Wellness-Centered Leadership: Equipping Health Care Leaders to Cultivate Physician Well-Being and Professional Fulfillment

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Abstract

There are challenging times for physicians. Extensive changes in the practice environment have altered the nature of physicians’ interactions with patients and their role in the health care delivery system. Many physicians feel as if they are “cogs in the wheel” of austere corporations that care more about productivity and finances than compassion or quality. They often do not see how the strategy and plan of their organization align with the values of the profession. Despite their expertise, they frequently do not feel they have a voice or input in the operational plan of their work unit, department, or organization. At their core, the authors believe all of these factors represent leadership issues. Many models of leadership have been proposed, and there are a number of effective philosophies and approaches. Here, the authors propose a new integrative model of Wellness-Centered Leadership (WCL). WCL includes core skills and qualities from the foremost leadership philosophies along with evidence on the relationship between leadership and physician well-being and distills them into a single framework designed to cultivate leadership behaviors that promote engagement and professional fulfillment. The 3 elements of WCL are: care about people always, cultivate individual and team relationships, and inspire change.

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hese are challenging times for physicians. Numerous, complex factors have contributed to extensive changes in the practice environment that have altered the nature of physicians’ interactions with patients and their role in the health care delivery system. Physicians are increasingly employed by large health care organizations, a fundamental shift from the solo or small-group practice model of the past. The structure of these organizations is also more complex than in years past, often involving large integrated systems with a matrix structure.

A summary of the mindset, behaviors, and outcomes of the elements of the WCL model is presented, and the application of the elements for physician leaders is discussed. The authors believe that learning and developing the skills that advance these elements should be the aspiration of all health care leaders and a foundational focus of leadership development programs. If cultivated, the authors believe that WCL will empower individual and team performance to address the current problems faced by health care organizations as well as the iterative innovation needed to address challenges that may arise in the decades to come.

This evolution has attenuated physicians’ sense of autonomy and control over their work. While most physicians derive great meaning and purpose from their work, many also feel as if they are “cogs in the wheel” of austere corporations that care more about productivity and finances than compassion or quality. Physician performance is now assessed by an array of metrics (e.g., measures of cost, patient satisfaction scores, how quickly they sign notes or answer electronic health record inbox messages) that can overshadow the appreciation and respect of patients and colleagues that has traditionally served as physicians’ main source of feedback. Disturbingly, some organizations attempt to motivate change by relying on tactics that may shame physicians (e.g., posting a public hierarchical “leader” board of these metrics). Such tactics can leave physicians feeling disrespected and micromanaged by a bureaucracy that fails to recognize the nature of their work.

The problem is compounded by extensive regulatory oversight, administrative burden, and other factors that can erode meaning and purpose in work. Physicians have readily identified these and other problems in the clinical practice environment but often feel disempowered to improve the system. Their suggestions often fall on deaf ears with operational leaders focusing on rigid standardization for predictable homogeneity rather than improving quality or service. All of these factors contribute to high levels of burnout and a decline in professional fulfillment among physicians.

At their core, we believe all of these factors represent leadership issues. Physician leaders who ignore these challenges perpetuate misalignment between organizational strategy and physicians’ deeply held professional values, even though these professional values are ones that these leaders themselves typically hold. Despite their expertise, physicians often do not feel that they have a voice or input in the operational plan of their work unit,
Rather than influence. This can lead to and to drive change through authority responsibility to come up with the answers problem-solving role in clinical contexts, making. Additionally, because of their tendency to be overreliant on data, as opposed to leadership decisions and can cause them reliance on evidence for clinical decision care delivery systems and organizations. 31 Most talented professionals in their health leaders are mismanaging some of the most crucial components of leadership in medicine that are not being appropriately invested in the development of senior physician leaders. 36–39 They rarely invest in developing the leaders that have the greatest impact on physicians’ well-being and professional fulfillment—that is, the leaders most proximal to care delivery (or those closest to the physicians caring for patients). 37 These first-line leaders are typically appointed based on their clinical excellence, expertise, seniority, research and academic achievements, or willingness to lead. 38 They often have not been prepared for this role and may have had limited past leadership experience.

