership role, as they struggle with putting cost over care (Boitet, et al., 2023; Luchinger, et al., 2024), and mis-aligned values (Shanafelt, et al.).

Many transitioning physician leaders face the further erosion of collegial relationships through the requirement of their new role by becoming the gatekeepers of disruptive physician behavior. Sharing her experience transitioning to a physician leader, J. Binderman, MD

indicated that the primary objective with most physician leaders is the expectation that they "deal with" disruptive physician behavior (Personal Communication, 2/19/2024). Her experience was not limited, appearing to be more of a general expectation. Placing physician leaders into the space of primary disciplinarians further erodes the collegial relationships that have been identified as a critical means of physician support (Chen, et al., 2024).

Social support. Miljeteir, et al., (2024) identified that younger, female physicians experienced greater moral distress than older ones. Results from the study validated the necessity of social support as the contributing variable. Social support, as described by Chen, et al., (2024), can range from a sense of feeling valued, finding meaning in work, trust, and self-confidence. The latter being important in the structure of leadership development that occurs through the learning process.

Somech and Drach-Zahavy (2004) provided additional insights into leadership style and greater group cohesion. Employees who have greater group cohesion are more likely to have better organizational support. For physicians this could point to the need for more internal cohorts thereby creating a new support system, rather than isolating them into outside academic business degrees (Prucjnicki, et al., 2023). However, as previously addressed, there are limitations around content and knowledge transfer in an isolated, physician only environment.

Healthcare as a whole is often inflexible, governed by a multitude of internal and external policies. Typical healthcare culture is known to be very formal and stoic, with little if any intolerance for mistakes. This is further elucidated by the hidden curricula as part of physician education (Huruta, et al., 2020; Lord & Schecter, 2016; Tolins, et al, 2023).

Hidden curricula. As part of their work, Huruta, et al., (2020) found the need for role models and professional belonging as a significant necessity among physician leaders. Tolins, et al.,

(2023) agreed, specifically calling out the long-term, unintended consequences of the hidden curricula identifying an inability through learned behavior among physicians to seek out help. This is further re-enforced through the lack of intervention among Well-being Officers who fail to intervene until there is a real problem with physicians (J. Kolkins, MD, Personal Communication, August 27, 2024).

Burn out

A substantial body of research affirms that burn out among physician leaders remains prevalent. Both Chew et al., (2022) and Holzgang, et al., (2023) have asserted that physician leaders who lack efficient coping styles experience greater burn out. When coupled with the fact that many transitioning physician leaders experienced a loss of collegial relationships (Lord & Schecter, 2016) this deterioration may be a significant lost source of personal coping methods and/or support. Of the more compelling, recent studies, Chen, et al., (2024) advanced the notion that social support, psychological capital, and multidimensional job burnout is a factor in turnover intention among physician leaders. Conclusions from this study most closely contribute to the hypothesis of leadership fatigue. Most notable: the strong correlation to the lack of social support, the erosion of psychological capital, and moral injury all contributing to turnover intent.

Intent to leave. What is most compelling about turnover intent is in the very word *intent*. Seminal research conducted by Withey and Cooper (1989) concluded that employees who intended, but were unable, to physically leave the organization were more likely to adopt disruptive or complacent behavior. While their research did not factor in physicians specifically, the body of overall evidence is supportive that hurt humans do behave in consistent ways regardless of education or experience.

Later work into the intent to exit, however, did reveal that leadership style had a significant influence. Results from Martinussen, et al., (2020) showed that respondents were twice as likely to leave when both the social climate vis-à-vis leadership style and value congruence was low. The influence of leadership style and turnover was also a repeated theme in Shanafelt, et al., (2021) and Yikilmaz, et al., (2024). Shaukat, et al., (2020) demonstrated that an increase in job- or role-related demands was a significant indicator in intent to leave. Yikilmaz et al., addressed increasing job demands and limited resources as a significant contributor to emotional exhaustion, a factor of burn out due to on-the-job surface acting.

Role stress and strain

Role stress and strain, often considered a panacea term, includes a variety of role-related issues that includes role-conflict, -ambiguity, -expectations, among others. Role-strain stress is heavily influenced by an individual's role, and like CWD may present alone or in combination. For example, role-stress, -incongruity, and -conflict may all be present at any given time. Regardless of how it presents, role strain is well known in the body of knowledge to be a cause of job dissatisfaction (Zheng, et al., 2013) as well as psychological stress (Mobily, 1991), and burn-out (Shanafelt, et al., 2021; Chew, et al., 2022).

Role-Stress. Just one of the role strain components, role-stress often includes role-conflict and -incongruity, both result in stress when role expectations are contradictory or mutually exclusive. It is highly correlated to job dis-satisfaction, increased stress, dis-engagement, and burnout; frequently associated with a lack of role clarity (Brumels & Beach, 2008; Zeng, et al., 2013) or content knowledge (Frich, et al., Ramedani, et al., 2022).

Defined by Chang and Hancock (2003) as the "consequence of disparity between an individual's perception of the characteristics of a specific role, and what is actually being

achieved by the individual currently performing the specific role" (p. 156). It has further been identified as a significant interference in personal and/or collegial relationships (Bacharach, et al., 1991; Yikilmaz, et al., 2024)) as well as role stressors that affect both job satisfaction (Brumels & Beach, 2008; Wiedman, 2023) and physical health (Kemery, et al., 1987; Shaheen & Mahmood, 2024; Yikilmaz, et al.). Moreover, a lack of adequate job socialization is a key contributor in fomenting role stress.

There is a wide array of literature that addresses CWD. While a great deal of it addresses the burn-out and a lack of support, little assesses the underlying need of inadequate leadership development as the root cause of physician leadership fatigue. CWD reflects the significant consequences of working in a stressful, or toxic, environment, generating additional role strain. A repeated theme among the literature specifically relates to CWD among physicians and their identity

RQ3: How soon will CWD begin to impact physicians in formal leadership roles?

Misaligned Professional Identify

The idea of professional identity is often deeply rooted among associates, and reinforced through professional socialization, addressed previously. Individuals develop this sense of identify often beginning as university students, then into graduate level work through their development of values formation (Luchinger, et al., 2024). Examining the nuances of role conflict, Wiedman (2023) suggested that it is the idea of clinician that is embedded in the professional identity of healthcare professionals through a set of shared values.

Medical students in particular work closely in a cohort over several years forming deep attachments, often marrying inside of their cohort. Over time, these cohort members develop an

in-group (Chew, et al., 2022) through a shared bonding experience like the challenges of medical school (Haruta, et al., 2020; Lord & Schecter 2016). These in-group attachments are further reinforced through the institutional socialization process. Shared values, language, and experiences (Angood & Birk, 2014) frequently become a common bond over time even as and when institutional shifts occur (Jackson-Lord, 2008; Luchinger, 2024).

Upon an examination of Swiss physicians, Luchinger et al., (2024) verified that identity was one of several factors that prevented them from seeing themselves as legitimate leaders as they moved into more institutional-oriented work. Most revealing were the negative emotions physicians expressed in relation to their hierarchical position, expressing a difficulty to reconcile their role as a health professional with that of a leader.

This sense of professional identity then becomes the exact social support that is needed, but often eroded as physicians transition into leadership roles. Inadequate role clarity through this transition often leaves them in a supportive vacuum as they struggle to make sense of new work. The lack of structured content knowledge or transfer may also be a limitation in assisting the physician to mentally and emotionally modify their professional identity through a loss of role support and clarity. Erosion of professional values creates further identity impasse among physicians who must distance their altruistic based principles with operational priorities (Boitet, et al., 2023; Hurata, et al., 2020; Luchinger, et al., 2024; Ramedani, et al., 2022; Shanafelt, et al., 2021), or the business of healthcare, which often conflict.

Shanafelt, et al., (2021) identified the value incongruence often experienced by physicians as they transitioned was a significant source of identify incongruence. With most physicians expressing an altruistic mindset, many have found the transition to leadership challenging. With

the emphasis on business of healthcare rather than leadership (i.e., emphasis on relationships more aligned with altruism) could be another source of mis-aligned identity.

Inadequate Role Clarity

Researchers have given little attention to the lack of physician leader role clarity. Role-clarity falls under the role-strain structure but differs in that it is ambiguous or lacks a commonly accepted framework. Brumels and Beach (2008) assessed role-strain looking at role-ambiguity, -incongruity, -incompetence, -complexity, -overload, and -conflict among collegiate athletic trainers. Their analysis showed that role-incongruity and role-ambiguity was most associated with job dissatisfaction among clinicians.

For the purposes of transitioning physicians' role-ambiguity, -incongruity, and -incompetence are most notable in terms of role clarity. In table three, the researchers extrapolated results from the Brumels and Beach (2008) study. Overall results as reported as low to moderate among the clinician sample, found in table two.

Table 3

Summary of role stress/strain variables

Role stress/ strain variable	Role strain variable definition	Clinician sample
Role ambiguity	Expectations are unclear or vague, ill-defined, associated with poorly defined requirements	23%
Role Incongruity	Role obligations and personal values are incompatible	18%
Role Incompetence	A person does not have the necessary skills or knowledge to successful perform or the responsibilities associated with a job	7%

Brumels & Beach, 2008

The low sample results were noted by Brumels and Beach (2008) as being incongruous with similar healthcare professionals. One possibility is that Collegiate Athletic Trainers, even as

physicians tend to have more tolerance for ambiguity overall. The most significant finding among their work was related to the poorly developed job descriptions and evaluation processes rather than the overall role strain associated with role-stress or even role-incompetence. It does shed further light on findings from Lord and Schecter (2016) on the lack of clarity around the role of Chief Medical Officer. Role-incongruity aligns both with the idea that ambiguity remains a challenging competency for physicians as well as moral injury.

Curtis, et al., (2025) identified some of the top limitations of physician leadership, indicating that their perceived knowledge expectation was inconsistent with reality. Role incongruence (physician knowledge) supports findings from Lord and Schecter that new physician leaders, who believed they were bringing years of expertise to the table only to learn that their input was not deemed of value. Schwatka, et al., (2024) noted similar challenges to physician leadership development.

Role ambiguity. It has been reported that physicians often experience the ambiguity of their role as they transition into leadership functions. Ambiguity among physicians, however, has not traditionally been a desirable competency. The very idea that physicians need time (Ramedani al., 2024), dialogue (Dixon, 1994; 1996), and greater competency development (Frich, et al., 2015; Schwatka, et al., 2024) to prepare for leadership roles is often considered unnecessary (Lord & Schecter, 2016) by nature of their education, background, and experience. Role stress, specifically role-ambiguity, together with a sense of increasing visibility and a recurring theme of feeling unsupported was a significant finding in Lord and Schecter (2016). Thirty percent of participants reported that the lack of the CMO role structure was a significant developmental limitation (Lord & Schecter).

Role incompetence. Many veteran leaders and executives have had years to sharpen their skills. Organizational managers spend several years in a myriad of roles, developmental activities like previously addressed succession-planning as part of their advancement over their tenure. Physicians it seems are immune to this support. As noted by veteran neurosurgeon and CMO,

> suddenly I am interacting with these people in a completely different way. You have to learn pretty fast, you don't get 20 years to learn it. I had 25 years of a gradual learning curve: I didn't have 25 years of innate subtleties of what to do or not to do. (Lord & Schecter, 2016, p. 32)

Considering that physicians spend years honing a unique skill set, but are given little if any time to develop new ones, often experience social loss and isolation especially as they transition to an administrative role (Chen, et al., 2024; Miljeteir, et al., 2024). Results from Luchinger, et al., (2024) noted that those who found unique coping mechanisms as they as their professional identity shifted fared better than those who did not.

