Hospitalist Shared Leadership for Safety, Health, and Well-Being at Work: United States, 2022–2023

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We assessed how hospitalists frame workplace safety, health, and well-being (SHW); their perception of hospital supports for SHW; and whether and how they are sharing leadership responsibility for each other's SHW. Our findings highlight the important role of local support for hospitalist SHW and reveal the systemic, hospital-wide problems that may impede their SHW. We believe that positioning hospitalists as leaders for SHW will result in systems-wide changes in practices to support the SHW of all care team members. (*Am J Public Health*. 2024;114(S2):S162–S166. https://doi.org/10.2105/AJPH.2024.307573)

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STUDY OBJECTIVE

Hospitalists, physicians, and advanced practice providers who care for hospitalized patients represent a rapidly growing health care workforce.[1] The hospitalist work model is a central component at most US hospitals, and such providers served as the frontline clinicians during the COVID-19 pandemic. Hospitalist work is primarily characterized as shift work. This work is demanding, frequently characterized by high workloads and high-risk decision-making for patients with complex medical needs. Hospitalists face high degrees of burnout,[2] anxiety, stress, and compassion fatigue.[3] Mazur et al.[4] recently studied the workload characteristics of hospitalists working in academic and community hospitals and found several factors that were related to burnout, many of which are modifiable and represent an opportunity for organizational improvement efforts.

Leadership development programs are widely used to support the well-being of clinicians. These programs are successful but lag in terms of generating system-wide changes that impact workforce and patient outcomes.[5] One method of enhancing leadership development programs in health care organizations is to adopt a shared leadership approach. This may be especially important when training leaders to guide initiatives that center on complex challenges in workforce safety, health, and well-being (SHW). Shared leadership is defined as "A dynamic, interactive influence process among individuals in groups for which the objective is to lead one another to the achievement of group or organizational goals or both. This influence process often involves peer, or lateral, influence and at other times involves upward or downward hierarchical influence."[6(p1)] Inherent in the definition is the idea that anyone is a leader, regardless of their training or whether they hold a formal leadership role.

RESEARCH QUESTION(S)

We posit that hospitalists are primed to lead SHW efforts because of their leadership efforts in clinical care, education, and systems improvement.[7] However, there have not been studies assessing how hospitalists understand SHW at work, their perceptions of hospital supports for SHW, and whether and how they are sharing leadership responsibility for each other's SHW at work.

PARTICIPANTS, SAMPLE, SETTING, AND YEAR OF STUDY

We recruited hospitalist clinicians participating in the Hospital Medicine Re-engineering Network (HOMERuN)

in September 2022. Members are geographically diverse. Because all participants in the September 2022 focus groups held a formal leadership role (n = 12), we recruited frontline hospitalist physicians and advanced practice providers (providers who directly interact with and treat patients) who did not hold formal leadership roles (n = 5) for additional focus groups in February 2023. Participants worked in the US Northeast (24%), Southeast (12%), Midwest (29%), and West (35%).

METHODS

Focus groups and surveys were conducted concurrently. Upon agreement to participate, participants were invited to take a short survey adapted from a similar survey conducted in the construction industry.[8] A semistructured 40-minute focus group guide was then used. We followed a rapid qualitative analytic approach[9] We generated descriptive statistics for the survey findings and used the *t* test to compare responses between leadership roles. More detail can be found in the "Methods" section of the Appendix (available as a supplement to the online version of this article at https://ajph.org).

KEY FINDINGS

Formal leaders generally reported better perceptions of their organizations, teams, leaders, and their own responses to SHW than frontline hospitalists (Table 1). Notably, frontline hospitalists were significantly less likely to report that their team and themselves were engaged in SHW efforts than formal leaders. Several themes emerged from the focus groups (see Box 1). Themes reflected the SHW threats they face as well as actions taken or not taken by their hospital, their leadership, their team, and themselves to protect and promote hospitalist SHW.