Second, physicians’ natural tendencies and professional training can be an Achilles’ heel to being an effective leader. 40 For example, physicians tend to be attentive to detail, and, in leadership positions, this tendency can lead some to be micromanagers. 41,42 Their reliance on evidence for clinical decision making can often lead them down “evidence rabbit holes” when considering leadership decisions and can cause them to be overreliant on data, as opposed to consensus building, in leadership decision making. Additionally, because of their problem-solving role in clinical contexts, physician leaders often assume it is their responsibility to come up with the answers and to drive change through authority rather than influence. This can lead to the mindset that the leader is a great individual surrounded by a supporting cast. 40 When combined with a lack of leadership development and an absence of feedback on their leadership behaviors, it is no wonder that first-line physician leaders often struggle in this role.

Finally, leading physicians can be quite challenging. Leaders of physicians must help oversee and direct a group of experts who are trained to think critically, be problem solvers, have opinions, and demand evidence for decision making. Effective leadership of such a group requires skills that are counter to many of the natural tendencies and training experiences of physicians.

Where Did Health Care Organizations Get Here?

In many respects, this void of physician leadership in medicine should not be surprising. First, developing physician leaders was a low priority in the era of solo and small-group practice or in large academic practice models of the past where physicians were managed with benign neglect that allowed unfettered independence. 34,35 Over the last 1–2 decades, although some health care organizations have invested in the development of senior physician leaders, 36–39 they rarely invest in developing the leaders that have the greatest impact on physicians’ well-being and professional fulfillment—that is, the leaders most proximal to care delivery (or those closest to the physicians caring for patients). 37 These first-line leaders are typically appointed based on their clinical excellence, expertise, seniority, research and academic achievements, or willingness to lead. 38 They often have not been prepared for this role and may have had limited past leadership experience.

Second, physicians’ natural tendencies and professional training can be an Achilles’ heel to being an effective leader. 40 For example, physicians tend to be attentive to detail, and, in leadership positions, this tendency can lead some to be micromanagers. 41,42 Their reliance on evidence for clinical decision making can often lead them down “evidence rabbit holes” when considering leadership decisions and can cause them to be overreliant on data, as opposed to consensus building, in leadership decision making. Additionally, because of their problem-solving role in clinical contexts, physician leaders often assume it is their responsibility to come up with the answers and to drive change through authority rather than influence. This can lead to the mindset that the leader is a great individual surrounded by a supporting cast. 40 When combined with a lack of leadership development and an absence of feedback on their leadership behaviors, it is no wonder that first-line physician leaders often struggle in this role.

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Where Do Health Care Organizations Go From Here?

Many models of leadership have been proposed, and there is a reason why there is no single model of effective leadership or leadership development. 43 There are a number of effective philosophies and approaches. The major schools of leadership philosophy over the last 70 years are summarized in Table 1. We have attempted to harness the key components and contributions of each of these schools along with evidence on the relationship between leadership and physician well-being to construct a new integrative model of Wellness-Centered Leadership (WCL).

Leadership requires a broad set of skills, and some leadership styles may work better in some situations than others. Thankfully, the skills that physician leaders must master to effectively promote the engagement and professional fulfillment of physicians and other highly trained professionals are a limited set that are not predicated on charisma or a certain personality. Some of the key skills and qualities of WCL include inclusion, keeping people informed, humble inquiry, developing individuals, empowering individuals and teams, and focusing on intrinsic motivators rather than extrinsic rewards or punishment. 27 These skills can be learned, strengthened, and developed. The most essential element is empowering, relational leadership that produces outcomes consistent with the altruistic values of the profession. This involves identifying and enabling implementation of improvements that advance the ability of physicians to provide high-quality compassionate care to patients in an equitable and just practice environment.

Foundations of WCL

Our model for WCL is inclusive of the core skills and qualities ascertained from the foremost leadership philosophies (see Table 1) along with evidence on the relationship between leadership and physician well-being and distills them into a single framework designed to cultivate leadership behaviors that promote engagement and professional fulfillment. The 3 elements of WCL are: care about people always, cultivate individual and team relationships, and inspire change (Figure 1). A more detailed summary of the 3 elements of the WCL model is presented in Table 2. Each element is broken down into mindset, behaviors, and outcomes. Mindset focuses on the attitude and intention of the leader, and as Carol Dweck noted, “how they perceive their abilities.” 44 Leaders who show up with curiosity and humility, open to opinions and opportunities, are far more effective at promoting wellness than “experts who think they know best.” 44,45 Behaviors focus on the leadership actions that bring about desired outcomes. Outcomes are interim measures of effectiveness that, when taken together, can lead to cultures of wellness for individuals, teams, and organizations. Specific examples of what the 3 elements of the WCL model may look like in practice are presented in Table 3.