Role incongruity. Role incongruity is defined as conflicting obligations and either personal skills or values are incompatible (Brumels & Beach, 2008). Carte & Williams (2017) describes role incongruity as the "demands [of] several attributes which are inconsistent" (p. 82). This is consistent with the content knowledge element from the socialization literature. An example role incongruity of within healthcare is assigning a peri-operative nurse to assist as an OB nurse without any additional education. For physicians emerging into leadership territory, this is most closely related to their perceived role of value as a physician caring for patients versus the value of cost over care (Lord & Schecter, 2016). In relation to the conflicting obligations and values, role incongruity is also closely aligned with moral injury (Byrne, 2024; Shanafelt, et. al., 2021).

RQ4: How does a lack of role clarity contribute to CWD as physicians transition to a formal leadership role?

RQ5: How does a lack of role clarity contribute to leadership fatigue as physicians transition into a formal leadership role.

The researchers have presented a framework of three distinct elements all related to events around how individuals, specifically physicians, learn and develop within organizations as well as the consequences of poor development. Several recurrent themes emerged as a part of this review: CWD, role or job dissatisfaction, loss of professional identity, role strain all of which appear to inexorably linked. Effective or adequate leadership development is so much more than attending a few classes. It involves time, dialogue, new supportive relationships, and managers who understand the learning needs of adults all within the loss of professional identity and collegial support. Table three provides a summary of the relationship between the variables within the conceptual framework.

Table 3

Summary of variables from literature

Variable	Sub-variable	Citations
Leadership Development	Healthcare leadership or the business of healthcare	Pruchnicki, et al., 2023 Ramedani, et a., 2024 Thoebes, et al., 2023
	Individual and organizational learning	Ashcraft & Saks, 1996 Dixon, 1994, 1996 Gnyawali & Stewart, 2003 Pham & Hong, 2019
	Learning Support	Chew, et al., 2022 Goleman & Boyatzis, 2008 Lord & Schecter, 2016 Lord, 2024 Ren, et al., 2024

		Somech & Drach-Zahavy, 2004 Schwatka, et al., 2024 Thoebes, et al., 2023
	Socialization	Ashforth & Saks, 1996 Frich, et al., 2015 Galema, et al., 2022 Jackson-Lord, 2007 King & Sethi, 1998 Lord, 2024 Luchinger, et al., 2024 Martinussen, et al., 2020
Cumulative workplace distress	Moral injury	Boitet, et al., 2023 Byrne 2024 Chen, et al., 2024 Haruta, et al., 2020 Luchinger, et al., 2024 Miljeteir, et al., 2024 Shanafelt, et al., 2021 Tolins, et al., 2023
	PTSD	Boitet, et al., 2023
	Burnout	Chen, et al., 2022 Holzgang, et al., 2023 Lord & Schecter, 2016 Shanafelt, et al., 2021 Withey & Cooper, 1989
	Role-strain	Akkoc, et al., 2020 Bacharach, et al., 1991 Brumels & Beach, 2008 Chang & Hancock, 2003 Kemerly, et al., 1987 Mobily, 1991
Misaligned professional identity	Inadequate role clarity	Brumels & Beach, 2008 Carte & Williams, 2017 Chen, et al., 2022 Haruta, et al., 2020 Lord & Schecter, 2016 Luchinger, et al., 2024 Miljeteir, et al., 2024

From the literature, the researchers present in figure three, a radar graph that visually represents the three main topics of the conceptual framework: leadership development, CWD, and mis-aligned professional identity overlayed with the three primary resulting symptoms (lack of support, role clarity, and role stress) that contribute to leadership fatigue.

Figure 3

Physician leadership dynamics: role clarity, role strain, and support gaps as presented in the literature

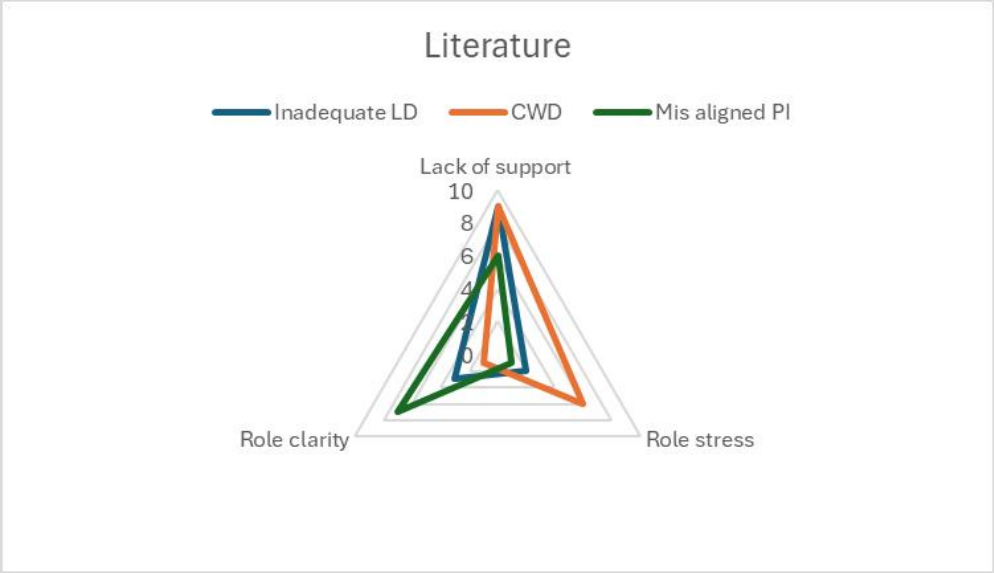


Table 4

Literature data themes

Participant – data themes			
	Lack of support	Role stress	Role clarity
Inadequate LD	9	2	3
CWD	9	6	1
Mis aligned PI	6	1	7

Table four, a cross-section of the data from the literature review supports figure three a visual representation of the current literature trends. Leadership Development: Shows the highest in area of lack of support, but not as much in role clarity or role stress. This suggests that while physicians are transitioning into leadership roles may understand their responsibilities, they may struggle with the resources and support needed to fulfill them effectively. CWD: Shows significant spikes in lack of support and role strain. This highlights how workplace stress compounds when physicians face unclear expectations or insufficient backing during their transition into leadership. Mis-aligned professional identity: Indicates lower scores across most dimensions, particularly in role clarity and misalignment. This suggests that misalignment between personal identity or performance indicators and professional roles could exacerbate leadership challenges.

In summary there are a variety of factors and sub-factors contributing to leadership fatigue among transitioning physicians. This multifaceted set of variables creates an intersection of complexity that is challenging at best for many transitioning physician leaders. The lack of intentional leadership development looked more closely at a variety of elements related to the practice of effective development, leadership competencies in the context of how adults and organizations learn in tandem. Cumulative workplace distress explored the relationship to social support, hidden curricula of medical school, and role strain. Finally, mis-aligned professional identity further assesses the relationship to the lack of role clarity.

There are two significant gaps in the knowledge: empirical and theoretical. What remains to be addressed is an in-depth assessment of what and how physicians need in order to successfully transition from clinician to leader. It is the objective of the researchers to more closely examine

how the absence of inadequate leadership development, specifically role clarity, for physician leaders contributes to physician leadership fatigue.

Methodology

The study was informed by a constructivist interpretivist paradigm, aiming to uncover meaning as constructed through participants' lived experience. This approach was chosen to provide a nuanced understanding of the key phenomena, allowing for flexibility in both data collection and analysis while prioritizing the voices and perspectives of the participants. It was important that the researchers capture the real, often raw, lived experience of the participants. While this is not formal grounded theory, IPA, or ethnography, it is rigorous and well-suited for applied, practitioner-relevant health research. This approach was aligned with the researcher's goal of better understanding if and when leadership fatigue would surface.

Reflexivity was promoted by recognizing the primary researcher's background in leadership and qualitative research, and by involving a diverse research team in all phases of data collection and analysis. Secondary researchers have extensive experience in healthcare and healthcare leadership. Any research has limitations including assumptions, and the lived experience of the participants may have influenced data collection and interpretation. Data coding and analysis were conducted by a non-physician to minimize coding bias.

Recruitment and sampling

Consistent with the primary research question and aim of the study, the sampling strategy was purposive targeting those with direct, lived experience of the current phenomenon of physician leader fatigue. However, there was no requirement that physicians currently held a senior level leadership role.

Recruitment was done among physicians apart of American Association for Physician Leadership; American Board of Physician Services; University of Tennessee, Knoxville; Physician Executive MBA cohort, LinkedIn, as well as personal and/or professional contacts of the researchers. A minimal amount of snowballing was present among the sample.

The initial sample size of 20 was a mixture of physicians with varying specialties all having served in the capacity of a senior physician leader (i.e., C-suite, Medical Director, etc.). For various reasons, three participants withdrew prior to the focus groups. Researchers were prepared to recruit additional participants, nevertheless data saturation was reached early in the coding process.

Participants received an invitation to attend one of several virtual-based focused groups of up to three physicians per event with two researchers present for data collection. Participants received the research abstract, informed consent (appendix one) along with demographic questions (appendix two) prior to scheduling. Since the sample consisted of participants across the United States, informed consent signatures were acquired using Google Docs and an electronic signature. Scheduling was conducted through Google calendar feature and pre-determined focus group dates, limited to three physicians per group. Table X highlights the focus group mixture. Each participant was given a Pseudonym to ensure anonymity and confidentiality (appendix four)

One limitation to the sample overall was that several participants were known to each of the researchers. Thus, this sample may have had a shared set of similar values and ethics that generated prevailing themes. It should also be noted however that several participants indicated that they did not experience leadership fatigue in the overall demographics, despite instances of the latter presented within their story.

The research followed established ethical principles for human subjects research, including informed consent, confidentiality, and the preservation of participant welfare.

Participant characteristics

Participants received the research questions (appendix three) upon signed informed consent and focus group confirmation. As there was limited time of one hour per focus group researchers encouraged participants to reflect on the questions ahead of time to give full consideration to each question. Even though more than half of the focus groups consisted of two or three participants, each confirmed that they felt the time was adequate to address their responses. The 15 questions were generated among the researchers to gather the lived experiences of physicians as they transitioned into leadership roles.

The physician sample (Table four) represents the diverse group of specialties and leadership experiences from across the United States. Table four displays the participant sample mix.