EVALUATION, TRANSFERABILITY, AND ADVERSE EFFECTS

Respondents in our study described many threats to hospitalist SHW. Across all focus groups, harassment and violence from patients and their families was the most salient concern. This is consistent with 2021–2022 data from the Bureau of Labor Statistics that show that hospital workers experience nonfatal injuries attributable to violence at a rate of 13.8 per 10 000 full-time equivalents, compared with a rate of 4.3 across all industries.[10] Beyond this, there was variation in SHW threats discussed. Participants discussed how the culture of medicine places health care workers at a disadvantage because it emphasizes care of others over themselves, whether that is patients or not inconveniencing coworkers when sick. Indeed, Trockel et al.[11] found that physicians have lower self-valuation than

TABLE 1— Mean Scores on Shared Leadership Survey Questions by Leadership Role

	In a Formal Leadership Role (n = 12), Mean (SD)	Not in a Formal Leadership Role (n = 5), Mean (SD)
My organization demonstrates commitment to employee safety and health.	3.83 (0.21)	3.60 (0.24)
My hospitalist team leader urges me to assume workplace health and safety responsibilities on my own.	3.75 (0.28)	3.80 (0.20)
My hospitalist team members behave in a way that displays a commitment to health and safety at work.*	4.17 (0.21)	3.20 (0.58)
My hospitalist team members and I spend time discussing our organization's purpose, goals, and expectations for workplace health and safety.	3.67 (0.36)	3.00 (0.55)
I proactively develop and make suggestions for workplace health and safety issues that may influence our hospitalist team.*	4.17 (0.24)	3.20 (0.37)
I see myself as a workplace health and safety leader.*	3.83 (0.27)	2.80 (0.49)

Note. All questions were rated on a 1 to 5, strongly disagree to strongly agree, Likert scale.
*$P < .05$ represents a *t* test for statistically significant difference in the mean scores for those in a formal leadership role compared with those not in a formal leadership role on a specific question.

BOX 1— Quotes That Best Represent Each Theme

Theme	Quotes
Broad theme: Culture of medicine	"There's a culture around working a lot and being very successful. And to do that you needed to work more and more and more." –FG3 with hospitalist leader
Theme 1: The concept of "health and safety at work" is perceived differently across individuals	"It's not something I think about very often, when I think about safety, I think about patient safety and what we are doing there, which is a big part of our job and roles. When I think about physicians . . . the major focus is less on physical safety, although with the pandemic that changed . . . wellness, burnout is something that we have been working hard to address . . .Workplace health is the long-term sustainability to be able to continue to do your job." –FG3 with hospitalist leader
Theme 2: Hospital system resources supporting workplace health are not easily identified by hospitalists and are not perceived to be of high value	"The bigger the organization, the less awareness those with boots on the ground actually have to some of the safety issues; you sort of become the worker bee with trust in the system that things will be taken care of and really only bring it up when they're not because if we have to worry about all our patients and our own health and safety and those with whom we're working aren't giving us that top cover, that's an extra thing, can't devote our attention to patient care or education or research." –FG1 with frontline hospitalist
Theme 3: Hospitalist teams perceive varying degrees of shared responsibility for safety, health, and well-being	"Know you can't run a section of like 80-plus people with one leader, like you need a team of leadership and you need constant development and you need to grow sort of everyday leader." –FG1 with hospitalist leader
Theme 4: Formal hospitalist leaders are responsible for team safety, health, and well-being	"At the bare minimum, I'm a leader on my teams and so it's my responsibility to make sure my teams are safe and I include that my, my students, my learners, my residents as well." –FG2 with hospitalist leader
Theme 5: Frontline hospitalists are unprepared to be leaders for safety, health, and well-being	"Think that maybe like one of the biggest barriers and on top of that too is just the work burden that's put on us. It's like, do we even have the time?" –FG1 with frontline hospitalist

Note. FG = focus group.

workers in other fields. Ultimately, hospitalists questioned the sustainability of their careers because of these concerns. This corroborates findings from Kulkarni et al.[12] that workforce well-being is a top workforce priority for the future of the field.