Element 1: Care about people always

At its foundation, and underpinning the success of the subsequent elements, WCL requires that leaders care about people always. This starts with leaders recognizing the pivotal role their behaviors play in the professional fulfillment, vitality, and wellness of their team members. 27,46 Caring about people always is the only reliable foundation on which to build relational leadership skills that inspire individual and team performance.

Leaders must emphasize integrity, servanthood, and seeking the best for people. Caring leaders demonstrate respect, empathy, and curiosity, and they continually seek to understand and validate the complex needs and contributions of individuals and teams. 30,39,47–51
Care about people always begins with caring for self. Leaders who wish to cultivate well-being, professional fulfillment, and vitality in their team and team members must also recognize the importance of nurturing these qualities for themselves. This begins with the fundamental premise that caring for self is integral to performance. Indeed, recent research from Stanford University demonstrates that a leader’s personal level of burnout, professional fulfillment, and self-valuation predicts their independently rated leadership behavior scores, as assessed by the members of their team. In turn, those leadership behavior scores have been shown to be one of the largest drivers of professional fulfillment among members of the work unit. Thus, leaders’ personal wellness impacts their performance as leaders.

Caring for self must encompass attention to exercise, nutrition, health, and rest (e.g., breaks, time off, vacation). Mounting evidence also demonstrates the critical role sleep plays in leadership effectiveness. Studies indicate that sleep deprivation in leaders damages their relationships with their subordinates and also increases the likelihood that subordinates will engage in unethical practices. Leaders’ devaluation of sleep (e.g., bragging about how little they sleep) also appears to adversely impact their effectiveness. It should be emphasized that caring for self is foundationally necessary but, on
its own, grossly insufficient to achieve the first element of WCL. Leaders must also nurture the leadership behaviors that demonstrate they are committed to the professional development and well-being of individuals and have empathy for team members. Empathy for others promotes leadership effectiveness more than cognitive task proficiency—the historical yardstick for entry into medical school. Empathetic concern and capacity for perspective taking drive relational leadership behaviors that inspire change and achievements that go beyond expectations.

Element 2: Cultivate individual and team relationships

WCL also requires that leaders engage in behaviors that cultivate individual and team relationships (i.e., that they nurture relationships with the individuals they lead as well as the interrelationships of the team as a whole). Health care is emotionally demanding work, and health care professionals are dependent on the support of their leaders and colleagues. Physicians work most effectively when they are part of a team that supports respectful relationships and provides meaning and purpose. WCL demands a deep respect for individuals, recognizing that people are both good and capable now (rather than broken and in need of being fixed) and immensely able to grow and improve. Leaders must embrace that the primary function of a leader is to unleash the talent of those they lead and harness that talent to accomplish the mission of the group. To achieve this, they must recognize people as individuals, gain insight into their values, and nurture professional development.

WCL requires that leaders treat each team member as an individual with unique needs, interests, challenges, and ambitions. Leaders should view their charge as investing in and developing that person, nurturing their talents, and directing that talent and passion to serve the needs of the team. Doing so requires an understanding of what motivates each individual, the aspects of their work that bring them the greatest meaning, and their professional ambitions.

Physician leaders have at least one distinct advantage: physicians typically derive tremendous meaning from their work. They approach their work with a sense of calling, which leads to high levels of dedication, commitment, and discretionary effort. This allows leaders the opportunity to harness the inspirational power of why people became physicians in the first place. Indeed, studies indicate that physicians who approach their work with a sense of calling may be at less risk for professional burnout.