Data collection

Data collection used a long-form, in-depth interview similar to grounded theory, but more flexible to generate narrative rich data. The researchers recorded the virtual focus groups and used the accompanying note-taking feature to ensure adequate capture of participants experience. Using the recording and notes feature allowed the researchers to more quickly compile final notes for member-checking, part of the qualitative validation process, and were deleted after 30 days. For consistency, two of the three researchers were involved in each focus group. Participants took turns responding to questions and often engaging with shared ideas and recollections. This also ensured that the researchers were able to collect narrative rich stories, identified emotional responses, while asking probing questions for clarity. In some, but not all instances, physicians had worked together in previous institutions. Participants received

Table 5

Physician participant sample

Gender	Male	7
	Female	10
Age	40 – 49	3
	50 – 59	7
	60+	7
Medical degree	MD	16
	DO	1
Specialty	Critical care	1
	Emergency Medicine	2
	Family medicine	3
	Surgery	2
	Geriatrics	2
	OB/GYN	1
	Pediatrics	3
	Physiatry	2
	Urology	1
Years in clinical practice (in years)	1 – 9	1
	10 – 19	6
	20 – 29	10
	30+	0
Years in leadership positions (in years)	1 – 9	3
	10 – 19	6
	20 – 29	8
Current leadership position	Executive	7
	CMO	3
	CMIO	2
	Director	5
Years in current leadership position (in years)	<1 year	
	1 – 5	13
	6 – 10	3
	11+	1
Leadership or team opportunities in medical school or residency	Yes	9
	No	8

transcripts for validation as part of the member checking process. Two participants asked for final comment validation prior to publication. Participants were not offered any compensation for their hour of time.

Data coding and analysis

Data coding and analysis used an open coding method to identify concepts, categories, and themes to capture the experience of physician leadership. Coding did not begin until participants had validated their transcript. Each transcript was read and coded by the primary researcher to capture themes, which emerged early. Themes were recorded in Excel with accompanying participant narrative. Themes were then coded in a manner that aligned with the conceptual framework often generating multiple codes per shared experience (i.e., LD, RS, LS). Data coding was conducted by the lead researcher who has qualitative research experience and reviewed by secondary researchers for consensus.

Data saturation was defined as the point at which no new codes or insights emerged in subsequent focus groups and was judged to be reached after analysis of 17 interviews. The theme of disillusionment was not immediately called out, but was pervasive and present early into the data coding process. Finally, theme and resulting participant data was married to the conceptual framework and one of the five research questions (appendix four). This ensured that resulting information could directly respond the each of the five research questions. Trustworthiness was enhanced through member checking, multiple coders, a detailed audit trail, and transparent reporting of researcher reflexivity and sample limitations

Table 6

Theme codes and grouping

Conceptual Framework	Code	Notes
Leadership Development	LD	Any reference to specific incidents of leadership: training, development, mentoring/coaching, or lack thereof
Lack of support	LS	References to feeling unsupported in the role
CWD	CWD	Included burn out, moral injury, etc.
Role stress/strain	RS	Specific incidents of role related confusion, i.e., stress, ambiguity, conflict
Professional ID	PI	References made to loss of collegial support, language, etc.
Role clarity/content	RC	Specific element of Role Stress that made reference to ambiguous responsibilities, lack of understanding role specifics including others

Summary of findings

Several themes emerged from the participant interviews. Data was collected and coded for themes and patterns that aligned with the conceptual framework and five research questions.

Central question: In the absence of effective development how quickly will physician leaders experience leadership fatigue

"from an emotional standpoint, I was a mess." (Ron)

The central research question itself, identifying a general timeline of leadership fatigue, was generally unsupported. Notable however was that all of participants interviewed showed some signs of CWD as a contributing factor to leadership fatigue. Responses were broad ranging from a determination to work harder by Peter,

> I assumed that if I worked harder, longer hours, got more people involved, had more resources that 18 months could be compressed into weeks or months. I can say this in retrospect, that's neither realistic nor sustainable in terms of pace.

To a shared range of emotions that transpired over an unspecified period of time such. These varied from: notable irritability or an increased prevalence for alcohol consumption. Kyle, Ron, and Jeff noted that the stress of the role took a toll on family life. Additionally, participants mentioned a myriad of physical (weight gain, self-medicating, appearance), mental (major depressive disorder), and emotional (anger management, "I'm not good enough") symptoms and thoughts.

An interesting reaction to leadership fatigue was role abandonment. Kevin, Angela, and Joshua shared that when things did not go as expected or they felt unsupported, the simplest course of action was to walk away. From Joshua's perspective it wasn't about fatigue but integrity,

> it was more about character integrity where my response, an oppositional defiant streak, is one to speak truth to power, and if I'm not lined up, I'll exit. I left because I couldn't align with leadership and the culture that they developed, but it wasn't about burnout, it was about integrity.

Even coming to the realization that having the ability to know that they could walk away was empowering. Joshua continues,

> I have a unique character…in that I can walk away. I can turn it off and I can walk away unless there's some really huge problem that that I have to deal with for some period of time, but otherwise I can turn it off and go on.

Kevin shared a similar reaction,

> I think whenever I get a sense that people aren't getting it, then I move. I don't want to try to belabor the point, I don't want to try to get them to see it. I'll give them a good amount of time, but, you know, if they're not gonna' get it, I'm not gonna' waste my time.

While this was not generally accepted as a sign of CWD among participants, the literature does recognize this as a correlation to both burn out and PTSD (Elisseou, 2023).

For many it wasn't as much of a specified time period, but an event --a moment of realization-- or series of incidents that created a visceral moment of awareness. It was this repeated pattern of events that contributed to the moment of incredulity: what they believed to be a role that would contribute to the betterment of healthcare overall, was in fact a sense of helplessness to change a giant ship adrift in systemic failure. Molly shared that, "I didn't hit a wall, but I could see where that wall was coming because the position was going to be squeezed between two sides that were saying two very different things with no trust."

Deb claimed how CWD, expressed as moral injury, contributed to a moment of insight,

> I didn't burnout in the beginning at all. It was, and it's hard to say this without saying it, it was experiencing the real hypocrisy and corruption that is behind some of the financial issues discussed at the highest levels inside of health systems that really rubbed me the wrong way. …when I was in one health system I was privy to very large, very secret, hidden bonuses that some of the executives could get. I was being lured by those in order to get in line and drink the Kool-Aid in a way that did not feel comfortable to me. It was the first time where I realized I could not become a complete yes woman just for a very large sum of money.

Ron had a similar experience, his was represented as an erosion of leadership confidence over time,

> The earliest instance that I felt motivation or energy declining is when I realized that healthcare, in general, is run by leaders who don't have a clue. When I realized that the people at the very top really just care about their bonuses and don't really give one iota about the care that patients are receiving.

While Lauren started her own healthcare company, she remained in clinical practice and felt the overwhelming sense of sexism and incompatible expectations by executive actions that contributed to her leadership fatigue,

> A male that could be married with a supportive wife that's at home. I was going through a divorce when I built this company. I'm a single mom with two small kids. I was still clinically practicing, plus trying to run the company and so for me, the first signs of the burnout was 'I just don't know if I can keep all of this above water.' And I think particularly for women, there's no infrastructure that supports all the other demands that we have because of really it comes down to like usually taking care of children.

This was a similar experience to Sharon, who was expected to return to work just weeks after a medical procedure.

For Aimee, it was the day-to-day incidents of prolonged and repeated CWD, along with the realization that no matter what she did, there was no beneficial outcome:

> Day-to-day and I had no confidence that I would get support from the senior leadership because I really wasn't the captain of the ship. And I think that's where I felt like nobody was listening, whereas clinical practice, in your practice or in the OR or in the office, they were all there to support me so that we all did the right thing. My team was there to support me, but they were no more visible at the at the executive table than I was. Every time I tried a different approach, it just got shot down and it wasn't just me looking to get shot down. I truly was shot down, no matter how much other acknowledgement and support I had from my peers and below me. It couldn't breakthrough the ceiling above. I wouldn't wish it on anybody. '[I am] coming with a very rational request and you're saying no,' It's a zero-sum game.

Lauren, Sarah, and Deb all shared how the hidden curricula (referenced eight times) of medical school contributes to physician leadership fatigue, "in many ways, clinical work can prepare you for leadership, but it also teaches you the unhealthy habits of pushing yourself too far without putting safety measures in place" (Lauren). Sarah agreed, "there was a constant sense of feeling like you were never doing enough." For Deb, it was one of the big challenges for physicians where "we think we're supposed to have all the answers all the time for everything." Being part of a merger and acquisition left her in a difficult situation, unsupported, surprised, and isolated. The moment of realization came for her who began to note the physical changes as a result of the leadership fatigue,

> It just all came together for me all at once, I was… I sort of took a look at myself. I had become more overweight than I wanted to be, I wasn't exercising and I knew that my long-term health was not going to be great if I stayed on the trajectory I was on, and I liked the idea of being able to move back and be closer to [family], and I liked the idea of doing meaningful work that mattered to me. And it just all consolidated where, I was like, I don't have to deal with these struggles anymore. I can do something and get paid for it that matters. And it just… came together.

Kyle had a similar experience to Deb, the point of realization that this role was not about creating better patient outcomes, but more revenue,

> Like that was not what I did 'this' for. I didn't do this to figure out how to bill and code and write and have my senior partner say, 'if you did like one or two more consults a month, or a week do you recognize that's like $25,000 more in billing?' [Kyle, incredulous responds with] 'what am I? Sandwich board?' you're trying to tell me to go out on the street with a sandwich board? I mean, they [patients] only show up when they need to show up. I don't know how you want me to generate more patients.

Angela's experience resulted from the loss of executive support and autonomy,

> I think for me, the thing that changed my decision to continue this work is when the culture changed and the job description became one of, 'we say jump, you say how high?' and, 'your job is to get the physicians in line at whatever cost.' It's not a bidirectional conversation anymore. That's just not how this is going to work.

The overall and prolonged lack of support is not only a reflection of the many incidents that contribute to physician leadership fatigue but are emblematic of CWD as part of the role and the lack of adequate preparation. Participants did not express leadership fatigue in terms of a timeframe, but a series of events that compounded overtime leading up to a sense that the position, no matter how good on paper, was not meeting their basic expectations of either physician or leader.

RQ 2 *Does inadequate leadership development contribute to CWD among transitioning physicians*

"You work 80 hours a week and you're angry 80 hours a week." (Kyle)

Question two is partially supported, with the lack of formal leadership development noted by all 17 of the participants with CWD referenced 17 times though not by all 17 participants. A majority of participants believed that their previous work-roles, as well as mentors or coaches, helped prepare them for leadership roles, and understood the specifics of leadership (i.e., good,

effective communication, varying the message for greatest impact, and motivation techniques). They were not prepared, however, for the challenges of interacting with non-clinicians, conflicts and unanticipated human behavior, or the slow pace of change in a complex and dynamic environment. Scope creep within the role, for example, was noted specifically by several participants.

Lack of leadership development

Stephen clarified that the leader orientation did not prepare him for the role. This included how to navigate conflicting expectations, the politics of how to escalate things, and how to avoid political landmines. For him, it was the incorporation of the increasing number of tasks or scope creep within the role, combined with the need to adequately deliver a motivating message was a significantly missing piece of development necessary for leadership at the executive level,

> We've heard [of] moral injury, essentially is the misalignment of having to do things that you don't agree with, whether it has to do with your provision of care, whether it has to do with where you're focusing your time and energy, whether or not you've got to do stuff that make you feel makes you feel gross. Just some real basic orientation. I'm just shocked at how little that actually happens.

Sharon recognized that many physicians are promoted simply because they are good at their work, but the promotion came with little training or support,

> It is a really hard job because you're out there trying to figure all these things out by yourself and often times a good clinician who's a nice person, maybe has some leadership skills, but it's often a promotion based on doing other kinds of things.

