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From Clinic to C-suite: Individual burden or systemic failure?

Findings from the lived experiences of physician leaders

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Executive Summary

Healthcare's increasing complexity demands that physician's step into executive roles, yet most are ill-prepared for this transition. Over ten years, two qualitative studies interviewed 33 physician leader participants to evaluate their lived experience as they transitioned from clinician to leader. Evidence reveals that deeply embedded training, socialization, and cultural norms leave new physician leaders exposed to unique stressors, poor support, emotional injury, and rapid disillusionment.

The result: leadership fatigue among physicians is rising, contributors include: a lack of support, professional-identity isolation, and cumulative workplace distress --problems rooted in systemic deficiencies, not individual resilience failures.

INTRODUCTION

Physician leadership is often described as an honor, but for many it also may carry a heavy, unspoken toll. Through multiple focus group discussions with physician leaders representing various healthcare settings, leadership roles, and tenure, a constellation of shared experiences and struggles emerged including but not limited to: misaligned expectations, persistent systemic pressures, identity disruption, and emotional isolation.

1. Disillusionment with the System of Healthcare

- Helplessness & frustration inability to drive meaningful change; feeling "set up to fail"
- Business of Healthcare ethical discomfort navigating financial pressures & organizational politics
- Resource scarcity expectations outpacing available tools and support
- “Pick Your Battles” Mindset foregoing speaking up; resignation as coping strategies in the face of systemic inertia

2. Personal Cost & Boundary Violations

- Emotional vulnerability relentless self-sacrifice and fear-driven expectations are exhausting
- Collateral damage strained personal relationships, poor coping mechanisms
- Invisible fatigue burnout described without naming it --felt but often invalidated

3. “Sink or Swim” Leadership Socialization

- Lack of clarity ambiguous roles and shifting expectations create confusion for physician leaders
- Expectation mismatch hiring executives unclear on physician leader role fuels misalignment
- Clinical vs. Leadership norms clinical decisiveness clashes with leadership ambiguity and unclear expectations
- Exercising initiative physician leaders must create clarity, seek support, and take initiative

4. Threats to Identity & Authenticity

- Loss of belonging straddling roles creates tension and perceived betrayal of clinical identity
- Punishment for dissent speaking up risks alienation or retaliation
- Perception of game playing optics overshadows authenticity & obscures patient focus amid organizational politics

5. Isolation & Moral Dissonance

- Loneliness navigating leadership without clinical peer camaraderie or shared understanding
- Moral conflict asked to act against one’s values or beliefs
- Double blind accountability vs. being liked by peers, neither fully attainable

6. Translation & Systems Fluency

- Code-switching needing to “speak multiple dialects” across administrative, clinical, and executive domains
- Decisiveness mismatch what works at the bedside doesn't translate in the boardroom
- Hidden curricula implicit expectations often go unspoken but heavily enforced
- Self-blame self-attribution for why things are not going well

METHODOLOGY

Data for these findings was derived from semi-structured interviews, focus groups, and in-depth narrative coding with U.S. physician leaders across multiple specialties and roles (CMO, director, executive, and more).

Robust qualitative approaches (open coding, member checking, thematic triangulation) enhance the trustworthiness of findings.

Participant sample:

Gender	Male	22
	Female	11
Age	40 – 49	8
	50 – 59	12
	60+	13
Medical degree	MD	3
	DO	1
Specialty	Anesthesia	1
	Critical care	2
	Emergency Medicine	2
	Family medicine	7
	Surgery	3
	Geriatrics	2
	OB/GYN	1
	Pediatrics	3
	Physiatry	3
	Urology	1
	Immunology	1
	Infectious disease	1
	Internal medicine	5
Years in clinical practice (in years)	1 – 9	2
	10 – 19	10
	20 – 29	19
	30+	1
Years in leadership positions (in years)	1 – 9	10
	10 – 19	10
	20 – 29	19
Current leadership position	Executive (CEO, Pres, VP)	9
	CMO	17
	CMIO	2
	Director	5
Years in current leadership position (in years)	<1 year	1
	1 – 5	22
	6 – 10	7
	11+	2
Leadership or team opportunities in medical school or residency	Yes	11
	No	22

KEY FINDINGS

Key Findings #1

The Clinician-to-Leader transition Is traumatic and poorly supported

- Medical training and residency reinforce expertise, independence, and clinical mastery, qualities that are not easily transferrable to modern, collaborative, ambiguous leadership.
- Most CMOs and physician executives report little or no leadership development, leaving them to figure it out alone.
- Leadership identity conflict and loss of collegial support exacerbate stress during the transition, leading to feelings of isolation and professional impasse.

Key Findings #2

Leadership fatigue stems from systemic gaps, not personal weakness

- "Cumulative Workplace Distress" (CWD), the cluster of burnout, moral injury, and emotional strain, emerges quickly and increases with vague roles, mounting administrative demands, and mismatches between physician values and institutional priorities.
- Most participants noted that leadership fatigue arises from repeated role ambiguity, conflicting demands, chronic lack of support, and loss of professional identity, not an individual inability to "cope".
- Social support is critical: the presence of peer connection, structured mentoring, and executive-level development programs markedly reduces reported fatigue.

Key Findings #3

Organizational culture and role stress are still undervalued

- Hidden curricula and rigid medical hierarchies suppress help-seeking, reinforces stoic coping, and discourages open discussion of emotional distress.
- Toxic, unsupportive executive cultures leave new leaders without advocacy, feedback, or clear authority, resulting in turnover, reduced effectiveness, and intent to leave.
- Burnout is better understood as a downstream product of "role stress, CWD, and culture," yet most interventions still target individual symptoms, not the root cause.

IMPLICATIONS

- Without intentional support, systemic clarity, and tailored development, physician leaders struggle, and so do health systems.
- Burnout and moral injury may be addressed by reengineering leadership roles, socialization, onboarding, interprofessional development, and culture --not just by promoting self-care or coaching.

RECOMMENDATIONS

For Health Systems and Leadership Teams:

- Define roles and expectations clearly for physician executives; formalize onboarding, peer-mentoring, and feedback mechanisms.
- Invest in longitudinal, cohort-based leadership training with a balance of “soft” (influence, emotional intelligence) and “hard” (strategy, finance) skills.
- Address toxic cultural elements: support for dissenting voices, psychological safety, and normalization of seeking help.
- Maintain clinical or collegial connection pathways for new leaders to prevent social isolation and identity erosion.
- Consider co-development and joint leadership cohorts (physicians + non-physicians) for cross-disciplinary empathy and knowledge sharing.

CONCLUSION

Physician leadership fatigue and attrition are organizational --not personal-- failures. Addressing these challenges demands a move away from quick-fix self-help and toward robust system redesign, intentional onboarding, and true cultural change. As health systems face new waves of reform and uncertainty, investing in physicians as both clinicians and leaders is no longer optional -it's a strategic and ethical imperative.

Contact us to request a complete copy of either or both studies, or to discuss strategies.

1. Physician-clinician to physician-leader: Understanding the development needs and practices of aspiring physician leaders (Lord & Schecter, 2016)
2. Understanding leadership fatigue in emerging physician leaders: A qualitative study of physicians transitioning into executive level roles (Lord, Kodama, & Granzotti, 2025)

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