Evidence also indicates that individuals who spend at least 20% of their professional effort dedicated to the activity they find the most meaningful are at markedly lower risk for burnout. Thus, a critical leadership opportunity is helping harness each individual’s passion and talents in ways that serve the needs of the team. There are specific organizational needs that must be met and tasks that must be completed. Leaders do, however, have the ability to deploy their team, identify new opportunities, help people develop new skills, and look for ways to optimize fit over time. Even small increases in the amount of time an individual dedicates to activities they find meaningful build alignment and strengthen intrinsic motivation. Such efforts by leaders to optimize career fit also typically make individuals more willing to take on other
Table 2

Summary of the 3 Wellness-Centered Leadership Elements

| Element | Mindset | Behaviors | Outcomes |
|---------|---------|-----------|----------|
| Care about people always | • Recognition of the role leaders play in the well-being, professional fulfillment, and vitality of team members and the team as a whole | • Recognize and appreciate individual contributions and talents | • Team members feel valued and appreciated as individuals |
| | • Curious and respectful | • Give credit | • Psychological safety for individuals |
| | • Empathetic and understanding | • Discover individual needs and gifts through dialogue | • Improved health for individuals and the community |
| | | • Demonstrate gratitude | • Team members believe self-care is valued and is demonstrated through support of reasonable working hours, scheduling, vacation, and time off |
| | | • Discuss and model self-care and self-valuation | • People proactively discuss their well-being needs without being prompted |
| | | • Lead conversations about work–life integration | • Team members help cross cover each other and support one another's wellness |
| | | • Adapt communication based on need (to-coach, to-profession, or needs) | • | |
| | | • Provide resources, support, and education on well-being | • | |
| | | • Recognize signs of distress | • | |
| | | • Role model concern for sleep, rest, vacations, and personal relationships through vulnerable and authentic self-disclosure | • | |
| | | • Listen for what is important to others and ask open-ended questions | • | |
| | | • Demonstrate humble inquiry | • | |
| | | • Practice “agenda-less” listening | • | |

| Element | Mindset | Behaviors | Outcomes |
|---------|---------|-----------|----------|
| Cultivate individual and team relationships | • Deep respect for the individual, recognizing people are both (1) good and capable now (rather than broken and in need of being fixed) and (2) immensely able to grow and improve | • Demonstrate respect for the choices others have made | • Greater retention and engagement |
| | • Each person has a unique career, personal and professional goals, and a path of development that may be different from their leader's or their peers | • Focus colleagues on what they are passionate about (the 20% principle) | • Recruitment is more effective |
| | • Humble | • Help people manage their reputation through respectfully giving feedback and advice | • Each team member's goals are understood, and the leader is invested in supporting them and supports professional development opportunities |
| | • Health care is emotionally demanding work, and health care professionals are dependent on the support of their colleagues | • Help others develop in the way they want (by asking): enrichment (in current role), moving into leadership, making lateral moves, or (when appropriate) transitioning to another profession | • Leader has formal and informal conversations with team members regularly to listen and provide support and guidance |
| | • People work more effectively in respectful and supportive relationships with coworkers | • Help others derive meaning from their work (reconnecting them to purpose) | • Values are aligned between team members |
| | • Being part of a supportive team provides meaning and purpose | • Listen for a sense of calling and aspects of work that bring the greatest meaning | • There is a culture of teamwork |
| | • A leader plays an important role in the cultivation, success, and failures of a team | • Give options rather than directions | • Psychological safety within the team |
| | • A leader plays an important role in keeping the community informed of organizational goals and needs | • Guide others to coach rather than direct | • Sense of community at work |
| | | • Identify people's values (and other sources of intrinsic motivation) by asking open-ended questions | • Higher levels of engagement from team members |
| | | • Help team members recognize their interdependence and the importance of providing support to colleagues | • People feel empowered to engage in collective problem solving without being prompted |
| | | • Develop a collective vision and shared sense of purpose using alignment methodology | • Improved collaboration across the care continuum |
| | | • Lead by consensus and empowerment | • Strong working relationships and collegiality throughout the community |
| | | • Tell stories to create shared meaning | • | |
| | | • Ensure everyone has a voice and is respected | • | |
| | | • Build alignment between people who disagree | • | |
| | | • Align values and norms | • | |
| | | • Advocate for the needs of the community | • | |
| | | • Connect individuals to each other on the basis of shared core values and interests | • | |
| | | • Keep community informed of organizational goals at appropriate intervals and shape communications to align with professional values | • | |
| | | • Promote formal and informal events that allow the community to connect, recognize shared experiences, and support one another | • | |

(Table continues)
tasks for the good of the team since their personal needs have been overtly recognized and respected.