Jeff's experience mirrored Sharons in that he was also promoted simply because he was good and highly effective at his role. He reflects, it's the classic scenario: "we'll promote you because you're good at your role is very alive in healthcare." He explains further, the sense of frustration that occurs overtime,

> because you just you can't figure out why people aren't following the leader,

> and you default to your worst characteristics to try to motivate them when you think the stakes are high, which I felt like the program was my responsibility… you start being unprofessional because they won't listen. When you're talking nice and calmly and explaining things, they won't do anything. So I guess I gotta kick some ass. That's the snowball turning into the avalanche. You're sitting at the lodge at the bottom of the hill with a hot chocolate, and here [it] comes. It was a complete and utter mess.

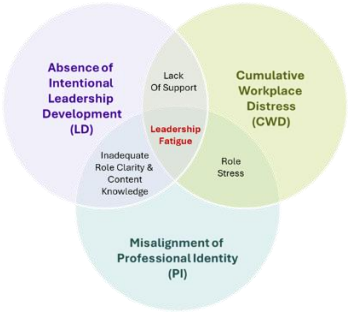
Whereas Helen stated that she felt "thrown into leadership"; from Nancy, "I got nothing."

Unsupported

Most notable, however, was the general lack of feeling unsupported, primarily by executive team members once participants had stepped into leadership roles. It was this intersection of inadequate leadership development and CWD is the idea of feeling unsupported (figure 4). The sense of feeling unsupported was identified 81 times by 14 of the 17 participants, much greater than previous research. Generally, comments related to feeling unprepared to an overall sense that even the executive leadership function did not seem prepared to take on a physician as part of the executive team (referenced as a lack of development 58 times). Sentiments like "I had no idea of what was expected, and in retrospect, I don't think they [executive team] had any idea what I should have been doing either" (Nancy), "figuring out how to how to motivate people to do something that is pretty far away from what they feel is their core duty to their patient," (Stephen), and "you just pick up what works" (Molly) were common themes.

Figure 4

Conceptual framework



Sharon recalled having to constantly defend the business decisions to peers as one of the more challenging instances where she felt a lack of support,

> having no backup or flexibility in the in that in particularly if you're in that situation where you're doing a clinical panel and leadership work at the same time, it is really hard. You're administration is often making these business decisions that have some incongruity with best clinical practices so it can be an extremely isolating thing.

Aimee had similar experiences in attempting to bring important issues to light,

> the executive team wasn't really interested in hearing about how to actually improve the situation, and it was about four months of literally dragging myself out of bed to go to work every day and finally, looking at the CIO and saying if we're going to get any of this done, I need a report to someone else because I can't stay here and keep doing this, so either I need to go, because this is just not working. It was draining. It was exhausting.

Molly felt that she had no ability to make meaningful changes or impacts in her role,

> I could make no progress there. And that felt, that was just it, just felt it was failure. It felt like failure, 'cause it was failure. I was not able to get done what we needed to get done. Obviously, everybody has failures, but this was, this was the situation where you just couldn't [participant reflecting]. It wasn't my problem alone to solve. and yet I feel like I had the key role in trying to solve it, and I wasn't able to. And then it's like then what? It just that felt very, very demoralizing, and I had to continue to have, recurrent meetings with this individual, other folks at that facility, and that felt that was like a piece of my job that I did not look forward to. I wanted it to go away.

The realization for Angela was the moment when she no longer felt that she, or other physicians, was part of the solution,

> [It] feels more like you’re a cog in the wheel and so I think that's the company's decision. If that's how they see this getting through this crisis, that's their call. But that's not something I want to be part of, and so that is the point that made me want to leave. I remember a physician who used to throw things in the ER. He was frustrated because he didn't feel like the quality of care was at the standard that he wanted it to be. Did he want to be someone that was throwing things? No. Did he have work to do? Yes.

Like Angela, Sarah describes a particularly frustrating experience in which her medical decision was nullified by administration,

> I needed this [redacted specific patient procedure] for a case management, whatever overhaul that I was working on that I assigned to, and nope, 'you can't have that'. I asked the question, then how do you expect me to generate these outcomes? If we're not doing this, and you've asked for this, which I did, but then they weren't willing to help hold themselves accountable to it. You know what I'm saying? It just the shell keeps kind of getting pushed around, and unfortunately, it's sad. It's unfortunate, because I think physician leaders that are honest and true to themselves and true to their ethics, I think sometimes just underneath get caught underneath that shell. And it's a hard thing. It is a hard thing, but I've seen it time and time again.

Equally frustrated, Nancy had a similar occurrence in which her medical expertise was questioned by administration, who took it upon themselves to cancel a direct physician order specific to a patient's need.

Among many of the participants the lack of voice or feeling unheard was both a constant state of feeling unsupported as well as a contributing factor to role stress and strain. These were subtle incidents that contributed to a sense a) abandoning physician principles, b) living up to conflicting expectations, while c) being labeled disruptive, which was the experience of Angela. She explains,

> I wanted to be able to have conversations that were meaningful, and it didn't feel like you could. Yeah, I don't know that it's disruptive when the physician that's, you know, being *disruptive* is being cheered on by their colleagues saying, thank you for bringing that up. Thank you for having the courage to speak up. Thank you for making those points.' Just because the points aren't what everybody wants to hear doesn't mean that's disruptive

Role Stress/strain

Role stress/strain was presented as another intersection in the conceptual framework bridging inadequate leadership development and professional identity. While most participants believed that clinician leadership roles had prepared them for leadership, (e.g., leading clinical teams, more), there was a general sense of a *sink or swim* approach, typically demonstrated through role stress and a lack of clear or unrealistic expectations. This is a repeated theme from earlier

research (Lord & Schecter, 2016), which established a set of assumptions that physicians should just *know how to do this*. While leading a team of physicians with a common understanding of work is indeed an important leadership attribute, the shared theme among the participants was that there was not always an easy crosswalk from the clinical to non-clinical role. Aimee struggled with the constant battle of seemingly endless contradictions and demands. Like others she expressed a feeling of being unsupported with limited resources to enable her success,

> You're telling me you want me to optimize all this and the experience for the providers, but you won't let me get them as soon as they come on board, to try to help them personalize their experience and become efficient right out of the gate. So what do you really want? I couldn't get approval to hire additional people even though I was bringing them analytical data to support getting more staff. I remember this conversation, was probably four years in, if I can't get what I need by going back to the executive team and I'm not getting the audience with the team, then I'm going to focus on all the stuff I can do under the radar, and so that was my first step down in hammering at the door to get in to figure out how do we get this done. I reported to the CMO at the time and he called and said I need you to fix this report, and it was a quality report around Medicare penalties. [thinking], OK, let me make sure that they ran it with all the right parameters. I'm happy to dive into that and do some spot checking and I came back and I said the report is right. No, it can't be [indicating from the CMO]. OK, Tell me what you think is this. CMO response, the numbers can't be right. Participant replied with, OK, let me pull another hundred charts and let's look at this. I was being so precise about this and he didn't even want to look at the numbers… it's just wrong. It's got to be wrong. I sat down with myself and I remember journaling. I don't know if I can continue to do this if they're gonna keep asking me to not be factual and real. That was really the first time I wondered, what are they really looking for in a leader? From there, it was kind of this thing by thing and I just felt like I was getting smacked down. I remember at one point I had it out with my boss and I was no longer meeting with the executive team, which had been a gradual thing. And then they let go the two other female VPs. And I was the sole remaining female VP and the sole remaining outsider on the executive team…And I thought, I don't want to play anymore.

Responses from participants demonstrated a consistent theme of feeling inadequate to a complete inability to influence change and even an inability to move projects forward.

RQ 3 How soon will CWD begin to impact physicians in formal leadership roles?

"Its not a person's inability to adapt, its because the job is traumatic." (Sharon)

Like research question one, there does not appear to be a consistent timeline related to how quickly CWD will contribute to leadership fatigue. A repeated theme, however, CWD is a contributing factor to leadership fatigue.

There were numerous themes that emerged through the participant experiences related to question three. These include the overall CWD that results from physician experience transitioning into leadership roles, constantly increasing tasks, boundary spanning, and the feeling of isolation resulting from erosion of collegial relationships and the expectation to manage disruptive physician behavior.

The most prevailing theme in research question three was that CWD was an influencing aspect that punctuated their leadership fatigue. While not all called it out specifically, references were made to situations that required personal sacrifice or cultivating some liability that was deeply against their collective values of caring for patients. As in research question one, it was not a specific timeframe, but compounding results of repeated level II trauma that built up over time. In table five, the researchers present an array of participant reactions.

Regardless of situations presented to physician leaders the constant demands and challenges left few with viable options in terms of feeling successful. For example, in Jeff's perspective it was the relentless CWD that eroded his motivation,

> You start to get into those situations where you are running up against your own values. Right now I have to choose for [redacted] problem. Do I abandoned this situation or do I worry about the optics of the program? Because people might be upset about it and then that will impair my credibility in being able to foster trust and make decisions and get people on board to lead other things.

Table 6

Physician reactions from emerging themes

Participant reactions	Participant(s)
A sense of feeling useless or physician leader was an impossible task	Nancy, Jeff
Feeling pulled in too many directions, an inability to do anything well	Colette
An ever increasing amount of tasks	Stephen, Joshua, Kyle, and Jeff
Never feeling that you're doing enough	Sarah
The message or image is more important that the truth or issues	Sharon and Lauren
Feeling mentally and emotionally torn	Molly
Trust avoidance and having to choose between the work and your own integrity	Joshua, Ron, and Kyle
The hypocrisy of the business of healthcare and health care	Deb, Kyle, and Sarah
Feeling abandoned	Kevin and Ron
Feeling like you're a tool	Kyle
Labeled as disruptive because you want to live your values	Angela, Jeff, and Sarah
Elevated to a leadership position, without wanting your opinion – identified as hood ornaments, baby in the corner, hand them coloring books, eye candy	Jeff, Kyle, Ron
Unnecessary, token leader	Collette
Nobody listens	Aimee

Serving on the Ethics Committee, Lauren noted that even they have limited ability to make an impact on moral injury,

> We do papers all the time, in particular [how] burnout and emergency medicine relates to moral injury because we're constantly asked to practice in a way that is not appropriate for our patients because of the resource limitation of the hospital or the facilities we are in. It puts physicians in a distressed [state], they feel distressed

> because we can't provide the care we want to provide because of these limitations. I feel like I'm not doing a good job, but you're pushing me to do that.

Boundary Spanning

Boundary violations, through boundary spanning, were a specific area of frustration among physician leaders. Consider the example from Kyle, presented as a general expectation was the expectation that he find more patients --as well as the constant demand of documentation-- as a means of generating more revenue, "like that was not what I did *this* for; I didn't do *this* to figure out how to bill and code and write." From Molly's perspective she felt that she was under "constant and increasing pressure to get physicians on board to do thing that were going to generate more revenue, and there was not really any guidance from leadership above me about how to translate that into something that would be meaningful to people when are doing clinical work." She explains further,

> that was definitely in my in my role where I was the medical director for the physician advisory group, that was 100%. I mean that that was that was our role, was making sure that we were recouping everything compliantly. I mean, that was always right, nobody was saying go forth and do fraud, nobody was saying that, but the focus was. It was like 'go make this make sense [of this]' because you know, there's some work that we that the physician advisory group is able do on our end. Fighting denials and that sort of thing, but there was another piece that that we were responsible for, which was getting the physicians in line in terms of how they were documenting and what was being coded and doctors are not trained in how to do any of that.