Hospitalists identified systematic reasons as to why these threats exist. The way hospitalist work is organized, such as staffing levels and workload, was identified as an important driver of SHW. In addition, unlike nursing staff, hospitalists are commonly not attached to specific hospital units and, therefore, are not always included in unit-based organizational SHW structures. Even within hospitalist groups, the structures to support them vary depending on how large the group is, with larger groups typically having more formal support. This demonstrates that there is a lack of clear organizational ownership of hospitalist SHW.

Consistent with literature regarding the importance of supervisor SHW leadership,[13] many hospitalists mentioned that it was important for their formal leaders to support SHW initiatives. However, hospitalists would benefit from a layered leadership approach in which multiple levels of leadership (formal and informal) collaborate to guide organizations, as 1 person cannot support the SHW of all. For example, any hospitalist can be a role model by taking leave when ill. These findings are in line with the promise of using shared leadership approaches to solve complex SHW problems.

This study highlights the internal conflict frontline hospitalists may face when considering taking an informal leadership role for SHW and the degree to which the notion of shared leadership is still a foreign concept to many frontline workers. We found uncertainty about what defines a SHW leader and the specific behaviors that leaders should engage in, and low awareness that nonformal leaders could guide these efforts. Frontline hospitalists did not feel equipped to serve as leaders in everyday work, which could create discomfort when care teams expect individuals to step up during threats to safety, such as harassment by patients. A similar finding was observed among construction crews. Crew members were less likely to report that they were

leaders for SHW than were foremen. The factors that predicted sharing leadership responsibilities were coworker support, training in SHW, and identifying as an SHW leader.[8]

The strengths of this study included broad geographic representation of participants and perspectives from those in both leadership and frontline roles. The multiple method approach illuminated the complexity of hospitalist perceptions. However, results should be reviewed with caution, as the study sample was small and only representative of hospitalists practicing in an academic medical setting. Results may not be transferable to all hospitalists in all clinical settings.

SCALABILITY

The scalability of this study is available as a supplement to the online version of this article at https://www.ajph.org.

PUBLIC HEALTH SIGNIFICANCE

The hospitalists in this study described work environments characterized by a variety of perceived psychosocial and physical hazards coexisting with limited understanding of who is leading organizational efforts to protect and promote SHW. Hospitalists in a formal leadership role all indicated that they were leaders for SHW, while most frontline hospitalists voiced some hesitancy in leading for SHW. Hospitalists were generally suspicious that the institution aimed to protect and promote their health and, in some cases, highlighted disparities in support. Our findings highlight the important role of local support for hospitalist SHW and shed light on systemic, hospital-wide problems that may impede worker health.

There are several steps that we need to take to advance the SHW of hospitalists and prepare them to take on leadership roles in this arena. First, the complexity of hazards they experience warrants a Total Worker Health approach to systematically consider all health hazards and to collaboratively design healthy work.[14] The first step should be to develop a shared understanding of what Total Worker Health is for hospitalists. All too often, approaches to worker health in this field (and other clinician fields) have focused on the limited scope of burnout and wellness with little overlap into other areas of health and safety.[15]

Second, we need to adapt existing SHW leadership models to hospital medicine and health care broadly. Guidelines for what shared leadership for this looks like for both formal and informal leaders will be important. Finally, we must develop intervention strategies to build SHW competencies among hospitalists generally and specific to shared leadership strategies, including cross-training of teams with overlapping duties (e.g., nursing and hospitalists).

Hospitalists are well-positioned to lead SHW efforts for hospital systems as they direct patient safety and quality.[7] Tools and training are one mechanism to support hospitalist SHW that should allow for skill acquisition to lead change efforts. However, if they are not educated about these issues and given the skills to lead change efforts, they will not be able to advocate systems changes that would benefit all care team members. AJPH

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CONFLICTS OF INTEREST

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HUMAN PARTICIPANT PROTECTION

This research was approved by the Colorado Multiple Institutional Review Board and was deemed non–human participant research.

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