WCL, however, goes far beyond individual development. Leaders must help develop and articulate the vision and mission for the team and guide the process of achieving it. Even if the goals have been prescribed from above, it is important for leaders to seek input from their team in developing the plan for how to accomplish those goals. Further, leaders play an important role in keeping the team informed of organizational goals and needs. This requires judgment to discern what information should be transparently shared with the team and what to shield from or share only intermittently to avoid undermining their sense of purpose and shared values (e.g., avoiding monthly updates on productivity [e.g., number of visits, relative value units, payer mix] relative to the financial plan).

At the team level, leadership that cultivates well-being and professional fulfillment requires attending to the interrelationships among team members to create a shared sense of alignment toward the team’s mission and goals. This includes both relationships between physicians as well as between physicians and other members of the interdisciplinary team. Teams develop their own subcultures. The current culture of many health care teams is characterized by cynicism, commitment to the work but not the organization, and low levels of trust in the organization. The role of the leader is to diagnose the relational health of the team as well as the degree of alignment of the team toward a common mission and goals. Once relational health and degree of alignment are determined, specific tactics can be deployed to cultivate relationships, teamwork, alignment, and a shared sense of purpose.

At the system level, organizations committed to WCL must integrate attention to productivity with concern for people, resulting in efficiency-focused cultures that encourage strong working relationships and make it easy for physicians to provide the care their patients need. Such organizations believe part of their purpose is to provide meaningful work and professional development for their people. The organization’s core values must align with the values of health care professionals, and their actions and behaviors must be congruent with those values. Consistent with these principles, senior leaders must consistently communicate—with their words and actions—the message that the primary purpose of leadership is to develop the talent of their team members, build alignment, and empower the team so the organization can achieve its mission. Although many organizations claim (with words) to have this view, their methods for evaluating leader performance often reveal (with actions) that they actually view leaders’ primary responsibility as enforcing top-down edicts, increasing standardization, and ensuring physicians deliver on productivity targets.

**Element 3: Inspire change**

The final component of WCL requires that leaders inspire change by encouraging teams to think beyond the status quo, empowering them to drive change, and helping them achieve meaningful results. Teams and individual team members should be provided the greatest possible flexibility and control over how they accomplish group and organizational aims. This does not mean that these individuals have unfettered autonomy to deliver care however they want, practice
Table 3
Examples of What the 3 Wellness-Centered Leadership Elements May Look Like in Practice