Angela shared an example of how physicians are seen only as a of cost, considered to be part of the boundary-spanning challenge felt by physicians,

> some of the medical directors put up a pie chart and it was about the costs attributable to the system. And the biggest part of the pie was about 40%. And they said as you can see, the biggest cost that we have is you all and I was like, 'yep, and we make 100% of the revenues so what are you going do about the other 60%?

Conflicting and competing demands

The constant and increasing demands, often unrealistic and/or conflicting tasks was addressed by Joshua, Stephen, Jeff, and Kyle. From Joshua's position this manifested through the endless need to function in an ambiguous state,

> You had to lead. You had to motivate. You had to console. You had to inspire. You Had to call out about their best nature. You had to, I mean, probably the most powerful tool in that situation is actually admitting that you know you're not doing your best. You're doing what you can and being really transparent about it, but you know, that's true leadership.

"Differing priorities – taking care of the patient vs taking care of the business. These are two completely sets of conflicting expectations." From Kyles perspective, he continues,

> No matter what we do, if you're taking care of people or you're an administrator taking care of providers or health plans, we're all privileged to be able to help improve the life of another human being, and I think if we lose that lens in the processes where, we get lost it's all just about bottom line stuff, and when physicians sense that they are turned off in a heartbeat. Considering I know that salary's are published, so we have a pretty good idea [what administrators] are [making]. I don't know many doctors, maybe some surgeons that makes seven figures.

Like Sarah, so many physicians (clinicians and leaders) from within the literature and anecdotally, express their frustration related to the increasing task that is associated with the intensification for more effective charting.

> … it is the business model and I think this idea that it's that way all over the country, but I think it's also the documentation integrity, the billing integrity, like you have to go through your box and like someone's telling you documented wrong and you're like, I'm pretty sure it's in my note like just not the way you wanted it. Like sure, change it. I don't care, but don't make me go back and change it.

In addition to the constant documentation demands it similarly represents the internal conflict experienced by physicians for having to discipline peers, and also mirrors the boundary-spanning demands placed on physician leaders.

Collegial relationships

Sharon shared her experience that demonstrated the constant increase in tasks, the often unclear role of leadership, and the resulting collegial isolation that was often the result of the incongruity between the business and clinical decisions,

> you get in this position of leadership where you have these responsibilities or problems are coming to you that require you to take some of these really hard actions. One of the things that I think organizations do, maybe not deliberately, but people in those roles, the leadership role, can become very isolated. Because you're kind of got one foot in each world, right? You've got one foot in administrative world and you've got one foot in the clinical world and there is a camaraderie, in clinical peers. But you're the administration is often making these business decisions that are that have some incongruity with best clinical practices. …it can be an extremely isolating thing if, for if you do not have the ability to establish a peer group and like one.

Lauren's experience was in the challenge of being clinically respected, but not as a leader in addition to the loss of collegial relationships,

> Where it's the first time where you're responsible for people who are like technically your peers, which is kind of what it's like in all of medicine, right? Like, physicians are really your peers even when you're their boss. So it's this weird thing where you have to have professional respect, but you, you know, like when things are not going right. So you have to also recognize when there's some problems, and in particular we had some residents that were like potentially going be let go from the program when we were there, which is really stressful and I found that it was more the social things that that led to a lot of burnout. Like you have these personal relationships with people and you know you have to make difficult decisions and then it puts you in a very strained social position where you're potentially responsible for altering someone's entire career or life path, and then you still have to interact with all the people who knew them and knew you. And there might be overlapping social and there's things that you're doing in and outside of that professional environment and, I feel like that's like the first example where I was like, oh, I don't know if like, this is worth it and that was very stressful.

Angela experienced similar situations, where the constant tension from the competing clinical and administrative priorities left her feeling exhausted and frustrated,

> We [physicians] find problems every single day. That is, our job is to see the problem and then find the solution and they don't always want the problems pointed out… there [were] a lot of pain points along the way, especially as it related to that.

Deb reflected on a similar experience,

> I identify feeling overwhelmed with when somebody develops, we'll call it analysis paralysis. When you've got so much coming at you so fast that you can't take it all in and you sort of shut down. Bottom line was they just kept doing more and more and more unethical and inappropriate, bad patient care things. And the reason that the health system had me do this is we were trying to get an alignment with these folks. We had an alignment… we had an agreement on paper and I had been tasked with really bringing it together and providing leadership, and it was a… it just kept getting worse and worse.

Boundary spanning, conflicting, ambiguous and sometimes competing expectations, as well as the role stress left participants feeling isolated, uncertain, and generally unsupported in their role as a physician leader.

RQ 4 *How does a lack of role clarity contribute to CWD as physicians transition into a formal leadership role?*

"I had no idea what was expected, and in retrospect, I don't think they had any idea what I should have been doing either" (Nancy)

RQ 5: *Does a lack of role clarity contribute to leadership fatigue as physicians transition into a formal leadership role*

"We were less affected by [a] cancer [diagnosis]" Jeff

Research questions four and five both assessed how and if role clarity had a contributing influence in CWD and leadership fatigue overall. Several participants revealed that physician professional identity, a significant component of the conceptual framework, was a source of overall stress, frustration, and friction among participants as they transitioned into leadership roles. Peter expressed that in comparison to being a physician, the work is very clear. For example, ordering tests, the work of leadership, however, is very oblique. From his experience,

one of the greater challenges of leading outside of the clinical context was the differing timeframe between physicians and non-clinical staff. Molly's experience left her feeling like there was always something to learn as well as a feeling of "not having a good handle on my work." Helen was challenged by the realization that she had a foot in each camp: clinical and administrative, and was conflicted by the differing expectations of each. She was conflicted by the faithfulness to the clinical role and the aspiration for administrative success,

> And when you transition into leadership, what I see most often and what was also true for me is nobody sets you up [for success]. So I think the biggest risk is like as a colleague, you can grumble about whatever frustrations you have and if you do that same grumbling as a leader, it's taken differently. It has different weight. You're a colleague and the next day you're a leader, and that shift is really hard.

Role clarity

While role clarity is associated with the panacea term of role stress, it is also specific element of professional identity overall. As such, the researchers have identified this as a separate component part of understanding the physician lived experience. Next to the lack of support, noted 58 times, it is an equally notable finding overall; a common theme identified 29 times by 15 participants. Affinity themes associated with role clarity were professional identity, referenced 22 times, and lack of support, noted 18 times.

Aimee shared her experience, the realization that as a physician leader your work is lacks credibility, while like Helen conflicted by fidelity and aspiration,

> the realization that you come to the executive table and are no longer in charge or have any influence - that was probably the hardest set of work I had to do in building that practice and then coming out of, of consulting with what I thought was a great education on people, skills, and listening to the client…and understanding the pain and hearing all the angst from the physicians that I was working with.

Angela also experienced the frustration of the identify challenge, "[its] separate roles, not part of the solution: I think I've had, you know, it's a little more natural with a physician maybe because you already speak a similar language."

Common language is a significant aspect of professional identity. Language is more unifying than any other aspect of professional identity. The lack of common language created further erosion or shared meaning through the *us and them* mentality, creating an even greater divide between physicians and executives leaving the physician leader somewhere in a grey area. While executive teams have a common language among themselves, they also have a tighter bond through their own set of common experiences, with the physician leader left somewhere in the middle. Aimee's left her having to navigate the tension induced-challenges as she became a clinical-administrative translator,

> I had to work through getting enough confidence that I brought a solidly thought Through solution to the table, but they didn't want to hear it, so that wasn't a failure of me personally, because I didn't always have the authority to go do where I did have the authority. Oh, believe me, I went and did and ate crow occasionally, but I think for me it was not taking everything personally, which we as physicians typically do right. If there's something that goes wrong. I was captain the ship. It's my fault.

Molly shared a similar encounter; the sensation of feeling stuck between both sides,

> the role I was in, I was expected to speak to physicians and translate things that were coming from the financial side of things. Financially, with the healthcare system at that time, I felt like I was speaking two different languages and then the my role was supposed to be the translator. It's like two different languages, but I didn't speak either.

The dominating theme identified by the researchers overall was a sense of disillusionment the moment of realization that healthcare is a business. The very *business* of healthcare is to make money, not necessarily to sustain the fiscal obligations or enhance patient outcomes (Deb, Ron, & Sarah), but to provide healthcare executives with large bonus' (Deb) and salaries (Kyle &

Joshua). Sarah shared her personal frustration with the conflicting values that are supposedly the same values designed to promote patient outcomes, but are frequently not rewarded,

> [there] were the times I think, that somebody's internal agenda in that Nonclinical space in that leadership role was, was pushing things so out of whack that I felt that didn't align with the values or mission of the organization and delivering patient outcomes. I mean, that's why we were there. If I'm brought in to help in decision making, and by no means did I know everything, but I know my clinical and I know what's going to impact, I'm going to connect these dots. And if something doesn't make sense from an outcome standpoint, you know, I, yeah. So that, that, that value, you felt that your value was impacted with that, but these, these nonsensical, purely business decisions sometimes were very hard to digest.

Deb's struggles arose from the hypocrisy of healthcare; the non-equivalent, yet coexisting models within the current system: the business of healthcare vs. the healing of healthcare. Her challenge presented as a conflicting narrative about patient care,

> for me it was seeing how things were coded and spoken about publicly as if they were about patient care. And I'm not talking about, of course, how businesses are run, you know, you've got to make profit. I'm not talking about those basic levels, but I'm talking about the personal profit and the hidden huge dollar amounts that in some health systems were flowing to the top executives and that hypocrisy of making it about patient care publicly but privately, it was all about certain personal monies.

The awareness of a competing set of values among healthcare leaders was perhaps the greatest incidence of CWD as expressed by Joshua and Ron. In an emotional expression of his leadership journey, Joshua laid out his experience overall. His recognition encapsulates the combination of CWD, constant demands and boundary spanning expectations, combined with the specific challenges of moral injury and misaligned values,

> I struggle with not-for-profit health systems where the executives are making Millions and millions of dollars. And I'm not saying that they shouldn't make a lot of money. It's really hard work. It's based upon certain factors, but you know you make 20 million bucks in healthcare and you're beating people up and you're laying people off and you're talking about quality and cost and you're raking in 20 million plus your other stuff. Is there integrity in that?

> It's not getting better; that's part of what still drives me to leadership is that realization that I haven't really done the thing that I set out to do, which was to make people have better health and a better experience in healthcare and I haven't done it. I've helped individuals - a lot of them. I've helped a lot of people, but globally?
>
> …it pisses me off because nobody in the corporate world of medicine wants to hear it. And they talk about access, they talk about quality. They talk about all this crap, right? And we do all these little things, and we don't make it better. In fact, we put in all these little tools and we push this work to the patient, this work to the doctor, and this work to somebody else and it just continues to degrade an experience that at the very, very core of it, medicine is a very human problem.
>
> It is about people interacting and communicating with people. There are a few Studies that came out that at least the early part, it's probably changed because artificial intelligence has already probably learned to be like us, but early on they were saying that AI generated responses were more empathetic than physician-related responses, probably because they're not… they haven't been challenged and burned out and have you know, compassion fatigue yet. But we'll teach it that.
>
> It's a choice that isn't a bad choice. And it's not comparable. And I have a huge issue when you're looking to take 20% of healthcare dollars and put it in an investor's pocket because all that means is people are not getting everything they need and just look around, you know, look at how many people are uninsured. And yet they stand up there and they talk about servant leadership and values and all this crap. And you're sitting there thinking, well, that's BS. In fact, an organization [redacted], the staff would very, very often come - even high level staff -and say, "how is it that the King and Queen don't understand that they're not wearing clothes?" And that was a common theme in the organization, which is really sad because they didn't, they wouldn't believe what they didn't want to believe.
>
> The organization was fear-based. "Well, it can't be fear based, even though there's data to show it. Well, it can't be that." So you argue with the data, you make a different argument, you do something else. That's the stuff that drives me crazy is the disingenuousness. But if you look around, if you look around really, really successful CEOS in the healthcare industry, you're going to find more narcissists than servants.

Likewise, Ron shares a like experience coupled with a comparable emotional response,

> It's maddening. I mean it's… and I'll say this is probably snobbery, [but] I'm going to be quite honest, but it is position snobbery, but I'm going say it anyways …my CEO… every CEO that I work for could not have gotten into medical school and could not have gone through medical school. Period. Full stop.

> So maybe it's my disdain for people who 'put baby in the corner,' because the physicians in that room have a lot to add and if you're merely hiring physician leaders, and I've heard two things: one is if you're hiring them as *physician eye candy* and putting them in the corner and patting them on the head and saying, 'we'll bring you out when we need you to talk to the doctors,' then you're not utilizing your physician as well, and the other term that I've heard is 'hood ornaments.' Because, you know, I think that physicians have a lot to add from, in terms of talking about strategic direction, the financial direction. I mean it… you know, physicians have run their private practices for 100 years. And that, to me, is concerning, because I think that's how we've gotten to where we are today in terms of so much that's broken in healthcare. But that's me and my soapbox. It hasn't just been at one place. It's been at multiple places that I realized that the people that get elevated into that seat, that CEO, COO, CFO position, they're not the people that… they're the people that play the political game, which is part of leadership. And I get it. But I think that we… this system is just…it is incredibly broken. And we have... I can tell you that it's almost like a Banana Republic.

The researchers took note of both experiences and the escalating sense of overall anger and pain from the experiences shared by both Ron and Joshua. Through Angela's lens, the ability for a physician to remove their sense of duty once in the administrative role was difficult to separate,

> I don't think that struggle is recognized by non-physicians. Patients are patients. They are not widgets on a conveyor belt that we are just moving through, right? These are human beings with all the complexities that human beings bring to the table, and to do that well takes time and not like just the drive to produce more and more and more and more and more.

Perhaps Lauren best summarized the results of research questions four and five. Her examination of the current macro-environment possesses a broader question about the ability of healthcare and the business of healthcare to coexist,

> I would say leadership in business is rough right now because of the polarization of the political climate. A lot of people feel like maybe they're pushed or required or doing something that just doesn't jive with their own moral compass. But they have pressure, financially or otherwise, within their organization and company to make decisions that are maybe economically advantageous, but don't coincide with like some of their moral beliefs. I think that I don't know if people are actually even identifying that. That's distressing, but they probably are kind of backed into a corner where they're like, I feel like I have to do this because I

> was hired to, like, perform in this way and make this company function, and we need to be profitable or whatever it is and that.

Data provided by proceeding studies tends to support that leadership fatigue among physician leaders is a simple and unavoidable event. From the participants however, we can draw a different conclusion: that physicians transitioning into leadership roles are experiencing leadership fatigue as result of a variety of emotional and mental responses to a lack of effective development, CWD, and professional identity isolation.

Discussion

Disillusioned. The theme that continued to emerge throughout the data. This was the most notable among the lived experiences shared by the participants; the general reality and difficult truth that healthcare is a business. The overwhelming sense of helplessness at the frustration of being unable to drive real change, feeling set up to fail, unsupported was not lost to the researchers. A sense of feeling that they --their years of dedication, education, and deeply held personal values of care-- didn't matter. Their role as a physician leader was purely an ornamental one. A common refrain from the participants: a loss for a vocation, a calling, that once placed into a role of leader they behaved in manner that somehow defied the very sense of purpose they set out to maintain through patient interactions. It's as if the role exposed the illusion of care or the meaning of care among physicians and administration: unsupported overall. Simultaneously leaving participants with an experience in which they felt little value, outlined in table six. Emotional responses of the physician participants ranged from anger, disbelief, indifference, incredulous, and frustration. These emotions were palpable, even though video interaction.

Table 7

Physician experiences

Experience	Participant
Eye candy; hood-ornament	Kevin and Ron
Sandwich board	Kyle
Getting handed the coloring book	Jeff
Putting baby in the corner	Ron
Just a spokesperson	Sharon
Not respected as a leader	Lauren
Token leader	Collette

Although disillusioned was the overall compelling theme that emerged, there were also significant associations to the several areas within the conceptual framework, notably CWD and lack of support – or a sense of feeling unsupported. Similar to figure three (p. 31) which drew connections from the literature, the researchers drew similar comparison of data from the participants, represented in table seven.

Table 8

Participant data themes

Participant – data themes			
	Lack of support	Role stress	Role clarity
Inadequate LD	58	25	29
CWD	10	2	2
Mis aligned PI	13	7	28

While the lack of support and role clarity did not intersect in the conceptual framework, it was a consistent theme that emerged 27 times.

Across role clarity and role stress, inadequate leadership development maintains a notable presence, emphasizing that insufficient preparation not only deprives leaders of support, but also

leaves them uncertain about their responsibilities (role content) and overwhelmed by associated stressors (systemic attribution). CWD is sharply diminished in the model presented by the current research. It still reinforces the concept that CWD directly erodes physician leaders' sense of security and role satisfaction.

CWD

While burn out, PTSD, and moral injury were all a part of the findings, role clarity and physician identity were more prevalent components of physician leadership fatigue. It is likely that the role conflict itself is an element of CWD. Incidents of profound CWD --that compounds overtime-- erodes self-confidence while creating a sense of diminishing ability to fulfill the job requirements. The idea that highly experienced and valued team members could be brought into a role with little clarity and expectations presents its own challenges, but more distressful was the experience of being mere figure heads, a convenient and expedient person to slip into a role that everyone has come to expect. Interestingly however, terminology like trauma, moral injury, burnout, and fatigue didn't seem to resonate with several of the participants. This is consistent with the participant demographics with only half of the participants noting that they experienced fatigue or burn out as part of their leadership experience. Though what they described is consistent with these concepts. It may also be the hidden curricula of healthcare education blinding physicians to their own emotional needs.

Lack of support

Though several of the participants experienced some type of CWD, most notably moral injury, it was not the most significant contributor to leadership fatigue. This is an interesting finding when compared to the literature (figure five). Overwhelmingly it was a general sense of

feeling unsupported and a lack of role clarity, both the result of inadequate preparation for the role; positioned in the Venn diagram as an absence of intentional leadership development.

Lack of support was by far the most compelling reaction among participants. Figure five shows the visual contrast of the three key factors presented in the conceptual framework: inadequate leadership development (LD), cumulative workplace distress (CWD), and misaligned professional identity (PI), across the thematic domains of lack of support, role clarity, and role stress. This comparison is structured to illustrate the conceptual framework presented by the researchers, the current literature, and the lived experience findings from participant interviews.

Figure 5

Physician leadership dynamics: role clarity, role strain, and support gaps as presented in the research

Figure five demonstrates that inadequate leadership development stands out as the most prominent driver, especially in the dimension of lack of support, which crests sharply compared to other variables. This suggests that both literature and participant testimony converge on the view that insufficient leadership development creates pervasive feelings of being unsupported, a

finding that appears more acute in the lived experience of physician leaders than previously suggested from the current literature, demonstrating a significant gap as well as operational need.

The visual comparison in table five crystallizes a critical finding: while all three variables interplay to shape leadership fatigue, it is lack of structured and sustained leadership development, as well as the resultant absence of support, that emerges as the most urgent and actionable need. This finding bridges the gap between conceptual frameworks in literature and the real, often more intense, experiences reported by study participants. Thus, substantiating the need for comprehensive organizational interventions (i.e., leadership development, succession planning) that directly address support, clarifies physician roles, and proactively aligns the physician identity with evolving leadership expectations.

Misaligned professional identity registers moderately among the three factors, rising closest around role clarity. This demonstrates a subtle but important effect: when the professional identities do not align with leadership expectations, it contributes mostly to confusion and ambiguity about their roles, supporting the current literature around role stress and strain during the clinician-to-leader transition. This is aligned with Kyle's expression of the erosion of self-worth, suggesting that they were nothing but tools. Existing within this phrase is a double-meaning. A tool: an instrument of change which can be wielded out of help or harm. In this context, the participant describing the experience as being the means of getting *disruptive* physicians in line. Tool also has pejorative meaning: someone who is manipulated, suggesting that they are used by others. Regardless, physician leaders are left feeling that their role, their voice, their experiences do not demonstrate value –a repeated expression from previous research (Lord & Schecter, 2016).

Other themes

There were several additional themes that emerged from the participants' conversations. These ranged from systemic attribution and self-blame, healthcare culture, lack of professional voice, and professional loneliness and/or isolation.

Systemic attribution vs. self-blame

The idea of system attribution is specific to internalizing issues rather than recognizing system failures of healthcare as well as ineffective leadership. Issues within the healthcare system are broad, most being systemic in nature with little ability for an easy fix. The researchers suggest that the hidden curricula derived from medical school education internalizes the idea that physicians can solve all problems if they contribute enough energy and resources to the challenge. This has created an expectation that physicians always be in a high-alert status, a significant contributor to both leadership fatigue and CWD. This imposed expectation will take time to unlearn years of experience and hidden curricula that impede the inability to say no as alluded to by Peter.

Further, the endless adaptation undermines meaning without any ability to make lasting change. Physicians in their role as clinician carry the weight of the final decision, yet when seated at the leadership table, their voice carries little weight. This is another consistent theme with previous research by Lord and Schecter (2016), the inability to feel that they can bring value outside of their clinical role. These are the experiences of the physicians placed into that system of which they had no real knowledge beyond their clinical role and are a direct connection back to the elements of socialization.

The lack of physician development may be connected to an overreliance on system flow. Meaning, the very nature of how the work somehow and someway just gets done, which

diminished the decision input by leaders. The lack of available development could be connected to an assumption that front line workers are too dependent on tasks rather than the purpose of the work.

Healthcare culture

This is a repeated theme from the literature review as well as participant experiences. The overall health of hospitals as well as leadership style should both be noted as contributing themes to leadership fatigue. Physicians in their clinical role are often at the top of the organizational hierarchy, which may have diminished their exposure to the administrative hierarchy that exists within the hospital structure. As stated by Joshua, "physicians are lone wolves."