| Context          | Care about people always                                                                 | Cultivate individual and team relationships                                                                 | Inspire change                                                                                           |
|------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| **Academic context** | Dr. Mary Garcia had been the chair of a busy academic division of internal medicine for 3 years. During a time of increasing financial pressure coupled with shrinking federal grant funding, she noticed several of her faculty were putting in increasingly long hours to write more grants, hoping to keep their labs intact. One of her associate professors, Dr. Glen Whitman, was still at his desk when Mary was leaving at 6:30 PM. She remembered that Glen had been at his desk when she arrived at 8:00 AM. Curious, she stopped and knocked at Glen's open door. Glen looked exhausted, with an open bag of chips and an energy drink on his desk. She asked what he was working on. He explained that he had 3 large grant proposals on his list for submission and was aiming to meet a federal deadline for all 3 in 15 days. He had one grant completed after working extremely long hours on 4 hours of sleep per night for the last week. Mary acknowledged Glen's incredible dedication to his work. She briefly shared her own experience with burning the candle at both ends and the increased creativity and well-being she experienced after prioritizing sleep. She asked whether he felt working on all 3 grants simultaneously was impacting the creativity and quality of each grant? Glen seemed interested and said that what she had described resonated with him, so Mary continued the conversation, asking how his family was doing. He commented that his daughter would leave for college in 2 weeks, as his face expressed the weight of the trade-off he was making. Mary asked Glen if he might benefit from heading home for the day and offered a 30-minute appointment the next day to further think through things together and talk about contingent professional development planning. The next morning, Mary met with Glen to strategize further. She asked Glen which of the remaining 2 grants he felt most passionate about and then asked what he felt the cost would be of deferring the other grant to the future rather than continuing his current work pace. Glen looked surprised and mildly relieved at this line of questioning from his leader. He shared that his concern was having to lay off members of his research team if he did not get at least one grant funded this cycle and that he wanted to maximize his chances. Mary expressed gratitude for his commitment to the welfare of his teammates. She then shared that, in her experience, focusing on submitting 2 finely polished grants may provide a better chance of achieving his goal than submitting 3 grants that had not been optimally refined. After further discussion, she said that his comments from the evening before suggested that he felt the next 2 weeks were also an important time of family transition with his daughter heading off to college. "When you reflect back on this window of time 5 years from now, what do you think will stick out to you as the most important things for you to have focused on?," she asked. Glen replied that, when considered from that perspective, he wanted to make sure he maximized the time he had with his daughter and to ensure her successful transition to college. He also indicated that one of the grant concepts was a bit premature but that he had been pushing it to try and keep the lab funded. After some further discussion, he mapped out a plan to focus on submitting 2 finely tuned grants and be home in time to spend quality time with his daughter. During her scheduled weekly reflection time that week, Mary noted that a number of her faculty were spread thin (like Glen) and that the members of the division seemed less connected to each other. She recalled the mounting evidence on the importance of community and the evidence that regular relationship building habits—even if seemingly stilted at first—can help people cultivate friendships at work. Over the next month, she directed the clinic coordinators to keep the Friday noon hour clear (no patient appointments) and invited all of her team members to attend lunch together, with food provided. Each week the team would either share their perspectives on a reflective question related to their professional experience or identify something they were grateful for that a colleague at work had done that week. Based on consistent feedback from her faculty regarding the growing pressure due to greater clinical productivity expectations and simultaneously shrinking federal research budgets, Mary convened several listening sessions. The sessions allowed faculty to share their experiences in these domains as well as their personal and professional impact. Based on a prioritization of needs by her faculty, Mary launched 2 taskforces. The first focused on strengthening institutional support of the grant writing process and improving the efficiency of submission. The second focused on the evaluation of milestones and timelines for academic promotion in light of increased clinical productivity expectations, which had shifted dramatically over the last decade. The first taskforce, composed of members of the division, developed a best practice guide for grant submission for junior faculty. The guide provided specific milestones for 9, 6, 3, and 1 month(s) before submission. It also involved the assignment of senior faculty not involved in the grant to review and provide input at each of those time points to help strengthen the quality of the grant. The taskforce further recommended divisional support to fund review by a professional grant writer for faculty who had not previously received a federal award. To launch the second taskforce, Mary helped build a coalition of leaders across multiple departments who shared concerns about how increased clinical expectations had made some academic milestones unrealistic without profound harm to work–life integration and personal relationships. The coalition helped draw attention to the fact that these changes had a disproportionate effect on women and junior faculty—an issue that resonated with the dean and other senior school leaders. The taskforce successfully framed the issues and proposed some modifications to the timelines and milestones so that they both recognized scholarly aspects of clinical contributions (i.e., quality improvement, development of best practice treatment protocols, and leadership) and adjusted some parameters (i.e., number of publications and presentations) to account for the 50% increase in time devoted to clinical duties over the last decade. The faculty were energized by the outcomes of these taskforces. They felt that their concerns had been heard and their greatest needs prioritized for action. More importantly, they felt they had been empowered to identify and develop practical solutions under the division's sphere of control. In addition, they were amazed by Mary's efforts to convene a broad coalition of senior leaders from multiple departments to advance an issue of importance to them. They felt inspired to be part of an organization that adapted to the times and grateful to have a leader who recognized and took their needs seriously. (Table continues) |
Dr. Jamal Hanson is the chief executive officer (CEO) of a small Federally Qualified Health Center (FQHC). Before becoming CEO, Jamal had served as the chief medical officer for almost 10 years.

When Jamal was interviewed for the CEO job, he emphasized the need to build a strong sense of community and shared purpose around the center’s mission. An organizational Gallup survey assessing indicators of supportive collegial relationships showed that the organization was a national average, but had been declining for 3 years in a row.

In his new role, Jamal spent one morning a month in the office staff and patient flow. He also spent time in the clinicians’ work areas, where he was able to see how they were delivering care. It highlighted his commitment to strengthening the sense of community for the team as a major reason for his decision to take on the new role.

One of his first actions in his new role was to organize an offsite session for all of the clinicians across all 10 locations. To prepare for the offsite session, he asked each participant to come with answers to 3 items: (1) why they chose to practice at the FQHC, (2) what was important to them as a patient, and (3) an idea on how the team could work together differently to better support patients. The team could see the ideas as ways they could work together to both build connection and better serve their patients.