Among the theme of healthcare culture was leadership style. This was a finding identified in the literature recognizing that leadership style had a direct connection to physician leader burn out. From the participant perspective, the observable and described leadership style was narcissistic and top-down within the executive leadership, a shared experience among participants. This is also supportive through the expression of a limited or any voice within the executive team.

Silenced: lack of voice and isolation

Decisiveness at the bedside doesn't translate well into leadership work. There is often an avoidance of truth in leadership. Any employee who has ever spoken truth to the business executive or administrative team knows they rarely want to hear it. Through their education, residency, and practice physicians are educated to speak truth to achieve the best outcome. Navigating the shift in professional initiative is often contrary to the reality of business leadership. This duality presents a wide chasm that may contribute to the conflicts presented by the participants.

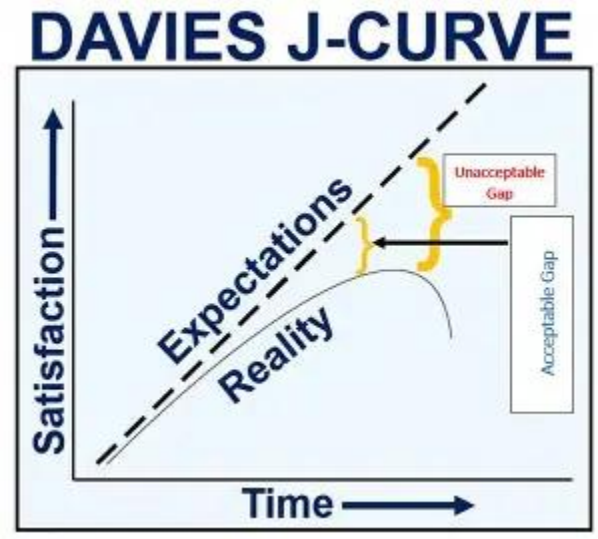
The work content is a missing element of the transition overall. Content specific knowledge is a key attribute to effective socialization, and notably a significant indicator of success or frustration. Misalignment of physician and supervisor expectations contributing to role clarity and mis-aligned identity. This was a relevant finding from Aimee's testimony, demonstrated as the complete lack of content specifics e.g., tactic of a SOW- type approach or a clarity about what physician's need to be most effective at their work. In addition to the role content specifics, this is also a noteworthy connection back to the systemic attribution theme as well as professional socialization.

This is also an additional carryover theme from role clarity and role stress and strain. The idea that somehow physicians can abandon their oath and values once they enter an administrative role is the working definition of moral injury. While a limited theme, participant perspectives indicated that their clinical voice and education were not just ignored (Nancy & Sarah), but physicians often experienced a sense of punitive retribution for dissenting (Aimee, Angela, Jeff, Kyle, & Molly). Finally, the sense of isolation that occurred from being abandoned by colleagues in tandem with a feeling of not being accepted to the administrative team, left participants feeling that they did not belong to either role. The accountability physicians place on themselves is further intensified in their leadership roles. This is deep accountability that can further drive the disparity of role identity.

When physicians are asking others about their "exit [from practice] strategy" (Helen), it is indicative of a larger problem. It discounts the perspective of an entire profession that is experiencing some type of CWD. The Davies J curve, (figure six) referred to by both political scientists and sociologists, is a theorized human condition. It explains that as the gap widens between acceptable realities while a system fails to meet expectations, humans will take control of the situation as the gap widens.

Figure 6

The Davies J-Curve



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https://www.bing.com/images/search?q=j+curve+political+theory&form=HDRSC3&first=1

An interesting and important point of consideration is that organizational behavior, or the collective culture as expressed by employees, is comprised of five social sciences: political science and sociology being two of those. At what point does an entire population of healthcare professionals simply take control as the expectations continue to erode while CWD expands.

Physicians are accustomed to role clarity in their medical practice, this is not always the case in management roles. This is a theme that points to the overall sense of loneliness, isolation, and disillusionment experienced by many.

Recommendations

Physician leaders are not getting the tools and resources they need to function at the executive level. Existing within the executive level is a managerial-hubris pointing to the need for physicians to change, but not administrative leaders. While physicians are often labeled *prima*

donnas, it's the administrative team that has demonstrated an unwillingness to change. This requires an in-depth look at how the executive team is socialized with an intent to assimilate a physician leader. In table eight the researchers provide a concise approach to practical recommendations.

Table 9

Recommendations

Recommendation	Summary/intended impact
Role readiness for the entire team	Ensure all team members (not just physicians) understand the physician leader's role; addresses systemic lack of leadership development across the organization.
Ethical case studies	Engage physicians in leadership with real-world, value-challenging scenarios to stretch beyond clinical experience and deepen ethical reasoning.
Leadership development opportunities beyond secondary degrees	Offer development experiences (e.g., succession planning, role preparation) that go further than graduate degrees to build practical readiness for system leadership.
Coaching and/or mentoring	Pair physicians with experienced mentors or coaches to navigate new roles and foster resilience and effective practice.
Differentiate non-clinical from clinical team leadership	Teach skills for leading cross-functional (often non-clinical) teams—distinct from the dynamics of clinical hierarchies.
Decouple hidden curricula from leadership assumptions	Challenge the myth that being a physician means having all the answers; develop leaders who are collaborative, humble, and realistic about what's possible in complex systems.
Content-specific, role-based preparation	Deliver concrete training and information tailored to the precise leadership role, reducing ambiguity and stress.
Change the story: change disruptive to distressed	This research offers a new perspective in how and why physicians respond to moral injury, through a response that takes into account the fine line that many walk day after day: saving lives while being expected to generate more revenue. The researchers propose a new term *disruptive* physician behavior to *distressed* physician behavior, which more accurately portrays the challenge of living their values and physician oath.
Relationships matter	Beneficial to anyone in any organization would be better alignment with Leader Member Exchange theory, balancing the need for relationships with task orientation. Specifically for the purposes of transitioning physicians would be increasing the executive team relationship better socializing physician leaders into existing teams.

Finally, the importance of hiring executives who possess an adequate understanding of physician's executive role and requirements are critical.

Additional research

Much of the existing quantitative literature on physician leadership fatigue and role transition uses large, heterogeneous samples, often pulling from survey-based data that may dilute context-specific nuance. However, several studies were homogenous (i.e., from one hospital system, similar culture) that may result in parallel findings from participants sharing a similar experience. Further, results trend towards generalizability missing the lived experience and emerging complexities of human nature, motivators, values, etc. The qualitative nature presented by the researchers provided interview-based responses that delivered context-rich, emotional findings. It is also possible that due to the more possibly homogeneous sample, missing elements of distress, identity loss, or organizational culture friction were highlighted with greater intensity. The dramatically smaller CWD results may point to the assumption that burn out is the most pressing theme, therefore creating a continuing reliance on burn out as a cause rather than a symptom. Thus, a propensity of literature with skewed results. Table nine outlines significant gaps in the current literature as a result of this research. The missing albeit important elements of research should be examined further to more fully understand and appreciate the development needs of physicians.

The researchers present figure seven, a comparison of the two radial graphs (presented previously in figures three and five) that assess the findings from the literature versus what was discovered in the research.

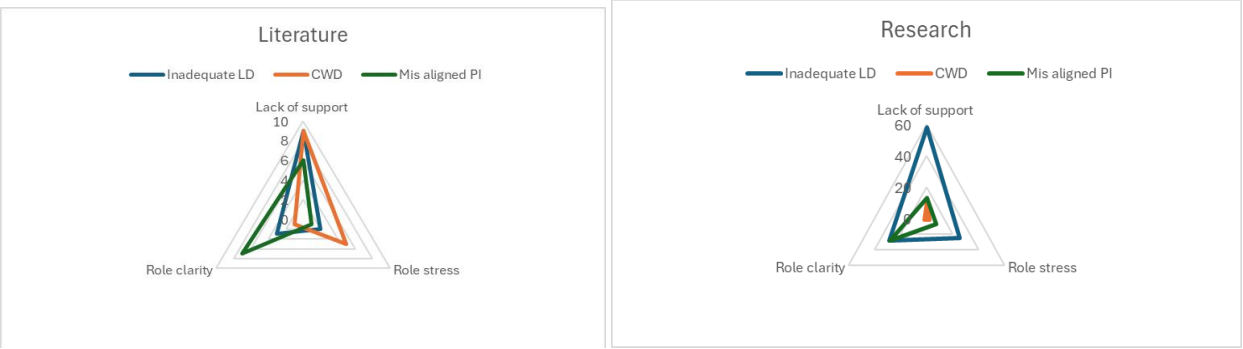
Table 10

Current research gaps

Role clarity	Though a nuance of role stress, participants noted a greater need for role specific content often missing as they transitioned
Lack of support	The lack of support demonstrates how the lack of cultural and role context erodes for physicians transitioning from clinician to leader How do microcultures as well other variables (e.g., the presence or absence of peer mentoring, hidden curricula, or gender dynamics) shape outcomes differently than the generalized
Professional identify	Currently there is very limited scholarship into the profession and the physician identify contributes to CWD.
Learning support	Quantitative studies may treat leadership development as a fixed, deliverable intervention, rather than a dynamic, interactive social process, not dissimilar from a Likert style learning evaluation that fails to measure behavior change over time.

Figure 7

Physician leadership dynamics: role clarity, role strain, and support gaps comparison



There are several questions that surfaced from the research. First, there appears to be a precipitous decline in the role stress and strain literature related to physicians in favor of burnout, making the latter more of a cause rather than a symptom of something larger. From a theoretical perspective researchers should continue to evaluate the responsibility of role stress and strain specifically as it relates to transitioning physicians. Secondly, a broader and ethical appraisal of the work of healthcare and the business of healthcare and related compatibilities. In addition to

the ethical and larger ramifications of continuing to reduce the physician pool through constant leadership fatigue?

From the empirical perspective, several additional questions emerged:

1. How does CWD impact an emotionally intelligent physician leader. Is there a discrepancy between the life and death decisions physicians make clinically versus a different emotional impact on purpose driven effective delivery of healthcare operations. The physician leader does not seem to want to disconnect from that responsibility.
2. Which specific elements of CWD most contribute to leadership fatigue overall?
3. What does a lack of support of feeling unsupported look like, sound like, feel like? How do we more clearly define it and correlate it to specific leadership behavior?
4. How do varying degrees of individual emotional intelligence (self-awareness) highlight or worsen with adequate development?
5. Do physicians with a business degree (i.e., MBA, MHA) have a different experience than those who do no or have a more holistic degree (i.e., leadership)?
6. What is the efficacy of a mixed physicians and administrative cohort better prepare physician leaders prepare for the business of healthcare?
7. What is the role of ambiguity among physicians and how they transition into leadership roles?
8. Should role stress be considered a component of CWD.
9. Is there a correlation between role clarity and a lack of support.

Implications

This study provides compelling evidence that leadership fatigue among physician leaders is chiefly a product of systemic gaps, especially unclear organizational roles, insufficient

development support, and persistent identity dissonance. These findings highlight the necessity for healthcare systems to move beyond piecemeal interventions and invest in comprehensive, ongoing leadership development, tailored integration, and cross-disciplinary mentorship opportunities. Importantly, the results also suggest broader applicability: any high-stakes professional sector where content expertise is presumed to translate into leadership readiness may benefit from a critical reassessment of development and support paradigms. By better understanding of systemic and cultural contributors to leadership fatigue, this work offers actionable pathways for both healthcare and organizational leaders seeking to reduce turnover, increase engagement, and retain top talent.

Limitations

This research utilized a small, self-selected sample of U.S.-based physician executives, which may limit the generalizability of findings to other healthcare contexts or national systems. While qualitative methods enabled deep, contextual exploration, all data relied on retrospective self-report, introducing the potential for recall and self-presentation bias. The absence of observational or longitudinal data further constrains assessment of causal mechanisms or temporal dynamics. Finally, as with all interpretive studies, researcher assumptions, relationships, and prior experience may have influenced data collection and analysis despite measures taken to enhance reflexivity and rigor.

There is an expectation of generalization within research, broadly understanding and impacting a variety of professions that will benefit from research findings. It should be noted however that the literature for this study included a variety of studies from across continents. Thereby potentially limiting the generalization with an assumption that education and experience among healthcare professionals worldwide shares a common experience.

Conclusion

The researchers began this investigation with an intent to better understand a timeline of physician leadership fatigue. Examining how inadequate leadership development, CWD, and misaligned professional identity contribute to physician leadership fatigue, the most notable findings arose from physician responses, specifically, a lack of support and role-related stress.

The current body of literature exposes where the quantitative literature risks mis-characterizing, underestimating, or oversimplifying physician leadership fatigue. Further, it has exposed a significant need to better understand what physicians are experiencing, a missing element in quantitative research alone in addition to the significant missing elements of research around leadership development needs.

This research highlights unique qualitative dimensions, the lived experience of isolation, role ambiguity, and emotional strain, suggesting that effective solutions require more than individual resilience training; they demand systemic change. Future inquiry should further dissect how microcultures, emotional intelligence, and tailored development pathways impact physician wellbeing and retention across organizations.

Disillusionment, found to be a predominant theme, brings additional light to the findings: the disparity and paradox of the care versus the business of healthcare. Thus dispelling a long-standing myth of the godlike complex often assigned to physicians. Whether it be through pop-culture, poorly recorded history, or the hidden curricula of healthcare, physicians and patients alike have lived under the illusion that physicians have a superiority complex. This research reveals that physicians, like all people, possess distinctly human qualities, needs, and emotions

Yet, they remain expected to rise above these needs; it's time to abrogate this outdated model of thought.

Furthermore, findings reveal that within the complexity of transitioning physicians expertise alone is enough for executive success. Recognizing this perspective helps shift the conversation from blaming individuals to questioning systems and organizational assumptions. As we examine this question in relation to the future of healthcare, perhaps it is the physicians that are better suited to lead health *care* through their attributes of vulnerability and values. This would require a significant paradigm shift, dissipating the incongruency in clinical versus administrative roles. Ultimately, addressing leadership fatigue is both an ethical responsibility and a strategic necessity. A failure to act risks eroding the physician leadership pipeline and, by extension, the long-term well-being of healthcare institutions and those they serve.

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Appendices

1. Informed consent

Thank you for your interest in participating in this research:

Understanding leadership fatigue in emerging physician leaders: a mixed methodological study of physicians transitioning into executive level roles

The researchers are attempting to better understand the learning and developmental needs of physician leaders, and if a lack of development contributes to physician leadership fatigue.

I, _____, understand that I am participating in data collection
(Full, legal name)

related to research on Physician Leadership Fatigue. This is a qualitative study that includes a series of questions in a virtual focus group.

The intention of this data collection is three-fold, to:

1) collect qualitative data to further generate insights into leadership fatigue,
2) provide important results to inform leadership development for future and on-going leadership development in or outside of healthcare, and
3) improve learning and development opportunities for leadership development.

Participation considerations: risks and disclosure; data collection and storage

Risks and disclosure:

The researchers are hoping to gain insights into a better understanding of the needs of emerging physician leaders. Furthermore, we are hoping to test our hypothesis related to how and/or if a lack of developmental support, role clarity, and cumulative workplace distress contributes to physician leadership fatigue.

While there should be no physical, mental, or emotional harm in data collection itself, it should be noted that as the primary tool of the research, there may be some emotional and/or mental discomfort in sharing your personal experience.

Data collection:
The data collector(s) will ensure the complete confidentiality and anonymity of all participants by keeping your name and personal contact information separate from the data itself. As part of good record keeping and in accordance with federal law and ethics, this document will be kept separately from the database of information. Participants will be given an alternate identity for the purposes of the final research.

Data use and storage:
All collected data will be saved by the researchers in accordance with federal law for seven years:

- In person interview documentation and survey data will be maintained in a storage cabinet,
- Google interviews will be recorded, using an AI read tool, transcribed electronically and kept on the researcher's business laptop. Recorded interviews will not be uploaded into the cloud or shared electronically within the pool of researchers.
- The AI tool will also be used to conduct "Member-checking" one of the ways that qualitative research is validated.

Consent:

Please initial the following to provide consent and a recognition of understanding of how this data will be used as well as consent to participate at will as a research participant.

_____ I understand that participation in this data collection is of my own free will and choice.

_____ I understand that I am free to leave this study at any given time.

_____ I understand that a part of the qualitative data collection process, I will receive a transcript in which I can edit to ensure my experience is shared correctly, from my own voice and perspective, and I am free to redact any information.

_____ I understand that my name and contact information will be redacted and kept separate and confidential for research related purposes.

_____ I understand that my anonymous data may be given to other members of the study who will participate in data analysis process.

On behalf of the researchers (Lord, PhD; Kodama, MD; and Granzotti, MD) thank you for your interest and participation in this important research. Our collective efforts will be part of ensuring that leaders in any industry receive a more positive experience. In addition, this work will help to produce a Physician Leadership Success Framework, supporting aspiring physician leaders.

Researcher contact information:

You should feel free to contact any one of the researchers should you have any questions regarding the research process.

Primary Researchers:

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Supporting researchers:

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2. Demographic information

Gender		
Female	62.5%	
Male	37.5%	
Avg Age	57	
Degree		
MD	94%	
DO	6%	
Add'l Degree		
All Degrees	75%	
MBA	50%	
MBA +	13%	
Other	25%	
None	25%	
Specialty		
Medical	81%	
Surgical	19%	
Avg Yrs - Clinical	20	
Avg Yrs- Leadership	18	
Lead-During Training	56%	
Burnout		
1st Role	56%	YES
Avg Mos	46	includes highest (312 months) & lowest (2 months) responses
Avg Mos-adj	14	taking out lowest and highest
Current	31%	YES none of the current roles are also 1st leadership roles
Avg Mos	8	includes highest (24 months) & lowest (1 month) responses
Avg Mos-adj	5	taking out lowest and highest

3. Research questions

1. How did your prior clinical experience prepare you (or not) for leadership demands?

2. After transitioning into your leadership role, describe the earliest instance when you felt your motivation or energy to lead began declining, if applicable. What factors contributed to this?

3. How did your ability to guide or inspire your team change in the first 12-18 months of your leadership role? What was working well and what specific challenges emerged?

4. Can you recall a moment when you felt that your leadership responsibilities were becoming unsustainable? What events or conditions led to this?

5. What leadership tasks or situations felt most overwhelming? To what do you attribute this (e.g., lack of training/formal preparation, etc.)? How did this affect your emotional or physical well-being?

6. Did you receive mentorship and/or formal training? How did the presence/absence of mentorship or training influence your sense of control over workplace challenges?

7. Describe a time when you felt un/supported in resolving a conflict or crisis. How did this impact your stress levels? Conversely, please describe a time when you felt adequately supported and how this impacted you.

8. If applicable, when did you first notice symptoms of emotional exhaustion or detachment? What were the specific triggers, if any? What were effective coping mechanisms for you?

9. What organizational or interpersonal factors, if any, accelerated your experience of workplace distress?

10. How did your job satisfaction evolve in the first year of leadership? What milestones marked this shift?

11. Describe an instance where unclear expectations about your role lead to conflict or inefficiency. How did this affect your stress?

12. How did ambiguity in decision-making authority impact your ability to lead effectively?

13. What strategies did you use to navigate role ambiguity, and how successful were they in reducing fatigue?

14. What resources or support systems (if any) mitigated your transition challenges?

15. If you could redesign physician leadership preparation, what changes would you recommend? (What might have better addressed any fatigue or distress you experienced?)

4. Participant focus groups

Focus group	Participant code	Transcript	Pseudonym	Known to each other
1	1-1	1	Collette	No previous relationship
	1-2	2	Nancy	
2	2-3	3	Stephen	Stephen and Sharon had a previous work relationship
	2-4	4	Sharon	
	2-5	5	Lauren	
3	3-6	6	Aimee	No previous relationship
	3-7	7	Molly	
4	4-8	8	Joshua	No previous relationships
	4-9	9	Deb	
5	5-10	10	Kevin	Previous work relationship
	5-11	11	Ron	
6	6-12	12	Jeff	N/A
7	7-13	13	Helen	N/A
8	8-14	14	Peter	N/A
9	9-15	15	Kyle	
	9-16	16	Angela	
10	10-17	17	Sarah	N/A

5. Coded data themes crosswalk

Theme	Sub	framework	RQ #
Disillusioned A sense of helplessness	The business of healthcare is icky Frustration in being unable to drive real change Feeling set up to fail Unsupported - limited resources to enable physician leader to be successful Pick your battles	PI CWD	RQ2
Personal sacrifice & boundary violations CWD that breeds, encourages, or surfaces a great sense of vulnerability	Systemic, not just personal burnout Family/life consequences, unhealthy coping Endless adaptation undermines meaning Narcissism, top-down fear, hypocrisy Terminology like trauma/moral injury/burnout/fatigue don't seem to hit for most interviewees, thought what they describe is consistent with these concepts.	CWD LS RS RC	RQ4
"Sink or Swim" Socialization clarity of expectations unrealistic expectations	Importance of hiring leaders having adequate understanding of what they are needing in a physician leader and their ability to convey that to the physician leader and others - mismatch of expectations Misalignment of incumbent vs. supervisor expectations e.g., tactic of an SOW-type approach (see FG#3, Binderman, #13); what is it	LD RC RS LS	RQ2

	that I'm being asked to do and how do I know I'm successfully accomplishing it (physicians are used to having role clarity in their medical practice, but this is not the case in management roles Translation (multi-fluency) Importance of learning the dialects you need to know in order to translate effectively		
Silencing/Authenticity Threats Identity issue Role confusion Confusing clinical passion w/ disruption Exercising initiative	Awkwardness of managing your peers Viewed by medical peers as having gone to the dark side (talking head) Friction between the need to maintain accountability vs. being liked/placing personal relationships at risk Incongruity when asked to do something that does not align with your values and/or what you believe it right MH: "put baby in the corner", "hood ornament" Decisiveness at the bedside and credibility don't translate well in leadership work Optics shift and seem to matter more with formal leadership (not as much for clinical) - FG#6 Demonstrate initiative to seek out opportunity, take risks and ask questions Accessing training (e.g., advanced degrees, etc.)	PI CWD RC	RQ3 & 5

Loneliness and isolation	Not just ignored, but punished for dissenting Belonging neither in clinical nor admin worlds		
Systemic attribution vs. self-blame	An inability to control or any influence from within the system Hidden curricula	CWD LLD LS	RQ2