In the offsite session, 53 clinicians participated, Jamal led the discussion about the shared values and how they aligned with organizational values. The clinicians were enthusiastic about the idea of identifying shared values and a sense of purpose. They subsequently identified shared values and shared how they aligned with organizational values. Also, people were energized by the team’s commitment to discussing values at the offsite session and the extent to which discussing values at the offsite session had energized people.

To address the gap between values and decision making, Jamal asked the organizational development team to set (or reset) the values of the FQHC. They subsequently led an initiative that involved identifying shared values and the extent to which discussing values at the offsite session had energized people.

After the process was complete, 72% of all employees and 68% of physicians reported that they felt more supported in their work at the FQHC.
in a manner that is inconsistent with the needs of patients or other team members, or fail to do their share of the collective work required of the group. Best practices must be followed, adequate access to care provided, equity ensured, and collegiality valued. However, the concept that all variability is waste, that standardization should be pursued simply to facilitate easy scheduling and staffing, or that most aspects of clinical care can be homogeneous and reduced to algorithmic recipes must be rejected. These beliefs are antithetical to the expertise and professionalism of physicians, the complexity of modern medicine, the coexistent health conditions and unique preferences of individual patients, and the different personal life demands and responsibilities of individual physicians. 1,31

Organizations that cultivate WCL primarily rely on intrinsic motivators to drive results rather than primarily focusing on aligning incentives using a carrot-and-stick model (e.g., rewarding physicians for relative value unit generation and high patient throughput). 2,7,9,17,59–61 Intrinsic motivators include meaning, purpose, values, voice, input, control, and professional development. Extrinsic motivators include financial incentives, titles, and awards. Which approach an organization relies on can be determined by their compensation plan, incentives, communication, and what they recognize people for. Unfortunately, many health care organizations have overrelied on extrinsic rewards to increase productivity and enhance performance in spite of compelling evidence that this approach has limited effectiveness. 31 Over time, relying on extrinsic motivators lowers motivation and can transform self-motivated individuals who pursue their work with a sense of calling into disengaged workers who view their work through a transactional lens (e.g., they work to earn a paycheck). 31

The format and structure of team discussions to identify opportunities for improvement are also critical. Leaders should begin by identifying a list of possible areas in which improvement may be pursued and allowing the group to determine which of those areas are the most important place to start. Once the team has identified an area for improvement, the primary focus should be on improvement in that area at the work unit level. 33,66,67 Although it is often helpful to give the group a few moments to identify some of the factors that may contribute to this challenge that are outside of the work unit’s control, dwelling on such factors often leads to a sense of victimization. Focusing on work unit opportunities to drive improvement in a specified time frame helps team members feel empowered and leads to identification of actionable improvement targets. 33,66

Focusing on factors that are under local control that can be altered to improve the work life of team members within the next 3 to 6 months can result in meaningful progress that builds momentum that can then help to tackle more challenging and longer-term objectives.

The Call to Action
Many of the skills and qualities essential for WCL have not traditionally been part of the selection criteria for physician leaders. In addition, evaluation of performance and opportunities for building skills and expertise in these domains has not been the focus of most leadership development programs for health care leaders. To advance WCL, organizations will need to consider the mindset and skills pertinent to WCL as part of the leader selection process. They will also need to consider how they will assess leader performance in these domains and determine which of the elements of WCL may need further development. Training programs and opportunities to build skills in the elements of WCL need to be incorporated into leadership development programs, and studies evaluating the most effective ways to develop these skills are needed. Further research evaluating the impact of WCL on individual, team, and organizational performance would be enlightening.

Conclusions
Here, we propose the new integrative model of WCL. Leadership is a complex set of skills that are required to motivate individuals and teams to help an organization accomplish its mission. We believe the elements of WCL have broad relevance for leaders in many fields but have applied the model here to physician leaders with the aim of addressing the epidemic of occupational distress in physicians. 24,25 We believe that the elements of WCL must be central to how organizations select, develop, and assess health care leaders. Only by attending to these elements can the health care delivery system achieve optimal outcomes for patients, communities, physicians, and health care workers.

Thus, learning and developing the skills that advance these elements should be the aspiration of all health care leaders and a foundational focus of leadership development programs. If cultivated, we believe that WCL will empower individual and team performance to address the current problems faced by health care organizations as well as the iterative innovation needed to address challenges that may arise in the decades to come.

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Ethical approval: Reported as not applicable.

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